

**BEDSIDE BUREAUCRATS:  
WHY MEDICARE REFORM HASN'T WORKED**

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*Notwithstanding its manifest importance, Medicare is almost invisible in the legal literature. Part of the reason is that administrative law scholars typically train their attention on the sources of external control over regulatory agencies' exercise of the vast discretion that Congress so often delegates to them. Medicare's administrators, however, wield considerably less policy discretion than the regulatory agencies that feature prominently in the legal commentary. Traditional administrative law thus yields slim insight into Medicare's operation.*

*But questions about external control do not—or at least they should not—exhaust the field. An old and often-disregarded tradition in administrative law focuses not on external constraints, but on the internal control measures that agencies employ to shape the behavior of the bureaucrats who implement government programs on the ground. A robust set of internal controls is necessary whenever central administrators seek to align the actions of line officers with programmatic goals. And they are all the more necessary when, as is so often the case in the modern administrative state, it is not government officers, but private actors, that are vested with implementation authority.*

*So it is with Medicare, whose street-level bureaucrats are hundreds of thousands of private physicians with strong professional commitments and no particular allegiance to governmental priorities. Yet Congress's persistent failure to address weaknesses in Medicare's administrative structure has stymied a series of major reform efforts that have sought to make the program's physicians more attentive to the cost and quality of the medical care for which it pays. What is more, similar congressional inattention threatens to stunt the effectiveness of a set of important Medicare reforms included in the Affordable Care Act. To remain vital well into the 21st century, Medicare will have to be refashioned around private organizations with the capacity, incentives, and legitimacy to align the practice patterns of private physicians—its bedside bureaucrats—with federal priorities.*

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## INTRODUCTION

Enacted in 1965 in the teeth of fierce opposition from the American Medical Association, Medicare was designed to cover the medical costs of its elderly beneficiaries while interfering as little as possible with the practice of medicine. So concerned was Congress with limiting federal power that it prohibited Medicare from “exercis[ing] any supervision or control over the practice of medicine or the manner in which medical services are provided.”<sup>1</sup>

Nearly five decades later, however, Medicare’s chief administrator could testify before Congress without fear of contradiction that one of Medicare’s “major, overarching goals” is “reducing costs by improving care.”<sup>2</sup> And indeed, Medicare’s history is littered with the acronyms of reforms designed to achieve that goal: PSROs (renamed PROs, now QIOs), DRGs, RB-RVSs, the VAP (now the SGR), M+C (now MA). Each of these reforms has aimed to encourage cost-conscious, high-quality care—in other words, to control the practice of medicine. And to varying degrees, each has failed. Runaway spending and shoddy medical care continue to plague Medicare. Now, with the 2010 health-care reform legislation, we have a new batch of Medicare reforms and a new set of acronyms: IPAB, CMI, PCORI, and ACOs. The future does not bode well for these either.

Explanations for Medicare’s lackluster performance when it comes to cost and quality are commonplace. Congress is loath to curb payments to powerful hospital and physician groups. The warring ideologies of Democrats and Republicans on charged health-care issues bedevil political reform. Cultural infatuation with medical technology and antipathy toward rationing led to the adoption of expensive new treatments, even those of uncertain value. And Medicare’s popularity makes the public, especially politically active elderly citizens, resistant to reform.

But a big and underappreciated part of the problem is Medicare’s institutional design. Here’s the crux of the dilemma. Only physicians have the opportunity, knowledge, and legitimacy to make clinically sensitive judgments about what medical care beneficiaries need and, by extension, what Medicare should finance. And so Congress, in the Medicare statute, put physicians at the center of the program. They judge whether treatments are medically necessary and thus eligible for reimbursement.<sup>3</sup> They certify the need for institutional care or Medicare pays nothing to hospitals, hospices, or skilled nursing facilities.<sup>4</sup> And they diagnose the medical conditions that establish how much Medicare pays for institutional care.<sup>5</sup> Physicians are

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<sup>1</sup> Social Security Amendments of 1965, Pub. L. 89-97, §102(a), 79 Stat. 290, 291 (1965) (amending §1801 of the Social Security Act) (codified at 42 U.S.C. §1395) [hereinafter 1965 Medicare Act].

<sup>2</sup> Statement of Donald M. Berwick before the Senate Committee on Finance, Nov. 17, 2010, at 6.

<sup>3</sup> See 42 U.S.C. §1395n(a)(2) (conditioning payment on physician certification that, “in the case of medical and other health services, ... such services are or were medically required”).

<sup>4</sup> See *id.* §1395f(a)(3) (making payment for “inpatient hospital services” available only if “a physician certifies that such services are required to be given on an inpatient basis for such individual’s medical treatment”); *id.* §1395f(a)(7) (same for hospice); *id.* §1395f(a)(2)(B) (same for skilled nursing facilities).

<sup>5</sup> See *id.* §1395ww(c)(4) (establishing a payment system for inpatient hospital care based on “diagnosis-related groups”).

Medicare's bureaucrats at the bedside. Taken together, their decisions constitute Medicare policy.<sup>6</sup>

A government program's success depends on its ability to align the behavior of the front-line bureaucrats that actually implement the program with governmental priorities.<sup>7</sup> Yet Congress in 1965 crippled Medicare's ability to exert control over its physician-bureaucrats. At every point, Congress indulged the assumption that physician behavior, driven by a professional commitment to supplying medical care without regard to financial considerations, would more or less align with Congress's goals for the program. Any modest misalignment was worth the price of avoiding government meddling in medical practice.

However understandable at the time, Congress's design choice has hamstrung subsequent efforts to assert control over the physicians that actually have the administration of the program in hand. Partly as a result, Medicare outlays have grown at a blistering pace over its forty-eight year history.<sup>8</sup> The United States cannot borrow indefinitely to cover these escalating costs, yet there appears to be little willingness to accept higher tax burdens to pay for them. In any event, the implied tax increases necessary to finance Medicare beyond 2020 are, as Joseph Newhouse puts it, "simply not plausible."<sup>9</sup> The picture is similarly grim on the quality side: avoidable hospital errors appear to contribute to the deaths of an estimated fifteen thousand Medicare beneficiaries *each month*.<sup>10</sup>

Something has to give. Although the regulatory innovations of a single payer, even one as large as Medicare, cannot alone cure what ails the nation's health care system—cost overruns and quality problems are also endemic in privately financed care—Congress will before long have no choice but to confront Medicare's mounting costs. Yet the modern debate over Medicare reform has been strikingly inattentive to the structural infirmities that have plagued past reform. Part of the reason, as Theodore Marmor laments in his iconic book on Medicare, is

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<sup>6</sup> See KARL LLEWELLYN, *THE BRAMBLE BUSH: ON OUR LAW AND ITS STUDY* 12 (1930) ("This doing of something about disputes, this doing of it reasonably, is the business of law. And the people who have the doing in charge, whether they be judges or sheriffs or clerks or jailers or lawyers, are officials of the law. What these officials do about disputes is, to my mind, the law itself."); MICHAEL LIPSKY, *STREET-LEVEL BUREAUCRACY* 16-18 (2d ed. 2010) ("[W]hen taken in concert, [street-level bureaucrats'] individual actions add up to agency behavior.").

<sup>7</sup> See generally JERRY L. MASHAW, *BUREAUCRATIC JUSTICE* (1983) (exploring how the Social Security Administration controls its disability examiners).

<sup>8</sup> On average, the rate of annual programmatic inflation has exceeded GDP growth by 2.5%. See Katherine Baicker & Michael E. Chernew, *The Economics of Financing Medicare*, *NEW ENG. J. MED.* e7(1) (2011).

<sup>9</sup> Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 *HEALTH AFFAIRS* 1, 8 (Sept. 2010).

<sup>10</sup> See Office of Inspector General for the Department of Health & Human Services, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (Nov. 2010) (available at [oig.hhs.gov/oei/reports/oei-06-09-00090.pdf](http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf)); David C. Classen et al., 'Global Trigger Tool' Shows that Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured, 30 *HEALTH AFFAIRS* 581 (2011); see also INSTITUTE OF MEDICINE, *TO ERR IS HUMAN* 1 (1999) (estimating that as many as 98,000 people die each year as the result of medical errors).

that scholars have given short shrift to “Medicare’s programmatic operation.”<sup>11</sup> Administrative law scholars in particular have paid scant attention to Medicare’s central accountability question: what tools do administrators have, and what tools should they have, to encourage Medicare’s physicians – its bedside bureaucrats – to practice inexpensive and high-quality care?

Indeed, Medicare is almost invisible in administrative law, perhaps because most modern commentary is consumed with questions relating to the external control of agency discretion: political and judicial oversight, separation-of-powers dynamics, and private influence on agency behavior.<sup>12</sup> An external perspective on Medicare has sharp limitations, however. Although many regulatory agencies exercise vast policy discretion, Medicare does not. Congress is intensely interested in the minutest details of a program that lavishes vast sums of money on politically important groups in every state and district. Congress’s tight control over Medicare drains the concerns that motivate an external approach to administrative law of much of their urgency.

But administrative law is – or should be – about more than just the external control of agency discretion. Rather, as Jerry Mashaw has urged, “[t]he task of administrative law is to generate institutional designs that appropriately balance the simultaneous demands of political responsiveness, efficient administration, and respect for legal rights.”<sup>13</sup> Systematic accounts of how Medicare’s legal structure enables and (more often) frustrates control over the physicians that administer the program are nonetheless scarce.<sup>14</sup> In offering such an account, I hope to usher Medicare into administrative law, and to build on an old and often-disregarded tradition

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<sup>11</sup> THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 185-86 (2d ed. 2000).

<sup>12</sup> See Jerry L. Mashaw, *Federal Administration and Administrative Law in the Golden Age*, 119 *YALE L.J.* 1362, 1470 (2010) (“Forgetting that administrative law both constitutes and empowers administrative action at the same time that it structures and constrains administrative behavior, administrative law is often thought of as just that set of external constraints that limit agency discretion.”). Timothy Jost’s 1991 article on Medicare’s governance is one of the few efforts to study Medicare through the lens of administrative law – and, in describing how Congress, the President, and the courts oversee the program, it is emblematic of this external approach. See Timothy S. Jost, *Governing Medicare*, 51 *ADMIN. L. REV.* 39, 41 (1999). David Frankford, Elizabeth Kinney, and, more recently, Jacqueline Fox, have also examined discrete features of Medicare, although none have grappled with Medicare’s regulatory structure as a whole. See, e.g., David M. Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 *YALE J. ON REG.* 273 (1993); Elizabeth Kinney, *National Coverage Policy Under the Medicare Program: Problems and Proposals for Change*, 32 *ST. LOUIS U. L.J.* 869 (1987); Jacqueline Fox, *Medicare Should, but Cannot, Consider Cost: Legal Impediments to a Sound Policy*, 53 *BUFF. L. REV.* 577 (2005).

<sup>13</sup> Jerry L. Mashaw, *The American Administrative Law: Federalist Foundations, 1787-1801*, 115 *YALE L. J.* 1256, 1264 (2006).

<sup>14</sup> David Hyman has gleefully cataloged various flaws in Medicare’s design. See DAVID A. HYMAN, *MEDICARE MEETS MEPHISTOPHELES* (2006). And Sallyanne Payton, in a short but vivid piece, grabs hold of two of Medicare’s major structural defects: its reliance on fee-for-service payments and the weakness of Medicare’s central administration. See Sallyanne Payton, *Professionalism as Third-Party Governance: The Function and Dysfunction of Medicare*, in *MAKING GOVERNMENT MANAGEABLE* 122 (Thomas H. Stanton & Benjamin Ginsberg, eds. 2004). But neither Hyman’s nor Payton’s project is to link the failure of major reform efforts to Medicare’s institutional design.

of investigating what Bruce Wyman in 1903 called “the science of common action.”<sup>15</sup> As Frank Goodnow elaborated two years later, “[s]ome method of control must be devised by which harmony and uniformity of administrative action and administrative efficiency may be secured.”<sup>16</sup>

But where Wyman and Goodnow understood “internal” administrative law to concern itself with the relationship between dispersed line officers and the central administration, the present-day dominance of arrangements in which governments enlist private actors to implement public programs requires a different emphasis. Internal administrative law must account for control not only of government officials, but of government’s private agents. In this, an internal approach dovetails with the recent emphasis in administrative law on the contracting out or privatization of governmental functions.<sup>17</sup> There, the central preoccupation is the dearth of governmental capacity to assure that the private actors that implement public programs remain faithful to democratic values.<sup>18</sup> Related scholarship in political science and public administration, led by Lester Salamon and sometimes going under the moniker of “new governance,” has sounded similar alarms about management weaknesses in a regulatory landscape characterized by third-party implementation of government programs.<sup>19</sup> Yet for all the talk of privatization, contracting out, and third-party governance, Medicare—the single largest public-private partnership in the country—rarely rates more than a passing mention.<sup>20</sup>

This article aims to rectify that situation. Part I sketches Medicare as it was enacted in 1965 before turning, in Part II, to the four most significant reform efforts over the nearly five-decade history of Medicare. Each of these reforms has attempted to enlist private actors to oversee how private physicians practice medicine, and each has run aground of Medicare’s flawed institutional structure. Part III argues that, to avoid failing again, successful Medicare reform will have to reshape the program to encourage the development of health-care organizations with the incentives, bureaucratic wherewithal, and legitimacy to adjust physician practice patterns. With this in mind, Part IV turns to health-care reform and the Affordable Care

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<sup>15</sup> BRUCE WYMAN, *THE PRINCIPLES OF THE ADMINISTRATIVE LAW GOVERNING THE RELATIONS OF PUBLIC OFFICERS* 15 (1903).

<sup>16</sup> FRANK J. GOODNOW, *THE PRINCIPLES OF THE ADMINISTRATIVE LAW OF THE UNITED STATES* 371 (1905).

<sup>17</sup> See, e.g., *GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY* (Jody Freeman & Martha Minow, eds. 2009); Gillian E. Metzger, *Privatization as Delegation*, 103 COLUM. L. REV. 1367 (2003); Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543 (2000).

<sup>18</sup> See Jody Freeman & Martha Minow, *Reframing the Outsourcing Debates*, in *GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY* 2 (Jody Freeman & Martha Minow, eds. 2009) (describing “[t]he primary concern ... that the ubiquity of governance-by-private-contractors strikingly outstrips our legal and political capacities of oversight meant to ensure that the contractors’ execution of those governmental functions complies with democratic norms”).

<sup>19</sup> See generally *THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE* 604 (Lester M. Salamon, ed. 2002).

<sup>20</sup> For a rare and recent take on “delegated governance” in Medicare Part D, see KIMBERLY J. MORGAN & ANDREA LOUISE CAMPBELL, *THE DELEGATED WELFARE STATE* (2011).

Act (ACA),<sup>21</sup> which made substantial changes to Medicare in an effort to slow the rate of increase in federal spending and improve beneficiaries' quality of care. Although promising on paper and much touted in the health policy literature, these reforms are not well-crafted to spur the development of health-care organizations that can actually shift how physicians practice medicine. They are thus unlikely to improve much on Medicare's past performance.

### I. MEDICARE'S DESIGN

The original Medicare statute contained obvious markers of the strategic choice to appease the medical establishment. Wilbur Cohen, Medicare's chief architect, later explained that "[t]he sponsors of Medicare, including myself, had to concede that there would be no real controls over hospitals and physicians. I was required to promise before the final vote...that the Federal agency would exercise no control."<sup>22</sup> Effectuating that promise required making four design choices—all of which remain part of Medicare's programmatic architecture—that would preclude the federal government then and into the future from asserting authority over the physicians that implement Medicare at the bedside.

*Medical necessity.* Subject to steep deductibles, copayments, and caps on per-beneficiary expenditures, the Medicare program's core was (and remains) a commitment to reimburse hospitals and physicians for the costs of providing all medically necessary care. Physicians were paid only if they certified that the "medical or other health services...are or were medically required."<sup>23</sup> Hospitals and other medical institutions were paid only if a physician certified that an institutional setting was medically necessary.<sup>24</sup> Because physicians' prevailing conception of medical necessity was (and is) cost-blind, eligibility for Medicare payments depended not at all on the costs of the treatment in question. Congress did exclude from coverage any medical care "not reasonable and necessary for the diagnosis or treatment of illness or injury,"<sup>25</sup> but the exclusion left nearly untrammelled discretion with treating physicians to determine medical necessity. Congress nowhere intimated that Medicare could refuse to pay for novel treatments they deemed unreasonable and unnecessary on cost grounds.

*Borrowing from the Blues.* In addition to linking reimbursement to medical necessity, Congress structured Medicare to operate along the lines of the indemnity insurance plans then offered through Blue Cross and Blue Shield organizations. Physicians and hospitals would have a statutory entitlement to reimbursement from Medicare akin to their contractual entitlement to reimbursement from the Blues.<sup>26</sup> Originally established by hospitals and doctors to provide a stable source of funding for medical services, Blue Cross and Blue Shield took a hands-off, no-

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<sup>21</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter "ACA"], as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter "Reconciliation Act"].

<sup>22</sup> RICK MAYES & ROBERT A. BERENSON, MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE 17 (2006) (quoting Cohen).

<sup>23</sup> 1965 Medicare Act, §102(a), 79 Stat. 290, 294 (1965) (amending §1835(a)(2)(B) of the Social Security Act).

<sup>24</sup> See *id.* §102(a) (amending §1814(a)(2)).

<sup>25</sup> See *id.* §102(a) (amending §1862(a)(1)).

<sup>26</sup> See *id.* §102(a) (amending §§1812 & 1832).

questions-asked approach to payment that jibed with Congress's vision of a federal program that interfered little in physician practice. What's more, the Blues—and now Medicare—reimbursed hospitals for their “reasonable costs”<sup>27</sup> and physicians for their “reasonable charges.”<sup>28</sup> In practical effect, that meant hospitals and physicians were responsible both for dispensing medical services and for gauging the reasonableness of their costs and charges.

Structuring Medicare as an entitlement to indemnification keyed to judgments of medical necessity meant that Congress surrendered direct control over the size of Medicare funding. Physicians—not Congress in an appropriations measure—would collectively establish what the government would pay out for medical services. Because judgments of medical necessity are partly shaped by physicians' sense of available resources, Medicare's unconstrained willingness to pay contributed to a loose sense of necessity.

Of equal importance, Medicare borrowed the Blues' practice of paying hospitals and physicians separately. Hospitals (and other institutional providers) recovered their reasonable costs under Medicare Part A and physicians their reasonable charges under Part B. This division reflected the structure of medical practice in 1965. In part because of state laws prohibiting the corporate practice of medicine, hospitals only rarely employed doctors and were viewed as little more than physicians' workshops.<sup>29</sup> With rare exceptions, no institutional actor existed that could have accepted Medicare payments and divvied them up among hospitals and physicians. But by creating separate payment silos, Congress reinforced the atomistic practice patterns that dominated medical practice in the mid-1960s.

*Delegated administration.* Congress didn't just embrace the indemnity model of the Blues, however. It actually stitched Blue Cross and Blue Shield into the fabric of Medicare. Instead of having Medicare process claims itself, as the Social Security Administration (SSA) did, Congress delegated that responsibility to “fiscal intermediaries” (for Part A) and “carriers” (for Part B).<sup>30</sup> These third-party contractors—mostly Blue Cross and Blue Shield plans—were to carry out the bulk of Medicare's day-to-day payment responsibilities.

Political exigency led the federal government to parcel out Medicare's regulatory authority to private insurers with close ties to organized medicine.<sup>31</sup> Even at the time, executive branch officials understood that “[a] considerable price would be paid in order to get the initial public relations advantages with professional groups that might come from using Blue Cross, e.g., loss of direct contact with providers so that the Federal Government would not have detailed knowledge of problems and because of this, the loss of ability to react quickly to problems of administration, budget, program.”<sup>32</sup> But as Wilbur Cohen explained in an oval

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<sup>27</sup> See *id.* §102(a) (amending §1814(b)).

<sup>28</sup> See *id.* §102(a) (amending §1832(a)(1)).

<sup>29</sup> See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 178 (1982).

<sup>30</sup> 1965 Medicare Act, §102(a) (amending §§1816 & 1842) (fiscal intermediaries and carriers, respectively).

<sup>31</sup> See Payton, *supra* n.14, at 126 (observing that the Blues “had been made in the image of the medical industry”).

<sup>32</sup> SYLVIA LAW, *BLUE CROSS: WHAT WENT WRONG?* 34 (2d ed. 1976) (quoting 1962 memo from an executive branch task force).



office meeting with President Johnson, that was the point: the Blues “would have to do all the policing so that the government wouldn’t have its long hand [in there].”<sup>33</sup>

Parceling out Medicare’s administrative responsibilities allowed Congress to run the program with a skeleton crew of federal employees. The bare-bones staffing of the central agency that oversaw Medicare—first housed in the Social Security Administration, and moving in 1977 to what became the Department of Health and Human Services (HHS)—was possible only because federal administrators were not directly responsible for deciding when and to whom Medicare would pay out. Their role was instead to manage relationships with those outside stakeholders that actually ran the program.

*Any willing provider.* Another tenet of the Blues’ model of indemnity insurance was that all licensed and willing providers would be eligible for reimbursement. So too with Medicare, which imposed no meaningful conditions on participation other than licensure.<sup>34</sup> In practical effect, this meant that Medicare ceded the authority to determine which physicians were eligible to bill Medicare to state medical societies, which were (and remain) not at all rigorous about policing their membership.<sup>35</sup>

Once physicians were in, they were hard to kick out. Only if a physician lost its state license, was “not complying *substantially*” with Medicare’s rules, or refused to disclose payment-related information could she be excluded from the program.<sup>36</sup> Administrators were loath to employ even this limited authority: disqualifying physicians can precipitate immense political blowback. Nor did administrators have any tools to encourage beneficiaries to favor certain providers over others. To the contrary, the Medicare statute guaranteed beneficiaries their “free choice” of hospital or physician.<sup>37</sup>

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In crafting a program to cover the costs of medical necessary care for the elderly, Congress delegated considerable discretionary authority to the physicians who would actually deliver that care. This made considerable sense. Only physicians had the expertise to make reliable judgments of medical necessity across the full range of medical problems that would confront the elderly. And because care must be tailored to the individual demands of the case, physicians would need the latitude to dispense covered services based on contextual and discretionary judgments about patient need. Physicians were therefore tasked with making

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<sup>33</sup> Larry DeWitt, *The Medicare Program as a Capstone to the Great Society – Recent Revelations in the LBJ White House Tapes* (May 2003), available at [www.larrydewitt.net/Essays/MedicareDaddy.htm#N\\_38\\_](http://www.larrydewitt.net/Essays/MedicareDaddy.htm#N_38_).

<sup>34</sup> See 1965 Medicare Act, §102(a) (amending §1861(e)(7)) (defining “hospital” to mean a state-licensed hospital); *id.* (amending §1861(r)) (defining “physician” to mean a state-licensed physician).

<sup>35</sup> Although Medicare was nominally empowered to impose additional participation requirements on hospitals, Congress circumscribed that power in providing that a hospital is deemed to meet any such requirements if accredited by the Joint Commission on Accreditation of Hospitals, as most were. See *id.* §102(a) (amending §§1861(e)(8) & 1865). Established by the American Hospital Association, the Joint Commission had a reputation for catering to the interests of its membership.

<sup>36</sup> See *id.* §102(a) (amending §1866(b)(2)) (emphasis added).

<sup>37</sup> See *id.* §102(a) (amending §1802).

treatment decisions that doubled as adjudicative judgments. Medical necessity would provide the substantive standard for deciding whether Medicare should cover the costs of treatment.

Even as it deputized each and every doctor in the country as a bedside adjudicator, however, Congress deprived federal administrators of the conventional roster of legal and management tools typically used to control front-line bureaucrats. In contrast to the Veterans Administration health care system, Medicare wouldn't directly employ its physicians. Administrators thus lacked direct leverage to encourage cost-conscious, high-quality practice patterns; still less could they inculcate a culture that rewarded such patterns of care.<sup>38</sup> Instead, physicians would operate as independent contractors—but contractors with a sinecure.

The contracting relationship between the federal government and private physicians is a loose one, so loose that Medicare is sometimes characterized as a voucher program: beneficiaries receive a voucher (their Medicare card) that they can use to seek out medically necessary care from private providers that freely choose whether to accept the vouchers and otherwise have little to do with the government.<sup>39</sup> For three reasons, however, the voucher characterization doesn't quite fit. First, vouchers usually have limited purchasing power, giving recipients a strong incentive to shop around with their vouchers to find the best deal.<sup>40</sup> (Food stamps go further in cheaper grocery stores, for example.) Not so with traditional Medicare, where beneficiaries are insensitive to the costs of the care they receive.<sup>41</sup> Second, physicians do not compete to offer a good or service at the lowest price. They instead receive uniform payments for their services, subject only to modest adjustments based on locality. Third, beneficiaries' "consumption" choices don't drive most medical decisions. Physician decisions do.<sup>42</sup>

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<sup>38</sup> See LIPSKY, *supra* n.6, at 20 ("The Veteran's Administration hospital system is a fascinating bureaucracy because it employs doctors, the preeminent professionals, in highly rule-bound organizations."); PHILLIP LONGMAN, *BEST CARE ANYWHERE: WHY VA HEALTH CARE IS BETTER THAN YOURS* (2d ed. 2011) (detailing VA's relative success at providing low-cost, high-quality care).

<sup>39</sup> See Payton, *supra* n.14, at 119.

<sup>40</sup> See C. Eugene Steuerle & Eric C. Twombly, *Vouchers*, in *THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE* 446 (Lester M. Salamon, ed., 2002).

<sup>41</sup> See JAMES Q. WILSON, *BUREAUCRACY: WHAT GOVERNMENT AGENCIES DO AND WHY THEY DO IT* 355 (1989) (so arguing). This delegation of decisional authority is one reason among many that giving patients more financial responsibility for medical decision-making—or "consumer directed health care"—is unlikely to curb much medical spending or improve quality of care. See Carl Schneider & Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?*, 35 *AM. J. L. & MED.* 7 (2009) (so arguing).

<sup>42</sup> See JOHN E. WENNBERG, *TRACKING MEDICINE: A RESEARCHER'S QUEST TO UNDERSTAND HEALTH CARE* 7-8 (2010) ("It is *physicians* who exert the greatest influence over demand—or really, utilization—because patients traditionally delegate decision making to them under the assumption that doctors know what is best.").

Contract provides the more apt analogy. In practical effect, Medicare has entered into separate output contracts with nearly every physician and hospital in the country.<sup>43</sup> They promise to provide medically necessary services to Medicare-eligible beneficiaries, and the government promises to pay them for those services. So understood, Medicare manages private-sector contracts worth more than all of the federal government's other contracts for goods and services *combined*.<sup>44</sup>

As a matter of sound administration, the choice of a contractual strategy was fraught from the outset. John Donahue has rightly emphasized that contracting works best for “commodity” tasks—those that are specific, easy to evaluate, and available in a competitive market.<sup>45</sup> The provision of medical care flunks all three conditions. Unable to specify up-front what it specifically wants from the physicians that care for the elderly and disabled, Congress must instead contract out in generic terms for medically necessary care. Lack of scientific consensus about appropriate medical treatments for all but the most common conditions makes evaluating the care that is provided next to impossible. And the market for medical care is hampered by several well-understood failings, including the absence of price transparency and consumer uncertainty about the efficacy of treatment alternatives. The provision of medical care is the sort of “custom” task that is not, in principle, an obvious candidate for contracting out.<sup>46</sup>

Compounding the intrinsic difficulties of contracting for medical care was (and remains) Medicare's programmatic design, which prohibited Medicare from using typical contracting tools—negotiation over price or quantity, competitive bidding, strict conditions on participation, and the like—to encourage adherence to program goals. Nor did administrators have anything like the manpower necessary to oversee the piecemeal submission of millions upon millions of claims. Any quixotic effort to do so would have in any event been compromised by the private insurers standing between Medicare and its physicians.

These challenges notwithstanding, Medicare must of necessity marry the professional commitment of its physicians to programmatic goals that emphasize cost-effective and high-quality care. In this, an examination of the history of Medicare reform offers a rich look at one of the preoccupations of the modern administrative state: how to manage the multitude of private actors that, in most cases, actually implement government programs on the ground.<sup>47</sup>

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<sup>43</sup> See BLACK'S LAW DICTIONARY (defining output contract as one “in which a buyer [i.e., Medicare] promises to buy all the goods or services that a seller [i.e., a physician] can supply during a specified period and at a set price”).

<sup>44</sup> Compare Stan Soloway & Alan Chvotkin, *Federal Contracting in Context*, in GOVERNMENT BY CONTRACT 192 (Jody Freeman & Martha Minow, eds. 2009) (“Today, total federal spending on contracts for goods and services of all kinds exceeds \$450 billion.”), with 2010 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY INSURANCE TRUST FUNDS 5 (2010) (reporting that Medicare spent \$502 billion in benefits in 2009).

<sup>45</sup> See John D. Donahue, *The Transformation of Government Work: Causes, Consequences, and Distortions*, in GOVERNMENT BY CONTRACT 41, 42 (Jody Freeman & Martha Minow, eds. 2009).

<sup>46</sup> See *id.* at 42.

<sup>47</sup> Lester M. Salamon, *The New Governance and the Tools of Public Action: An Introduction*, in THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE 2 (Lester M. Salamon, ed. 2002) (observing that “a

## II. THE MAJOR REFORMS

The central concern of the contracting literature is the potential threat that the outsourcing of government functions poses to democratic values.<sup>48</sup> Outsourcing can blur lines of accountability, shroud governmental activities in secrecy, and enable powerful groups to wield untoward influence in the democratic process.<sup>49</sup> On this account, the ineffective management of government contractors is not just a technical or budgetary concern, but an urgent democratic problem.

In many respects, Medicare represents the apotheosis of the threat to democratic values to which government contracting can give rise. The physicians that control Medicare expenditures are accountable not to the public at large, but instead to their professional peer groups. Keeping tabs on how physicians dispense government benefits is devilishly hard. And Medicare has empowered a host of powerful interest groups—including the elderly, hospitals, and physicians—that, by exerting their considerable political influence in the political process, can swamp more diffuse public input.

In other respects, however, Medicare complicates the conventional threat-to-democracy account. For Medicare, the absence of institutional capacity to manage the private physicians with which it contracts reflects a deep social commitment that government should keep out of the examining room. Medicare thus exploits its institutional weakness to enhance its public legitimacy. Distance between the federal government and the physicians with which it contracts—a relative *lack* of accountability, transparency, and public participation—is itself a public value.<sup>50</sup> Enhancing institutional capacity to shape physician practice patterns may respond to some democratic urges (cost and quality control), but it will conflict with others (physician independence and patient choice). Questions of bureaucratic power and democratic responsiveness are thus tightly interwoven.

Congress in 1965 struck the balance decisively in favor of physician autonomy. Almost immediately, however, the assumption that physicians could make decisions on Medicare's behalf without regard to resource constraints came under considerable strain. In response, Congress has spent the past four decades casting about for strategies to assert some measure of control over the physicians that have Medicare's implementation in hand. It has, in other words, sought to establish an internal law for Medicare.

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major share—in many cases *the* major share—of the discretion over the operation of public programs routinely comes to rest not with the responsible government agencies, but with the third-party actors that actually carry the programs out”).

<sup>48</sup> See, e.g., Martha Minow, *Public and Private Partnerships: Accounting for the New Religion*, 116 HARV. L. REV. 1230, 1259 (2003) (“The urgent question posed by a shifting mix of public and private providers of education, welfare, and prison services is how to ensure genuine and ongoing accountability to the public.”).

<sup>49</sup> See Freeman & Minow, *supra* n.18, at 1.

<sup>50</sup> See MASHAW, *supra* n.7, at 32 (noting that in Medicare, “[t]he professional defines and legitimates the actions of the agency, rather than the other way round”).

Yet Congress has restricted its own field of choice. As Paul Pierson observes, new policy regimes encourage massive investments in skills and infrastructure, foster dense networks of individuals and organizations dedicated to the new regimes, and encourage the attitude that the regimes are essential features of the political landscape. The deeper these new commitments, the harder to shift course.<sup>51</sup> Just so with Medicare. The basic contours of the program—public financing, private care—were fixed in 1965. Beneficiaries grew accustomed to subsidized coverage without meaningful restrictions, and physicians, hospitals, and other providers committed themselves to the new world order in which the government would pay the bills but assert no control. Their substantial investments (financial, social, and psychological) in these institutional arrangements have limited the range of plausible reform. As such, the urgent and interesting question is not, as it is in so much of the contracting literature, whether a privatization strategy for the provision of medical care is normatively attractive. It is instead how to yoke the immense network of Medicare’s private physicians to a broader notion of public values.

Medicare’s weakened administrative apparatus has similarly constrained the choice of reform strategy. Without extraordinary increases in its size and power, the Centers on Medicare and Medicaid Services (CMS) could not even begin to oversee the work of hundreds of thousands of front-line physicians. Yet resistance to building government runs deep—and where the purpose of a government build-up is to shape how physicians practice medicine, resistance would be far greater still.<sup>52</sup>

In response to these constraints, the methods that Congress has lit on to assert control over the physicians that administer Medicare share a common attribute: they parcel out oversight and management responsibilities to private organizations. This sort of “indirect” approach to program administration—to use Salamon’s typology—absolves the federal government of direct responsibility for controlling physicians and, in bypassing agency officials, mutes public concerns with government interference.<sup>53</sup> Turning to private organizations also allows Congress to leverage organizational resources that are available in the private sector (or could be pulled together on short order) while at the same time avoiding the need to increase the power of the federal bureaucracy.

Enlisting private contractors to assert a greater measure of control over other private contractors is nothing new.<sup>54</sup> The pressures that lead to government outsourcing in the first

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<sup>51</sup> See Paul Pierson, *Increasing Returns, Path Dependence, and the Study of Politics*, 94 AM. POLI. SCI. REV. 251, 255 (2000) (“As social actors make commitments based on existing institutions and policies, their cost of exit from established arrangements generally rises dramatically.”).

<sup>52</sup> See MORGAN & CAMPBELL, *supra* n.20, at 3 (finding that outsourcing allows for a “response to pressing social demands without seeming to expand the size of the federal government.”).

<sup>53</sup> See Salamon, *supra* n.47, at 27 (“The more extensively functions are performed by ‘third parties,’ the more organizationally distinct and autonomous these third parties are from the authorizing body, and the greater the discretion the third parties enjoy in the conduct of their functions, the more *indirect* the tool.”).

<sup>54</sup> See Paul Posner, *Accountability Challenges of Third-Party Government*, in THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE 540 (Lester M. Salamon, ed. 2002) (cataloging various examples).

place also push for the outsourcing of oversight functions. In Medicare, however, the practice is unusually entrenched and pervasive. In this section, I review the four most ambitious efforts to reform Medicare to date: peer review organizations, prospective payment, Medicare managed care, and coverage limitations.<sup>55</sup> Each of these reforms vested in a private mediating institution the power and the incentives to shape the practice patterns of Medicare physicians. In establishing peer review organizations, Congress empowered private physician groups to monitor individual treatment decisions. In shifting to prospective payment, Congress sought the aid of hospitals and medical societies in discouraging overzealous and wasteful treatment. More recently, Congress has turned to managed care organizations to push physicians to attend to resource constraints and to coordinate care. And an increasing use of coverage determinations has restored to Medicare's contractors a role in overseeing medical practice.

Experience with these reforms provides a remarkable case study in the pitfalls of the use-a-contractor-to-oversee-the-contractor approach. For Medicare, the failure of each intervention showcases Congress's startling and repeated inattention to the capacity of those private institutional actors to overcome the program's core structural obstacles—its fragmented fee-for-service payment system; its willingness to pay for high-cost, low-value medical interventions; its inability to favor certain physicians over others; and the weakness of CMS and its dependence on insurance companies to process claims. In this, the story of Medicare's implementation reinforces one of the most prominent conclusions of the contracting literature: that policy-makers routinely underestimate the managerial challenges that third-party governance poses.<sup>56</sup>

#### A. *Peer Review*

##### 1. Background

In the wake of a scathing report documenting egregious Medicare fraud, Congress in 1972 called for the creation of regional Professional Standards Review Organizations (PSROs) to oversee the ranks of Medicare's physicians. With memberships drawn from the ranks of local doctors, PSROs were private organizations vested with the authority to deny approval for payment of Medicare claims,<sup>57</sup> to oversee utilization patterns through statistical data,<sup>58</sup> and to refer individual providers for disciplinary action.<sup>59</sup> In other words, Congress enlisted private physicians to watch Medicare's physicians at the bedside.

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<sup>55</sup> Because my focus is on Medicare's design and implementation, I do not discuss several significant changes in the scope of Medicare benefits, including the 1972 expansion of coverage to the disabled and those with end-stage renal disease, the 1988 enactment and subsequent repeal of the Medicare Catastrophic Coverage Act, and the 2003 creation of the Part D drug benefit.

<sup>56</sup> See Donald F. Kettl, *Managing Indirect Government*, in *THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE* 491 (Lester M. Salamon, ed., 2002) (“[P]olicymakers have often shown little interest in and less knowledge about the management implications of the indirect systems they have created.”).

<sup>57</sup> See Social Security Amendments of 1972, Pub. L. 92-603, §249F(b), 86 Stat. 1329, 1437 (1972) (adding §1158(a) to the Social Security Act) (hereinafter “1972 Amendments”).

<sup>58</sup> See *id.* §249F(b) (adding §1155(a)(4)).

<sup>59</sup> See *id.* §249F(b) (adding §§1157 & 1160(b)(1)(A)).

By any measure, the PSROs were abject failures. Even under optimistic estimates, the costs of operating PSROs exceeded what they saved.<sup>60</sup> President Reagan sought to eliminate them when he took office, but Congress resisted scrapping the program altogether. Influential senators saw PSROs “as the only logical answer to the question: who should police hospitals and doctors?”<sup>61</sup> Instead of eliminating PSROs, Congress in 1982 replaced them with Peer Review Organizations (PROs) and made several programmatic changes.<sup>62</sup> Of greatest significance, Medicare administrators were armed with the authority to negotiate service contracts with PROs and to offer those contracts on a competitive basis.<sup>63</sup> Competitive bidding gave Medicare officials more authority to direct peer-review activities toward areas of perceived greatest need.

Over time, PROs’ contractual responsibilities have evolved. Early rounds of contracting emphasized painstaking case-by-case utilization review.<sup>64</sup> Yet PROs made little headway on either cost control or quality improvement. In tacit recognition of their failure, the Health Care Financing Agency (HCFA)—the agency now known as CMS—announced in 1992 that PROs would shift away from utilization review. PROs were instead to monitor patterns of care and give providers the data and support they needed to improve the quality of patient care.<sup>65</sup>

Subsequent contracts have emphasized quality improvement efforts over utilization review,<sup>66</sup> and in 2002 Medicare even began referring to PROs as Quality Improvement Organizations.<sup>67</sup> In their current incarnation, PROs act as government-sponsored consultants. They enter into voluntary partnerships with health-care organizations—in particular hospitals and nursing homes—to share data, teach best practices, and offer technical support. They bear little resemblance to the utilization review agencies that Congress once envisioned.

## 2. Assessment

Notwithstanding their \$370 million annual price tag,<sup>68</sup> PROs have done little or nothing to enhance Medicare’s ability to influence its physicians. To understand how flawed programmatic architecture and congressional inattention have contributed to the failure, it helps to distinguish between the two modes in which PROs have operated: the assertive

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<sup>60</sup> See CONGRESSIONAL BUDGET OFFICE, *THE EFFECT OF PSROs ON HEALTH CARE COSTS: CURRENT FINDINGS AND FUTURE EVALUATIONS* x (1979).

<sup>61</sup> Spencer Rich, *Who Should Police Hospitals and Doctors?*, WASH. POST, Nov. 29, 1983, at A15.

<sup>62</sup> See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, subtit. C, 96 Stat. 381 (1982).

<sup>63</sup> See CONGRESSIONAL RESEARCH SERVICE, *MEDICARE’S PEER REVIEW ORGANIZATIONS* 5 (1990).

<sup>64</sup> See INSTITUTE OF MEDICINE, *MEDICARE’S QUALITY IMPROVEMENT ORGANIZATION PROGRAM: MAXIMIZING POTENTIAL* 41 (2006).

<sup>65</sup> See Stephen F. Jencks & Gail R. Wilensky, 268 J. AM. MED. ASS’N 900, 900 (1992); see also INSTITUTE OF MEDICINE, *MEDICARE: A STRATEGY FOR QUALITY ASSURANCE* (1990) (recommending that HCFA deemphasize case review and embrace a quality improvement mission).

<sup>66</sup> See INSTITUTE OF MEDICINE, *supra* n.64, at 52.

<sup>67</sup> See Final Rule, 67 Fed. Reg. 36540 (2002).

<sup>68</sup> See GOVERNMENT ACCOUNTABILITY OFFICE, *CMS NEEDS TO COLLECT CONSISTENT INFORMATION FROM QUALITY IMPROVEMENT ORGANIZATIONS TO STRENGTHEN ITS ESTABLISHMENT OF BUDGETS FOR QUALITY OF CARE REVIEWS* 2 (2010).

regulatory mode characterized by utilization review, now largely abandoned, and the voluntary cooperative mode that is ascendant today.

*Utilization review.* When it created Medicare, Congress vested in physicians front-line responsibility for deciding whether a given treatment is medically necessary and hence reimbursable. To carry out ex post claims review, then, Congress had to embed physicians into the review process and ask them to assess the medical necessity determinations of their fellow physicians. As Congress saw it, no other group save physicians had the necessary medical knowledge.

PRO physicians, however, approach this review task with considerable hesitation. Medical necessity is not a crisp concept, and scientific evidence rarely establishes the inappropriateness of a particular course of treatment. Judgments about medical necessity and quality are also context-dependent, yet peer reviewers look only to a cold and often incomplete patient record. They may be reluctant to deny payment for medical services already rendered, and in any event there's a professional aversion to criticizing or sanctioning the work of other doctors. Treating physicians subject to review are often piqued at what they perceive as a referendum on their medical judgment from an outside physician who, lacking direct patient contact, is in no good position to criticize.<sup>69</sup> Apart from a medical license, PRO reviewers have no particular qualifications and receive no specialized training.<sup>70</sup>

Even if physicians had the appetite to diligently oversee their colleagues' practice patterns, Medicare's medical necessity standard would limit their ability to curb over-utilization. As Clark Havighurst and James Blumstein have observed, much wasteful care may be marginally beneficial – think here of using an MRI to rule out a very unlikely diagnosis.<sup>71</sup> But because peer review only polices conformity with Medicare's cost-blind coverage limitations, that sort of care wouldn't raise a peer reviewer's eyebrow.

To give peer review teeth, PROs are supposed to sanction and even exclude those providers that abuse Medicare. In this, however, they are paper tigers. As a natural consequence of allowing all licensed providers to participate in Medicare, there is immense political pressure to afford them robust procedural protections before imposing sanctions. In the absence of a coherent constituency pushing for a streamlined sanctions scheme, Congress has bowed to that pressure. The resulting process for sanctioning providers is arcane and cumbersome even by Medicare standards,<sup>72</sup> and providers can only be excluded from Medicare if they have failed “substantially” to comply with Medicare rules in a “substantial” number of

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<sup>69</sup> See CONGRESSIONAL RESEARCH SERVICE, *supra* n.63, at 47 (“[T]he review process can become contentious.”).

<sup>70</sup> See Haya V. Rubin et al., *Watching the Doctor Watchers: How Well Do Peer Review Organization Methods Detect Health Care Quality Problems?*, 267 J. AM. MED. ASS'N 2349, 2350 (1992).

<sup>71</sup> See Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 32 (1975).

<sup>72</sup> For a chart detailing the process that will make your head hurt, see INSTITUTE OF MEDICINE, *supra* n.65, at 164.



cases or have “grossly and flagrantly” violated the rules.<sup>73</sup> Unsurprisingly, PROs almost never recommend sanctions.<sup>74</sup>

Standard contractual tools have been ineffective at improving PRO performance. There is little competition in awarding PRO contracts<sup>75</sup> and the already-overstretched federal bureaucracy has a poor record of monitoring PRO conduct.<sup>76</sup> Nor are PROs entirely to blame for their lackluster performance. Congress has given them nowhere near the resources that they would need to police the 4.8 million claims that Medicare processes every day.<sup>77</sup> Plus, Medicare’s balkanized structure means they lack direct access to the information they need to do their jobs. Fiscal intermediaries and carriers must share claims data to enable PRO review and, when PROs disapprove payment for medical services, they must then coordinate with Medicare contractors to dock provider reimbursement. This complex information-sharing process hampers effective, timely case review.<sup>78</sup>

All told, Medicare’s structural inadequacies have combined with congressional inattention to confound utilization review. Lacking adequate power over Medicare’s front-line physicians, PROs engaging in utilization review have made no dent in rising Medicare costs.<sup>79</sup> Nor have they improved quality of care: a number of studies have found that PROs are almost comically bad at identifying quality problems.<sup>80</sup>

*Voluntary cooperation.* As the ineffectiveness of case review became apparent, Medicare gave it up. Over time, PROs have shifted toward voluntary, cooperative efforts focused on quality improvement. These more-conciliatory efforts, however, appear no more successful at changing physician practice patterns. The Institute of Medicine concluded in 2006 after

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<sup>73</sup> Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §143 (amending §1156(b)(1) of the Social Security Act), 96 Stat. 381, 388 (1982).

<sup>74</sup> See OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, QUALITY CONCERNS IDENTIFIED THROUGH QUALITY IMPROVEMENT ORGANIZATION MEDICAL RECORD REVIEWS ii (2007) (finding that PROs “rarely initiated sanction activity in response to a confirmed [quality concern]”).

<sup>75</sup> See INSTITUTE OF MEDICINE, *supra* n.64, at 72 (noting “history of very limited competition for QIO contracts”).

<sup>76</sup> See *id.* at 76-78 (finding serious deficiencies in HHS contract monitoring); CONGRESSIONAL RESEARCH SERVICE, *supra* n.63, at 17 (same); GENERAL ACCOUNTING OFFICE, MEDICARE: BETTER CONTROLS NEEDED FOR PEER REVIEW ORGANIZATIONS’ EVALUATIONS 4 (1987) (same).

<sup>77</sup> See Berwick, *supra* n.2, at 4.

<sup>78</sup> See CONGRESSIONAL RESEARCH SERVICE, *supra* n.63, at 21, 54 (discussing PSRO-contractor coordination challenges); LAW, *supra* n.32, at 129 (same).

<sup>79</sup> Even during the heyday of utilization review, PROs denied or reduced payment for the provision of unnecessary care in just 2% of reviewed cases. See CONGRESSIONAL RESEARCH SERVICE, *supra* n.63, at 37, 42 (1990). By 2006, PROs nationwide identified just \$14.5 million in overpayments to hospitals, representing less than 0.01% of what Medicare spent in Part A outlays. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, REPORT TO CONGRESS ON THE EVALUATION OF THE QUALITY IMPROVEMENT ORGANIZATION (QIO) PROGRAM FOR MEDICARE BENEFICIARIES FOR FISCAL YEAR 2006, at 5.

<sup>80</sup> See Rubin et al., *supra* n.70, at 2353 (finding that medical experts and the PRO agreed about the existence of quality-related issues about as often as would be expected by chance); INSTITUTE OF MEDICINE, *supra* n.65, at 183 (concluding that case review provides a “poor yield of quality problems”).

reviewing the extant studies that the quality records of hospitals that cooperate with PROs are indistinguishable from those that do not.<sup>81</sup> Although a few studies have observed modest quality improvement in hospitals that participated in PRO-sponsored efforts, similar quality measures have tended to improve at non-PROs hospitals.<sup>82</sup> Anecdotally, the overwhelming majority of providers believe that PROs are useless.<sup>83</sup>

Why this poor record? The root cause, again, is inattention to whether the private actors that Congress has embedded in a flawed Medicare program have the incentives, capacity, and legitimacy to adjust physician practice patterns. Three blind spots are of particular importance.

First, lacking the resources to coordinate with the hundreds of thousands of private physicians that implement Medicare, PROs focus their quality improvement efforts on hospitals (and to a lesser extent nursing homes). This means that quality issues that arise in physician practices are ignored—an enormous gap for a program where the need for high-quality outpatient care to treat chronic conditions looms so large.

Second, the split between Medicare Parts A and B reinforces the tendency of physicians to operate independently of the hospitals in which they practice. Encouraging PROs to consult with private hospitals to lean on physicians over whom the hospitals lack much influence is not a strategy that's well-calculated to lead to meaningful changes in physician practice patterns. As one hospital quality manager has implored CMS, "Go to the physicians directly. We can monitor all these indicators, but it's in the physicians' power. If they don't prescribe the aspirin at discharge, it's not the hospital's fault."<sup>84</sup>

Third, hospitals aren't all that receptive to PRO influence. Medicare eligibility depends not one whit on cooperating with PROs, and hospitals are more likely to attend to quality concerns raised by the Joint Commission (which can withdraw accreditation) or insurers (which can remove hospitals from their networks) than to those raised by PROs (which can do nothing). Predictably, voluntary quality-improvement efforts involve those providers that are most receptive to PRO help—a group that is unlikely to include those institutions in greatest need of it.<sup>85</sup> What's more, instituting quality improvement measures may, perversely, lead to

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<sup>81</sup> See INSTITUTE OF MEDICINE, *supra* n.64, at 234; see also Claire Snyder & Gerard Anderson, *Do Quality Improvement Organizations Improve the Quality of Hospital Care for Medicare Beneficiaries?*, 293 J. AM. MED. ASS'N 2900 (2005) (same).

<sup>82</sup> See William Rollow et al., *Assessment of the Medicare Quality Improvement Organization Program*, 145 ANNALS OF INTERNAL MED. 342 (2006); Stephen F. Jencks et al., *Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001*, 289 J. AM. MED. ASS'N 305 (2003); Thomas A. Macriniak et al., *Improving the Quality of Care for Medicare Patients with Acute Myocardial Infarction: Results from the Cooperative Cardiovascular Project*, 279 J. AM. MED. ASS'N 1351 (1998).

<sup>83</sup> See TROYEN A. BRENNAN & DONALD M. BERWICK, *NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE* 320 (1996).

<sup>84</sup> Elizabeth H. Bradley et al., *From Adversary to Partner: Have Quality Improvement Organizations Made the Transition?*, 40 HEALTH SERVICES RESEARCH 458, 471 (2005) (internal quotations omitted).

<sup>85</sup> See GOVERNMENT ACCOUNTABILITY OFFICE, *NURSING HOMES: FEDERAL ACTIONS NEEDED TO IMPROVE TARGETING AND EVALUATION OF ASSISTANCE BY QUALITY IMPROVEMENT ORGANIZATIONS* 4 (2007).

reduced compensation for hospitals and other providers.<sup>86</sup> Absent a persuasive business case for quality improvements, even those institutional providers inclined in principle to cooperate with PROs may decline to dedicate the resources to the difficult business of shifting physicians' practice patterns.

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As a strategy for assuring that dispersed line officers adhere to the concerns of the central bureaucracy, peer review has failed miserably. Physicians are loath to second-guess their colleagues' work, and Medicare's structural infirmities—the cost-blindness of medical necessity, the bifurcated claims-based payment system, the decentralized administrative apparatus, and the sheer volume of claims—further impair the sort of utilization review that Congress envisioned. Nor has the shift to quality consulting fared any better. PROs can exhort hospitals all they want to oversee their physicians, but Medicare gives hospitals few incentives to play along. Indeed, Medicare's payment model discourages quality improvement efforts that would harm hospitals' bottom line.

As the failure of peer review suggests, efforts to assert control over the physicians that implement Medicare on the ground must be tailored to institutional context and subject to effective management. Yet policy-makers rarely attend to these mundane implementation questions. Indeed, Medicare's poor experience with outsourcing auditing functions is not unique. Parceling out auditing authority to private third parties is most appealing when the central bureaucracy suffers from resource constraints—but, as Paul Posner has pointed out, those very constraints routinely plague efforts to oversee the auditors themselves.<sup>87</sup>

## B. *Prospective Payment*

### 1. Background

The apparent failure of peer review to constrain relentless increases in Medicare expenditures drew Congress's attention to alternative strategies. In the next round of major reform, Congress pinned its hopes on changing how hospitals were paid. To that end, Congress in 1983 adopted a "prospective payment system," still in place today, under which hospital patients are assigned at discharge, depending on their diagnosis, to differently weighted diagnosis-related groups (DRGs).<sup>88</sup> To determine how much to pay the hospital for a particular patient stay, the assigned DRG is multiplied by the national average cost of treating a hospital patient (subject to variations for, among other things, higher-wage and lower-wage areas).<sup>89</sup>

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<sup>86</sup> See Robert A. Berenson, *Paying for Quality and Doing It Right*, 60 WASH. & LEE L. REV. 1315, 1320 (2003) ("[I]nvesting resources and effort in quality improvement often does not pay for itself and therefore meets resistance.").

<sup>87</sup> See Posner, *supra* n.54, at 540 ("Although a delegated, ex post oversight process may cover salient instances of third-party noncompliance, it would be unrealistic to expect this process to be responsibly and effectively managed.").

<sup>88</sup> See Social Security Amendments of 1983, Pub. L. No. 98-21, tit. VI, 97 Stat. 65, 149 (1983).

<sup>89</sup> See 42 U.S.C. §1395ww(d).

The shift to prospective payment flipped hospitals' former financial incentives. Under the preexisting "reasonable cost" approach, a hospital earned more for long and resource-intensive stays. Under the prospective payment system, however, a hospital that spent less on a particular patient than the DRG-weighted payment would retain the excess, and a hospital that spent more would be in the hole. For the first time, it was in a hospital's financial interest to treat patients conservatively and discharge them quickly. The hope was that prospective payment would encourage hospitals to push their physicians to adopt low-cost practice patterns.<sup>90</sup>

Physicians, however, remained free to bill Medicare for their reasonable charges. And during the 1980s, physician payments began spiraling out of control.<sup>91</sup> Alarmed, Congress in 1989 called for the creation of a fee schedule for physician payments. Establishing this fee schedule required estimating the relative "work" (measured with reference to time, stress, and physical and mental effort) for every medical service. Each service was then assigned a relative value unit (RVU) depending on the work that went into the service. A service that required twice as much "work" as another was assigned an RVU twice as high. To calculate what a physician is owed under the fee schedule, the RVU for the service is multiplied by a practice expense adjustment (practices in high-cost areas have a higher adjustment) and a monetary conversion factor that Congress updates each year.<sup>92</sup> The end result is known as the resource-based relative value scale (RB-RVS), which went into effect in 1992.<sup>93</sup>

Consistent with Medicare's commitment to cost reimbursement, the goal of the fee schedule was to roughly match the costs of providing care.<sup>94</sup> In this, however, the schedule still tied physician reimbursement to treatment intensity and volume. To counter the inflationary incentives of this fee-for-service system, Congress adopted an annual expenditure target now known as the sustainable growth rate (SGR), and which is linked to the rate in GDP growth.<sup>95</sup> If physician payments for a particular year exceeded the target, fee-schedule payments would be cut. Because it would operate as a global cap on physician payments, the hope was that the SGR would "encourage the leadership of medicine to become more active in the support of activities to better inform physicians of the medical benefits and risks of procedures and to play a more active and constructive role in peer review activities."<sup>96</sup>

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<sup>90</sup> Skilled nursing facilities, outpatient hospital clinics, and home health agencies entered similar prospective payment systems in 1997. See Balanced Budget Act of 1997, Pub. L. No. 105-33, §§4432 (skilled nursing), 4523 (outpatient hospital), 4603 (home health), 111 Stat. 251 (1997).

<sup>91</sup> Between 1978 and 1987, when coverage expanded little and enrollment grew by about 2% annually, physician payments increased, on average, 16% each year. See MAYES & BERENSON, *supra* n.22, at 83.

<sup>92</sup> See 76 Fed. Reg. 42772, 42779 (July 19, 2011).

<sup>93</sup> See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, §6102, 103 Stat. 2106, 2169 (1989).

<sup>94</sup> See MAYES & BERENSON, *supra* n.22, at 87.

<sup>95</sup> Initially known as the "volume performance standard," the spending cap was amended and renamed in 1997. See Bruce C. Vladeck, *Fixing Medicare's Physician Payment System*, 362 NEW ENG. J. MED. 1955 (2010).

<sup>96</sup> PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS 208 (1989).

## 2. Assessment

More than any other change in Medicare, prospective payment has slowed the rate of cost escalation. The effect has been particularly pronounced for hospital inpatient care.<sup>97</sup> Without denying its successes, however, prospective payment remains only a partial solution. As with peer review organizations, the hospitals and medical societies upon which prospective payment depends lack adequate incentives and capacity to adjust physician practice patterns to account for Medicare's cost-conscious and quality-improvement goals. Once again, congressional inattention and Medicare's structure are the culprits.

*Cost control.* In part because physicians have a secure source of fee-for-service revenue through Medicare Part B, even for care provided in an inpatient hospital setting, most physician groups still practice independently of hospitals. This means not only that hospitals enjoy little financial leverage over physicians, but that hospitals' financial incentives (decrease care intensity) are at loggerheads with those of their medical staffs (increase care intensity).<sup>98</sup> Complicating matters still further, the Medicare statute prohibits hospitals from making any "payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided" to Medicare beneficiaries.<sup>99</sup> And hospital efforts to assert control could alienate the physicians upon which the hospital depends for patient admissions.

And so, although hospitals have successfully encouraged early discharges, they have otherwise only modestly reshaped how physicians practice medicine.<sup>100</sup> Hospitals have instead cut costs in three principal ways. First, they have reduced overhead and eliminated staff, particularly nurses.<sup>101</sup> Second, they have shifted patients from inpatient to outpatient settings.<sup>102</sup> As other institutional providers—skilled nursing facilities, home health care agencies, and ambulatory surgery centers—have come under prospective payment, the locus of care has lurched toward physician offices. Costs are shifted, not necessarily reduced. Third, some hospitals have inflated Medicare payments by "upcoding" patients—improperly shifting a patient's diagnosis from one DRG code to a more remunerative one.<sup>103</sup> A functional bureaucracy might police this sort of manipulative behavior, but Medicare lacks a functional bureaucracy.

What's more, and contrary to expectations, prospective payment did not discourage physicians from adopting expensive new technologies of no proven benefit over alternatives.

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<sup>97</sup> See MAYES & BERENSON, *supra* n.22, at 53.

<sup>98</sup> See Stuart H. Altman, *The Lessons of Medicare's Prospective Payment System Show that the Bundled Payment Program Faces Challenges*, 31 HEALTH AFFAIRS 1923, 1928 (2012) (observing that "many physician groups operate independently of the hospital and often view the hospital as hostile to their interests").

<sup>99</sup> 42 U.S.C. §1320a-7a(b)(1).

<sup>100</sup> See MAYES & BERENSON, *supra* n.22, at 54 ("The extent to which Medicare's new payment model transformed physician behavior turned out to be relatively modest.").

<sup>101</sup> See *id.* at 97-98.

<sup>102</sup> See Bruce C. Vladeck, *Hospital Prospective Payment and the Quality of Care*, 319 NEW ENG. J. MED. 1411, 1412 (1988).

<sup>103</sup> See David C. Hsia et al., *Accuracy of Diagnostic Coding for Medicare Patients Under the Prospective-Payment System*, 318 New Eng. J. Med. 352 (1988) (OIG study finding rampant DRG creep).

Under the physician fee schedule, such new technologies often involve more “work” and are thus better remunerated. Hospitals in turn compete to attract physicians who, in part for financial reasons, want to use the new technology. Because DRGs are periodically updated whenever a sufficient number of hospitals adopt a new technology, hospitals may have little compunction about embracing costly medical innovations without regard to their benefits. Medicare administrators can do little to address this problem: setting DRGs for new technologies with reference to anticipated health outcomes would, if it contemplated below-cost reimbursement, violate the Medicare statute’s mandate to reimburse for all reasonable and necessary care.<sup>104</sup>

Restraining payments to physicians under the fee schedule has posed a particularly vexing challenge. Congress’s most assertive effort to counteract the incentives generated by a fee-for-service payment system—the global cap on Part B payments known as the SGR—has proven ineffective. Although physicians as a group stand to see their compensation fall if they bill Medicare for too many services, an individual physician maximizes her reimbursement by increasing the volume and intensity of the care she provides. It’s a standard collective-action problem. Nor have medical societies assumed the wished-for leadership role in promoting cost-conscious care. Even if they were willing to risk alienating their physicians, they lack anything like the leverage to combat fee-for-service incentives.<sup>105</sup>

As physician expenditures have exceeded the caps, Congress has repeatedly caved to overwhelming political pressure not to follow through with promised cuts. This too is a consequence of Medicare’s design. By including virtually all physicians in a program on which their livelihoods depend, Congress has enabled a powerful constituency to mobilize against slashing payments rates. As a result, Part B costs have increased at an average rate of 9% annually over the past decade.<sup>106</sup>

Part of the trouble is that the overstretched CMS bureaucracy cannot itself update the thousands of RVUs that form the backbone of the fee schedule. Out of necessity, the agency has enlisted the help of an AMA panel called the Specialty Society Relative Value Update Committee (RUC), comprising mainly physician specialists, to review codes and recommend updates.<sup>107</sup> Lacking the resources and expertise necessary to push back with any force, CMS approves nine out of ten RUC recommendations.<sup>108</sup> As Uwe Reinhart has noted, CMS has *de jure* authority to adjust rates, but the RUC is the *de facto* decision-maker.<sup>109</sup> The large majority of adjustments increase the RVUs for particular medical services, and most of those adjustments

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<sup>104</sup> See Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525, 1558 (1996).

<sup>105</sup> See MAYES & BERENSON, *supra* n.22, at 92.

<sup>106</sup> Data for this calculation were drawn from the Department of Labor’s assessment of annual CPI-U and from the annual reports of the Boards of Trustees for the Medicare Trust Funds.

<sup>107</sup> See 76 Fed. Reg. 42772, 42778 (July 19, 2011).

<sup>108</sup> See Miriam J. Laugesen et al., *In Setting Doctors’ Medicare Fees, CMS Almost Always Accepts the Relative Value Update Panel’s Advice on Work Values*, 31 HEALTH AFFAIRS 5695 (2012).

<sup>109</sup> See Uwe E. Reinhardt, *The Little-Known Decision-Makers for Medicare Physicians Fees*, N.Y. TIMES ECONOMIX BLOG, Dec. 10, 2010.

are for specialty services. That encourages Medicare's bureaucrats at the bedside to provide larger volumes of these often-expensive services.<sup>110</sup>

Even if it had the resources, CMS lacks the timely data it would need to update the fee schedule. As it stands, CMS must wait for eighteen months or more for claims data from its carriers—another consequence of using contractors to process claims.<sup>111</sup> The lag time creates problems when a new treatment is introduced. The payment for the service is typically pegged to the initial costs of the treatment, but those costs often decline as the treatment becomes more common. The absence of timely review means that, over time, the new procedure is overcompensated and, hence, overprovided by Medicare's physicians. In the meantime, categories of services that lack new procedures—in particular, primary care—become relatively less remunerative.<sup>112</sup>

*Quality improvement.* There is little evidence that the shift to prospective payment has pushed physicians to practice higher-quality care.<sup>113</sup> In one sense, this is unsurprising: prospective payment was designed to address cost inflation, and little attention was paid to quality.<sup>114</sup> Along several dimensions, however, prospective payment may actually exacerbate quality concerns.

In the hospital setting, prospective payment rewards hospitals for providing low-quality care if such care leads to complications that generate higher DRG classifications or rapid readmissions.<sup>115</sup> In addition, hospital encouragement of early discharges poses a risk that patients will be discharged “quicker and sicker,”<sup>116</sup> especially where too-early discharges may lead to readmissions. Hospitals have also slashed nursing staff in response to prospective payment. This too is a consequence of Medicare's architecture: the fact that physicians are paid separately from the hospitals in which they practice means that hospital administrators often

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<sup>110</sup> See Vladeck, *supra* n.95, at 1956.

<sup>111</sup> See Chantal Worzala et al., *Challenges and Opportunities for Medicare's Original Prospective Payment System*, 22 HEALTH AFFAIRS 175, 177-78 (2003); see also MAYES & BERENSON, *supra* n.22, at 67 (“[T]he difference between making decisions in ‘real time’ versus ‘lag time’ is significant” and can lead to serious distortions in care delivery.”).

<sup>112</sup> See MEDICARE PAYMENT ADVISORY COMMISSION, MEDICARE AND THE HEALTH DELIVERY SYSTEM 16 (June 2011).

<sup>113</sup> See David M. Cutler, *The Incidence of Adverse Medical Outcomes Under Prospective Payment*, 63 ECONOMETRICA 29 (1995) (finding that, under prospective payment, “[t]here are more deaths in the hospital and the first two months post-discharge, but there is no change in the percentage of patients who have died after one year”); John F. Fitzgerald et al., *The Care of Elderly Patients with Hip Fracture*, 319 NEW ENG. J. MED. 1392 (1988) (finding worse quality outcomes for hip fractures after introduction of prospective payment); but see Lisa V. Rubenstein et al., *Changes in Quality of Care for Five Diseases Measured by Implicit Review, 1981 to 1986*, 15 J. AM. MED. ASS'N 1974 (1990) (finding that quality improved after introduction of prospective payment for five diseases);

<sup>114</sup> See DAVID G. SMITH, PAYING FOR MEDICARE 55 (1992).

<sup>115</sup> See DAVID S. GOODMAN ET AL., AFTER HOSPITALIZATION: A DARTMOUTH ATLAS REPORT ON POST-ACUTE CARE FOR MEDICARE BENEFICIARIES (2011) (documenting wide variation in readmission rates).

<sup>116</sup> See Jacqueline Kosecoff et al., *Prospective Payment System and Impairment at Discharge*, 264 J. AM. MED. ASS'N 1980 (1990) (finding 43% increase in unstable discharges after adoption of prospective payment).

find it easier to fire nurses than to shift physician practice patterns. But it's problematic. Copious research suggests that reductions in nursing staff contribute to lower-quality care.<sup>117</sup>

For physicians, the quality concerns are different. The fee schedule encourages the overuse of some specialty services, some of which are harmful to patients. Consider imaging services, for example. Because of the fee-for-service incentives baked into the fee schedule, physicians who own or lease their own imaging equipment can bill for each and every scan that they order. The result has been explosive growth in the volume of inappropriate diagnostic imaging services, including CT scans.<sup>118</sup> Yet CT scans involve relatively high doses of radiation and their increasing prevalence increases cancer risks.<sup>119</sup> To the extent that it encourages intensive medical care of negligible value, the fee schedule is inimical to quality care.

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When it comes to restraining cost growth, prospective payment remains the most successful reform in Medicare's history. But congressional inattention to the incentives and capacities of hospitals and medical societies, combined with Medicare's rickety administrative structure, has undermined its effectiveness in reshaping how physicians practice medicine. Hospitals often have little capacity to change how physicians with a separate source of revenue do their jobs. Medicare's abiding commitment to compensating for the full costs of care encourages both physicians and hospitals to adopt new and expensive technologies. When it comes to adhering to the global cap on Part B growth, medical societies have never even tried to restrain physician expenditures. And a hollow central bureaucracy without access to timely data has struggled without much success to restrain growth in payment rates to intensive specialty services.

### C. Medicare Managed Care

#### 1. Background

Believing that the private sector holds promise for controlling costs and improving quality, Congress has long authorized Medicare to purchase private insurance from managed care organizations on behalf of its enrollees.<sup>120</sup> The program assumed a prominent place in Medicare after legislation was enacted in 1982 authorizing the payment of a capitated amount—95% of the per capita expenditures for Medicare beneficiaries in the same county—for each enrollee in an approved health maintenance organization (HMO).<sup>121</sup> The assumption was that

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<sup>117</sup> See INSTITUTE OF MEDICINE, KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES (2004); Jonathan Gruber & Samuel A. Kleiner, *Do Strikes Kill? Evidence from New York State*, 4 AM. ECON. J. 127 (2012).

<sup>118</sup> See MEDICARE PAYMENT ADVISORY COMMISSION, *supra* n.112, at 35, 36.

<sup>119</sup> See David J. Brenner et al., *Computer Tomography—An Increasing Source of Radiation Exposure*, 357 NEW ENG. J. MED. 2277 (2007).

<sup>120</sup> See 1972 Amendments, §226 (adding §1876 to the Social Security Act).

<sup>121</sup> See Tax Equity and Fiscal Responsibility Act of 1982, §114(a), 96 Stat. 324, 342 (1982) (amending §1876(a)(1)(C) of the Social Security Act).



the HMOs could provide the full range of benefits more cheaply than traditional Medicare.<sup>122</sup> That assumption proved faulty. Because these HMOs enrolled disproportionately healthy beneficiaries, they increased overall Medicare expenditures.<sup>123</sup>

Redoubling its commitment to the program, Congress in 1997 expanded the range of insurance organizations that could contract with HCFA.<sup>124</sup> To keep costs in check, however, Congress also introduced risk adjustment (i.e., paying more for sicker enrollees and less for healthier enrollees) and capped most annual increases in payments to plans.<sup>125</sup> It quickly became apparent that Congress had cut into bone. A growing imbalance between rapidly rising medical costs and the low rate of increase in Medicare payments meant that offering Medicare+Choice plans became unprofitable for many insurers. Many fled the program.<sup>126</sup>

So in 2003, Congress again renamed the program—it would now be known as Medicare Advantage—and gave back what it had taken away.<sup>127</sup> To implement Medicare Advantage, CMS establishes county-level and regional benchmark amounts. Those benchmarks are in turn set through a complicated formula at an amount that exceeds the average costs of care for an enrollee in traditional Medicare. Local managed care plans then submit “bids,” which are their estimates of what it will cost to cover an average enrollee. If a plan’s bid is greater than the benchmark, Medicare will pay only the benchmark and enrollees must pay larger premiums to make up the difference. If a plan’s bid is less than the benchmark, the plan is paid its bid *plus* a rebate of 75% of the difference between the benchmark and the bid.

The inflated benchmarks, together with the rebates, means that Medicare Advantage plans receive artificially high capitated payments for every enrolled beneficiary. Insurers flocked back into the program and, by 2010, one in four Medicare beneficiaries was enrolled in a Medicare Advantage plan.<sup>128</sup> At the same time, however, per-capita spending for Medicare Advantage beneficiaries was 14% higher than under traditional Medicare.<sup>129</sup>

To cut what were thought to be excessive payments to Medicare Advantage plans, the ACA reduced the benchmark calculation.<sup>130</sup> In a move that partly offsets the ACA’s cuts, however, CMS has rolled out a “quality bonus” program that inflates reimbursement for the

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<sup>122</sup> See GOVERNMENT ACCOUNTABILITY OFFICE, *MEDICARE+CHOICE: PAYMENTS EXCEED COST OF FEE-FOR-SERVICE BENEFITS, ADDING BILLIONS TO SPENDING* 6 (2000).

<sup>123</sup> See *id.* at 3-4 (2000).

<sup>124</sup> See TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT* 114-15 (2003).

<sup>125</sup> See Balanced Budget Act of 1997, Pub. L. No. 105-33, §4001, 111 Stat. 251, 300, 301 (1997) (amending §§1853(a)(3) & 1853(c) of the Social Security Act).

<sup>126</sup> See Robert A. Berenson, *Medicare Disadvantaged and the Search for the Elusive “Level Playing Field”*, *W4 HEALTH AFFAIRS* 572, 574 (2004).

<sup>127</sup> See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, tit. II, 117 Stat. 2066, 2176 (2003).

<sup>128</sup> See MEDICARE PAYMENT ADVISORY COMMISSION, *REPORT TO THE CONGRESS* 291 (Mar. 2011).

<sup>129</sup> See *id.* at 294.

<sup>130</sup> See MEDICARE PAYMENT ADVISORY COMMISSION, *REPORT TO THE CONGRESS* xiv (Mar. 2009).

Medicare Advantage plans that cover almost all enrollees.<sup>131</sup> Because the benchmarks still exceed what traditional Medicare would spend, because of the quality bonus program, and because managed care plans are adept at enrolling low-risk beneficiaries, it still costs about 7% more to cover an enrollee in Medicare Advantage than in traditional Medicare.<sup>132</sup>

## 2. Assessment

For all its promise of tapping into market efficiencies, Medicare managed care has performed abysmally as a cost-control device. The reason, as before, is Congress's inattention to the incentives, capacity, and legitimacy of the private actors that it has embedded in Medicare to assert control over physicians.

The most serious challenge for private plans is that Congress put them in competition for enrollment with traditional Medicare, which guarantees free choice of provider and imposes few obstacles to receiving desired care. Medicare beneficiaries can opt out of Medicare Advantage plans almost at will.<sup>133</sup> Plus, there is little financial downside to switching to traditional Medicare.<sup>134</sup> As a result, the more aggressively a private plan manages care—by excluding high-cost physicians from networks, requiring specialist referrals from “gatekeeper” primary care doctors, or engaging in utilization review—the more likely a beneficiary will abandon the private plan for traditional Medicare.<sup>135</sup> In short, pushing physicians to change how they practice medicine threatens to depress enrollment.

In the face of this competition, Medicare Advantage plans remain viable by securing extra funding that they pass on to enrollees in the form of expanded benefits or reductions in Part B premiums. That extra funding comes from linking Medicare Advantage payments to benchmarks that exceed what is spent on enrollees in traditional Medicare.<sup>136</sup> Paying at parity, as MedPAC has advocated for a decade, would likely lead to an exodus of private plans. (Fear of such an exodus is probably why CMS rolled out its otherwise-indefensible “quality bonus” program.) But tying Medicare Advantage payments to cost inflation in traditional Medicare erodes the cost advantage that the plans are supposed to provide.

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<sup>131</sup> See MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS xx (June 2012).

<sup>132</sup> See *id.* at xx.

<sup>133</sup> See CMS, Tip Sheet: Understanding Medicare Enrollment Periods, at 7, 11 (2011), available at [www.medicare.gov/Publications/Pubs/pdf/11219.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11219.pdf) (explaining that beneficiaries can at a minimum opt out of Medicare Advantage from January 1 through February 14 and from October 15 through December 7 of each year).

<sup>134</sup> Some private plans are free, but so is Part A, and it costs less than \$100 per month for most beneficiaries to enroll in Part B. See Medicare.gov, FAQ on Medicare Premiums and Coinsurance Rates for 2012.

<sup>135</sup> See JOST, *supra* n.124, at 119, 120.

<sup>136</sup> See NATIONAL ACADEMY OF SOCIAL INSURANCE, THE ROLE OF PRIVATE HEALTH PLANS IN MEDICARE 14 (2003) (“The payment structure Congress established in law is an administered pricing system, not a market-based system.”).

The problem runs deeper than this competitive mismatch. The collapse of the managed-care revolution in the 1990s suggests that most (although not all) Medicare Advantage plans operate at too far a remove from the physicians with whom they contract to enlist them in a cooperative cost-reduction and quality-improvement endeavor. As James Robinson has described, insurers lack “the clinical skills to distinguish the experimental from the accepted therapy, the appropriate from the inappropriate procedure, the qualified from the unqualified physician, or the patient who is truly ill from the worried well.”<sup>137</sup> Market actors perceived as illegitimate by physicians face intense resistance when they move to reshape how physicians practice medicine. This resistance partly explains why private insurers have such a dismal cost-control record in the private sector.<sup>138</sup> At a minimum, the conflict that defines the relationship between insurers and physicians retards the sort of collaborative innovation upon which successful reform depends.<sup>139</sup>

As for quality, Medicare managed care—like all managed care—raises concerns because its capitated payments create incentives for plans to encourage their affiliated physicians to stint on care. Stinting may be especially attractive to Medicare Advantage plans if it encourages the costliest enrollees to switch back to traditional Medicare. Yet CMS’s resource constraints have given rise to acute managerial shortcomings when it comes to overseeing managed care plans.<sup>140</sup> Overwhelmed, CMS has been faulted time and again for shoddy oversight.<sup>141</sup>

What’s more, the limited oversight that does occur does not emphasize quality of care. The agency depends for quality review on reports of performance measures that reliably fail to capture important aspects of plan performance.<sup>142</sup> And regional CMS team charged with on-site monitoring typically lack the staffing and the medical expertise to assess the quality of medical care provided.<sup>143</sup> Notwithstanding the purported care-management prowess of Medicare Advantage plans, the evidence suggests that they perform no better than traditional Medicare on most dimensions and may do worse for beneficiaries with chronic conditions.<sup>144</sup>

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<sup>137</sup> Robinson, *supra* n.178, at 2627.

<sup>138</sup> See NATIONAL ACADEMY OF SOCIAL INSURANCE, *supra* n.136, at 93 (“There is little evidence that private insurance, which relies on market forces, has reduced the rate of growth in private health spending over the long term ...”).

<sup>139</sup> See Payton, *supra* n.14, at 136 (so arguing).

<sup>140</sup> See Richard Kronick, *Medicare and HMOs – The Search for Accountability*, 360 NEW ENG. J. MED. 2048, 2050 (2009) (“CMS lacks the mandate, resources, and flexibility to hold private health plans accountable ...”).

<sup>141</sup> See OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, *MEDICARE’S OVERSIGHT OF MANAGED CARE: IMPLICATIONS FOR REGIONAL STAFFING* i-ii (1998); U.S. GENERAL ACCOUNTING OFFICE, *MEDICARE: 21ST CENTURY CHALLENGES PROMPT FRESH THINKING ABOUT PROGRAM’S ADMINISTRATIVE STRUCTURE* 8 (2000).

<sup>142</sup> See NATIONAL ACADEMY OF SOCIAL INSURANCE, *supra* n.136, at 15 (reporting that “none of the current mechanisms for monitoring quality under either original Medicare or [Medicare managed care] can measure certain crucial dimensions of practice”).

<sup>143</sup> See Jonathan Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL. POL’Y & LAW 595, 623 (1997) (so reporting).

<sup>144</sup> See *id.* at 610 (canvassing mixed evidence on quality of care in HMOs).

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Medicare Advantage is a fraught program. By putting private plans in competition with a traditional Medicare program that eschews managed care tools, Congress has hobbled private plans' capacity to use those very tools to control the behavior of Medicare's physicians. Private insurers may also lack the knowledge and legitimacy to reshape physician practice patterns to account for governmental priorities. On top of that, Medicare's weakened central administration lacks the capacity to ensure that private plans do not stint on necessary care. The result is a managed care program that neither saves money nor improves quality.

#### D. *Limits on Technology*

##### 1. Background

Per the original 1965 statute, Medicare excluded coverage for care that was "not reasonable and necessary for the diagnosis or treatment of illness or injury."<sup>145</sup> This language remains in force today,<sup>146</sup> and has in practice been understood to exclude medically unnecessary services. In Medicare's early years, physicians and hospitals would coordinate with fiscal intermediaries and carriers to establish the scope of covered services, with significant deference given to physicians' assessment of medical necessity.<sup>147</sup> Few coverage questions demanded the attention of the federal bureaucracy.

As the fiscal consequences of paying for expensive new services became more apparent, however, pressure for additional federal oversight grew. On three separate occasions since the early 1980s, HCFA (now CMS) explored the possibility of using cost-effectiveness in excluding certain treatments from the scope of Medicare coverage. Each time, however, HCFA retreated in the face of fierce opposition from providers invoking fears of government rationing.<sup>148</sup> Thrice denied, CMS still lacks a regulation defining "reasonable and necessary." But the agency is quite clear that "the cost of a particular technology is not relevant in the determination of whether the technology improves health outcomes or should be covered for the Medicare population."<sup>149</sup>

With that cost-blind rule in mind, the Medicare program issues thousands of coverage determinations relating to medical efficacy each year. The overwhelming majority of such determinations issue from Medicare's insurance contractors (fiscal intermediaries and carriers);

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<sup>145</sup> 1965 Medicare Act, §102(a) (amending §1862(a)(1)).

<sup>146</sup> See 42 U.S.C. §1395(a)(1)(A).

<sup>147</sup> See Sean R. Tunis, *Why Medicare Has Not Established Criteria for Coverage Decision*, 350 NEW ENG. J. MED. 2196, 2196 (2004).

<sup>148</sup> See Susan Bartlett Foote, *Why Medicare Cannot Promulgate a National Coverage Rule: A Case of Regula Mortis*, 27 J. HEALTH POL. POL'Y & LAW 707 (2002).

<sup>149</sup> CENTERS FOR MEDICARE & MEDICAID SERVICES, GUIDANCE, FACTORS CMS CONSIDERS IN OPENING A NATIONAL COVERAGE DETERMINATION (Apr. 11, 2006). Cost considerations nonetheless appear to surreptitiously influence the level of scrutiny that CMS gives to new procedures. See Jacqueline Fox, *The Hidden Role of Cost: Medicare Decisions, Transparency, and the Public Trust*, 79 U. CIN. L. REV. 1, 5 (2010).

these “local coverage determinations” (LCDs) govern only in the contractors’ catchment areas.<sup>150</sup> To date, Medicare contractors have issued more than 2,000 LCDs.<sup>151</sup> Significantly, those LCDs are usually not all-or-nothing determinations. Instead, most LCDs provide that the treatment will be covered only for certain populations or conditions.<sup>152</sup>

When there are conflicting LCDs on a particular technology, or when the benefits of the technology are controversial, CMS may initiate proceedings to make a national coverage determination (NCD).<sup>153</sup> CMS issues between ten and fifteen NCDs each year,<sup>154</sup> for a total, to date, of 331 NCDs.<sup>155</sup> Fiscal intermediaries and carriers are responsible for policing compliance with NCDs and LCDs.

## 2. Assessment

The adoption of new medical technology, much of it of questionable medical value, appears to account for about 50% of Medicare’s cost growth.<sup>156</sup> For at least three reasons, however, coverage determinations have not enabled fiscal intermediaries and carriers to deter Medicare’s physicians from adopting novel and unproven technologies.

First, Medicare’s contractors have neither the capacity nor the incentives to enforce compliance with the thousands of local coverage determinations they issue each year. To get a sense of the scope of the enforcement challenge, consider that most LCDs conditionally approve medical interventions for use in certain subpopulations. Checking whether providers have complied with LCDs thus requires detailed clinical information—information that is rarely found in claims forms.<sup>157</sup> (The same sort of problem has plagued PRO efforts at utilization review.<sup>158</sup>) Although Medicare’s contractors can and sometimes do request additional information, the cost of collecting clinical information on millions of claims relating to thousands of different LCDs would be prohibitive.<sup>159</sup> And even if the contractors had the capacity to enforce coverage limitations, they would have little incentive to do so. There is no

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<sup>150</sup> See Alan M. Garber, *Commentary: The Impact of Medicare Coverage Policies on Health Care Utilization*, 43 HEALTH SERVICES RESEARCH 1302, 1304 (2008).

<sup>151</sup> See Susan Bartlett Foote et al., *The Impact of Medicare Coverage Policies on Health Care Utilization*, 43 HEALTH SERVICES RESEARCH 1285, 1287 (2008).

<sup>152</sup> See *id.* at 1289-93 (describing coverage restrictions of various LCDs).

<sup>153</sup> See 64 Fed. Reg. 22619, 22621 (1999).

<sup>154</sup> See Peter J. Neumann et al., *Medicare’s National Coverage Decisions, 1999-2007*, 27 HEALTH AFFAIRS 1620, 1621 (2008).

<sup>155</sup> See Centers for Medicare and Medicaid Services, Medicare Coverage Database, available at [www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx) (visited on Sept. 7, 2012).

<sup>156</sup> See Sheila Smith et al., *Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?*, 28 HEALTH AFFAIRS 1276 (2009); David M. Cutler, *Technology, Health Costs, and the NIH*, NAT’L BUREAU OF ECONOMIC RESEARCH, at 9 (Sept. 1995).

<sup>157</sup> See Alan M. Garber, *surpa* n.150, at 1305.

<sup>158</sup> See *supra* Part II.A.2.

<sup>159</sup> See Susan Bartlett Foote et al., *surpa* n.151, at 1300.

indication that CMS evaluates its contractors on whether they enforce their coverage determinations – or that CMS would even have the resources to do so.<sup>160</sup>

These enforcement challenges go some distance to explaining why a recent study, in comparing the effects of conditional local coverage determinations across different geographic regions, concluded that “coverage policies alone can, but generally do not, impact provider behavior.”<sup>161</sup> Although there has been no systematic research on national coverage determinations, there is suggestive evidence that Medicare contractors do not reliably enforce NCDs either. For just one example, Medicare does not cover colonoscopies within ten years of a prior colonoscopy that revealed no abnormalities. Yet Medicare contractors deny only about 2% of claims for inappropriate repeat colonoscopies.<sup>162</sup> From the perspective of Medicare’s physicians, few coverage limitations are of practical relevance.

Second, because CMS lacks clear statutory authority to consider costs, the coverage determinations that Medicare’s contractors are supposed to enforce are cost-blind. Even if the coverage determinations were adhered to, Medicare’s physicians would only avoid medical interventions of no proven value. So far as Medicare is concerned, where two treatments have been shown to be equally effective, physicians remain free to choose the more expensive one.

Nor is Medicare’s cost-blind posture likely to change anytime soon. Read in isolation, the Medicare statute’s exclusion of items and services that are “not reasonable and necessary” is ambiguous: it’s plausible that care is both “reasonable and necessary” whenever it confers a medical benefit, regardless of cost; it’s also plausible that expensive care of limited marginal benefit is neither reasonable nor necessary. CMS remains convinced that it could, per *Chevron*,<sup>163</sup> resolve that ambiguity to authorize the consideration of costs in passing on the scope of Medicare coverage.<sup>164</sup> To date, however, it has chosen not to.

Any such interpretation would be vulnerable to serious challenge. Read in context, the Medicare statute excludes coverage for “any expenses incurred for items or services ... which ... are not reasonable and necessary for the diagnosis or treatment of illness or injury.”<sup>165</sup> The “reasonable and necessary” clause immediately follows, and thus appears to modify, “items or services,” not “expenses.”<sup>166</sup> With that in mind, the textual connection between “reasonable and necessary” and “the diagnosis or treatment of illness or injury” suggests that reasonableness

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<sup>160</sup> See Medicare Contracting Reform: Redacted Benchmark Metric Reports, available at [www.cms.gov/MedicareContractingReform](http://www.cms.gov/MedicareContractingReform) (visited Aug. 9, 2011) (providing spreadsheet of contracting benchmarks, none of which mention LCDs).

<sup>161</sup> See Susan Bartlett Foote et al., *supra* n.151, at 1299.

<sup>162</sup> See James S. Goodwin et al., *Overuse of Screening Colonoscopy in the Medicare Population*, 171 ARCH. INTERN. MED. 1335, 1342 (2011).

<sup>163</sup> *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

<sup>164</sup> Appellants’ Reply Br. \_\_\_, *Hays v. Sebelius*, 589 F.3d 1279 (D.C. Cir. 2009).

<sup>165</sup> 42 U.S.C. §1395y(a)(1)(A).

<sup>166</sup> See *Barnhart v. Thomas*, 540 U.S. 20, 26 (2003) (discussing “the rule of the last antecedent”).

and necessity are to be gauged mainly with reference to an item or service's medical benefit.<sup>167</sup> Confirming the point, subsequent subparagraphs that lack a reference to "expenses" link the same "reasonable and necessary" clause to "items or services" and their use in the "prevention of illness"<sup>168</sup>—not to any assessment of cost.

Inferences from the Medicare statute's structure lend further support to the conclusion that the scope of coverage was to be cost-blind. When Medicare was enacted in 1965, many payments, including hospital payments, were keyed to the "reasonable cost" of the service provided.<sup>169</sup> At the time, this was understood to authorize Medicare's fiscal intermediaries to deny payment for costs they deemed unreasonable. The conferral of authority on intermediaries to consider the cost of medical treatment finds no counterpart in the Medicare statute's mandate to cover all "reasonable and necessary" medical care. This is arguably suggestive: Congress knew how to authorize the consideration of costs, and its failure to do so in connection with coverage determinations should perhaps carry weight.

To be sure, it would do no particular violence to English usage to say that an item or service is not "reasonable ... for the diagnosis or treatment or illness or injury" because it's too expensive. But that's probably not the most natural reading of the statute, and in any event courts might balk at a CMS interpretation that empowered it to ration care. The enacting Congress's painstaking efforts to avoid interfering in physician treatment decisions, Congress's refusal in the 48 years since to explicitly authorize CMS to consider costs, and a deep societal distaste for government rationing all lend considerable force to the intuition that Congress has never authorized Medicare to consider cost in making coverage determinations.<sup>170</sup>

Whatever the ultimate outcome in litigation, the critical point is that CMS would face a serious court challenge were it to insert cost into coverage determinations. Why invite such a test of its authority? Three prior agency efforts to allow for the consideration of costs have incited political resistance that was too formidable for the bureaucracy to withstand. CMS would be foolish to squander scarce agency resources on a politically fractious rulemaking that, even if successful, would stand a decent chance of judicial invalidation—or, failing that, of reversal by a Congress concerned that CMS had arrogated to itself authority to ration care.

The flexibility that the "reasonable and necessary" language ostensibly affords CMS is thus a mirage: the agency is effectively incapable of considering costs in issuing coverage determinations. From the perspective of encouraging physicians to practice cost-conscious care, this is problematic. Not only must Medicare devote taxpayer dollars to expensive treatments that offer no greater health benefit than cheaper alternatives. Worse, as Einer Elhauge has

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<sup>167</sup> The "reasonable and necessary" phrase was lifted from an Aetna insurance contract, apparently on the understanding that it imposed no meaningful check on treatment decisions. See Fox, *supra* n.12, at 593.

<sup>168</sup> See, e.g., 42 U.S.C. §1395y(a)(1)(B) (providing that "in the case of items and services described [elsewhere], which are not reasonable and necessary for the prevention of illness").

<sup>169</sup> 1965 Medicare Act, §102(a) (amending §1814(b) of the Social Security Act).

<sup>170</sup> See *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000) ("In extraordinary cases, ... there may be reason to hesitate before concluding that Congress has intended ... an implicit delegation [of gap-filling authority]."). For a discussion of the so-called "major questions" exception to *Chevron* deference, see Cass R. Sunstein, *Chevron Step Zero*, 92 VA. L. REV. 187, 231-47 (2006).

pointed out, Medicare's cost-blindness encourages the development and adoption of expensive treatments that offer only trivial health benefits over cheaper alternatives.<sup>171</sup>

Third, CMS has no gatekeeping authority to insist that physicians and hospitals demonstrate the efficacy of a new treatment through scientific trials. (FDA does have such authority, which goes some distance to explaining its power when compared to the weak CMS.<sup>172</sup>) Yet the agency lacks the resources to finance rigorous exploration of safety and efficacy of those technologies and services for which the available evidence is lacking. And so, in the rare case that CMS does issue an NCD, the evidence upon which it bases its coverage determination is usually of very poor quality.<sup>173</sup> Even then, the agency's focus on medical innovations scratches only the surface of the problem. Researchers estimate that only between ten and twenty percent of the therapies in widespread use have ever been subjected to rigorous analysis of their safety and efficacy.<sup>174</sup> Without conscientious review of older therapies in widespread use, Medicare coverage determinations can do little to nudge physicians to practice cost-conscious, high-quality care.

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Medicare's tentative efforts to limit the diffusion of wasteful medical technology have come to naught. The program relies on woefully inadequate outside contractors to police conformity with coverage limitations. It is unable to consider costs in deciding what to cover. And it lacks the resources to evaluate novel medical technology. Taken together, these factors have hobbled Medicare's efforts to influence physicians' use of costly medical technologies of limited or uncertain benefit.

### III. HOW TO THINK ABOUT MEDICARE REFORM

If Medicare reform has persistently failed to align physician practice patterns with federal priorities, what are we to make of that? One plausible response is: not much. The instinct to shrug could come from at least three sources. First, consider the possibility that the pattern of failure is a kind of backhanded success. Maybe Congress's inattention and persistent refusal to rethink Medicare's structure reflects a deep-seated cultural view that, although cost control and quality improvement would be nice, they aren't important enough to warrant government meddling in the physician-patient relationship.

Second, it's possible that Medicare reform, however thoughtfully crafted, is predestined to fail. All countries in the developed world have struggled to constrain rising health expenditures and to address persistent quality concerns. Maybe no government program stands

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<sup>171</sup> See Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1471 (1994).

<sup>172</sup> See generally DANIEL CARPENTER, REPUTATION AND POWER: ORGANIZATIONAL IMAGE AND PHARMACEUTICAL REGULATION AT THE FDA (2010) (offering exhaustive account of FDA's use of gatekeeping authority to augment its power).

<sup>173</sup> See Peter J. Neumann et al., *supra* n.154, at 1623 (finding that "CMS considered the evidence only fair or poor for most of the technologies evaluated since 1999").

<sup>174</sup> See OFFICE OF TECHNOLOGY ASSESSMENT, IDENTIFYING HEALTH TECHNOLOGIES THAT WORK 21 (1994)



a chance. Plus, Medicare is only one payer among many, covering just one-fifth of medical spending in the country.<sup>175</sup> How much leverage over physicians can it expect to have?

Third, perhaps the reforms were unnecessary and unwise to begin with. Better that private payers—employers and insurers—take the lead in reshaping how physicians practice medicine. Private payers will calibrate their efforts with reference to what the market demands, not cater to confused and ambivalent public opinion about the “right” amount of medical spending or the “right” level of investment in quality improvement. Given the risk of unintended consequences arising from government intervention, Medicare should be the incidental beneficiary of private-market reforms, not the other way round.

Yet a shrug is not in order. A complete response to these objections is that Medicare reform is coming. However uncommitted Congress may have been to meaningful reform in the past, however unlikely that Medicare reform will succeed, and however unnecessary or unwise governmental intervention might be, it’s still coming. Absent a revolutionary willingness on the part of the American public to accept a much higher tax burden, a far greater share of medical costs, or indiscriminate Medicare cuts, the federal government cannot long continue to bear ever-increasing Medicare expenditures.<sup>176</sup> If reform is in the offing, its success—at least as measured by its professed aims of slashing costs and improving quality—will depend on whether it enables the assertion of control over the physicians that implement the program at the bedside.

None of this is to deny the imperative that physicians retain discretion to practice medicine in line with their professional judgments. The staggering complexity of the practice of medicine cannot be reduced to simple formulas, especially for those Medicare patients that suffer from chronic conditions and multiple co-morbidities. In addition, responsible medical practice demands sensitivity to patient desires—and the exercise of considerable human judgment when patients are confused or uncertain about what they want. Discretion is part of what physicians do.

As important, this discretion serves a critical legitimization function.<sup>177</sup> The centrality of discretion to the legitimacy of intervention in the physician-patient relationship was on vivid display in the collapse of the managed-care revolution of the late 1990s, where patients rebelled against insurers that, in their efforts to restrain medical spending, were thought to have trenched too far on physician discretion.<sup>178</sup> Physician discretion is the linchpin of Medicare’s legitimacy and popularity.<sup>179</sup> The challenge is to preserve Medicare’s legitimacy by channeling

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<sup>175</sup> See KAISER FAMILY FOUNDATION, *MEDICARE CHARTBOOK 78* (4th ed. 2010).

<sup>176</sup> See Newhouse, *supra* n.9, at 8 (so arguing).

<sup>177</sup> See LIPSKY, *supra* n.6, at 14 (“For both workers and clients, maintenance of discretion contributes to the legitimacy of the welfare-service state.”).

<sup>178</sup> See James C. Robinson, *The End of Managed Care*, 285 J. AM. MED. ASS’N 2622, 2627 (2001) (arguing that managed care “can be characterized as a partial economic success and total political failure”).

<sup>179</sup> See Richard B. Stewart, *Administrative Law in the Twenty-First Century*, 78 N.Y.U. L. REV. 437, 449 (2003) (noting that “government-stakeholder network structures” are adopted for a variety of reasons, among

physician discretion in a clinically sensitive manner, one that both physicians and beneficiaries accept, if sometimes grudgingly. On this front, Troyen Brennan and Donald Berwick's central lesson about health-care regulation is apt: that its legitimacy and effectiveness depends on whether it engages physicians in a cooperative endeavor or instead foments acrimony.<sup>180</sup>

Reforming Medicare to enable the assertion of control over physician behavior is all the more difficult in that Congress still has only a limited range of action available to it. The same constraints that influenced its choice of reform policy in the past—stiff public resistance to governmental interference in medical practice, an immovable commitment to the public financing of private care, and a deep reluctance to expand the size and power of the federal bureaucracy—all remain in place.

It's worth identifying what that takes off the table. The creation of a new government bureaucracy directly responsible for providing medical care—socialized medicine along the lines of Britain's National Health Service—is not a politically plausible option. It is no more realistic to wish for the sort of monumental expansion of the resources and authority of CMS that would be needed to assert control over hundreds of thousands of physicians scattered across the country. Such an expansion would trigger not only visceral antipathy toward the expansion of the federal government. It would also provoke acute anxiety about government meddling in the practice of medicine. Plus, it's far from obvious that even a legion of federal functionaries could successfully push front-line physicians to reduce costs and improve quality. In all likelihood, Medicare's very legitimacy would be threatened by such an assertive effort to salvage the program.

What's left? If past is prologue, Congress will attempt again to enlist private actors in the task of adjusting physician practice patterns. In contrast to the private actors that have come before, these actors must have the capacities and incentives to sidestep Medicare's core structural failings and adjust the practice patterns of private physicians. Perhaps encouragingly, such private actors—known variously as integrated delivery systems, integrated hospital systems, and multispecialty group practices—do exist. For one celebrated example, take Kaiser Permanente in California. Kaiser provides comprehensive care to its patients in exchange for a prepaid fee; patients in turn are restricted to Kaiser hospitals and Kaiser physicians, giving the organization a financial interest in keeping medical costs low by coordinating patient care. In part because its physicians are salaried employees, Kaiser has the leverage to assure that its physicians practice medicine consistently with organizational priorities. Kaiser has in turn developed a culture that values collaboration, adherence to practice guidelines, and cost-conscious medicine. Other integrated medical organizations—including Intermountain Healthcare in Utah, the Geisinger Health System in Pennsylvania, and the Mayo Clinic in Minnesota—offer similar success stories.<sup>181</sup>

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them “tapping the knowledge and experience of these constituencies, and securing their participation in more effective implementation of an agency's policies”).

<sup>180</sup> See BRENNAN & BERWICK, *supra* n.83, at 28.

<sup>181</sup> See WENBERG, *supra* n.42, at 13 (discussing the systems).

In principle, the concept is elegant. To effectively manage programs that rely on a network of private actors for implementation, the government cannot depend on the rules and hierarchies of classic Weberian bureaucracies. Instead, the government must develop techniques for assuring that private organizations shape the conduct of the front-line actors who work there.<sup>182</sup> In this, enlisting organized medical systems offers a kind of Weberian solution to the accountability and management troubles created by Medicare's reliance on private actors. Physicians have long functioned as the program's bedside bureaucrats, but with so few trappings of bureaucracy that it escapes conscious notice. If reform is to succeed, Medicare must bring bureaucracy to the bureaucrats.

The notion that Medicare needs more bureaucracy may have a somewhat dystopian ring to it. But bureaucracy does not necessarily imply endless red tape, rigid rules, or insensitivity to patient needs. The challenge is to honor physician demands for clinical autonomy while at the same time protecting organizational (and, by extension, governmental) priorities. Existing care organizations have developed a variety of techniques to meet that challenge. At Intermountain, for example, committees of physicians and nurses have developed dozens of treatment protocols for relatively common conditions based on a mix of medical evidence, common practices, and informed guesswork. Distributed throughout the organization, these protocols become default treatment options. Although physicians can easily deviate from these defaults, they do so rather infrequently, and the protocols have both reduced treatment variation (usually by reducing care intensity) and improved quality of care.<sup>183</sup> Other organized systems have rolled out "checklists" to guide physicians and nurses in carrying out routine treatments. Some of these checklists have been shown to dramatically improve care quality without materially infringing on physician discretion.<sup>184</sup> Still other systems are experimenting with remote "command centers" that allow a physician-led team at a central location to oversee a number of far-flung intensive-care units. Interactions between the remote team and the physicians at the bedside often partake of a negotiation—a suggestion here, a question there—that may nonetheless aid in standardizing care and improving quality.<sup>185</sup>

The point is not that these are ideal models of physician control. It is rather that organized systems bent on adjusting how their physicians practice medicine can successfully rebalance the interests of physicians, patients, and payors without surrendering their legitimacy. In this, they offer a contrast to the managed care organizations whose heavy-handed tactics proved so controversial in the late 1990s. Perhaps health-care organizations with patient care and not actuarial tables in their organizational DNA could improve on insurers' performance.

The attractiveness of using integrated systems of medical care as a model for reform has not gone unnoticed. John Wennberg, for example, has argued at length that organized health-

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<sup>182</sup> See Kettl, *supra* n.56, at 493 (observing that government officials "must find tools to influence the behavior of frontline service providers who work in other organizations").

<sup>183</sup> See David Leonhardt, *Making Health Care Better*, N.Y. TIMES MAGAZINE, Nov. 3, 2009.

<sup>184</sup> See Peter Pronovost et al., *An Intervention to Decrease Catheter-Related Bloodstream Infection in the ICU*, 355 NEW ENG. J. MED. 2725 (2006).

<sup>185</sup> See Atul Gawande, *Big Med*, NEW YORKER, Aug. 13, 2012.

care systems are key to reducing spending on unnecessary treatments and improving quality.<sup>186</sup> The refrain, however, is often followed by a lament that few successful organized systems exist and that there is no easy way to replicate what they have accomplished.<sup>187</sup> However much Congress would like to put integrated delivery systems at the center of the program—to contract directly with them for the delivery of care, instead of with a distributed network of physicians—there are not enough to go around.<sup>188</sup>

This dearth of appropriate contractors, however, is not at all unusual for government programs. Where the market doesn't offer what the government needs, the government must motivate the market to do so.<sup>189</sup> In the past, Medicare itself has deliberately and successfully stimulated market innovation: the enactment of Part D spurred the rapid proliferation of previously unknown stand-alone drug plans.<sup>190</sup> And some measure of greater integration is happening already, as more and more physicians leave private practice to join larger medical organizations.<sup>191</sup> The task of Medicare reform is to capitalize on this emerging trend and accelerate the development of organized systems of medical care that have the financial incentives, institutional capacities, and societal legitimacy to change how physicians practice medicine.

Against that backdrop, I detail below how the same structural features of Medicare's design that bedeviled past reform efforts have retarded, and will continue to retard, the development of organized systems of care. This will allow for the tentative exploration of politically plausible reform measures that could foster the development of these organized systems.

#### A. *Bundling.*

Medicare's disaggregated fee-for-service payment model encourages the zealous provision of intensive and uncoordinated medical care.<sup>192</sup> Physicians are often reluctant to trade a payment system that rewards them for high-intensity care for a position in a bureaucracy that will interfere with how they practice medicine. The integrated systems that do exist face similar perverse incentives: reductions in care intensity lead to a reduction in their fee-for-service

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<sup>186</sup> See WENBERG, *supra* n.42, at 12.

<sup>187</sup> See, e.g., Austin B. Frakt & Rick Mayes, *Beyond Capitation: How New Payment Experiments Seek to Find the 'Sweet Spot' in Amount of Risk Providers and Payers Bear*, 31 HEALTH AFFAIRS 1951, 1955 (2012) ("An unanswered question is how [organizations like Geisinger and Kaiser] can be successfully replicated.").

<sup>188</sup> See WENBERG, *supra* n.42, at 12 ("The bad news is that the United States does not have enough of them.").

<sup>189</sup> See Kettl, *supra* n.56, at 496 (arguing that government's burden is to "stimulate the market to produce goods and services that otherwise would not be produced").

<sup>190</sup> See MORGAN & CAMPBELL *supra* n.20, at 159 (noting that one indication of Part D's success "is that a market of stand-alone drug plans came into being at all").

<sup>191</sup> See Gardiner Harris, *More Doctors Giving Up Private Practices*, N.Y. TIMES, Mar. 25, 2010.

<sup>192</sup> See Mark McClellan et al., *A National Strategy to Put Accountable Care Into Practice*, 29 HEALTH AFFAIRS 982, 982 (2010) ("The current system, based on volume and intensity, does not disincentivize, but rather pays more for, overuse and fragmentation.").

payments. Intermountain's successful efforts to reduce service intensity and improve quality, for example, have proven "financially destabilizing."<sup>193</sup> In the early 2000s, the Mayo Clinic billed Medicare an average of \$53,432 for each chronically ill patient over the patient's last two years of life. The UCLA Medical Center, in contrast, billed \$93,842.<sup>194</sup> Similar variations exist across the country. What possible financial incentive does UCLA have to look more like Mayo?

To accelerate a shift toward organized systems with the proper incentives to encourage their physicians to practice cost-conscious care, Medicare must move away from separately paying hospitals and physicians for discrete interventions. It must instead embrace lump-sum payments that go not to individual physicians, but to organizations that would enter into private arrangements with care providers to distribute the Medicare payments. Those lump-sum payments could be keyed to a single intervention (e.g., a hip replacement), a discrete episode of care (e.g., an acute care stay plus post-inpatient treatment for 60 days), or to an individual beneficiary (e.g., capitation). Whatever its precise shape, however, Medicare must start to pay for care in much bigger bundles.<sup>195</sup>

An assertive shift to bundled payments would encourage the development of organizations that could accept and distribute such payments. Lump-sum payments would in turn give these health-care organizations a financial incentive to discourage their physicians from practicing high-intensity care of little medical value. Paying in bundles would also erode the artificial regulatory divide between Parts A and B, a divide that perpetuates the fragmentation of the health-care system and impedes care coordination for the elderly and disabled beneficiaries whose chronic conditions demand comprehensive management.

Medicare must also assure that physicians embed themselves in such organizations. As it stands, Medicare is sufficiently generous that an average physician who saw only Medicare patients would still make roughly \$240,000 in a year.<sup>196</sup> Small wonder, then, that 96% of the nation's physicians participate and that many are reluctant to relinquish independent practice.<sup>197</sup> To encourage them to do so, Part B payments should be cut for those complex treatments or chronic episodes of care that should ideally be provided in integrated systems. Facing reductions in direct Part B payments, more physicians would find it attractive to abandon the relative freedom of private practice for the constraints of institutional affiliation.

Medicare managed care stands as the program's most elaborate experiment with bundled payments. Medicare Advantage plans are today paid in very large bundles—capitated payments. Yet the plans cannot assiduously manage physician practice patterns while they try to compete with traditional Medicare, and in any event may lack the capacity or legitimacy to

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<sup>193</sup> WENNBERG, *supra* n.42, at 220.

<sup>194</sup> *See id.* at 172.

<sup>195</sup> *See* Ezekiel Emanuel, *Saving by the Bundle*, N.Y. TIMES, Nov. 20, 2011 (endorsing bundled payments).

<sup>196</sup> *See* ROBERT BERENSON ET AL., WHAT IF ALL PHYSICIAN SERVICES WERE PAID UNDER THE MEDICARE FEE SCHEDULE?, at 13, 14 (Mar. 2010).

<sup>197</sup> *See* KAISER FAMILY FOUNDATION, *supra* n.175, at 28.

recruit private physicians in a cooperative push to constrain spending and improve quality.<sup>198</sup> Organized health-care systems are much closer to the physicians that practice within them, and are much better-positioned to establish the internal procedures and organizational culture that will lend legitimacy to cost-control efforts. Theodore Ruger puts it nicely: “By enlisting (or conscripting) individual treating physicians in the cost-control enterprise, payment reform does not unsettle the longstanding for of the treatment interaction in the way that direct managed care utilization review did, even as it shifts key incentives behind the scenes.”<sup>199</sup>

On a smaller scale, Medicare has had some provisional success with bundled payments. In a demonstration project carried out from 1991 to 1996, HCFA dubbed seven hospitals “Centers of Excellence” for coronary artery bypass graft (CABG) surgery and offered to those Centers a lump sum per CABG surgery that would then be distributed between the hospitals and their affiliated physicians. As MedPAC explained, “with a global payment for hospital and physician services, the hospital can restructure physicians’ payment to give them the financial incentive to be more cost efficient.”<sup>200</sup> The Centers of Excellence cut CABG costs by 10% even as they reduced mortality.<sup>201</sup>

On the quality side, mandatory bundling could invigorate Medicare’s nascent pay-for-performance initiatives.<sup>202</sup> Under such initiatives, payments are increased in connection with adherence to clinical guidelines, reductions in unnecessary care, avoidance of errors, or improved patient outcomes. Although the early returns on Medicare’s pay-for-performance initiatives are not inspiring,<sup>203</sup> the program has charged ahead. In 2008, CMS launched its first program-wide pay-for-performance scheme and eliminated payments to inpatient hospitals for ten preventable hospital-acquired conditions.<sup>204</sup> The ACA includes two additional pay-for-performance initiatives: one that cuts Medicare payments for hospitals with high rates of

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<sup>198</sup> See *supra* Part II.C.2.

<sup>199</sup> Theodore W. Ruger, *Plural Constitutionalism and the Pathologies of American Health Care*, 120 YALE L.J. ONLINE 347, 364 (2011), [yalelawjournal.org/2011/3/21/ruger.html](http://yalelawjournal.org/2011/3/21/ruger.html).

<sup>200</sup> MEDICARE PAYMENT ADVISORY COMMISSION, VARIATION AND INNOVATION IN MEDICARE 139 (June 2003).

<sup>201</sup> See *id.* at 140.

<sup>202</sup> See INSTITUTE OF MEDICINE, REWARDING PROVIDER PERFORMANCE (2007) (embracing pay-for-performance); DAVID M. CUTLER, YOUR MONEY OR YOUR LIFE 100-113 (2004) (same).

<sup>203</sup> See Meredith B. Rosenthal, *Beyond Pay for Performance – Emerging Models of Provider-Payment Reform*, 359 NEW ENG. J. MED. 1197, 1197 (2008) (noting that pay-for-performance initiatives have shown “somewhat lackluster early results” and are “characterized by some as putting lipstick on a pig”); Andrew M. Ryan et al., *Medicare’s Flagship Test Of Pay-For-Performance Did Not Spur More Rapid Quality Improvement Among Low-Performing Hospitals*, 31 HEALTH AFFAIRS 797 (2012) (describing significant slowdown in quality improvements from the first few years of the program); Peter K. Lindenauer et al., *Public Reporting and Pay for Performance in Hospital Quality Improvement*, 356 NEW ENG. J. MED. 486 (2007) (reporting modest improvement in quality measures).

<sup>204</sup> 72 Fed. Reg. 47130, 47200-18 (2009).

readmission,<sup>205</sup> and the other that distributes a pool of money to hospitals according to their relative performance on twelve clinical care measures.<sup>206</sup>

Offering bundled payments to organized health-care systems could put these pay-for-performance efforts on a better footing. Intractable questions of measurement and assignment foreclose pay-for-performance initiatives targeted directly at Medicare's physicians.<sup>207</sup> The second-best option—and the one that CMS has gravitated to—is to pay for performance at institutions, usually hospitals. But this means that Medicare ignores medical care outside hospitals, a striking oversight given the large amount of care (particularly care for chronic conditions) offered in non-institutional settings. Nor is it obvious that paying for performance at the hospital level will reliably adjust physician practice patterns.<sup>208</sup> Hospitals often lack much influence over their treatment decisions. Integrated health-care organizations are much better-positioned to encourage physicians to attend to quality concerns.

Bundling might even allow Medicare to use competitive bidding to improve the efficiency and quality of the services for which it pays. David Hyman, for one, wonders why “almost no one has asked why the form of price setting used by the government in other parts of procurement (competitive bidding) is effectively nonexistent in Medicare.”<sup>209</sup> Part of the answer is structural. To date, Medicare has embraced competitive bidding only for durable medical equipment, where the market is vibrant and where holding a manageable number of national competitions could yield large programmatic savings.<sup>210</sup> These conditions are altogether absent for traditional Medicare, where an insistence on paying separately for individual physician services would make competitive bidding impossibly cumbersome. Encouraging the development of organized health-care systems could facilitate competition between them for the opportunity to cover services arising from discrete episodes of care.<sup>211</sup>

#### B. Restricting.

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<sup>205</sup> See ACA, §3025, modified by Reconciliation Act, §10309.

<sup>206</sup> See ACA, §3001(a) (adding §1886(o) to the Social Security Act) (establishing the Hospital Value-Based Purchasing Program); 76 Fed. 2454, 2481-83 (Jan. 13, 2011) (discussing method of payment distribution).

<sup>207</sup> See Karen Milgate & Sharon Bee Cheng, *Pay-For-Performance: The MedPAC Perspective*, 25 HEALTH AFFAIRS 413, 416-17 (2006) (noting that paying physicians for performance is challenging “because of the lack of a data infrastructure, the wide variety of specialties, and the sheer number of physicians”).

<sup>208</sup> See Andrew Ryan & Jan Blustein, *Making the Best of Hospital Pay for Performance*, 366 NEW ENG. J. MED. 1557, 1559 (2012) (noting that “we know little about how information about financial incentives is processed in the ‘nervous system’ of hospitals, how that knowledge is transmitted to the appropriate actors, or how actors mount effective responses”).

<sup>209</sup> HYMAN, *supra* n.14, at 22.

<sup>210</sup> See Robert F. Coulam et al., *Competitive Pricing and the Challenge of Cost Control in Medicare*, 36 J. HEALTH POL. POL'Y & LAW 649, 657 (2011) (citing “reports from the initial round of DME rebidding show the possibility of substantial savings—the average savings across all product categories was 32 percent”).

<sup>211</sup> See *id.* at 651 (observing that competitive bidding could work in principle “[f]or health plan premiums and other plausible items or bundles of health care services”).

By statute, Medicare is committed to reimbursing providers for the reasonable costs of their chosen treatment. Accordingly, when it sets prices under the prospective payment system—whether through DRGs or the fee schedule—Medicare attempts to reimburse providers for the median cost of providing medically necessary care to a representative patient.<sup>212</sup> As a result, prospective payment rates increase as new technologies are adopted, even if those technologies are expensive and offer no benefits over alternatives. From a fiscal perspective, this is problematic. Because at least half the cost growth in health care can be chalked up to medical technology, any plausible Medicare reform must somehow check the propensity of Medicare physicians to adopt expensive treatments of little or no marginal value.

Paying in bundles could help. If an organization is paid a flat rate and can achieve equivalent results with cheaper technology, it will adopt that technology.<sup>213</sup> Experience in Britain is instructive. The National Health Service's relative success in managing the use of expensive medical technology has much to do with its fixed national budget for health-care expenditures. Around 80% of that national budget is distributed to roughly 150 regional boards known as "primary care trusts," which in turn allocate those funds among general practitioners and hospitals, which employ specialist physicians. GPs and hospital must then stretch their allocated resources to cover patient care, forcing difficult but necessary tradeoffs between investments in new technology and other costs (additional personnel, new facilities, etc.).<sup>214</sup> As Henry Aaron and William Schwartz have described, providers in resource-constrained systems must of necessity harmonize their professional obligations with their role as "society's agents" in dispensing medical benefits.<sup>215</sup> Although professional and social obligations may clash, the NHS has retained its legitimacy by shifting decisions of how most effectively to allocate scarce resources onto the medical community. Medicare could stand to do the same.<sup>216</sup>

But how big should the bundled payments be? If the Medicare statute continues to require coverage of the costs of marginally beneficial treatments, pressure will inevitably build to expand the size of the bundles to cover expensive treatments of uncertain or dubious value. Assured of continuing increases in bundled payments, organized health-care systems may have inadequate incentives to avoid useless new treatments. (The same sort of dynamic has interfered with the effectiveness of the prospective payment system for hospitals.<sup>217</sup>) To

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<sup>212</sup> See *supra* Part II.B.1.

<sup>213</sup> See Elhauge, *supra* n.104, at 1526 (observing that "any shift to cost-sensitive means of financing and providing health care *decreases*, not *increases*, the need to restrict the entry of expensive new technologies").

<sup>214</sup> See HENRY J. AARON & WILLIAM B. SCHWARTZ, CAN WE SAY NO? THE CHALLENGE OF RATIONING HEALTH CARE 19-20, 30-92 (2005) (documenting how budget constraints have shaped the British health care system).

<sup>215</sup> *Id.* at 102.

<sup>216</sup> See Lester M. Salamon, *The Tools Approach and the New Governance: Conclusions and Implications*, in THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE 602 (Lester M. Salamon, ed. 2002) (observing that relying on private organizations may "offer an added measure of legitimacy to public action by engaging a number of other institutions in public work").

<sup>217</sup> See *supra* Part II.B.2.



discipline these systems, Congress should relax Medicare's commitment to covering a median provider's reasonable costs. After all, current costs will be artifacts of a system that encourages the over-provision of supply-sensitive care. Instead, CMS should be authorized to set bundled payments with reference to the costs that low-cost benchmark organizations spend to cover the costs of medically necessary care (per patient or per episode of care). Any shift to benchmark payments should be gradual: as Stuart Altman has emphasized, precipitate cuts might be politically unsustainable, and the important point at the outset is to force major changes in care management.<sup>218</sup> Over time, however, falling reimbursement would put immense pressure on organized systems to learn from benchmark organizations how they encourage their physicians to practice cost-conscious care—or to innovate their own solutions.

On this model, Medicare would no longer make coverage determinations. It would instead set bundled payments with an eye to established best practices. Medicare has tried a similar tactic before: for a brief period, it employed a pricing strategy for durable medical equipment and some drugs known as the “least costly alternative,” under which Medicare payment was set with reference not to the item in question, but to the lowest-cost item that would achieve comparable clinical results.<sup>219</sup> The policy was abandoned, however, when the D.C. Circuit held that it violated the Medicare statute.<sup>220</sup>

All of which raises an important and provocative question. Should organizations receiving bundled payments have the legal latitude to deny care deemed insufficiently cost-effective? Should they, in other words, be empowered to ration care? At least in the short to medium term, winnowing out medical treatments that provide no demonstrated benefit may be sufficient to stave off stratospheric cost escalation.<sup>221</sup> In the longer run, however, Congress may need to explore relieving health-care organizations of their obligations (under both state and federal law) to provide cost-ineffective care. Yet doing so would necessitate wrenching and controversial changes to the current legal regime—a regime that, as Elhauge has argued, is unremittingly hostile to private efforts to deny marginally beneficial care on cost grounds.<sup>222</sup>

### C. *Culling.*

Part of the original Medicare deal was that all licensed physicians would be eligible to receive Medicare reimbursement and that all beneficiaries would have their free choice of physician.<sup>223</sup> As a result, in the words of one former acting administrator, “the worst physician

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<sup>218</sup> See Altman, *supra* n.98, at 1926.

<sup>219</sup> See MEDICARE PAYMENT ADVISORY COMMISSION, ALIGNING INCENTIVES IN MEDICARE 6 (June 2010).

<sup>220</sup> See *Hays v. Sebelius*, 589 F.3d 1279 (2009).

<sup>221</sup> See WENBERG, *supra* n.42, at 3 (“[C]ontrolling costs will not necessarily require rationing—if by ‘rationing’ we mean the withholding of care that patients want, and that is effective in improving outcomes.”).

<sup>222</sup> See Elhauge, *supra* n.104, at 1526 (“We encourage market participants to minimize cost but simultaneously subject them to the constraint that they not do so by denying any beneficial care.”).

<sup>223</sup> See *supra* Part I.D.

in America can participate in [Medicare]—and probably does, in fact.”<sup>224</sup> In a number of ways, this has complicated the development of those organized, integrated health-care systems that could exert control over the practice patterns of physicians. Assured of their continued participation in Medicare, physicians are often reluctant to surrender their autonomy. Those that do join integrated systems can credibly threaten to leave if efforts to shift their practice patterns are thought too onerous. And because patients can seek care from anyone, integrated systems have limited capacity to direct patients to those physicians over whom the systems have some measure of control.

Repeated calls from lawmakers<sup>225</sup> and commentators<sup>226</sup> to empower CMS to favor efficient, high-quality providers have gone nowhere. In an important 2007 report, GAO joined the chorus and concluded CMS could reduce spending growth were it to profile physicians and avoid outlier physicians with remarkably high costs.<sup>227</sup> Yet GAO noted that Medicare lacks statutory authority to “designate preferred providers, assign physicians to tiers associated with varying beneficiary copayments, tie fee updates of individual physicians to meeting performance standards, or exclude physicians who do not meet practice efficiency and quality criteria.”<sup>228</sup>

The problem, however, runs deeper than GAO imagines. An ingrained and intense distrust of government power—particularly in the health-care field—precludes giving CMS the authority and resources it would need to evaluate its physicians, much less to then tier them or exclude large numbers of them.<sup>229</sup> The trick, again, is to accelerate the development of third-party organizations with the incentives, capacity, and legitimacy to do what Medicare cannot: direct beneficiaries to efficient, high-quality physicians. Medicare Advantage plans have already assumed that responsibility, and—in a marked deviation from the Medicare statute’s bedrock commitments to universal physician participation and free patient choice—can tailor their provider networks as they deem appropriate. The Medicare statute should be revised along similar lines to condition coverage on staying within integrated medical systems for the entire episode of care that a bundled payment covers.

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<sup>224</sup> John K. Iglehart, *Doing More with Less: A Conversation with Kerry Weems*, HEALTH AFFAIRS WEB EXCLUSIVE w688, w694 (June 18, 2009).

<sup>225</sup> See Medicare Value-Based Purchasing for Physicians’ Services Act of 2005, H.R. 3617, 109th Cong. (2005) (proposed bill).

<sup>226</sup> See Robert A. Berenson & Dean M. Harris, *Using Managed Care Tools in Medicare—Should We? Could We?*, 65 LAW & CONTEMP. PROBS. 139, 147-49 (2002) (suggesting use of selective contracting in Medicare); LYNN ETHEREDGE, REENGINEERING MEDICARE: FROM BILL-PAYING INSURER TO ACCOUNTABLE PURCHASER 7 (1995) (arguing that “Medicare needs the authority to select providers based on quantifiable measures of quality, outcomes, and service”).

<sup>227</sup> See U.S. GOVERNMENT ACCOUNTABILITY OFFICE, MEDICARE: FOCUS ON PHYSICIAN PRACTICE PATTERNS CAN LEAD TO GREATER PROGRAM EFFICIENCY 21 (2007).

<sup>228</sup> *Id.* at 20.

<sup>229</sup> See MORGAN & CAMPBELL *supra* n.20, 226 (arguing that one of the “basic parameters of American politics” is “that the public wants the government to cushion them from a host of social risks, but that this should be achieved by minimizing the direct role of government”).

D. *Managing.*

Lastly, the feebleness of Medicare's administrative apparatus could frustrate the development of integrated health-care organizations. Assuring the legitimacy of private actors that have a financial incentive to stint on medical care would require a dramatic bureaucratic reorientation and reinvigoration. As Mark Hall reports in his article on the role of trust in health care, the rise of managed care threatened to undermine the very trust that formed the basis for the physician-patient relationship.<sup>230</sup> Paying organized systems in bundles will precipitate similar threats to trust. Two years ago, for one example, Medicare started to bundle payments to dialysis centers to cover the costs of both their treatments and drugs. Almost immediately, this prompted concern that centers cut back far too much on needed—but expensive—medications.<sup>231</sup>

To assuage these worries and ease the development of risk-bearing organized systems, Medicare's core task would have to shift away from assuring the prompt processing of claims. The agency would instead have to manage a network of private risk-bearing entities, to guarantee that these actors provide high-quality care even as financial incentives tempt them to cut corners, and to respond to the inevitable concerns that arise from asking private, risk-bearing entities to assume a position of greater clinical authority over physicians.

As it stands, CMS is not remotely up to the task. In 1975, Medicare spent almost \$5 on administration for every \$100 it reimbursed and was still thought to be under-resourced. By 2009, that number had dropped to \$1.10.<sup>232</sup> And so, with a staff about the same size at the Smithsonian Institution, CMS oversees distribution of a Medicare budget the size of South Africa's economy.<sup>233</sup> To call the agency beleaguered would be an understatement. In an open letter to Congress and the President in 1999, two former Medicare administrators and a raft of Medicare experts observed that "many of the difficulties that threaten to cripple [then-HCFA, now-CMS] stem from an unwillingness ... to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment."<sup>234</sup>

Medicare's enervated bureaucratic structure has already hindered the development of organized medical systems in a more indirect way. Medicare is good at prompt and (relatively) hassle-free payment, but neither CMS nor its contractors has anything like the capacity to scrutinize the claims that are paid out. Unsurprisingly, Medicare has spawned an enormous amount of fraud and abuse, which has provoked Congress to prohibit—most significantly, in the anti-kickback statute and self-referral legislation<sup>235</sup>—a bewildering array of financial relationships between providers that, in Congress's view, distort treatment decisions and

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<sup>230</sup> See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 473 (2002).

<sup>231</sup> See Kevin Sack, *Unintended Consequences for Dialysis Patients as Drug Rule Changes*, N.Y. TIMES, May 11, 2012.

<sup>232</sup> See KAISER FAMILY FOUNDATION, *supra* n.175, at 80.

<sup>233</sup> See John K. Iglehart, *supra* n.224, at w689.

<sup>234</sup> Gail Wilensky et al., *Crisis Facing HCFA & Millions of Americans*, 18 HEALTH AFFAIRS 8 (1999).

<sup>235</sup> See 42 U.S.C. §1320a-7b (anti-kickback statute); *id.* §1395nn (self-referral legislation).

encourage overtreatment. But in proscribing such financial arrangements more closely integrating institutional providers and physicians, Congress has also stunted the development of organized medical systems.<sup>236</sup>

Yet nothing is done. Part of the reason is that it only takes a small group of federal officials to carry out CMS's current mission—overseeing the prompt distribution of federal money. Providers and beneficiaries are both basically happy with this arrangement, sapping political energy to adequately fund the agency when Congress pushes for reform efforts. Plus, as Bruce Vladeck, the former head of HCFA (now CMS) puts it, “everybody hates HCFA.”<sup>237</sup> The bureaucracy is perceived as sclerotic, unresponsive, and inept. There's some irony here: Congress broke CMS and now won't fund it because it's broken. But the situation is not unusual. Because Congress routinely underestimates the managerial challenges posed by third-party governance,<sup>238</sup> federal agencies that oversee public-private networks often have small budgets, inadequate personnel, and insufficient legal flexibility. Government agencies are then lambasted for problems they were never equipped to handle.<sup>239</sup>

There is thus every reason to think that Congress will resist allocating sufficient resources to allow for the effective oversight of organized health-care systems. But centering Medicare around organized medical systems could at least reduce the funding problem to more manageable dimensions. Bringing integrated systems into Medicare would mean that the locus of payment would no longer be hundreds of thousands of individuals physicians and hospitals submitting 1.2 *billion* claims for payment each year, but a more discrete set of organizations submitting a far smaller number of claims for bundled (or capitated) payment.

Putting organized systems at the center of Medicare could also free up additional resources by reducing or eliminating the need for fiscal intermediaries and carriers. That's all to the good. As GAO reported in 1999, inadequate oversight of Medicare's contractors has spawned “[m]any of the financial weaknesses in Medicare.”<sup>240</sup> Although high-profile scandals involving those contractors<sup>241</sup> have prompted some stabs at reform<sup>242</sup>—in 2003, the functions of

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<sup>236</sup> See Mark A. Hall, *Making Sense of Referral Fee Statutes*, 13 J. HEALTH POL. POL'Y & LAW 623, 624 (1988) (noting that the anti-kickback statute “has been threatening both to conventional practices and to innovative business arrangements”).

<sup>237</sup> CMS Oral History Project, at 178 (interview with Bruce Vladeck), available at [www.cms.gov/History](http://www.cms.gov/History); see also John K. Iglehart, *supra* n.224, at w688; U.S. GENERAL ACCOUNTING OFFICE, *supra* n.141, at 2.

<sup>238</sup> See Kettl, *supra* n.56, at 491 (observing that Congress “assume[s] that the management of government services through indirect mechanisms will happen spontaneously and with little need for government oversight”).

<sup>239</sup> See MORGAN & CAMPBELL *supra* n.20, at 15 (noting that “various program failures arise that are frequently blamed on government officials who have never been sufficiently empowered to deal with these problems”).

<sup>240</sup> U.S. GENERAL ACCOUNTING OFFICE, *HCFA MANAGEMENT: AGENCY FACES MULTIPLE CHALLENGES IN MANAGING ITS TRANSITION TO THE 21ST CENTURY* 10 (1999).

<sup>241</sup> See Robert Pear, *Fraud in Medicare Increasingly Tied to Claims Payers*, N.Y. TIMES, Sept. 20, 1999.

<sup>242</sup> See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §911(a), 117 Stat. 2066, 2378 (2003) (adding §1874A to the Social Security Act).

fiscal intermediaries and carriers were collapsed and turned over to Medicare Administrative Contractors (MACs), which now compete for their Medicare contracts at least once every five years<sup>243</sup>—it’s difficult to defend continued reliance on private insurers to process Medicare claims. The federal government’s oversight of a distributed network of private physicians and hospitals is hard enough without inserting another layer of private contractors between them.

A more ingenious and comprehensive solution to CMS’s resource constraints may be available, however. When a bipartisan commission in 1999 called for transforming Medicare into a premium-support program—one in which private insurers would compete for beneficiaries and receive capitated payments for covering their care—the commission recommended the creation of an independent Medicare Board to vet the private insurers, contract with qualified plans, and enforce financial and quality standards.<sup>244</sup> Critically, the 1999 proposal would have given the new board power to levy assessments on participating plans to cover its expenses, obviating the need to go hat in hand to Congress for meager appropriations.<sup>245</sup> This self-financing model, typical for the banking agencies, would have given the agency access to the resources necessary to ensure that private plans were neither gaming the system nor stinting on care.

The same approach could be adapted for an agency that distributes large bundled payments to organized health-care systems. This by itself would not assure administrative success. The agency’s staff would still have had to master an unfamiliar skill-set emphasizing quality monitoring and tough negotiation.<sup>246</sup> But a self-financing approach would at least take seriously the imperative of creating a functional bureaucracy to manage the third-party organizations that will have to bear primary responsibility, if anyone is to be held responsible, for shaping the behavior of Medicare’s bedside bureaucrats.

#### IV. MEDICARE REFORM AND THE AFFORDABLE CARE ACT

Enter the Affordable Care Act. Although the Act’s principal goal is to provide for near-universal coverage, it also aims to reshape the health-care delivery system in an effort to reduce costs and improve quality. Medicare is the ACA’s most important policy lever for reform; the hope is that Medicare reform will drive private reform.<sup>247</sup> As I will show, however, the ACA reforms are inattentive to the structural features of Medicare that have frustrated the development of organizations with the incentives, bureaucratic wherewithal, and legitimacy to reshape physician practice patterns to accommodate federal priorities. As a result, the ACA’s reforms will likely disappoint.

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<sup>243</sup> See *id.* §911(a), 117 Stat. at 2379 (adding §1874A(B)(1) to the Social Security Act).

<sup>244</sup> See NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE, BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW (1999).

<sup>245</sup> See Medicare Preservation and Improvement Act of 1999, S. 1895, 106th Cong. §2246(b) (1999).

<sup>246</sup> See Kettl, *supra* n.56, at 496 (detailing skills necessary for effective third-party governance).

<sup>247</sup> See David Cutler, *How Health Care Reform Must Bend the Cost Curve*, 29 HEALTH AFFAIRS 1131, 1133 (2010) (observing that the “philosophy of the new health reform law ... is to use the leverage of Medicare payments to change provider incentives throughout the medical system and thus encourage more efficient care”).

A. *Independent Payment Advisory Board*

In its most controversial effort to rein in Medicare cost inflation, the ACA creates a new agency known as the Independent Payment Advisory Board (IPAB).<sup>248</sup> Comprising fifteen health-care experts appointed by the President and removable only for cause, the Board's authority is nothing short of remarkable. Starting in 2015, the Board must submit to the President and Congress annual "proposals" for cutting Medicare if spending over a five-year period increases faster than pre-selected targets linked to economy-wide inflation (through 2019) and economic growth (for 2020 and after).<sup>249</sup> IPAB proposals are subject to few constraints: they cannot ration care, modify Medicare eligibility, or increase beneficiary cost-sharing.<sup>250</sup>

Eight months after the Board issues a proposal, the Secretary of HHS must implement it—wholesale and without amendment—unless Congress has enacted and the President has signed legislation making different but equally deep cuts.<sup>251</sup> The proposal goes into effect "[n]otwithstanding any other provision of law,"<sup>252</sup> meaning that Board proposals can override even preexisting congressional statutes with which they conflict. Judicial review of an IPAB proposal or its implementation is prohibited.<sup>253</sup>

The Board's insulation from political influence is both its principal virtue and its biggest vice. To its proponents, the Board's insulation allows it to bring policy expertise to bear on how most effectively to hold down rising Medicare costs.<sup>254</sup> To its detractors, the Board is an anti-democratic abdication of congressional authority to unaccountable green-eyeshade types.<sup>255</sup> (For the time being, the detractors have the upper-hand: Republican Senators have threatened to block any IPAB nominees and the Obama administration has so far nominated no one.<sup>256</sup>) Either way, the Board is generally recognized as one of the most significant of the cost-reduction measures embedded in the Affordable Care Act.<sup>257</sup>

How does IPAB stack up as Medicare reform? Not very well. As Timothy Jost has rightly pointed out, IPAB's statutory imperative to cut spending to hit pre-established targets

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<sup>248</sup> See ACA, §3403, modified by Reconciliation Act, §10320 (adding §1899A to the Social Security Act).

<sup>249</sup> See *id.* §3403, modified by Reconciliation Act, §10320(a)(1)(D)(ii) (amending §1899A(c)(2)(A)(i), (c)(3)(A)(i)).

<sup>250</sup> See *id.* §3403 (amending §1899A(c)(2)(A)(ii)).

<sup>251</sup> See *id.* §3403 (amending §1899A(e)).

<sup>252</sup> See *id.* §3403 (amending §1899A(e)).

<sup>253</sup> See *id.* §3403 (amending §1899A(e)(5)).

<sup>254</sup> See Peter R. Orszag and Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 *NEW ENG. J. MED.* 601 (2010).

<sup>255</sup> See Health Care Bureaucrats Elimination Act, S. 3653, 111th Cong (2010) (aiming to "remove unelected, unaccountable bureaucrats from seniors' personal health decisions by repealing the Independent Payment Advisory Board").

<sup>256</sup> See Brian Beutler, *GOP Sens Threaten to Block Key Element of Health Care Law – and They Can*, *TALKING POINTS MEMO*, Mar. 24, 2011.

<sup>257</sup> See Orszag & Emanuel, *supra* n.254, at 601 (extolling the Board).

will inevitably privilege measurable, short-term cuts over longer-term reform.<sup>258</sup> As a result, the Board's major leverage will likely come from slashing reimbursement rates. Yet cuts won't lead to payment bundles, introduce considerations of cost-effectiveness into the program, allow for greater discrimination among providers, or arm CMS with new resources.

What's more, by instructing IPAB to make automatic cuts to enforce spending targets, the ACA has established something like the sustainable growth rate for the entire Medicare program. The Board may turn out to work as poorly. And if reimbursement rates drop low enough, the risk of hospital closures and physician threats to exit the program may prompt Congress to overrule IPAB just as it has overruled the SGR.

About the best that can be said about IPAB is that steadily mounting Medicare cuts could bring providers to the negotiating table. This has been a consistent pattern in Medicare reform: legislative threat followed by negotiation. The 1983 enactment of the prospective payment system for hospitals was possible, for example, because hospitals preferred it to a raft of poorly conceived cuts that Congress had adopted just the year before.<sup>259</sup> By the same token, IPAB proposals may put pressure on provider groups to accept Medicare reforms they might otherwise have successfully resisted.

#### B. Center on Medicare and Medicaid Innovation

The delegation to IPAB is not the only sweeping delegation in the ACA. In order "to test innovative payment and service delivery models to reduce program expenditures... while preserving or enhancing quality of care,"<sup>260</sup> the ACA establishes the Center of Medicare and Medicaid Innovation (CMI) within CMS. The Innovation Center has *carte blanche* to waive any Medicare rules—including statutory requirements—to test payment and service delivery models that might eliminate deficits or avoid unnecessary expenditures.<sup>261</sup> Judicial review of any of CMI's activities is altogether precluded.<sup>262</sup>

Startlingly, the Secretary of HHS is authorized to expand the implementation of any model upon finding, in coordination with the Chief Actuary at CMS, that an expansion would save money or improve quality, "including implementation on a nationwide basis."<sup>263</sup> On its face, the delegation is jaw-dropping: in taking a successful model and applying it nationwide, the Secretary could essentially reconstitute the Medicare program without regard to pre-existing Medicare rules, and all without congressional involvement. Yet even as the delegation

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<sup>258</sup> Timothy S. Jost, *The Independent Medicare Advisory Board*, 11 YALE J. HEALTH POL'Y L. & ETHICS 21, 30 (2011) (arguing that "the necessity of making year-to-year cuts is likely to focus the IPAB's attention on short-term payment cuts rather than on changes in program incentives").

<sup>259</sup> See SMITH, *supra* n.114, at 28-31.

<sup>260</sup> ACA, §3021 (adding §1115A(a)(1)).

<sup>261</sup> See *id.* §3021 (adding §1115A(d)(1)).

<sup>262</sup> See *id.* §3021 (adding §1115A(d)(2)).

<sup>263</sup> See *id.* §3021 (adding §1115A(c)).

of authority to IPAB has occasioned severe criticism, the Innovation Center's sweeping authority has passed almost unnoticed.<sup>264</sup>

But does the immense power of the Innovation Center portend a robust effort to encourage the development of organized health-care systems? In a word, no. CMS is instead likely to tread cautiously. An acute lack of resources at the agency will preclude any aggressive effort to put organized health-care systems at the center of Medicare. As Kerry Weems, a former head of CMS, has explained, "[t]he agency feels very vulnerable, in many ways, ... because the agency wishes it could do more, but the resources aren't there."<sup>265</sup> And the Innovation Center can't will into existence a bureaucracy that could manage a structural overhaul and usher 50 million beneficiaries into a new payment model. It is almost inconceivable that a beleaguered, defensive agency that struggles to carry out its core assignment – paying provider bills – would court massive internal disruption in an ambitious attempt to reshape Medicare.

Indeed, the Innovation Center has already exhibited an unfortunate degree of caution in rolling out a pilot program to explore bundled payments.<sup>266</sup> By any measure, the pilot program is feeble. Because it is voluntary, health-care organizations will sign up only if they believe they can secure more money through the pilot program than under traditional Medicare. That means either that few providers will participate or that cost savings won't materialize. Perhaps a need to find willing volunteers explains why the four payment models that the Center hopes to pilot are so tepid. Three of the four don't offer true bundled payments: hospitals and physicians are still paid separately for their services, the only difference being that they can split among themselves cost savings they generate for Medicare.<sup>267</sup> Yet the uncertain prospect of splitting a modest reward sometime down the line is unlikely to overcome physicians' and hospitals' immediate financial incentives under traditional Medicare. Although the fourth model does involve true bundled payments, those payments are keyed only to individual hospitals stays and don't cover post-acute care (not to mention any readmissions) that are part and parcel of many episodes of care.<sup>268</sup>

Furthermore, any desire that CMS (and, by extension, the sitting administration) might have to advance an ambitious reform agenda through the Innovation Center will be tempered by the practical imperative of assuring congressional support. It's true, as Peter Orszag and Ezekiel Emanuel have noted, that CMS can bypass Congress in rolling out new Medicare programs.<sup>269</sup> But the notion that this confers on CMS the authority to remake Medicare assumes that Congress will acquiesce in whatever the agency happens to do. This assumption is not well-founded. Congress cares deeply about Medicare and assiduously micromanages the

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<sup>264</sup> For an exception, see Timothy S. Jost, *The Real Constitutional Problem with the Affordable Care Act*, 36 J. HEALTH POL. POL'Y & LAW 501, 503 (2011).

<sup>265</sup> John K. Iglehart, *supra* n.224, at w688.

<sup>266</sup> See ACA, §3023 (requiring bundled payment pilot program).

<sup>267</sup> See CMS Fact Sheet, Bundled Payments for Care Improvement Initiative, Aug. 23, 2011, at 3 (available at [innovation.cms.gov/Files/fact-sheet/Bundled-Payment-Fact-Sheet.pdf](http://innovation.cms.gov/Files/fact-sheet/Bundled-Payment-Fact-Sheet.pdf)).

<sup>268</sup> See *id.*

<sup>269</sup> See Orszag & Emanuel, *supra* n.254, at 602.



program. Of particular relevance, it has repeatedly pulled the plug on demonstration projects that it dislikes.<sup>270</sup> CMS will assuredly look for some congressional imprimatur before using its newly granted authority before undertaking anything but the most uncontroversial of projects.

As a result, the Innovation Center's authority is, as a practical matter, quite circumscribed. The structural features of Medicare that have plagued past reform efforts and that have retarded the development of organized health-care systems are likely to remain entrenched for the foreseeable future. It's difficult to resist the conclusion that the Center more closely resembles an airy promise to do better in the future rather than a resolute commitment to confront Medicare's structural failings now.<sup>271</sup>

### C. Patient-Centered Outcomes Research Institute

In what amounts to its most concerted effort to forestall the rapid diffusion of needlessly expensive medical technology, the ACA establishes and funds the Patient-Centered Outcomes Research Institute (PCORI).<sup>272</sup> PCORI isn't a governmental agency; it's instead a private non-profit group funded by the government and subject to oversight from a Board of Governors selected mainly by the Comptroller General.<sup>273</sup> PCORI's charge is to conduct, sponsor, and promote "comparative effectiveness research"—research that assesses the relative health benefits of different medical procedures, typically measured with reference to quality-adjusted-life years (QALYs) saved.

PCORI's role is solely informational. Although its research can guide government or private coverage determinations, it binds no one—including Medicare.<sup>274</sup> Indeed, to parry charges that PCORI was a rationing board, the ACA limited what Medicare can do with PCORI-generated research.<sup>275</sup> Specifically, Medicare is forbidden from using such research unless it engages in an open, public process; from relying "solely" on comparative-effectiveness research in denying coverage for services; from using PCORI-generated evidence in a manner that values the extension of the life of an elderly, disabled, or terminally ill individual at a lower rate than the extension of the life of someone who is younger, nondisabled, or not terminally ill; or from using QALYs as a "threshold" to determine coverage.<sup>276</sup>

In point of fact, none of the Medicare-specific prohibitions appear all that constraining. Medicare already has on open processes in issuing coverage determinations. It will rarely rely "solely" on any one thing in denying coverage, and in any event nothing prevents the program from assigning great weight to comparative-effectiveness research. Invoking PCORI research is

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<sup>270</sup> See, e.g., Reconciliation Act, §1102(f) (repealing program designed to test competitive bidding in Medicare Advantage).

<sup>271</sup> See Jonathan Oberlander, *Throwing Darts: Americans' Elusive Search for Health Care Cost Control*, 36 J. HEALTH POL. POL'Y & LAW 477 (2011) (reaching a similar conclusion).

<sup>272</sup> ACA, §6301 (adding §1181(b)).

<sup>273</sup> See *id.* §6301 (adding §§1181(b), (f)).

<sup>274</sup> See *id.* §6301(c) (adding §1182(j)).

<sup>275</sup> Kavita Patel, *Health Reform's Tortuous Route to the Patient-Center Outcomes Research Institute*, 29 HEALTH AFFAIRS 1777, 1778 (2010).

<sup>276</sup> ACA, §6301(c) (adding §1182(a), (b), (c), and (e)).

fair game so long as Medicare assigns a single value to the extension of one year of life, whatever the age, disability, illness of the individual in question. And Medicare could avoid using QALYs as “a threshold” to determine coverage by taking an all-things-considered approach.

But while PCORI places no meaningful limits on Medicare’s power to issue coverage determinations, it likewise adds very little. Congress was quite explicit that it did not intend to supersede or modify Medicare’s obligation to cover all reasonable and necessary medical services.<sup>277</sup> In other words, Medicare still cannot make cost-conscious coverage determinations or even set the size of bundled payments with reference to low-cost benchmarks—making it hard to see how PCORI could meaningfully slow the adoption of expensive new technologies of marginal value.

About the best that can be said for PCORI is that it could generate information that private risk-bearing organizations—managed care plans or integrated medical groups—could use to encourage their affiliated physicians to favor cost-effective treatments. But Medicare’s programmatic structure still discourages the development of these organizations. Indeed, given Medicare’s continued reliance on fee-for-service payment system, PCORI could, perversely, draw physician attention to those treatments that are no more effective than alternatives but that are considerably more remunerative.<sup>278</sup>

#### D. Accountable Care Organizations

Most promisingly, the ACA launches a “shared savings program” under which so-called accountable care organizations (ACOs) can, if they achieve certain spending and quality benchmarks, share in any Medicare savings that result. The ACO model draws on the insight that most patients receive care from a relatively stable network of physicians and hospitals.<sup>279</sup> Even if those providers are not formally affiliated, the hope is that a thin institutional structure—the ACO—can nonetheless knit them together in a collaborative effort, driven by the prospect of financial gain, to improve quality and decrease costs.

Designing the ACO program was largely left to CMS, which issued its final ACO regulations in November 2011.<sup>280</sup> Under the regulations, ACOs are entitled to share a fraction of any programmatic savings they achieve relative to a benchmark of what they likely would have been paid under traditional Medicare. A proposed rule under which ACOs would have shared

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<sup>277</sup> ACA, §6301(c) (adding §1182(b)(1)).

<sup>278</sup> See Elhauge, *supra* n.104, at 1527 (observing that technology assessment could “*exacerbate* cost problems by encouraging the use of innovations that confer relatively small marginal benefits at much higher cost”).

<sup>279</sup> See Elliot S. Fisher et al., *Creating Accountable Care Organizations: The Extended Medical Staff*, HEALTH AFFAIRS WEB EXCLUSIVE w44 (Dec. 3, 2006).

<sup>280</sup> See 76 Fed. Reg. 67802 (2011).

in losses if they exceeded their benchmarks was mostly (albeit not entirely) abandoned in the final regulation.<sup>281</sup>

The basic idea behind ACOs is sound: putting integrated medical groups at the center of Medicare administration could introduce traditional bureaucratic tools—monitoring, measuring, benchmarking, even disciplining—in a hierarchical setting to better align the practice patterns of front-line physicians with Medicare’s priorities. But the ACOs that CMS envisions do not appear well-positioned to actually change how physicians practice medicine.

First, ACO hospitals and ACO physicians will still be paid as they have been before, the only caveat being that their ACO will distribute any shared savings. There is no shift to bundled payments—none—meaning that the sharp divide between Parts A and B, as well as the perverse incentives of the fee-for-service system, will remain entrenched.<sup>282</sup> Particularly given the limited downside risk to which they’re exposed, the temptation of shared savings is unlikely to push physicians to change their practice patterns: why should any individual physician worry about marginal shared savings or losses when she can protect her paycheck just by providing expensive and intensive care? Physicians remain locked into the same sort of collective-action problem that made the SGR such an ineffective cost-containment tool. Similarly, hospitals may have little financial incentive to reduce hospital care, even if doing so would save the ACO money on the whole. The benefits of keeping admission rates high may outweigh potential shared savings.<sup>283</sup>

Second, although ACOs can pick and choose from among providers in building a network, they have no authority to keep beneficiaries within that network.<sup>284</sup> Should an ACO’s network prove too restrictive, beneficiaries can simply seek care elsewhere. This will blunt ACOs’ ability to assure that beneficiaries receive care from physicians who practice cost-conscious, high-quality care.

Third, Medicare contractors still play a central role in collecting and dispensing claims information for ACOs. Yet they introduce a delay in providing to ACOs the data they need to

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<sup>281</sup> For a terse rundown, see Donald M. Berwick, *Making Good on ACOs’ Promise – The Final Rule for the Medicare Shared Savings Program*, 365 NEW ENGL. J. MED. 1733, 1754 (2011).

<sup>282</sup> See Harris Meyer, *Now Department from [CMS], Berwick Receives High Marks for His Tenure at Agency*, 30 HEALTH AFFAIRS 1, 8 (2011) (reporting the view of major health systems that “they couldn’t afford to provide more efficient, coordinated services under an ACO model when they were still being paid primarily under a fee-for-service system that rewards greater volume and intensity of services”).

<sup>283</sup> See Francis J. Crosson, *The Accountable Care Organization: Whatever Its Growing Pains, the Concept Is Too Vitaly Important to Fail*, 30 HEALTH AFFAIRS 1250, 1253 (2011) (“Many hospital administrators, including those considering forming an accountable care organization, are concerned that improved care management will result in unfilled beds and a decline in revenue.”).

<sup>284</sup> See 76 Fed. Reg. 67851 (stating that assignment to an ACO “in no way implies any limits, restrictions, or diminishment of the rights of Medicare [fee-for-service] beneficiaries to exercise complete freedom of choice in the physicians and other health care practitioners and suppliers from whom they receive their services”).

reform their approach to health-care delivery.<sup>285</sup> Compounding the problem are proposed CMS rules governing how beneficiaries will be assigned to ACOs. Providers favor prospective assignment so that they know in advance which individuals they are responsible for; CMS, however, has endorsed a complex formula for retrospective assignment of beneficiaries.<sup>286</sup> Before ACOs can use the claims data, CMS will have to inform them which beneficiaries should count—introducing still further delays. ACOs can't easily lean on participating physicians to change their practice patterns if they only learn of problems two years (or more) down the line.

In short, the ACO program is much too timid. Past experience with this sort of half-hearted model is not encouraging. A major CMS initiative that ran from 2005 to 2010, the Physician Group Practice Demonstration, was designed to assess whether ten integrated group practices could, if given bonuses for hitting certain quality and efficiency benchmarks, save money while improving quality. As Gail Wilensky reports, the results were “sobering.”<sup>287</sup> Few groups realized any cost-savings, and the cost savings that did materialize were not substantial.<sup>288</sup> Somewhat more encouragingly, almost all the groups did well on the measured quality indicators. But it's hard to know if this reflected broad improvement or just a narrow focus on the particular quality measures.<sup>289</sup>

In any event, why expect a weak voluntary program that leaves Medicare's structure almost entirely intact to usher in a new era in which integrated medical organizations push their physicians to attend to resource constraints and quality improvement? The ACO program doesn't demand robust integration; it doesn't aggressively foster such integration by offering capitated or bundled payments; it precludes ACOs from holding limiting the choices of beneficiaries; and it doesn't provide ACOs ready access to needed claims data.<sup>290</sup> Cultivating organizations that can manage physician practice patterns in a clinically sensitive fashion will require a much more thorough-going restructuring of Medicare than is currently contemplated.<sup>291</sup>

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<sup>285</sup> See Harris Meyer, *Accountable Care Organization Prototypes: Winners and Losers?*, 30 HEALTH AFFAIRS 1227, 1230 (2011) (noting that “[a] big lag in Medicare claims data was a serious problem” in an ACO-like demonstration project).

<sup>286</sup> See 76 Fed. Reg. 67851.

<sup>287</sup> Gail R. Wilensky, *Lessons from the Physician Group Practice Demonstration – A Sobering Reflection*, NEW ENG. J. MED. PERSPECTIVES 1 (Sept. 14, 2011).

<sup>288</sup> See CENTERS ON MEDICARE AND MEDICAID SERVICES, FACT SHEET: MEDICARE PHYSICIAN PRACTICE GROUP DEMONSTRATION, July 2011, at 4-6. Even for the groups that did cut costs, it's unclear that the demonstration project had anything to do with the reduced health-care spending. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PHYSICIAN GROUP PRACTICE DEMONSTRATION EVALUATION REPORT 18 (2009).

<sup>289</sup> See Wilensky, *supra* n.287, at 1.

<sup>290</sup> See Robert A. Berenson, *Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere?*, 16 AM. J. MANAGED CARE 721, 725 (2010) (observing with dismay that the ACO program “attempts to upset or dislocate no one”).

<sup>291</sup> See Posner, *supra* n.54, at 538 (“In the past, the federal government has also created entirely new types of providers to deliver services when it felt that existing delivery networks were not responsive to federal programs.”).

As it stands, the enthusiasm for ACOs is reminiscent of past enthusiasms for peer review organizations, for hospitals under prospective payment, and for Medicare Advantage plans. Each time, inattentiveness to the incentives and capacities of third-party actors to adjust the practice patterns of Medicare's physicians meant that these reforms failed to live up to their promise. The embrace of ACOs is characterized by the same sort of inattentiveness. The ACO concept may be "too vitally important to fail," as Francis Crosson recently put it.<sup>292</sup> But so too were past efforts to fix Medicare – and they did fail.

#### CONCLUSION

Medicare reform is inevitable. The shape it takes is not. But whatever hard-fought changes are made, the success of any particular reform will depend fundamentally on whether it addresses the panoply of structural obstacles that have discouraged the development of health-care organizations with the incentives, capacity, and legitimacy to align the practice patterns of Medicare's physicians – its bedside bureaucrats – with federal priorities. We cannot afford to remain inattentive to the ways that Congress, nearly fifty years ago, made Medicare impossible to manage.

It appears, however, that we are at risk of precisely such inattention. In its recent recommendations to the Joint Select Committee on Deficit Reduction, and again in its proposed 2013 budget, the Obama administration recommended no meaningful structural changes to Medicare, content instead to allow the ACA's reforms play out.<sup>293</sup> The White House has also distanced itself from a report issued by a majority of the members of a bipartisan presidential commission on fiscal responsibility chaired by Erskine Bowles and Alan Simpson. Even that report is much too mild: it recommends dramatic one-time cuts in Medicare expenditures, but offers not one concrete suggestion for structural change.<sup>294</sup> Only if Medicare outlays grow faster than 1% of GDP after 2020, as they almost certainly will, does the report even "recommend" that Congress consider "structural reforms."<sup>295</sup>

Those who self-consciously seek to transform Medicare likewise underestimate the scope of the problem. Under a much-ballyhooed plan proposed by Senator Ron Wyden and Representative Paul Ryan, Medicare beneficiaries would receive a premium-support credit that they could, on a health-insurance exchange, use to buy coverage either from traditional Medicare or from a private plan. Private plans would have to cover all the services that traditional Medicare covers. The amount of the credit would be pegged to the premium costs of the second-least expensive private plan in the exchange or to traditional Medicare, whichever is

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<sup>292</sup> Francis J. Crosson, *The Accountable Care Organization: Whatever Its Growing Pains, the Concept Is Too Vitally Important to Fail*, 30 HEALTH AFFAIRS 1250 (2011).

<sup>293</sup> See OFFICE OF MANAGEMENT AND BUDGET, LIVING WITHIN OUR MEANS AND INVESTING IN THE FUTURE 35-40 (2011); OFFICE OF MANAGEMENT AND BUDGET, FISCAL YEAR 2013 BUDGET OF THE U.S. GOVERNMENT 107-15 (2012).

<sup>294</sup> See NATIONAL COMMISSION ON FISCAL RESPONSIBILITY AND REFORM, THE MOMENT OF TRUTH 37-39 (2011).

<sup>295</sup> *Id.* at 42.

cheaper.<sup>296</sup> The idea is to put traditional Medicare in competition with private insurers and let the market sort out which beneficiaries prefer.

But the Wyden-Ryan plan does little more than augment Medicare Advantage, where private plans are already in competition with traditional Medicare. Establishing a Medicare exchange would be new, but that would just reorganize the market, not revamp it. The only significant change from current law would be that some beneficiaries could no longer enroll in traditional Medicare for the cost of Part B premiums. Instead, if two or more private plans in a geographical area were to offer a complete roster of benefits at a lower cost, beneficiaries in that area would have to pay out of pocket to remain in traditional Medicare. This would mitigate one important obstacle to Medicare Advantage's smooth operation, namely, that beneficiaries who grow dissatisfied with constraints on their care can at little or no cost flip back into traditional Medicare.

Otherwise, however, the Wyden-Ryan plan retains the flaws in Medicare Advantage's design. Instead of proposing an invigoration of regulatory capacity to oversee an enormous expansion of Medicare's managed care program, the plan blandly anticipates that "CMS will retain the authority it currently possesses" to oversee private insurers.<sup>297</sup> More worrying, the plan assumes that the insurance companies it enlists will have the capacity and legitimacy to change how physicians practice medicine. Although some managed care plans are tightly affiliated with organized health-care systems—the Geisinger Health System and Sharp HealthCare, for example, both have Medicare Advantage plans—most operate at a distance from physicians, have no proven track record at reducing costs or improving quality, and may be perceived as illegitimate managers of health-care decisions. Stoking the development of private insurers is a distant second-best to fostering the creation of integrated health systems.

The inattention to Medicare administration from both political camps is worrisome. Whatever the particulars of the approach to Medicare reform, Congress will have to assure that Medicare's private agents can influence the behavior of physicians at the bedside. To do otherwise would be to slight other valid demands on taxpayer dollars and consign Medicare beneficiaries to fragmented, low-quality care.

There is a loose analogy here to another massive and dysfunctional federal program that funneled taxpayer dollars to favored constituencies on the say-so of private physicians: the pension program for disabled Civil War veterans. Although qualifying for a pension depended on a variety of factors, the most critical was usually an examining surgeon's report documenting whether and to what degree a soldier was disabled.<sup>298</sup> But examining surgeons—most of them private practitioners—proved quite solicitous to veterans' disability claims. And no wonder. Then as now, surgeons were paid on a fee-for-service basis—a fee for every examination they made of a veteran, regardless of the outcome of that examination. To attract

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<sup>296</sup> See RON WYDEN & PAUL RYAN, *GUARANTEED CHOICES TO STRENGTHEN MEDICARE AND HEALTH SECURITY FOR ALL* 7-11 (2011).

<sup>297</sup> *Id.* at 2.

<sup>298</sup> See Jerry L. Mashaw, *Federal Administration and Administrative Law in the Gilded Age*, 119 *YALE L.J.* 1362, 1428 (2010).

customers, surgeons cultivated reputations as generous examiners.<sup>299</sup> The result was a program that lavished taxpayer dollars on veterans, many with dubious disability claims.

In response, as Jerry Mashaw recounts, the federal government repeatedly attempted over the later part of the 19th century to make the surgeons more attentive to the concerns of the Pension Bureau than to those of the claimants.<sup>300</sup> When those efforts proved inadequate, and as the taxpayers footing the bill grew increasingly agitated, Congress at the beginning of the twentieth century finally stopped paying doctors a fee for each examination. Instead, Congress put its surgeons on a fixed government salary.<sup>301</sup> As Nicholas Parrillo explains, “Congress thereby established a government capable of saying ‘No’ to service recipients, in a way that acknowledged (if crudely) rival claims to public resources.”<sup>302</sup>

The challenge for Medicare is similar: how to create an administrative structure that forces its army of physicians to account for competing demands on taxpayer dollars. But the nation’s physicians can’t be made into federal employees. Instead, Medicare will have to be refashioned around private organizations with the incentives and leverage to shape physician practice patterns in a cost-conscious and clinically-sensitive manner. The shift will inevitably alienate some Medicare beneficiaries and physicians, and political resistance will be intense, perhaps insuperable. But only by restructuring Medicare can the program remain vital well into the 21st century.

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<sup>299</sup> See NICHOLAS PARRILLO, *AGAINST THE PROFIT MOTIVE: THE SALARY REVOLUTION IN AMERICAN GOVERNMENT, 1780-1940*, at \_\_ (forthcoming 2012).

<sup>300</sup> See Mashaw, *supra* n.298, at 1428, 1432.

<sup>301</sup> See PARRILLO, *supra* n.299, at \_\_.

<sup>302</sup> *Id.* at \_\_.