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Bedside Bureaucrats: Why Medicare Reform Hasn't Worked

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Bedside Bureaucrats: Why Medicare Reform Hasn’t Worked

Nicholas Bagley*

Notwithstanding its obvious 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 agencies’ exercise of the vast discretion that Congress so often delegates to them. Medicare’s administrators, however, wield considerably less policy discretion than the 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, implementation authority is vested in private actors, not government officers.

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. This dismal history suggests that drafting an effective internal law for Medicare will require Congress to refashion the program around private organizations with the capacity, incentives, and legitimacy to align the practice patterns of private physicians—its bedside bureaucrats—with federal priorities. Measured against that baseline, the set of Medicare reforms included in the Affordable Care Act is a disappointment. A more muscular, thoughtful, and sustained effort is needed.

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INTRODUCTION

Enacted in 1965 in the teeth of fierce opposition from the American Medical Association (AMA), 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.”

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.” 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), and 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, after health-care reform, 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. Warring partisan ideologies on charged health-care issues bedevil political reform. Cultural infatuation with medical technology and antipathy toward rationing spur the rapid 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 part of the problem is also 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

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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. They must certify the need for institutional care or Medicare pays nothing to hospitals, hospices, and skilled nursing facilities. And they diagnose the medical conditions that establish how much Medicare pays for institutional care. Physicians are Medicare’s bureaucrats at the bedside. Taken together, their decisions constitute Medicare policy.

A government program’s success depends on its ability to align the behavior of the frontline bureaucrats that actually implement the program with governmental priorities. Yet in 1965 Congress crippled Medicare’s ability to exert control over its physician–bureaucrats. At every point, Congress instead 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. 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 much beyond 2020 are, as Joseph Newhouse puts it, “simply not plausible.” 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.

3. See 42 U.S.C. § 1395n(a)(2)(B) (2006 & Supp. IV) (conditioning payment on physician certification that, “in the case of medical and other health services, . . . such services are or were medically required”).

4. 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).

5. See id. § 1395ww(d)(4) (establishing a payment system for inpatient hospital care based on “diagnosis-related groups”).

6. See Michael Lipsky, Street-Level Bureaucracy: Dilemmas of the Individual in Public Services 13, 16–18 (2d ed. 2010) (“When taken in concert, [street-level bureaucrats’] individual actions add up to agency behavior.”); K. N. Llewellyn, The Bramble Bush: Some Lectures on Law and Its Study 3 (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.”).


Something has to give. Bracket first-order questions about the wisdom of governmental intervention in medicine, the palatability of reform, or the possibility that a single payer, even one as large as Medicare, can alone cure what ails the nation’s health-care system. The blunt fact is that, before long, Congress will have no choice but to confront Medicare’s mounting costs. Yet the modern debate over Medicare reform, as Theodore Marmor laments in his iconic book on Medicare, has given short shrift to “Medicare’s programmatic operation.”

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? Only by crafting an institutional structure that allows for the assertion of greater control over physicians can Medicare reduce cost growth to a sustainable level and improve quality of care, particularly for the majority of Medicare patients that suffer from chronic conditions.

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. An external

http://www.oig.hhs.gov/oei/reports/oei-06-09-00090.pdf; see also INST. OF MED., To Err Is Human: Building a Safer Health System 1 (1999) (estimating that as many as 98,000 people die each year as the result of medical errors); David C. Classen et al., ‘Global Trigger Tool’ Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured, 30 HEALTH AFF. 581, 584 (2011) (finding that “adverse events occurred in 33.2 percent of hospital admissions”).


On average, the rate of annual Medicare inflation has exceeded GDP growth by 2.5%. See Katherine Baicker & Michael E. Chernew, The Economics of Financing Medicare, NEW ENG. J. MED., July 28, 2011, at e7(1). Whatever the optimal level of cost growth is—one that modestly exceeds GDP growth is probably appropriate—the current rate is plainly unsustainable. See Newhouse, supra note 8.

In most markets, quality improvements are costly. That’s not always, or even usually, true in medicine. Powerful evidence suggests that a prodigious fraction of medical spending goes toward care that does not improve patient outcomes. See John E. Wennberg, Tracking Medicine: A Researcher’s Quest To Understand Health Care 156–69 (2010). Greater health-care spending is in fact associated with, and may contribute to, lower quality care. See Katherine Baicker & Amitabh Chandra, Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care, 7 HEALTH AFF. 184 (2004). Although difficult tradeoffs between cost and quality do arise, the phenomenon of rampant overtreatment suggests that efforts to reduce costs by improving quality will not invariably work at cross-purposes.

See Jerry L. Mashaw, Federal Administration and Administrative Law in the Gilded 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 Stoltzfus 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 Stoltzfus Jost, Governing Medicare, 51 ADMIN. L. REV. 39, 41 (1999). David Frankford, Eleanor 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); Eleanor D. Kinney,
perspective on Medicare has sharp limitations, however. Although many regulatory agencies exercise vast policy discretion, Medicare does not. Congress is intensely interested in even the minutest details of a program thatlavishes 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.” Systematic accounts of how Medicare’s legal structure enables and (more often) frustrates control over the physicians that administer the program are nonetheless scarce. In offering such an account, I hope to usher Medicare into administrative law and to build on an old and often disregarded tradition of investigating what Bruce Wyman in 1903 called “the science of common action.”

Yet where Wyman 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 the government enlists 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. There, the central preoccupation is the dearth of governmental capacity to assure that the private actors who implement public programs remain faithful to democratic values. Related

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16. Bruce Wyman, The Principles of the Administrative Law Governing the Relations of Public Officers 15 (1903); see also Frank J. Goodnow, The Principles of the Administrative Law of the United States 371 (1905) (“Some method of control must be devised by which harmony and uniformity of administrative action and administrative efficiency may be secured . . .”).


18. See Jody Freeman & Martha Minow, Introduction: Reframing the Outsourcing Debates, in Government by Contract: Outsourcing and American Democracy, supra note 17, at 2 (describing
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.\textsuperscript{19} Yet for all the talk of privatization, contracting out, and third-party governance, traditional Medicare—the single largest public–private partnership in the country—rarely rates more than a passing mention.\textsuperscript{20}

That's a shame. The tools that administrative law scholars have developed in the outsourcing context can teach us a great deal about Medicare. As Part I explains, they shed light on how the design choices that Congress made in 1965 have frustrated Medicare's ability to shape the practice patterns of private physicians. That in turn helps explain why reform efforts have so consistently foundered. Part II explores Congress's numerous attempts over Medicare's forty-eight year history to reduce cost growth and improve quality. Each of Medicare’s major reforms has responded to the challenge of asserting control over physicians by attempting to enlist private actors to oversee how private physicians practice medicine. And each reform has run aground of Medicare’s flawed institutional structure.

Drawing on this sorry history allows for a richer understanding of what Medicare must do in order to get a handle on cost escalation and poor quality care. Part III argues that the pattern of past failure points to a singular conclusion: that Congress must reshape Medicare to encourage the development of organized health-care systems with the incentives, bureaucratic wherewithal, and legitimacy to adjust physician practice patterns. Features of Medicare’s organizational structure that impede the development of such organizations must be swept away or sidestepped. Measured against this baseline, as Part IV argues, the set of Medicare reforms included in the Affordable Care Act (ACA) is a disappointment.\textsuperscript{21} Although promising on paper and much touted in the health-policy literature, the ACA's reforms are not well-crafted to stimulate the development of health-care organizations that can actually shift how physicians practice medicine. A more muscular, thoughtful, and sustained effort is needed.


I. Medicare’s Design

The original Medicare statute contained evident 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 in 1965 that there would be no real controls over hospitals and physicians. I was required to promise . . . that the Federal agency would exercise no control.”22 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.

A. 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 and other health services . . . are or were medically required.”23 Hospitals and other medical institutions were paid only if a physician certified that an institutional setting was medically necessary.24 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,”25 but the exclusion left treating physicians nearly untrammeled discretion to determine medical necessity. Congress nowhere intimated that Medicare could refuse to pay for novel treatments it deemed unreasonable and unnecessary on cost grounds.

B. 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.26 Physicians and hospitals would have a statutory entitlement to reimbursement from Medicare akin to their contractual entitlement to reimbursement from the Blues.27 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-questions-asked approach to payment that jibed with Congress’s vision of a federal

24. See id. sec. 102(a), § 1814(a)(2).
25. See id. sec. 102(a), § 1862(a)(1).
26. See Payton, supra note 15, at 118–19 (observing that “[t]he Medicare program was designed to replicate the standard Blue Cross benefit package and the Blue Cross pattern of administration”).
27. See 1965 Medicare Act, sec. 102(a), §§ 1812, 1832.
program that interfered little in physician practice. What’s more, the Blues—and now Medicare—reimbursed hospitals for their “reasonable cost[s]” and physicians for their “reasonable charges.” Because the Blues didn’t assiduously review claims for payment, hospitals and physicians were in practice 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 recovered 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. 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.

C. 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). 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. Even at the time, executive branch officials understood that

28. See id. sec. 102(a), § 1814(b).
29. See id. sec. 102(a), §§ 1832(a)(1), 1833.
31. 1965 Medicare Act, sec. 102(a), § 1816 (fiscal intermediaries); id. sec. 102(a), § 1842 (carriers).
32. See Payton, supra note 15, at 126 (observing that the Blues had been “made in the image of the medical industry”).
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, etc.33

But as Wilbur Cohen explained in an oval 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].”34

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—which was housed in the Social Security Administration until a 1977 move to the agency that became the Department of Health and Human Services (HHS)—was possible only because federal administrators were not directly responsible for processing claims. Their role was instead to manage relationships with those outside stakeholders that actually processed Medicare claims.

D. ANY WILLING PROVIDER

Another tenet of the Blues’ model of indemnity insurance was that all licensed and willing providers would be eligible for reimbursement. The same tenet applied to Medicare, which imposed no meaningful conditions on participation other than licensure.35 In practice, 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.36

Once physicians were in, they were hard to kick out. Only if a physician lost her state license, was “not complying substantially” with Medicare’s rules, or refused to disclose payment-related information could she be excluded from the program.37 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.38

33. SYLVIA A. LAW, BLUE CROSS: WHAT WENT WRONG? 34 (2d ed. 1976) (quoting a 1962 memo from an executive branch task force) (internal quotation marks omitted).
34. Larry DeWitt, The Medicare Program as a Capstone to the Great Society—Recent Revelations in the LBJ White House Tapes (May 2003) (unpublished manuscript) (on file with author).
35. See sec. 102(a), § 1861(e)(7) (defining “hospital” to mean a state-licensed hospital); id. sec. 102(a), § 1861(r) (defining “physician” to mean a state-licensed physician).
36. 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. sec. 102(a), §§ 1861(e)(8), 1865. Established by the American Hospital Association, the Joint Commission had a reputation for catering to the interests of its membership.
37. See id. sec. 102(a), § 1866(b)(2) (emphasis added).
38. See id. sec. 102(a), § 1802.
WHY MEDICARE REFORM HASN’T WORKED

In crafting a program to cover the costs of medically necessary care for the elderly, Congress delegated immense 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 demands of each individual case, physicians would need the latitude to dispense covered services based on contextual and discretionary judgments about patient need. Therefore, physicians were tasked with making treatment decisions that doubled as adjudicative judgments.

As it effectively 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 frontline 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. 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 secure medically necessary care from private providers that freely choose whether to accept the vouchers and otherwise have little to do with the government. But the voucher characterization doesn’t quite fit. Vouchers usually have limited purchasing power, giving recipients an incentive to shop around to find the best deal. For example, food stamps go further in cheaper grocery stores. This is not so with traditional Medicare, where beneficiaries are insensitive to the costs of care they receive and lack much reason to comparison shop. Physicians therefore don’t compete to offer Medicare services at the lowest price. Even more significantly, beneficiaries’ “consumption” choices don’t drive most medical decisions as the voucher characterization

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40. See Payton, supra note 15, at 119.
41. See C. Eugene Steuerle & Eric C. Twombly, Vouchers, in THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE, supra note 19, at 445–46 (observing that, in defining a voucher, “the amount of purchasing power a voucher provides is limited”).
42. Although Medicare’s entitlement is not open-ended, more than nine out of ten beneficiaries have some form of supplemental insurance that covers a substantial portion of their deductibles, coinsurance, and (most importantly) catastrophic expenses. See Marilyn Moon, Medicare: A Policy Primer 5–6 (2006).
43. See James Q. Wilson, Bureaucracy: What Government Agencies Do and Why They Do It 355 (1989) (rejecting characterization of Medicare as a “true [voucher]” program because it “do[es] not supply the beneficiary with strong incentives to shop around”).
might suggest. Physician decisions drive them.\textsuperscript{44} (That's also why giving patients more financial responsibility for medical decision making—or "consumer directed health care"—is unlikely to reduce much cost growth or improve quality of care.\textsuperscript{45})

Contract provides the better analogy. In practical effect, Medicare has entered into separate output contracts with nearly every physician and hospital in the country.\textsuperscript{46} For whatever medically necessary services physicians choose to provide to Medicare beneficiaries, the government undertakes to pay for those services. Conceiving of Medicare as a network of standardized but individual contracts focuses attention not on beneficiary choices, but on the multitude of physician–bureaucrats who actually drive most Medicare spending. So understood, Medicare manages private-sector contracts worth more than all of the federal government's other contracts for goods and services combined.\textsuperscript{47}

As a matter of sound administration, this quasi-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.\textsuperscript{48} The provision of medical care flunks all three conditions. Unable to specify upfront 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 quality of care 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.

Assuring that the government gets good value for its money when it contracts for custom services is intrinsically challenging. Cost overruns and quality

\textsuperscript{44} See Wennberg, supra note 12, at 7–8 ("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." (emphasis added)).

\textsuperscript{45} See Carl E. Schneider & Mark A. Hall, The Patient Life: Can Consumers Direct Health Care?, 35 Am. J.L. & MED. 7 (2009) (arguing that health-care consumers lack the choices and information necessary to demand better health care at a better price).

\textsuperscript{46} See Black's Law Dictionary 347 (8th ed. 2004) (defining output contract as one "in which a seller [for example, a physician] promises to supply and a buyer [for example, Medicare] to buy all the goods or services that a seller produces during a specified period and at a set price").


\textsuperscript{48} See John D. Donahue, The Transformation of Government Work: Causes, Consequences, and Distortions, in Government by Contract: Outsourcing and American Democracy, supra note 17, at 41–42.
concerns, for example, routinely plague efforts to purchase new fighter jets\(^49\) or to privatize welfare services.\(^50\) But Medicare is an extreme case. Typically, contract officers have the luxury of selecting discrete suppliers to provide contracted-for services. Because the number of contracting entities is kept within manageable bounds, specifying contractual terms and monitoring performance, however challenging, is at least remotely feasible.

For Medicare, however, the suppliers of the contracted-for service were, in 2012, more than three-quarters of a million physicians scattered across the country.\(^51\) Contractual specification at that scale is a practical impossibility for any agency, particularly one as small as the Centers for Medicare and Medicaid Services (CMS). And so Medicare takes shortcuts. Instead of soliciting competitive bids, Medicare contracts with all licensed physicians. Instead of dickering over what it wants to purchase or how much of it, Medicare pays for care that physicians deem medically necessary. Instead of bargaining over price terms, Medicare originally allowed physicians to set their own “reasonable charges” and today pays for services on a fixed fee schedule.\(^52\)

Because Medicare’s standardized quasi-contracts with physicians are so under-specified, the need for vigorous ex post performance monitoring is all the more acute. But overseeing the services that hundreds of thousands of physicians supply to nearly fifty million beneficiaries dwarfs the capacity of CMS—or indeed any agency. Medicare’s structure compounds the difficulty. The private insurers standing between Medicare and its physicians complicate any quixotic effort to assiduously monitor physician behavior. And Medicare cannot even deploy a realistic threat of contract termination in an effort to improve performance.


\(^{50}\) See, e.g., David Super, Indiana Court Autopsies Welfare Privatization Effort, BALKINIZATION (Aug. 3, 2012, 6:30 AM), http://balkin.blogspot.com/2012/08/indiana-court-autopsies-welfare.html (reporting on an Indiana Superior Court decision and documenting “a stunningly incompetent picture of state officials’ design and implementation” of a $1.3 billion, ten-year contract to administer welfare services).

\(^{51}\) See Total Professionally Active Physicians, November 2012, KAISER FAMILY FOUND., http://www.statehealthfacts.org/comparemaptable.jsp?ind=934&cat=8 (last visited Jan. 8, 2013) (estimating that 834,769 physicians are currently active); see also KAISER FAMILY FOUND., MEDICARE CHARTBOOK 28 (4th ed. 2010) (reporting that ninety-six percent of active physicians participate in Medicare Part B).

\(^{52}\) Judicial review does not help at all to improve the quality of contracting. Under federal contracting rules, disgruntled bidders can go to court to protest the selection of someone else for a government contract. The hope is that protest litigation will prod the government to contract with high-quality, low-cost suppliers. See Steven L. Schooner, Fear of Oversight: The Fundamental Failure of Businesslike Government, 50 AM. U. L. REV. 627, 640 (2001) (observing that protests “deputize the private sector, specifically the contractor community, to regulate government behavior”). In Medicare, however, there are no upset bidders. All licensed physicians can participate. Those injured by inappropriate Medicare expenditures—taxpayers—lack standing to challenge them. See Massachusetts v. Mellon, 262 U.S. 447 (1923). And judicial review at the behest of providers and beneficiaries serves only to increase government expenditures, never to reduce them.
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, the history of Medicare reform offers a rich look at repeated efforts to orient private actors toward public goals—what Jody Freeman has aptly termed “publicization.” And it showcases the challenges of managing the multitude of private actors that, in most cases, actually implement government programs on the ground.

II. THE MAJOR REFORMS

The central concern of the contracting literature is the potential threat that the outsourcing of government functions poses to public values. Outsourcing can blur lines of accountability, shroud governmental activities in secrecy, and enable powerful groups to wield untoward influence in the political process. 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 public 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, can swamp more diffuse public input.

In other respects, however, Medicare complicates the conventional threat-to-public-values account. For Medicare, the absence of institutional capacity to manage the private physicians with whom 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 legitimacy. Distance between the federal government and the physicians with whom it contracts—a relative lack of accountability, transparency, and public participation in medical decisions—is itself a public value. Enhancing institutional capacity to shape

53. See Jody Freeman, Extending Public Law Norms Through Privatization, 116 Harv. L. Rev. 1285, 1343 (2003) (arguing that “the inability to specify a [contractual] task because it is value-laden, politically contentious, and complex” demands strenuous efforts to orient private actors toward public goals).

54. See Super, supra note 17, at 403 (“Virtually every significant social welfare program is partially privatized; operating these programs without private entities performing some important roles is virtually unthinkable in our political culture.”).


56. See Freeman & Minow, supra note 18, at 1.

57. See Mashaw, supra note 7, at 32 (noting that, in Medicare, “[t]he professional defines and legitimates the actions of the agency, rather than the other way round”).
physician practice patterns may respond to some public values (cost and quality control), but it will conflict with others (physician independence and patient choice).

Attentive to widespread and understandable concern about government meddling in the practice of medicine, in 1965 Congress 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 Medicare’s physicians without interfering too much in the practice of medicine. It has, in other words, sought to establish a palatable and effective internal law for Medicare.

Yet Congress has restricted its own field of choice. As Paul Pierson has observed, 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 commitments, the harder to shift course, which is the case 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 (the make-or-buy decision) is normatively attractive. It is instead how to yoke the immense network of Medicare’s private physicians to a broader notion of public values, one that’s more attentive to questions of cost and quality.

Medicare’s weakened administrative apparatus has similarly constrained the choice of reform strategy. Without extraordinary increases in its size and power, CMS could not even begin to oversee the work of hundreds of thousands of frontline physicians. Yet resistance to building government runs deep. Where the purpose of a government buildup is to shape how physicians practice medicine, resistance would be far greater still.

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:

59. See Schooner, supra note 52, at 676–77 (noting “the present political climate of Executive and Legislative obsession with reducing the size of the Federal workforce”).
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.60 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 not unique to Medicare.61 The pressures that lead to government outsourcing in the first 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 limitations on the coverage of new technology.62 Each of these reforms sought to vest in private mediating institutions the authority to reshape the practice patterns of Medicare’s physicians. And the myriad failings of each serve as a stark reminder of one of the most prominent conclusions of the contracting literature: that policy makers routinely underestimate the managerial challenges posed by third-party governance.63 Perhaps a thorough understanding of their inadequacies can point a way forward.

A. PEER REVIEW ORGANIZATIONS

1. Background

In the wake of a scathing report documenting egregious Medicare fraud, in 1972 Congress 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,64 to oversee utilization patterns through statistical data,65 and to

62. 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.
63. See Donald F. Kettl, Managing Indirect Government, in THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE, supra note 19, at 490–91 (“[P]olicymakers have often shown little interest in and less knowledge about the management implications of the indirect systems they have created.”).
65. See id. sec. 249F(b), § 1155(a)(4).
refer individual providers for disciplinary action. In other words, Congress enlisted private physicians to watch Medicare’s physicians at the bedside.

By any measure, the PSROs were abject failures. Even under optimistic estimates, the costs of operating PSROs exceeded what they saved. 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?” Instead of eliminating PSROs, in 1982 Congress replaced them with Peer Review Organizations (PROs) and made several programmatic changes. 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. 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. 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.

Subsequent contracts have emphasized quality improvement efforts over utilization review, and in 2002, Medicare even began referring to PROs as Quality Improvement Organizations. 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.

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66. See id. sec. 249F(b), §§ 1157, 1160(b)(1)(A).
73. See INST. OF MED., supra note 71, at 52.
2. Assessment

Notwithstanding their $370 million annual price tag,\textsuperscript{75} 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 regulatory mode characterized by utilization review, now largely abandoned, and the voluntary cooperative mode that is ascendant today.

\textit{a. Utilization Review.} When it created Medicare, Congress vested in physicians frontline 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 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 is 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.\textsuperscript{76} Apart from a medical license, PRO reviewers have no particular qualifications and receive no specialized training.\textsuperscript{77}

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. But because peer review only polices conformity with Medicare’s cost blind coverage limitations, that sort of needless care wouldn’t raise a peer reviewer’s eyebrow.

\textsuperscript{75} See U.S. Gov’t Accountability Office, GAO-11-116R, Medicare: CMS Needs To Collect Consistent Information From Quality Improvement Organizations To Strengthen Its Establishment Of Budgets For Quality Of Care Reviews 2 (2010).

\textsuperscript{76} See Fuchs, supra note 70, at 47 ("[T]he review process can become contentious.").


\textsuperscript{78} 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).
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, and providers can only be excluded from Medicare if they have failed "substantially" to comply with Medicare rules in a "substantial" number of cases or have "grossly and flagrantly" violated the rules. Unsurprisingly, PROs almost never recommend sanctions.

Standard contractual tools have been ineffective at improving PRO performance. There is little competition in awarding PRO contracts and the already overstretched federal bureaucracy has a poor record of monitoring PRO conduct. 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. Plus, Medicare’s balkanized structure denies them 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 these contractors to dock provider reimbursement. This complex information-sharing process hampers effective, timely case review. Unsurprisingly, PROs engaging in utilization review have made no dent in rising Medicare costs. Nor have they improved quality of care: a number of

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79. For a chart detailing the process that will make your head hurt, see Inst. of Med., supra note 72, at 164 fig.6.2A.
82. See Inst. of Med., supra note 71, at 72 (noting a “history of very limited competition for QIO contracts”).
83. See id. at 76–78 (finding serious deficiencies in QIO contract monitoring by CMS); see also Fuchs, supra note 70, at 17 (same); see also U.S. Gen. Accounting Office, Medicare: Better Controls Needed for Peer Review Organizations’ Evaluations 4 (1987) (same).
84. See Berwick Statement, supra note 2, at 34 (reporting that Medicare processes 4.8 million claims every day).
85. See Fuchs, supra note 70, at 21, 54 (discussing PRO–contractor coordination challenges); Law, supra note 33, at 129 (same).
86. Even during the heyday of utilization review, PROs denied or reduced payment for the provision of unnecessary care in just two percent of reviewed cases. See Fuchs, supra note 70, at 37. In 2006, PROs nationwide identified just $14.5 million in overpayments to hospitals, see Ctrs. for Medicare & Medicaid Servs., Report to Congress on the Evaluation of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year 2006, at 5 (2009), representing less than 0.005% of what Medicare spent in Part A outlays.
studies have found that PROs are almost comically bad at identifying quality problems.87

b. 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 than case review at changing physician practice patterns. In 2006, after reviewing the extant studies, the Institute of Medicine concluded that the quality records of hospitals that cooperate with PROs are almost indistinguishable from those that do not.88 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-PRO hospitals.89 Anecdotally, the overwhelming majority of providers believe that PROs are useless.90

Why this poor record? The root cause, again, is Congress’s inattention to whether the private actors that it 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). They basically ignore quality issues that arise in physician practices—an enormous gap for a program where the need for high-quality outpatient care to treat chronic conditions is essential.

Second, hospitals often lack much influence over the physicians that work there. The split between Medicare Parts A and B reinforces the tendency of physicians to operate independently of the hospitals in which they practice. Why should physicians affiliate more closely with hospitals when they can secure a healthy income directly through Part B? As one hospital quality manager has implored CMS, “Go to the physicians directly. We can monitor all those indicators, but it’s in the physicians’ power. If they don’t prescribe the

87. See Inst. of Med., supra note 72, at 183 (concluding that case review provides a “poor yield of true quality problems”); Rubin et al., supra note 77, 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).

88. See Inst. of Med., supra note 71, 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, 2900 (2005) (same).


WHY MEDICARE REFORM HASN’T WORKED

arm at discharge, it’s not the hospital’s [fault].” 91

Third, hospitals aren’t all that receptive to PRO influence. Medicare eligibility depends not one whit on cooperating with PROs. Hospitals are more likely to attend to the quality concerns raised by the Joint Commission (which can withdraw accreditation) or insurers (who can remove hospitals from their networks) than to those raised by PROs (which can do nothing). Predictably, voluntary quality-improvement efforts involve those hospitals that are most receptive to PRO help—a group that is unlikely to include those hospitals in greatest need of it.92 What’s more, instituting quality improvement measures may, perversely, lead to reduced compensation for hospitals and other providers.93 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 various structural features of Medicare—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 originally envisioned. Nor has the shift to quality consulting fared any better. PROs can encourage hospitals to oversee their physicians all they want, but hospitals have few incentives and insufficient capacity to play along. Indeed, Medicare’s payment model discourages quality improvement efforts that would harm hospitals’ bottom lines.

As the peer review example 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. Nor is Medicare alone in its poor experience with outsourcing auditing functions. As Paul Posner has noted, parceling out auditing authority to private third parties is most appealing when the central bureaucracy suffers from resource constraints. These same constraints, however, routinely plague efforts to oversee the auditors themselves.94

93. See Wennberg, supra note 12, at 220.
94. See Posner, supra note 61, 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 ensure that programs are responsibly and efficiently managed.”).
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 reform, Congress pinned its hopes on changing how hospitals were paid. To that end, in 1983 Congress adopted the “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). To determine how much to pay a 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, high- and low-wage areas).

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 spends less on a particular patient than the DRG-weighted payment can retain the excess, and a hospital that spends more is in the hole. As such, it is generally in a hospital’s financial interest to treat patients conservatively and discharge them quickly. Congress’s hope was that prospective payment would encourage hospitals to push their physicians to adopt low-cost practice patterns.

Physicians, however, remained free to bill Medicare for their reasonable charges. And during the 1980s, physician payments began spiraling out of control. Alarmed, in 1989 Congress 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 was owed under the fee schedule,

96. See 42 U.S.C. § 1395ww(d).
97. In practice, DRGs are not always keyed to patient diagnoses. As Mark McClellan has observed, “some particular treatments or types of treatments—primarily intensive surgical procedures—still define administered price groups,” and “one can imagine a more aggregated DRG system at the level of diagnoses only.” See Mark B. McClellan, Medicare Reimbursement and Hospital Cost Growth, in ADVANCES IN THE ECONOMICS OF AGING 149, 159 (David A. Wise ed. 1996).
99. Between 1978 and 1987, when coverage expanded minimally and enrollment grew by about two percent annually, physician payments increased sixteen percent each year on average. See MAVIS & BERENSON, supra note 22, at 83.
the RVU for the service was 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.\textsuperscript{100} The end result, known as the resource-based relative value scale (RB-RVS), went into effect in 1992 and remains in effect today.\textsuperscript{101}

Consistent with Medicare’s commitment to cost reimbursement, the goal of the fee schedule was to roughly match the costs of providing care.\textsuperscript{102} The schedule, however, 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), which is linked to the rate in GDP growth.\textsuperscript{103} If physician payments for a particular year exceeded the target, fee-schedule payments would be cut.

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.\textsuperscript{104} Without denying its successes, however, prospective payment has not enabled Medicare to assert sufficient authority over its bedside bureaucrats. At best, the prospective payment system serves as a partial and imperfect stopgap measure.

\textit{a. Cost Control.} Prospective payment for inpatient hospitalizations was supposed to encourage hospitals to adjust the practice patterns of their affiliated physicians. In this respect, it has proven a qualified failure. Although hospitals have successfully encouraged early discharges, they have otherwise only modestly reshaped how physicians practice medicine.\textsuperscript{105} This is in large part because physicians are not usually employed by the hospitals in which they work and have a secure source of fee-for-service revenue through Medicare Part B, even for care provided in an inpatient hospital setting. As Mark McClellan observes, “[v]esting the residual rights of production [for example, treatment] decisions in the physician, and separating physicians reimbursement incentives from hospital reimbursement incentives, clearly reduces the strength of the physician–hospital agency relationship.”\textsuperscript{106} Not only do hospitals often enjoy

\begin{itemize}
\item \textsuperscript{100} See 76 Fed. Reg. 42772, 42778 (July 19, 2011).
\item \textsuperscript{102} See \textit{Mayes & Berenson}, supra note 22, at 87.
\item \textsuperscript{103} See Bruce C. Vladeck, \textit{Fixing Medicare’s Physician Payment System}, 362 NEW ENG. J. MED. 1955, 1955 (2010). Initially known as the “volume performance standard,” the spending cap was amended and renamed in 1997.
\item \textsuperscript{104} See \textit{Mayes & Berenson}, supra note 22, at 51, 53 tbl.3.1.
\item \textsuperscript{105} See \textit{id.} at 54 (“The extent to which Medicare’s new payment model transformed physician behavior turned out to be relatively modest.”).
\item \textsuperscript{106} See McClellan, \textit{supra} note 97, at 155.
\end{itemize}
little leverage over physicians, but hospitals' financial incentives (decrease care intensity) are at loggerheads with those of their medical staffs (increase care intensity). Further complicating matters, 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.\(^{107}\)

Instead of pushing physicians to practice cost-conscious care, hospitals have instead cut costs in three principal ways. First, they have reduced overhead and eliminated staff, particularly nurses.\(^{108}\) Second, they have shifted patients from inpatient to outpatient settings.\(^{109}\) 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 profitable one.\(^{110}\) 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 the adoption and use of expensive new technologies of uncertain value. 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,\(^{111}\) hospitals are too ready to embrace 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 contemplated below-cost reimbursement, violate the Medicare statute’s mandate to reimburse for all reasonable and necessary care.\(^{112}\)

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. The hope was that the SGR would “encourage the leadership of medicine to become more active in

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108. See Mayes & Berenson, supra note 22, at 53.
109. See Bruce C. Vladeck, Hospital Prospective Payment and the Quality of Care, 319 NEW ENG. J. MED. 1411, 1411–12 (1988).
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."\textsuperscript{113} That hope never materialized. 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. Medical societies have not assumed the wished-for leadership role in promoting cost-conscious care,\textsuperscript{114} and why would they? They’re trade associations, not regulators.

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 payment rates. As a result, Part B costs have increased at an average rate of nine percent annually over the past decade.\textsuperscript{115}

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.\textsuperscript{116} Lacking the resources and expertise necessary to push back with any force, CMS approves nine out of every ten RUC recommendations.\textsuperscript{117} As Uwe Reinhardt has noted, CMS has de jure authority to adjust rates, but the RUC is the de facto decision maker.\textsuperscript{118} The large majority of adjustments increase the RVUs for particular medical services, and most of those adjustments are for specialty services. That encourages Medicare’s bureaucrats at the bedside to provide larger volumes of these often expensive services.\textsuperscript{119}

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 eighteen months or more for claims data from its carriers—another consequence of using contractors to process claims.\textsuperscript{120} The lag time creates problems when a new treatment is

\textsuperscript{113} PHYSICIAN PAYMENT REVIEW COMM’N, ANNUAL REPORT TO CONGRESS 208 (1989).
\textsuperscript{114} See MAYES & BERENSON, supra note 22, at 92.
\textsuperscript{115} 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.
\textsuperscript{117} 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 AFF. 965, 965 (2012).
\textsuperscript{119} See Vladeck, supra note 103, at 1956.
\textsuperscript{120} See Chantal Worzala et al., Challenges and Opportunities for Medicare’s Original Prospective Payment System, 22 HEALTH AFF. 175, 177–78 (2003); see also MAYES & BERENSON, supra note 22, at 66–67 (‘‘[T]he difference between making decisions in ‘real time’ versus ‘lag time’ is significant.’’).
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.121

b. Quality Improvement. There is little evidence that the shift to prospective payment has pushed physicians to practice higher quality care.122 To the contrary, prospective payment may exacerbate some 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.123 In addition, hospital encouragement of early discharges poses a risk that patients will be discharged “quicker and sicker,”124 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 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.125

For physicians, the quality concerns are different. The fee schedule encourages physicians to overuse 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

121. See Medicare Payment Advisory Comm’n, Report to the Congress: Medicare and the Health Care Delivery System 16 (2011).
services, including CT scans. Yet CT scans involve relatively high doses of radiation and increase cancer risks. 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 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 market 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. The program assumed a prominent place in Medicare after legislation was enacted in 1982 authorizing the payment of a capitated amount—ninety-five percent of the per capita expenditures for Medicare beneficiaries in the same county—for each enrollee in an approved health maintenance organization (HMO). The assumption was that the HMOs could provide a full range of benefits more cheaply than traditional Medicare. That assumption proved faulty. Because these HMOs enrolled disproportionately healthy beneficiaries, they increased overall Medicare expenditures.

Redoubling its commitment to managed care, in 1997 Congress dubbed the program Medicare+Choice and expanded the range of insurance organizations

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126. See Medicare Payment Advisory Comm’n, supra note 121, at 35–36 (describing the eighty-five percent growth in imaging between 2000 and 2009).
131. See id. at 3-4.
that could contract with HCFA. To keep costs in check, however, Congress also introduced risk adjustment (it would pay more for sicker enrollees and less for healthier enrollees) and capped most annual increases in payments to private plans. 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.

So in 2003, Congress again renamed the program—it would now be known as Medicare Advantage—and gave back what it had taken away. Medicare Advantage remains in place today. To implement the program, 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 percent 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. After 2003, insurers flocked back into the program, and by 2010, almost one in four Medicare beneficiaries was enrolled in a Medicare Advantage plan. At the same time, however, per capita spending for Medicare Advantage beneficiaries was fourteen percent higher than under traditional Medicare.

To cut what were thought to be excessive payments to Medicare Advantage plans, the ACA slashed the benchmark calculation. In a move that partly offsets the ACA’s cuts, however, CMS has recently rolled out a controversial “quality bonus” program that inflates reimbursement for the Medicare Advantage plans that cover almost all enrollees. Because the new benchmarks still exceed what traditional Medicare would have spent, because of the quality bonus program, and because managed-care plans are adept at enrolling low-risk

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137. See id. at 294.
138. See id. at 263–65.
139. See id. at 309.
WHY MEDICARE REFORM HASN’T WORKED

beneficiaries, it still costs about seven percent more to cover an enrollee under Medicare Advantage than under traditional Medicare. 140

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 enrollees free choice of provider and imposes few obstacles to receiving desired care. Medicare beneficiaries can opt out of Medicare Advantage plans almost at will. 141 Plus, there is little financial downside to switching to traditional Medicare. 142 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. 143 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 traditional Medicare spends on enrollees. 144 Paying at parity, as the Medicare Payment Advisory Commission (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.

The problem runs deeper than this competitive mismatch. The collapse of the managed-care revolution in the late 1990s suggests that many (although not all) Medicare Advantage plans operate at too far a remove from the physicians with

140. See id.
141. See CYRS. FOR MEDICARE & MEDICAID SERVS., TIP SHEET: UNDERSTANDING MEDICARE ENROLLMENT PERIODS 7, 11 (2011), available at http://www.medicare.gov/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).
142. 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 HHS FAQ, U.S. DEP’T OF HEALTH & HUMAN SERVS., http://answers.hhs.gov/questions/3006 (last visited Sept. 30, 2012).
143. See Jost, supra note 132, at 119–20.
144. See NAT’L ACAD. OF SOC. INS., FINAL REPORT OF THE STUDY PANEL ON MEDICARE AND MARKETS: THE ROLE OF PRIVATE HEALTH PLANS IN MEDICARE: LESSONS FROM THE PAST, LOOKING TO THE FUTURE 46 (Kathleen M. King & Mark Schlesinger eds., 2003) (“The payment structure established by Congress is an administered-pricing system, not a market-based system.”).
whom they contract to enlist them in a cooperative cost-reduction and quality-improvement endeavor. First, even the most lavishly detailed contract can’t specify in advance the complex bundle of low-cost, high-quality services that the insurers would prefer to purchase. Second, financial incentives included in managed care contracts are at best blunt and imprecise instruments to reshape how physicians practice medicine. Third, insurers cannot reliably monitor how physicians carry out their contractual responsibilities. As James Robinson has described, “[i]nsurers 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.” Fourth, outside are insurers perceived as heavy-handed and illegitimate and face intense physician resistance. At a minimum, the conflict that defines the relationship between insurers and physicians impedes the sort of collaborative innovation upon which successful reform depends.

Medicare managed care—like all managed care—also raises quality 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, as the evidence indicates, 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. Overwhelmed, CMS has been faulted time and again for shoddy oversight.

What’s more, the limited oversight that does occur does not emphasize quality of care. For quality review, the agency depends on reports of performance measures that fail to capture important aspects of plan performance. And regional CMS teams charged with on-site monitoring typically lack the staffing and the medical expertise to assess the quality of medical care pro-

145. Cf. id. 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 . . . .”).
149. See Michael A. Morrisey et al., Favorable Selection, Risk Adjustment, and the Medicare Advantage Program, 48 Health Servs. Res. (forthcoming 2013) (providing evidence that disenrollment from Medicare Advantage plans is “disproportionately concentrated among the highest cost beneficiaries”).
152. See Nat’l Acad. of Soc. Ins., supra note 144, at 15 (reporting that “none of the current mechanisms for monitoring quality under either original Medicare or [Medicare+Choice] can measure certain crucial dimensions of practice”).
vided.\textsuperscript{153} 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.\textsuperscript{154}

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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. As important, private insurers are typically unable to work cooperatively with physicians to account for governmental priorities. On top of that, Medicare’s weakened central administration is incapable of assuring that private plans do not stint on needed care. The result is a managed-care program that neither saves money nor improves quality.

D. COVERAGE LIMITATIONS

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.”\textsuperscript{155} This language remains in force today\textsuperscript{156} 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.\textsuperscript{157} 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 excluding cost-ineffective treatments from the scope of Medicare coverage.\textsuperscript{158} Each time, however, HCFA retreated in the face of fierce opposition from providers invoking fears of government rationing.\textsuperscript{159} Thrice denied, CMS still lacks a regulation defining “reasonable and necessary.” But the

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\textsuperscript{153} See Jonathan B. Oberlander, Managed Care and Medicare Reform, 22 J. Health Pol., Pol’y & L. 595, 623 (1997).
\textsuperscript{154} See id. at 610–11 (canvassing mixed evidence on quality of care in HMOs).
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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.”160 (Cost considerations, however, do appear to surreptitiously influence the level of scrutiny that CMS gives to new procedures.)161

With that cost blind rule in mind, the Medicare program issues thousands of coverage determinations relating to medical efficacy each year.162 The overwhelming majority of such determinations issue from Medicare’s insurance contractors (fiscal intermediaries and carriers); these “local coverage determinations” (LCDs) govern only in the contractors’ catchment areas.163 To date, Medicare contractors have issued more than 2,000 LCDs.164 Most LCDs are not all-or-nothing determinations and instead provide that the treatment in question will be covered only for certain populations or conditions.165

When there are conflicting LCDs on a particular technology, or when the technology is especially controversial, CMS may initiate proceedings to make a national coverage determination (NCD).166 CMS issues between ten and fifteen NCDs for controversial technologies each year,167 for a total, to date, of 331 NCDs.168 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 fifty percent of Medicare’s cost growth.169

165. See id. at 1289–93 (describing coverage restrictions of various LCDs).
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.170 (The same sort of problem has plagued PRO efforts at utilization review.)171 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.172 In any event, the contractors have few incentives to assiduously enforce coverage determinations. There is no indication that CMS evaluates its contractors on whether they enforce their coverage determinations—or that CMS would even have the resources to do so.173

These enforcement challenges help to explain why a recent study comparing the effects of conditional LCDs across different geographic regions concluded that “coverage policies alone can, but generally do not, impact provider behavior.”174 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 purports not to cover colonoscopies within ten years of a prior colonoscopy that revealed no abnormalities. Yet Medicare contractors deny only about two percent of claims for inappropriate, repeat colonoscopies.175

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. As 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 “reason-

170. See Garber, supra note 163, at 1305.
171. See supra section II.A.2.
172. See Foote et al., supra note 164, at 1300.
174. See Foote et al., supra note 164, at 1299.
175. See James S. Goodwin et al., Overuse of Screening Colonoscopy in the Medicare Population, ARCHIVES INTERNAL MED. 1335, 1342 (2011).
able 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*, resolve that ambiguity to authorize the consideration of costs in passing on the scope of Medicare coverage. To date, however, it has chosen not to.

Any such interpretation would be legally vulnerable. 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." The "reasonable and necessary" clause immediately follows and thus appears to modify "items and services," not "expenses." With that in mind, the textual connection between "reasonable and necessary" and "the diagnosis or treatment of illness or injury" suggests that reasonableness and necessity are to be gauged mainly with reference to an item or service's medical benefit. Confirming the point, subsequent subparagraphs that lack a reference to "expenses" link the same "reasonable and necessary" clause to "items and services" and their use in the "prevention of illness"—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. At the time, this was understood to authorize Medicare's fiscal intermediaries to deny payment for costs they deemed unreasonable. Yet the explicit 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. In *Whitman v. American Trucking Association*, the Supreme Court "refused to find implicit in ambiguous sections of the [Clean Air Act] an authorization to consider costs that has elsewhere, and so often, been expressly granted." The same could be said about the Medicare statute.

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180. The "reasonable and necessary" phrase was lifted from an Aetna insurance policy contract, apparently on the understanding that it imposed no meaningful check on treatment decisions. *See Fox, supra* note 13, at 593–94.

181. *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").


WHY MEDICARE REFORM HASN’T WORKED

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 forty-eight years since to explicitly authorize the consideration of 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.¹⁸⁴

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.

In practice, then, the agency is 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 still, as Einer Elhauge has pointed out, Medicare’s cost blindness encourages the development and adoption of expensive treatments that offer only trivial health benefits over cheaper alternatives.¹⁸⁵

Third, CMS has no gate-keeping 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.)¹⁸⁶ Yet the agency lacks the resources to investigate 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 authorize cost-benefit analysis for [one] test, though it does so for two of the other tests, displays an intent to forbid its use").

¹⁸⁴. 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 authority to fill a statutory gap]."). 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, 236–42 (2006).

¹⁸⁵. See Einer Elhauge, Allocating Health Care Morally, 82 Calif. L. Rev. 1449, 1471 (1994).

¹⁸⁶. See generally Daniel Carpenter, Reputation and Power: Organizational Image and Pharmaceutical Regulation at the FDA (2010) (offering exhaustive account of FDA’s use of gate-keeping authority to augment its power).
upon which it bases its coverage determination is usually of poor quality. Even then, the agency's focus on medical innovations only scratches 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 careful analysis of their safety and efficacy. Without conscientious review of older therapies, 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, the pattern of failure may reflect a kind of backhanded success. Perhaps 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 destined 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 a chance. Plus, Medicare is only one payer among many, covering just one-fifth of medical spending in the country. 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

187. See Neumann et al., supra note 167, at 1623 (finding that “CMS considered the evidence only fair or poor for most of the technologies evaluated since 1999”).
190. See KAISER FAMILY FOUND., supra note 51.
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 may 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. If reform is in the offing, its success 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 medicine cannot be reduced to simple formulas, especially for those Medicare patients that suffer from chronic conditions and multiple comorbidities. 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.

This discretion also serves a critical legitimation function.191 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.192 Physician discretion is the linchpin of Medicare's legitimacy and popularity.193 The challenge is to preserve Medicare's legitimacy by channeling 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 depend on whether it engages physicians in a cooperative enterprise.194

191. See Lipsky, supra note 6, at 15 ("For both workers and clients, maintenance of discretion contributes to the legitimacy of the welfare-service state.").
192. See Robinson, supra note 146 (arguing that managed care “can be characterized as a partial economic success and total political failure”).
193. See Richard B. Stewart, Administrative Law in the Twenty-First Century, 78 N.Y.U. L. REV. 437, 448–49 (2003) (noting that “government-stakeholder network structures” are adopted for a variety of reasons, among them “tapping the knowledge and experience of these constituencies, and securing their participation in more effective implementation of an agency’s policies”).
194. See Brennan & Berwick, supra note 90, at 28.
Reforming Medicare to enable the assertion of control over physician behavior is all the more difficult because 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. No more realistic is a monumental expansion of the resources and authority of CMS. Even if the political branches could overcome visceral public antipathy toward the expansion of the federal government, it’s far from obvious that legions of federal functionaries could successfully monitor and adjust the practice patterns of hundreds of thousands of scattered physicians. Even if they could, Medicare’s very legitimacy would be threatened by such an assertive effort to salvage the program.

What’s left? Physicians have long functioned as Medicare’s bedside bureaucrats, albeit with so few trappings of bureaucracy that it escapes conscious notice. If Medicare cannot depend on the rules and hierarchies of classic Weberian bureaucracies to manage this vast network of private physicians, then it must—as it has before—turn to private organizations to do the job for it.195 Medicare must, in other words, bring bureaucracy to its bureaucrats. Enlisting third-party organizations thus offers a kind of privatized Weberian solution to Medicare’s accountability and management troubles.196

Medicare’s unhappy reform history suggests just how challenging this will be. The list of groups that have been tapped to reshape physician practice patterns is long—peer review organizations, hospitals, medical societies, managed-care organizations, and the insurers that process Medicare claims—but the list of successes is short. Encouragingly, however, bureaucracies with a proven track record of managing physicians—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

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195. See Kettl, supra note 63, at 493 (observing that government officials “must find tools to influence the behavior of frontline service providers who work in other organizations”).

196. To put it somewhat differently, enabling private organizations to better control physicians would function as a workaround. See Jon D. Michaels, Privatization’s Pretensions, 77 U. Cinn. L. Rev. 717, 719 (2010) (defining “workarounds” as “government contracts . . . that provide the outsourcing agency with the means of achieving distinct public policy goals that . . . would be impossible or much more difficult to attain in the ordinary course of nonprivatized public administration”).
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 ensure 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 systems—including the Geisinger Health System in Pennsylvania, Intermountain Healthcare in Utah, and the Mayo Clinic in Minnesota—offer similar success stories. As the Dartmouth Atlas studies have exhaustively documented, these organizations consistently offer their Medicare beneficiaries high-quality care at relatively low cost. Organized systems perform particularly well when it comes to treating those suffering from chronic conditions. Although providing effective chronic care demands close cooperation between disparate providers, the current approach, as Elhauge puts it, “couples the mother of all team production problems with the mother of all refusals to use centralized ownership structures to solve them.” Organized medical systems have the potential to create the structures, provide the incentives, and institute the routines necessary to shift Medicare’s focus away from acute care and toward the treatment of chronic conditions.

The notion that Medicare needs more organizational 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 physicians’ need 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 infrequently, and the protocols have both reduced treatment variation (usually by reducing care intensity) and improved quality of care. 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 in complex cases. Still others, including Geisinger, have successfully experi-

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197. See Wennberg, supra note 12, at 13 (discussing the systems).
198. See id. at 167 (documenting “an association between organized care, higher technical quality, and lower care intensity”).
200. See Wennberg, supra note 12, at 164–68.
mented with payment models that reward physicians for providing efficient, high-quality care.\footnote{203} The point is not that these are ideal models of physician control. It’s that organized systems bent on adjusting how their physicians practice medicine can successfully rebalance the interests of physicians, patients, and payers without surrendering their legitimacy. In this, they offer a contrast to the managed-care organizations of the late 1990s whose heavy-handed tactics alienated physicians and patients alike.\footnote{204} Perhaps health-care systems 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 and Alain Enthoven, for just two prominent examples, have both argued that organized health-care systems are key to reducing spending on unnecessary treatments and improving quality.\footnote{205} The refrain, however, is often followed by a lament that few successful organized systems exist and that we don’t know how to foster their development.\footnote{206} 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.\footnote{207}

What’s more, the integrated systems that do exist face perverse incentives: reductions in care intensity lead to a reduction in their fee-for-service payments. Intermountain’s successful efforts to reduce service intensity and improve quality, for example, have proven “financially destabilizing.”\footnote{208} 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, by contrast, billed $93,842.\footnote{209} Similar variations exist across the country and are not explained by differences in the health status of those

\footnote{203. See Thomas H. Lee et al., \textit{How Geisinger Structures Its Physicians’ Compensation To Support Improvements in Quality, Efficiency, and Volume}, supra note 199, at 61.}
\footnote{204. See Shannon Brownlee, \textit{Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer} (2007) (observing that managed care plans “borrowed the cost-control policies from the [true HMOs] in other words, prepaid group plans, while ignoring the need for doctors who were committed to a new way of practicing medicine”).}
\footnote{205. See Wennberg, supra note 12, at 12; see also Alain Enthoven, \textit{Curing Fragmentation with Integrated Delivery Systems}, in \textit{The Fragmentation of U.S. Health Care: Causes and Solutions}, supra note 199, at 61.}
\footnote{206. See, e.g., Austin B. Frakt & Rick Mayes, \textit{Beyond Capitation: How New Payment Experiments Seek To Find the ’Sweet Spot’ in Amount of Risk Providers and Payers Bear}, supra note 199, at 61.}
\footnote{207. See Wennberg, supra note 12, at 12 (“The bad news is that the United States does not have enough of them.”).}
\footnote{208. Id. at 220.}
\footnote{209. See id. at 172.}
receiving treatment. What possible financial incentive does UCLA have to look more like Mayo?

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. 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. Some measure of greater integration is happening already as more and more physicians leave private practice to join larger medical organizations. 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.

How should it be managed? Drawing on the lessons of Medicare’s history of failed reform—and saving for Part IV a full evaluation of the Medicare reforms included in the ACA—I argue that Medicare must move to bundled payments, key those payments to what efficient providers spend to provide medical care, and allow for greater restrictions on patient choice of physician. Medicare must also be given the resources necessary to monitor and manage the organized systems of care that would be at the center of Medicare administration. Taken together, these changes would promote the development of organizations that could successfully encourage their physicians to practice cost-conscious, high-quality care.

A. BUNDLING

To accelerate a shift toward organized systems, 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 in turn enter into private arrangements with care providers, including physicians, to distribute the Medicare payments. Those payments could be keyed to a single intervention (like a hip replacement), an episode of care (an acute care stay plus postinpatient treatment for sixty days), or to an individual beneficiary (capitation or global payments). Whatever its precise shape, however, Medicare must pay for care in much bigger bundles.

Bundled payments are in some sense already at the core of traditional Medicare. The prospective payment system for inpatient hospitalizations offers

\[210. \text{See Ketel, supra note 63, at 496 (arguing that government’s burden is to “stimulate the market to produce goods and services that otherwise would not be produced”).}\]
\[211. \text{See Morgan & Campbell supra note 20, at 159 (noting that one indication of Part D’s success “is that a market of stand-alone drug plans came into being at all”).}\]
hospitals a lump sum—a bundle—to cover the costs of a particular episode of care. Alone among Medicare’s reforms, prospective payment has successfully moderated cost growth while maintaining, or at least not much diminishing, quality of care. Nothing else has worked nearly as well. The lesson appears straightforward: if Medicare wants its agents to act as if they faced resource constraints, Medicare must constrain their resources. And if the primary flaw of the prospective-payment system is that it excludes physician services from DRG payments, a shift to true bundled payments would remedy that defect.

On a smaller scale, Medicare has had some provisional success with true 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 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.”

The Centers of Excellence cut CABG costs by ten percent, even as they reduced mortality.

Apart from the prospective payment system, Medicare Advantage stands as Medicare’s most elaborate experiment with bundled (specifically, capitated) payments. Insurers, however, operate at a disadvantage relative to organized medical systems when it comes to recruiting private physicians in a cooperative push to constrain spending and improve quality. The theory of the firm offers some insight here. As Ronald Coase famously explained, a firm will prefer to produce a good or service itself when the transaction costs of securing that good or service on the open market are higher than the agency costs incurred in producing the good or service internally. Extraordinary transaction costs hamper insurers’ efforts to purchase a complex basket of low-cost, high-quality medical services on the open market.

The internal production of medical services (or a subset of such services) within organized systems of care may prove superior to market forces in reducing unit costs. Organized systems are much closer to the physicians that practice within them and much better positioned to establish the internal procedures, monitoring tools, and organizational culture that could successfully reshape how physicians practice medicine. Yet a variety of financial and regulatory obstacles—including the absence of true competitive pressures in Medicare Advantage and physician

215. See id. at 140–41.
217. See James Robinson, The Corporate Practice of Medicine 106 (1999) (“[I]nsurers have only meager resources at their disposal to influence the physicians’ style of practice.”).
disinclination to relinquish private practice—have impeded efforts to bring production in-house.

Enlarging bundled payments to include physician services would remove a significant obstacle to the in-house production of medical services. As it stands, Medicare is sufficiently generous that an average physician seeing only Medicare patients would still make roughly $240,000 in take-home pay each year. Small wonder that ninety-six percent of the nation’s physicians participate and that many are reluctant to relinquish independent practice. A shift to bundled payments, especially if complemented by cuts in physician payments for those complex treatments or chronic episodes of care that ought to be provided in integrated systems, would encourage more physicians to abandon the relative freedom of private practice for the constraints of institutional affiliation.

Bringing physicians in-house would mean that health-care organizations would have an acute financial incentive to assure that their physicians avoid wasteful and expensive care. Competition between such systems would favor those organizations that could effectively manage their physicians. Embedding physicians in organized systems of care would also erode the artificial 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.

On the quality side, mandatory bundling could invigorate Medicare’s nascent pay-for-performance initiatives. Under such initiatives, payments are increased in connection with adherence to clinical guidelines, reductions in unnecessary care, avoidance of errors, and improved patient outcomes. Although the early returns on pay-for-performance initiatives are uninspiring, Medicare 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. The ACA includes two addi-

219. See supra section II.C.2.
220. Elhauge, supra note 199, at 10 (arguing that “the current organizational structures are not the result of free market forces, but rather are dictated by a complex set of laws that prevent different organizational forms from being used.”).
222. See KAISER FAMILY FOUND., supra note 51.
224. 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”).
tional pay-for-performance initiatives: one that cuts Medicare payments for hospitals with high rates of readmission, and another that distributes a pool of money to hospitals according to their relative performance on twelve clinical-care measures.

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. 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 noninstitutional settings. Nor is it obvious that paying for performance at the hospital level will reliably adjust physician practice patterns. Hospitals often lack much influence over physicians’ treatment decisions. Integrated health-care organizations are much better positioned to encourage physicians to attend to quality concerns.

Bundling may 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.” 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. These conditions are altogether absent for traditional Medicare, where an insistence on paying separately for individual physician services would make competitive bidding impossibly cumbersome. Bundled payments, however, could perhaps facilitate competition between organized systems for the opportunity to cover services arising from discrete episodes of care.
WHY MEDICARE REFORM HASN’T WORKED

B. BENCHMARKING

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 physicians to adopt expensive treatments of little or no proven value. Top-down efforts to use coverage policy to forestall the adoption of unproven medical technology have proven ineffective; no agency or organization can plausibly monitor hundreds of thousands of physicians to assure compliance with thousands of coverage policies. Nor has the prospective payment system successfully slowed the adoption of new medical technology. 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.233 As a result, prospective payment rates increase as new technologies are adopted, even if those technologies are expensive and offer no proven benefits over alternatives. For just one example, more and more hospitals are using proton-beam therapy to treat prostate cancer, even though it has not been shown to be more effective than conventional treatments and installing the proton-beam facilities can cost up to $100 million.234 From a fiscal perspective, this is problematic.

Paying in bundles could help. If an organization is paid a flat rate and can achieve equivalent results with cheaper technology, it will likely opt for the less expensive alternative.235 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 three-quarters of that national budget is distributed to roughly 150 regional boards known as “Primary Care Trusts.” Those trusts in turn allocate the funds among general practitioners and hospitals, which employ specialist physicians.236 General practitioners and hospitals 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.).237 As Henry Aaron, William Schwartz, and Melissa Cox have described, providers in resource constrained systems must harmonize their professional obligations with their role as “society’s agents” in dispensing...
Although professional and social obligations may clash, the NHS has retained its legitimacy by shifting decisions of how to most effectively allocate scarce resources onto the medical community. Medicare could stand to do the same.

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 dubious value. Assured of continuing increases in bundled payments, organized health-care systems have inadequate incentives to avoid useless new treatments. To discipline these systems, Congress should relax Medicare’s statutory commitment to covering a median provider’s reasonable costs. After all, current costs are artifacts of a system that encourages the overprovision of supply-sensitive care. Instead, bundled payments should be set 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. Over time, however, falling reimbursement would put immense pressure on organized systems to learn from benchmark organizations how to 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 least costly item that would achieve comparable clinical results. The policy was abandoned, however, when the D.C. Circuit held that it violated the Medicare statute.

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...

238. Id. at 102.
239. See Lester M. Salamon, The Tools Approach and the New Governance: Conclusion and Implications, in The Tools of Governance: A Guide to the New Governance, supra note 19, at 602 (observing that private organizations may “offer an added measure of legitimacy to public action by engaging a number of other institutions in public work”).
241. See MEDICARE PAYMENT ADVISORY COMM’N, ALIGNING INCENTIVES IN MEDICARE 6 (2010).
stratospheric cost escalation. In the long 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.

C. SORTING

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. As a result, in the words of one former acting administrator of CMS, “the worst physician in America can participate in [Medicare]—and probably does, in fact.” 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 and commentators to empower CMS to favor efficient, high-quality providers have gone nowhere. In an important 2007 report, the Government Accountability Office (GAO) joined the chorus and concluded that CMS could reduce spending growth were it to profile physicians and avoid outlier physicians with remarkably high costs. Yet GAO noted that Medicare appears to lack 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.”

The problem, however, runs deeper than GAO imagines. An ingrained and intense distrust of government power—particularly in the health-care field—likely precludes giving CMS the authority and resources it would need to

243. See Wennberg, supra note 12, at 4 (“[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.”).
244. See supra section I.D.
247. See, e.g., 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” (emphasis omitted)); Robert A. Berenson & Dean M. Harris, Using Managed Care Tools in Traditional Medicare—Should We? Could We?, 65 LAW & CONTEMP. PROBS. 139, 147–49 (2002) (suggesting use of selective contracting in Medicare).
249. Id. at 20 (footnotes omitted).
evaluate its physicians, much less to then tier them or exclude large numbers of them. The trick, again, is to accelerate the development of third-party organizations that can 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.

D. MANAGING

To 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 learn to manage a network of private risk-bearing entities, guarantee that these actors provide high-quality care even as financial incentives tempt them to cut corners, and respond to the inevitable concerns that arise from asking private, risk-bearing entities to assume a position of greater clinical authority over physicians.

As the dismal history of Medicare reform suggests, CMS is not remotely up to the task. In 1975, almost $5 out of every $100 that Medicare reimbursed was spent on administration, and it was still thought to be underresourced. By 2009, that number had dropped to $1.10. And so, with a staff about the same size as that of the Smithsonian Institution, CMS oversees distribution of a Medicare budget that exceeds the size of Argentina’s economy. To call the agency beleaguered would be an adventure in 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.” Medicare’s low administrative costs are not the unalloyed good they are sometimes taken to be; sometimes, you get what you pay for.

250. See MORGAN & CAMPBELL, supra note 20, at 226–27 (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”).

251. See KAISER FAMILY FOUND., supra note 51, at 80.


253. Stuart M. Butler et al., Crisis Facing HCFA & Millions of Americans, 18 HEALTH AFF. 8, 8 (1999).

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 has pointed out, the rise of managed care threatened to undermine the very trust that forms the basis of the physician–patient relationship. Paying organized systems in bundles will precipitate similar threats to trust, which could in turn impede the development of organized systems of care. 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 dialysis centers had cut back far too much on needed—but expensive—medications.

In a more indirect way, Medicare’s enervated bureaucratic structure has already hindered the development of organized medical systems. 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 antikickback statute and self-referral legislation—a bewildering array of financial relationships between providers that, in Congress’s view, distort treatment decisions and encourage overtreatment. In proscribing financial arrangements that more closely integrating institutional providers and physicians, however, Congress has also stunted the development of organized medical systems. The antikickback and self-referral legislation will have to be relaxed or amended, and analogous state laws preempted, in order to facilitate the needed integration.

Congress, however, has consistently declined to give CMS the resources it would need to do its job well. Part of the reason is that it only takes a small group of federal officials to carry out CMS’s essential 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. Plus, as Bruce Vladeck, the former head of HCFA (now CMS) puts it, “everybody hates HCFA.” 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

258. See Mark A. Hall, Making Sense of Referral Fee Statutes, 13 J. Health Pol’y, Pol’y & L. 623, 624 (1988) (noting that the antikickback statute “has been threatening both to conventional practices and to innovative business arrangements”).
Congress routinely underestimates the managerial challenges posed by third-party governance, and 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.

There is thus every reason to think that Congress will resist allocating sufficient resources to allow for effective oversight. But centering Medicare around organized medical systems would at least reduce the funding problem to more manageable dimensions. No longer would hundreds of thousands of separate physicians and hospitals submit 1.2 billion claims for payment each year. Instead, a more discrete set of organizations would submit a far smaller number of claims for bundled (or capitated) payment. To borrow a concept from James Scott, organized systems are much more “legible” to centralized authorities than a vast army of private physicians, and they are more readily amenable to oversight.

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 would be a welcome change. As GAO reported in 1999, inadequate oversight of Medicare’s contractors has spawned “[m]any of the financial weaknesses in Medicare.” Although high-profile scandals involving those contractors have prompted some stabs at reform—in 2003, the functions of fiscal intermediaries and carriers were collapsed and turned over to Medicare Administrative Contractors (MACs)—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 1999 bipartisan commission called for

260. See Kettl, supra note 63, 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”).

261. See Morgan & Campbell, supra note 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”).

262. See James C. Scott, Seeing Like a State: How Certain Schemes To Improve the Human Condition Have Failed 11 (1998) (“Certain forms of knowledge and control require a narrowing of vision... [That] makes the phenomenon at the center of the field of vision more legible and hence more susceptible to careful measurement and calculation.”).


266. See id. sec. 911(a), § 1874A(B)(1).
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. 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. 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, financial auditing, and negotiation. 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

Now enters 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. As I will show, however, the ACA reforms are inattentive to the structural features of Medicare that have frustrated the development of organized systems of care that have 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.

A. INDEPENDENT PAYMENT ADVISORY BOARD

In its most controversial effort to rein in Medicare cost inflation, the ACA created a new agency known as the Independent Payment Advisory Board


269. See Super, supra note 17, at 423 (“Quite different interpersonal skills, such as negotiating prowess, are necessary to be an effective contract officer.”).

270. See David Cutler, How Health Care Reform Must Bend the Cost Curve, 29 Health Aff. 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”).
Comprising of fifteen health-care experts appointed by the President who are 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 preselected targets linked to economy-wide inflation (through 2019) and economic growth (for 2020 and after). IPAB proposals are subject to few constraints: they cannot ration care, modify Medicare eligibility, or increase beneficiary cost sharing.

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. The proposal goes into effect “[n]otwithstanding any other provision of law,” 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.

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. To its detractors, the Board is an antidemocratic abdication of congressional authority to unaccountable green-eyeshade types. (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.) Either way, the Board is generally recognized as one of the most significant of the cost-reduction measures embedded in the ACA. It is also the most controversial.

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

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274. See id. sec. 3403, § 1899A(e).
275. See id.
276. See id. sec. 3403, § 1899A(e)(5).
280. See Orszag & Emanuel, supra note 277 (extolling the Board).
established targets will inevitably privilege measurable, short-term cuts over long-term reform. As a result, the Board’s primary source of leverage will likely come from slashing reimbursement rates. Yet these 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 a sustainable growth rate for the entire Medicare program. The Board may turn out to work as poorly: if reimbursement rates drop low enough, the risk of hospital closures and physician threats to exit the program may prompt Congress to overrule IPAB’s spending cuts just as it has overruled the SGR.

About the best that can be said about IPAB is that steadily mounting cuts to Medicare could bring providers to the negotiating table. This has been a consistent pattern in Medicare reform: legislative threats 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. By the same token, IPAB proposals may put pressure on provider groups to accept Medicare reforms that 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,” the ACA established the Center of Medicare and Medicaid Innovation 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. Judicial review of any of the Innovation Center’s activities is altogether precluded.

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.” 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 preexisting Medicare rules and without congressional involvement. Yet even as the delegation of authority to IPAB has occasioned severe criticism, the Innovation Center’s sweeping authority has passed almost unnoticed.\textsuperscript{288}

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.”\textsuperscript{289} And the Innovation Center can’t will into existence a bureaucracy that could manage a structural overhaul and usher fifty 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.

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.\textsuperscript{290} But the notion that this grants 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 program. Of particular relevance, it has repeatedly pulled the plug on demonstration projects and pilot programs that it dislikes.\textsuperscript{291} CMS will assur-edly look for some congressional imprimatur before using its newly granted authority to undertake anything but the least controversial of projects.

As a result, the Innovation Center’s authority is, as a practical matter, quite circumscribed. Indeed, the Center has already exhibited an unfortunate degree of caution in rolling out a feeble pilot program to explore bundled payments.\textsuperscript{292} Because the program is voluntary, health-care organizations will likely sign up only if they believe they can secure more money through the pilot program than through traditional Medicare. That means either that few providers will participate or that cost savings won’t materialize. Perhaps the 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

\textsuperscript{288} For an exception, see Timothy Stoltzfus Jost, \textit{The Real Constitutional Problem with the Affordable Care Act}, 36 J. Health Pol. Pol’y & L. 501, 503–06 (2011).

\textsuperscript{289} Iglehart, \textit{supra} note 245, at w688.

\textsuperscript{290} See Orszag & Emanuel, \textit{supra} note 277, at 602–03.


\textsuperscript{292} See ACA, § 3023 (requiring bundled payment pilot program).
physicians are still paid separately for their services, and the only difference is that they can split among themselves cost savings they generate for Medicare. 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 hospital stays and don’t cover postacute care (including readmissions) that is part and parcel of many episodes of care.

Given the likely timidity of the Innovation Center, the structural features of Medicare that have plagued past reform efforts and stunted 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 Innovation 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.

C. PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

In what amounts to Congress’s most concerted effort to forestall the rapid diffusion of needlessly expensive medical technology, the ACA established and funded the Patient-Centered Outcomes Research Institute (PCORI). PCORI isn’t a government agency, but a private nonprofit group funded by the government and subject to oversight from a Board of Governors selected mainly by the Comptroller General. PCORI’s charge is to conduct, sponsor, and promote “comparative clinical effectiveness research”—research that assesses the relative health benefits of different medical procedures, typically measured with reference to the number of 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. Indeed, to parry charges that PCORI was a rationing board, the ACA limited what Medicare can do with PCORI-generated research. 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 patient over the health of an otherwise healthy person.

294. See id.
296. ACA, sec. 6301, § 1181(b).
297. See id. sec. 6301, § 1181(b), (f).
298. See id. sec. 6301, § 1182(a), (e).
299. See id. sec. 6301(c), § 1181(j).
300. See Kavita Patel, Health Reform’s Tortuous Route to the Patient-Centered Outcomes Research Institute, 29 Health Aff. 1777, 1778-79 (2010).
ill individual at a lower rate than the extension of the life of someone who is younger, nondisabled, or not terminally ill; and from using QALYs as a “threshold” to determine coverage.\(^\text{301}\)

As a practical matter, none of the Medicare-specific prohibitions appear all that constraining. Medicare already has an open process for issuing coverage determinations. It rarely relies “solely” on any one factor to deny coverage, and nothing prevents Medicare from assigning great weight to comparative-effectiveness research. Invoking PCORI research is fair game so long as Medicare assigns a single value to the extension of one year of life, whatever the age, disability, or 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 although the provisions of the ACA establishing PCORI don’t much limit Medicare’s authority, they don’t enhance it either. Congress was quite explicit that it did not intend to supersede or modify Medicare’s obligation to cover all reasonable and necessary medical services.\(^\text{302}\) 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 medical value.

The best-case scenario 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, PCORI could, perversely, draw physician attention to those treatments that are no more effective than alternatives but that are considerably more remunerative.\(^\text{303}\)

D. ACCOUNTABLE CARE ORGANIZATIONS

Most promisingly, the ACA launched 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.\(^\text{304}\) The ACO model draws on the insight that most patients receive care from a relatively stable network of physicians and hospitals.\(^\text{305}\) Even if those providers are not formally affiliated, the hope is that a thin institutional struc-

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301. ACA, sec. 6301(c), § 1182(a)–(e), (e).
302. Id. sec. 6301(c), § 1182(b)(1).
303. See Elhauge, supra note 112, 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”).
304. ACA, sec. 3022, § 1899.
305. See Elliot S. Fisher et al., Creating Accountable Care Organizations: The Extended Hospital Medical Staff, 26 HEALTH AFF. w44, w48–49 (2006).
WHY MEDICARE REFORM HASN’T WORKED

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.\(^\text{306}\) 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 in losses if they exceeded their benchmarks was mostly abandoned in the final regulation.\(^\text{307}\)

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 frontline 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.\(^\text{308}\) 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.\(^\text{309}\)

Second, although ACOs can pick and choose from among providers in building a network, they have no authority to keep beneficiaries within that network.\(^\text{310}\) Should an ACO’s network prove too restrictive, beneficiaries can simply seek care elsewhere. This will blunt ACOs’ ability to ensure that

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\(^{307}\) For a terse rundown, see Donald M. Berwick, Making Good on ACOs’ Promise—The Final Rule for the Medicare Shared Savings Program, 365 New Eng. J. Med. 1753, 1754 (2011).

\(^{308}\) See Harris Meyer, Now Departed from the Centers for Medicare and Medicaid Services, Berwick Receives High Marks for His Tenure at Agency, 30 Health Aff. 2277, 2284 (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”).

\(^{309}\) See Francis J. Crosson, The Accountable Care Organization: Whatever Its Growing Pains, the Concept Is Too Vitally Important to Fail, 30 Health Aff. 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.”).

\(^{310}\) See 76 Fed. Reg. at 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
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 reform their approach to health-care delivery.\footnote{311} 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.\footnote{312} Before ACOs can use the claims data, CMS will have to inform them which beneficiaries should count—introducing 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 mild. Past experience with this sort of half-hearted model is not encouraging. An important 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 notes, the results were “sobering.”\footnote{313} Few groups realized any cost savings, and the cost savings that did materialize were not substantial.\footnote{314} 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.\footnote{315}

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 and it doesn’t aggressively foster such integration by offering capitated or bundled payments. Instead, it precludes ACOs from limiting the choices of beneficiaries and it doesn’t provide ACOs ready access to needed claims data.\footnote{316}

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\footnote{311. See Harris Meyer, Accountable Care Organization Prototypes: Winners and Losers?, 30 HEALTH AFF. 1227, 1230 (2011) (noting that “[a] big lag in Medicare claims data was a serious problem” in an ACO-like demonstration project).}

\footnote{312. See 76 Fed. Reg. at 67851.}

\footnote{313. Gail R. Wilensky, Lessons from the Physician Group Practice Demonstration—A Sobering Reflection, 365 NEW ENG. J. MED. PERSPECTIVES 1659, 1660 (2011).}

\footnote{314. See CTRS. FOR MEDICARE & MEDICAID SERVS., supra note 293, at 4-6. Even for the groups that did cut costs, it is unclear that the demonstration project had anything to do with the reduced health-care spending. See DEP’T OF HEALTH & HUMAN SERVS., REPORT TO CONGRESS: PHYSICIAN GROUP PRACTICE DEMONSTRATION EVALUATION 18 (2009).}

\footnote{315. See Wilensky, supra note 313.}

\footnote{316. 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”).}
CMS has the legal authority to establish a more robust ACO program than it has, the ACA contemplates that any such program would remain voluntary. Yet any redesigned ACO program that actually promised to revolutionize care delivery and slash Medicare expenditures would thin the ranks of potential volunteers. That partly explains why the program that CMS has devised is so uninspiring and why it will probably remain uninspiring going forward.

As it stands, the enthusiasm for ACOs is reminiscent of past enthusiasms for peer review organizations, the prospective payment system, and Medicare Advantage. 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. 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 to play out. The Administration 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. Only if Medicare outlays grow faster than one percent of GDP after

317. See ACA, sec. 3022, § 1899(b)(1), (b)(2)(A) (defining “eligible” groups of providers to include those “willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it”).
318. See Crosson, supra note 309, at 1250.
2020—as they almost certainly will—does the report even “recommend” that Congress consider “structural reforms.”

Those who self-consciously seek to transform Medicare likewise underestimate the scope of the problem. Under the widely publicized 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 cheaper. 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. 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

321. Id. at 42.
323. See id.
324. Id. at 2.
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-care 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 once 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. But examining surgeons—most of them private practitioners—proved quite solicitous to veterans’ disability claims. 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 veterans, surgeons cultivated reputations as generous examiners. 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 nineteenth century to make the surgeons more attentive to the concerns of the Pension Bureau than to those of the claimants. 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. Nicholas Parrillo explains that “Congress thereby established a government capable of saying ‘No’ to service recipients, in a way that acknowledged (if crudely) rival mass claims to public resources.”

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

326. See Mashaw, supra note 13, at 1428.
328. See Mashaw, supra note 13, at 1432.
329. See Parrillo, supra note 327, at intro.
330. Id.
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 twenty-first century.