

University of Michigan Journal of Law Reform

Volume 49

2015

Spending Medicare's Dollars Wisely: Taking Aim at Hospitals' Cultures of Overtreatment

Jessica Mantel
University of Houston Law Center

Follow this and additional works at: <https://repository.law.umich.edu/mjlr>



Part of the [Health Law and Policy Commons](#), [Insurance Law Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Jessica Mantel, *Spending Medicare's Dollars Wisely: Taking Aim at Hospitals' Cultures of Overtreatment*, 49 U. MICH. J. L. REFORM 121 (2015).

Available at: <https://repository.law.umich.edu/mjlr/vol49/iss1/2>

<https://doi.org/10.36646/mjlr.49.1.spending>

This Article is brought to you for free and open access by the University of Michigan Journal of Law Reform at University of Michigan Law School Scholarship Repository. It has been accepted for inclusion in University of Michigan Journal of Law Reform by an authorized editor of University of Michigan Law School Scholarship Repository. For more information, please contact mLaw.repository@umich.edu.

SPENDING MEDICARE'S DOLLARS WISELY: TAKING AIM AT HOSPITALS' CULTURES OF OVERTREATMENT

Jessica Mantel*

With Medicare's rising costs threatening the country's fiscal health, policymakers have focused their attention on a primary cause of Medicare's high price tag—the overtreatment of patients. Guided by professional norms that demand they do “everything possible” for their patients, physicians frequently order additional diagnostic tests, perform more procedures, utilize costly technologies, and provide more inpatient care. Much of this care, however, does not improve Medicare patients' health, but only increases Medicare spending.

Reducing the overtreatment of patients requires aligning physicians' interests with the government's goal of spending Medicare's dollars wisely. Toward that end, recent Medicare payment reforms establish a range of financial incentives that encourage more efficient practices among physicians. Physicians, however, do not practice medicine in a vacuum. Rather, they are profoundly influenced by the organizational cultures of hospitals. Far too often hospitals' cultures lead physicians to provide Medicare patients care of questionable value. If Medicare is to successfully contain costs, it must prod hospitals to move from cultures of overtreatment to cultures of efficiency.

Current Medicare reform proposals, however, do too little to address hospitals' cultures of overtreatment. That is unfortunate, as regulators will have limited success in constraining Medicare's growth if hospitals' cultures continue to foster the overtreatment of Medicare patients. This Article therefore sets forth a more robust proposal for reforming Medicare payment policy, one that would facilitate hospitals fully embracing a culture of efficiency. Specifically, federal regulators should reform the Medicare Hospital Value-Based Purchasing Program so that a hospital's Medicare payment rates are tied to the hospital's success in lowering the cost of treating patients both inside and outside the hospital setting. Regulators could accomplish this goal by incorporating into the program efficiency measures based on broadly defined episodes of care.

* Assistant Professor, University of Houston Law Center. Thank you to Nicole Huberfeld, Jessica Roberts, participants in the University of Saint Louis School of Law's 2014 Health Law Scholars Workshop, and participants in the University of Houston Law Center Work-In Progress series for their useful discussion and suggestions; and to Emily Lawson, Alison Mills, and Theresa Langley for their research assistance.

Headlines frequently bemoan Medicare's "runaway" costs,¹ and for good reason. Over the past few decades Medicare spending has consistently risen faster than the general inflation rate, often by significant amounts.² In 2014, Medicare spending comprised 14.6 percent of the federal budget,³ as compared to only 3.5 percent in 1970.⁴ This sustained growth in Medicare spending threatens to bankrupt the program, with the Social Security and Medicare Boards of Trustees estimating that the Medicare Hospital Insurance Trust Fund will be depleted by 2030.⁵

Although the reasons for Medicare's growth are complex and varied, a primary cause is the high volume and intensity of care provided to Medicare patients. For most medical conditions, physicians must choose among a range of treatment options, such as acute hospital care, surgery, drug therapy, life style changes, and watchful waiting. Many physicians err on the side of doing more for their patients. They prescribe more drugs, order more diagnostic tests, perform more invasive procedures, and hospitalize patients more frequently.

Doing more arguably would be justified if a higher volume and intensity of care led to improved health for Medicare patients. After all, conventional wisdom suggests that more frequent care and cutting-edge interventions constitute better care.⁶ Often, however, this

1. See, e.g., William R. Brody, *Taming Runaway Medicare Costs*, WASH. POST (Sept. 25, 2009), <http://www.washingtonpost.com/wp-dyn/content/article/2009/09/24/AR2009092403935.html>; *How to Rein in Medicare's Runaway Costs*, BLOOMBERG BUSINESSWEEK (Apr. 17, 2014), <http://www.businessweek.com/articles/2014-04-17/medicare-costs-give-doctors-incentives-to-use-cheaper-drugs>; Pragya Kakani, *Runaway Medicare and Medicaid Spending*, HARV. POLITICAL REV. (Oct. 24, 2011), <http://harvardpolitics.com/arusa/runaway-medicare-and-medicare-spending/>.

2. See LISA POTETZ ET AL., HENRY J. KAISER FAMILY FOUND., *MEDICARE SPENDING AND FINANCING: A PRIMER 2* (2011) (showing that from 1985–2009, average annual growth in Medicare spending of 8.5 percent exceeded the annual average consumer price index of 2.9 percent).

3. See CONG. BUDGET OFFICE, *AN UPDATE TO THE BUDGET AND ECONOMIC OUTLOOK: 2015 TO 2025*, at 74, 76 (2015).

4. See POTETZ ET AL., *supra* note 2, at 1. The Social Security and Medicare Board of Trustees projected even higher growth for Medicare, estimating that the program will grow to 5.3 percent of GDP by 2035. See SOCIAL SECURITY & MEDICARE BDS. OF TRS., *STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2015 ANNUAL REPORTS* (2015), <http://www.ssa.gov/OACT/TRSUM/index.html>.

5. See SOCIAL SECURITY & MEDICARE BDS. OF TRS., *supra* note 4. The Medicare Hospital Insurance Trust Fund funds Medicare spending under Medicare Part A. The Trustees estimate that the Supplementary Medicare Insurance fund, which pays the cost of physician services and other outpatient expenses under Medicare Part B, will remain adequately financed into the indefinite future because current law provides for automatic financing adjustments to meet expected costs. See *id.*

6. See John Wennberg et al., *Extending The P4P Agenda, Part 2: How Medicare Can Reduce Waste And Improve The Care of The Chronically Ill*, 26 HEALTH AFFAIRS 1575, 1577 (2007) (noting the "widely held assumption that more frequent intervention constitutes better care").

conventional wisdom proves untrue. Medicare patients that receive a higher volume or intensity of care frequently do *not* enjoy improved life expectancy or quality of life as compared to those receiving less care. Close analysis reveals the reason for this result—much of the care given to Medicare beneficiaries is medically unnecessary, inefficient, or of questionable value.⁷ In addition, such care needlessly exposes patients to medical errors and other health risks.⁸

Medically unnecessary care includes ineffective and unsafe care, such as tests that do not provide useful diagnostic or therapeutic information, interventions that do not improve a patient's condition, and care with health risks that clearly outweigh any potential benefit.⁹ Researchers have repeatedly documented that far too often patients in the United States, including Medicare patients, receive medically unnecessary care.¹⁰ For example, contrary to recommendations from the National Kidney Foundation, more than seventy percent of Medicare patients with end-stage renal disease start dialysis with catheters, the least effective and least safe access method.¹¹ Similarly, studies have found that as many as 21.8 percent of coronary angiographies performed on patients who suffer heart attacks or heart disease are inappropriate.¹²

7. Wasteful care also includes care that results from failures of care delivery and coordination and from fraud and abuse. For example, lapses in patient safety and poor coordination between providers can lead to spending on preventable injuries or complications. See generally Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in U.S. Health Care*, 307 JAMA 1513, 1513 (2012) (describing different types of wasteful health care spending). These forms of waste are beyond the scope of this Article, which instead focuses on overtreatment of patients.

8. See *infra* note 23 (explaining the risks faced by patients receiving medical treatment).

9. See Peter Boland et al., *Accountable Care Organizations Hold Promise, But Will They Achieve Cost and Quality Targets?*, MANAGED CARE, Oct. 2010, <http://www.managedcaremag.com/archives/1010/1010.ACOs.html> (stating that unnecessary care includes services that do not provide useful diagnostic or therapeutic information); Timothy Stoltzfus Jost, *The American Difference in Health Care Costs: Is There a Problem? Is Medical Necessity the Solution?*, 43 ST. LOUIS U. L.J. 1, 13 (1999) (a test or procedure is medically unnecessary if it is not appropriate or effective for addressing a patient's condition); Allison Liptiz-Snyderman & Peter B. Bach, *Overuse of Health Care Service: When Less is More . . . More or Less*, 173 JAMA INTERNAL MED. 1277, 1277 (2013) (defining overuse to include "services where the expectation is that the potential harms exceed the potential benefits").

10. See generally Deborah Korenstein et al., *Overuse of Health Care Services in the United States: An Understudied Problem*, 172 ARCHIVES OF INTERNAL MED. 171 (2012) (reviewing the research literature on clinically inappropriate use).

11. See THE DARTMOUTH INST. FOR HEALTH POL'Y & CLINICAL PRACTICE, VARIATION IN THE CARE OF SURGICAL CONDITIONS: SPINAL STENOSIS 5.13 (2015) (discussing variation in the treatment of Medicare patients with end-stage renal disease).

12. See Korenstein *supra* note 10, at 175. A coronary angiography is an ex-ray photograph or visualization of the coronary arteries taken after radiopaque materials has been injected into the patient's bloodstream. See J.E. SCHMIDT, ATTORNEY'S DICTIONARY OF MEDICINE 103 (LexisNexis 2014).

In addition, some of the care provided to Medicare beneficiaries is inefficient. Inefficient care includes interventions providing only slight clinical benefit compared to their costs.¹³ A commonly offered example of this form of overtreatment is expensive cancer treatments that on average extend a patient's life by a few weeks.¹⁴ Inefficient care also includes tests and treatments that are more costly than alternatives of similar therapeutic value.¹⁵ For example, Medicare patients with prostate cancer regularly receive expensive, aggressive treatments despite the absence of evidence demonstrating that these treatments are superior to less expensive options.¹⁶ Medicare patients also receive care of unnecessary intensity or in more costly settings than warranted, such as surgeries performed in the inpatient setting that could have been done in the less expensive outpatient setting.¹⁷

Studies also indicate that Medicare patients receive a high volume of discretionary care of questionable value. Researchers have found large regional disparities in Medicare spending, with per capita spending in high-spending regions over two times greater than that in low-spending regions (even after controlling for differences in prices and health status).¹⁸ Most of this regional variation in Medicare spending is attributable to differential use of discretionary medical services,¹⁹ or services of minimal or unknown clinical

13. See Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778, 784 (1986) (defining wasteful medical technology to include “technologies that do not yield adequate net benefits”).

14. See Ari Hoffman & Steven D. Pearson, *‘Marginal Medicine’: Targeting Comparative Effectiveness Research to Reduce Waste*, HEALTH AFFAIRS w710, w713 (2009).

15. See Mehlman, *supra* note 13, at 789 (“A technology might also be regarded as wasteful if it is expected to yield the same net benefit as another technology but at a greater cost—that is, if it is not the most efficient, cost-effective technology to treat or to diagnose a patient’s condition.”).

16. See THE DARTMOUTH INST., *supra* note 11, at 6.13–14 (discussing variation in the treatment of prostate cancer among Medicare patients).

17. Cf. CTR. FOR THE EVALUATIVE CLINICAL SERVS., SUPPLY-SENSITIVE CARE 1 (2007), http://www.dartmouthatlas.org/downloads/reports/supply_sensitive.pdf (stating that overuse in health care includes an overdependence on the acute care sector, such as admitting chronically ill patients to the hospital rather than treating them as outpatients).

18. See Elliott S. Fisher & Kristen K. Bronner, *Regional Insights and U.S. Health Care Savings*, in THE HEALTH CARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES: WORKSHOP SERIES SUMMARY 95, 95 (Pierre L. Young & Leigh Anne Olsen eds., 2010) (describing regional variations in Medicare spending).

19. See *id.* at 96 (“Almost all of the differences in spending across regions can be explained by greater use of discretionary medical services.”); ROBERT A. BERENSON & ELIZABETH DOCTEUR, DOING BETTER BY DOING LESS: APPROACHES TO TACKLE OVERUSE OF SERVICES 3–4 (2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403697 (summarizing evidence suggesting that the provision of inappropriate care failed to explain geographic variations in the intensity or cost of care, and that geographic differences “can be explained largely as a difference in use of so-called discretionary services . . .”).

benefits.²⁰ For example, from 2001–2011, the rate of inpatient spinal decompressions for lumbar spinal stenosis among Medicare patients varied more than eightfold across hospital referral regions.²¹ Yet Medicare patients in high-spending regions do not enjoy greater life expectancy or quality of life than those residing in low-spending regions despite visiting physicians more frequently, making greater use of specialists, and receiving more diagnostic tests, procedures, and inpatient care.²² In fact, some studies find that high-spending regions perform *worse* on certain measures, as medical interventions often expose patients to medical errors and other health risks.²³

Clearly many Medicare dollars are spent on overtreatment—wasteful care that is ineffective, unsafe, inefficient, or of questionable value. Indeed, analysts estimate that between twenty and thirty percent of Medicare expenditures are spent on inefficient interventions or care of little or unknown value.²⁴ Reducing the

20. See BERENSON & DOCTEUR, *supra* note 19, at 4 (defining discretionary care).

21. See THE DARTMOUTH INST., *supra* note 11, at 4.8. A spinal cord decompression is a surgical operation that relieves pressure on the spinal cord. See SCHMIDT, *supra* note 12, at 104–05.

22. See JOHN E. WENNBURG ET AL., THE DARTMOUTH INST. FOR HEALTH POL'Y & CLINICAL PRACTICE, TRACKING THE CARE OF PATIENTS WITH SEVERE CHRONIC ILLNESS 4, 13, 54 (2008). These findings hold true even after controlling for differences in the prevalence of disease and other population characteristics. See *id.* at 3 (noting that differences in the level of illness and other patient characteristics account for only a small fraction of the variation in the amount of care delivered).

23. As explained by researchers at The Dartmouth Institute for Health Policy & Clinical Practice:

[T]he more time spent in the hospital, the greater [patients'] exposure to error, infection, and adverse events. As care becomes more complex, and as more physicians get involved in an individual patient's care, it becomes less and less clear who is responsible, and miscommunication—and medical errors—become more likely. Greater use of diagnostic tests increases the risk of finding—and being treated for—abnormalities that are unlikely to have caused the patient any problem. . . . Patients who receive care for conditions that would have never caused a problem can only experience the risk of the intervention.

JOHN E. WENNBURG ET AL., THE DARTMOUTH INST. FOR HEALTH POL'Y & CLINICAL PRACTICE, AN AGENDA FOR CHANGE: IMPROVING QUALITY AND CURBING HEALTH CARE SPENDING: OPPORTUNITIES FOR THE CONGRESS AND OBAMA ADMINISTRATION 3–4 (2008).

24. See Fisher & Bronner, *supra* note 18, at 100–01 (estimating that decreased use of discretionary services in the Medicare program would lead to a decline in Medicare spending by eighteen to twenty percent overall, an estimate they describe as “relatively conservative”); Elliott S. Fisher & John E. Wennberg, *Health Care Quality, Geographic Variations, and the Challenge of Supply-Sensitive Care*, 46 PERSP. IN BIOLOGY & MED. 69, 76 (2003) (“If the United States were able to reduce Medicare spending in the highest-cost regions to the level in the lowest-cost regions, up to one-third of annual Medicare spending could be reallocated to pressing needs.”). Cf. BERENSON & DOCTEUR, *supra* note 19, at 1 (“Extrapolating from studies focusing on particular conditions or services, some analysts have estimated that as much as a third of U.S. health care spending is unnecessary or wasteful.”).

overtreatment of patients thus would go a long way toward constraining Medicare spending. The question is how best to do so.

Attention rightly has been given to motivating physicians to do less. Importantly, the Affordable Care Act (ACA)²⁵ seeks to accomplish this by changing the way Medicare pays physicians. Yet payment reform that narrowly focuses on physicians' financial incentives overlooks the broader context in which physicians practice medicine, namely that most physicians affiliate with hospitals that powerfully influence physicians' clinical judgments.

Too frequently a hospital's organizational culture—its norms, values, policies, and internal structures—lead physicians to provide patients with unnecessary, wasteful, or inefficient care.²⁶ Consequently, payment reforms that encourage physicians to reduce the overtreatment of patients will have limited success if hospitals' cultures promote the opposite. Tackling the problem of overtreatment, then, requires shifting hospitals' organizational cultures from cultures of overtreatment to cultures of efficiency. Regulators therefore must not only alter how Medicare pays physicians, but also must change how Medicare pays hospitals.

Traditional approaches to paying hospitals and other providers under Medicare do little to reduce the overtreatment of patients, or worse, encourage overtreatment. This troubling dynamic has captured the attention of federal regulators, who, on January 26, 2015, announced the ambitious goal of shifting ninety percent of Medicare payments from traditional payment approaches to new payment alternatives by 2018.²⁷ Unfortunately, the reforms proposed by government regulators are too modest and do not fully address hospitals' cultures of overtreatment. This Article therefore offers a novel reform proposal that would hold hospitals accountable when their cultures promote overtreatment of Medicare patients.

Specifically, this Article argues for linking a hospital's Medicare payment rates to the hospital's success in lowering the cost of treating patients both inside *and outside* the hospital setting. This would be done by expanding the existing Medicare Hospital Value-Based Purchasing (VBP) Program to include efficiency measures that evaluate the average cost of caring for patients with certain conditions,

25. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

26. See *infra* Part II.

27. See Press Release, U.S. Dep't of Health & Human Servs., Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals & Timeline for Shifting Medicare Reimbursements from Volume to Value (Jan. 26, 2015), <http://www.hhs.gov/news/press/2015.pres/01/20150126a.html>.

such as heart disease, cancer, and chronic back pain. Hospitals that, together with their affiliated physicians, reduce unnecessary or excessive care in the treatment of the selected conditions would be rewarded with higher reimbursement rates under Medicare. In contrast, inefficient hospitals would be penalized with lower reimbursement rates. This approach would incentivize hospitals to shift from cultures of overtreatment to cultures of efficiency.

The Article begins by describing in Part I how Medicare's design has contributed to physicians' overtreatment of patients. Part II then describes how a hospital's organizational culture powerfully influences the clinical practices of its affiliated physicians. In particular, it explains how the words and deeds of hospital leadership contribute to patterns of excessive care. This, in turn, explains why changing how Medicare pays physicians, without simultaneously addressing hospitals' organizational cultures, will have limited success in reducing the overtreatment of Medicare beneficiaries. Part III evaluates how Medicare currently pays hospitals, and concludes that more must be done if hospitals are to embrace a culture of efficiency. Part IV sets forth a new payment reform proposal that would accomplish this goal. Part IV also discusses potential concerns raised by this Article's proposal, including the potential for undertreatment of Medicare patients, and concludes that they do not render the approach unworkable.

I. PHYSICIANS' SPENDING OF MEDICARE DOLLARS

Medicare's design affords physicians unfettered discretion over the medical care provided to their patients. This discretion allows physicians to exert tremendous influence over how much Medicare spends on patient care. Physicians' control over Medicare spending would not itself be problematic if physicians spent Medicare's dollars wisely. Too often, however, physicians adhere to clinical practices that result in a high volume and intensity of care without any corresponding increase in patients' health status. This Part explains why this is so.

A. Medicare's Design

Passage of the original Medicare statute was possible only after Congress secured the cooperation of the medical establishment.²⁸ The original Medicare statute thus reflects a series of political compromises favorable to physicians. Specifically, Medicare's initial design shielded the physician-patient relationship from direct government interference, preserved patients' freedom to choose their physicians, and protected physicians' professional independence and financial interests. These policy choices largely remain a part of Medicare's programmatic structure today. The end result has been a Medicare program that gives physicians a central role in determining what care Medicare beneficiaries receive, and, by extension, what Medicare spends on beneficiaries' health care.²⁹

In enacting Medicare, Congress adopted several design features that protected physicians' existing relationships with their patients. All physicians licensed under state law were eligible to participate in the Medicare program.³⁰ Medicare also did not employ physicians, but instead allowed them to maintain their independent practices.³¹ In addition, Medicare beneficiaries were free to choose among the physicians participating in the program.³²

Congress also structured Medicare as an indemnity program that reimbursed physicians and hospitals for all care "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."³³ As an indemnity program, Medicare paid physicians and other providers

28. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 375 (1982) ("In setting up Medicare, Congress and the [Johnson] administration were acutely concerned to gain the cooperation of the doctors and hospitals."); Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 *Geo. L.J.* 519, 526 (2013) ("The original Medicare statute contained evident markers of the strategic choice to appease the medical establishment.").

29. See generally Bagley, *supra* note 28, at 526–32 (describing Medicare's initial programmatic structure and the authority given to physicians).

30. See Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 102(a), § 1861(r), 79 Stat. 303 (defining "physician" to mean a state-licensed physician).

31. See Bagley, *supra* note 28, at 529 ("In contrast to the Veterans Administration health-care system, Medicare wouldn't directly employ its physicians.").

32. See Social Security Amendments of 1965, sec. 102(a), § 1802.

33. *Id.*, at sec. 102(a), § 1862(a)(1). Generally, Medicare Part A covers inpatient hospital services, hospice services, skilled nursing facility services, and certain home health care, 42 U.S.C. § 1395d, while Medicare Part B covers physician services, diagnostic services, and durable medical equipment. 42 U.S.C. § 1395k. However, specific items and services within these broad categories are excluded from coverage if not deemed reasonable and necessary. 42 U.S.C. § 1395y(a)(1)(A).

on a fee-for-service basis, with providers receiving a separate payment for each unit of service provided to their Medicare patients.³⁴ Determinations as to whether care was reasonable and necessary were based on the prevailing standards among medical professionals, and in practice, Medicare largely deferred to the treating physician's judgment that the provided care was appropriate.³⁵ In addition, medical necessity determinations did not consider an intervention's cost-effectiveness.³⁶ This "cost-blind," "no questions asked" approach to coverage appeased physicians' desire for autonomy and virtually guaranteed them reimbursement for their services.³⁷

Although the "reasonable and necessary" language incorporated into the original Medicare statute remains in force today,³⁸ today's Medicare administrators have new powers that in theory allow them to exercise greater scrutiny of whether the care provided to patients is medically necessary. Specifically, Medicare administrators may issue coverage policies that dictate when specific interventions are considered medically necessary.³⁹ In practice, however, these review procedures are more bark than bite.

The task of developing and implementing Medicare coverage policies rests with the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare program and

34. Social Security Amendments of 1965, sec. 102(a), §§ 1812, 1832. Although initially the Medicare program reimbursed hospitals and physicians their reasonable costs, today Medicare's fee-for-service payment rates to physicians and hospitals are based on fee schedules established by the Centers for Medicare and Medicaid Services. 42 U.S.C. §§ 1395w-4(a); 1395ww(d) (2014).

35. See Bagley, *supra* note 28, at 526 (observing that the original Medicare statute's exclusion from coverage of care that is not reasonable and necessary "left treating physicians nearly untrammelled discretion to determine medical necessity"); Sean R. Tunis, *Why Medicare Has Not Established Criteria for Coverage Decisions*, 350 *NEW ENG. J. MED.* 2196, 2196 (2004) (explaining that in Medicare's early years the Medicare program gave significant deference to physicians' assessments of medical necessity).

36. The Medicare statute is ambiguous as to whether medical necessity determinations may consider cost-effectiveness such as whether an intervention's clinical benefits justify its costs or whether less expensive alternatives offer similar clinical benefit. See Tunis, *supra* note 35, at 2197 ("The Medicare statute is silent on the role of costs, and Medicare has not explicitly considered costs in making coverage decisions."). CMS's proposals to incorporate cost-effectiveness criteria into the coverage determination process met fierce industry resistance and cries of government rationing, leading CMS to abandon its attempts to do so. See generally Jacqueline Fox, *The Hidden Role of Cost: Medicare Decisions, Transparency and Public Trust*, 79 *U. CIN. L. REV.* 1, 18-21 (2011) (summarizing CMS's efforts to adopt cost-effectiveness criteria); Eleanor Kinney, *The Affordable Care Act and the Medicare Program: The Engines of True Health Reform*, 13 *YALE J. HEALTH POL'Y L. & ETHICS* 253 (2013) (same).

37. See Bagley, *supra* note 28, at 526-27. Cf. STARR, *supra* note 28, at 291-306 (describing the medical profession's preference for indemnity payments over other forms of payment).

38. 42 U.S.C. § 1395y(a)(1)(A).

39. See *infra* note 41 (explaining national and local coverage determinations).

Medicare Administrative Contractors (MACs),⁴⁰ the private organizations that review Medicare claims.⁴¹ CMS and MACs unfortunately lack both the administrative resources and clinical evidence necessary for developing coverage rules for the thousands—perhaps millions—of different treatment decisions made by physicians.⁴² MACs also rarely have the necessary clinical information to enforce existing guidelines or otherwise conduct meaningful review of individual claims.⁴³ Consequently, physicians continue to exercise tremendous discretion over whether care is reasonable and necessary.

40. 42 U.S.C. §§ 1395h(a), 1395u(a) (delegating responsibility for coverage determinations, including determinations of medical necessity, to MACs).

41. Both CMS and MACs issue generally applicable rules regarding coverage of particular health services or items. At the national level, CMS issues national coverage determinations (“NCDs”), or instructions to MACs directing them on whether to grant or deny coverage for specific care. 42 U.S.C. § 1395ff(f)(1)(B) (defining national coverage determinations). In the absence of an NCD, MACs may issue local coverage determinations (LCDs), which apply only to the claims reviewed by the MAC issuing the LCD. 42 U.S.C. § 1395ff(f)(2)(B) (defining local coverage determinations). MACs also review medical necessity determinations on a case-by-case basis based on a patient’s particular factual situation. See Michael John DeBoer, *Medicare Coverage Policy and Decision Making, Preventive Services, and Comparative Effectiveness Research Before and After the Affordable Care Act*, 7 J. HEALTH & BIOMED. L. 493, 505 (2012).

42. See CONG. BUDGET OFFICE, RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF MEDICAL TREATMENTS: ISSUES AND OPTIONS FOR AN EXPANDED FEDERAL ROLE 11 (2007), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/88xx/doc8891/12-18-comparativeeffectiveness.pdf> (explaining that less than half of all medical decisions are supported by adequate evidence regarding an intervention’s effectiveness); Jessica Mantel, *A Defense of Physicians’ Gatekeeping Role: Balancing Patients’ Needs with Society’s Interests*, 42 PEPP. L. REV. 633, 690–93 (2015) (arguing that government lacks the administrative resources to issue explicit rules of rationing for the full range of medical decisions); Brenda Sirovich et al., *Discretionary Decision Making by Primary Care Physicians and the Cost of US Health Care*, 27 HEALTH AFFAIRS 813, 814 (2008) (discussing a review by BMJ Clinical Evidence finding that more than half of treatments for a variety of conditions fall into medicine’s gray zone). Continuous advancements in medical knowledge and technology also necessitate frequent modification to NCDs and LCDs, further tasking CMS and MACs’ resources. See Hoangmai Pham et al., *Episode-Based Payments: Charting a Course for Health Care Payment Reform*, NIHCR POL’Y ANALYSIS, Jan. 2010, at 7, http://www.nihcr.org/Episode_Based_Payments (“[G]uidelines change over time as scientific evidence grows, and regularly updating guideline-based payment rates could be a costly and time-consuming endeavor.”).

43. See Bagley, *supra* note 28, at 551 (“Checking whether providers have complied with LCDs . . . requires detailed clinical information—information that is rarely found in claims forms.”); BERENSON & DOCTEUR, *supra* note 19, at 4 (“[T]he determination of appropriateness requires review of clinical information, which generally cannot be ascertained from claims data.”). Although MACs sometimes request the relevant clinical information from providers, they do not have sufficient resources to do so for every claim. See Bagley, *supra* note 28, at 551 (“[T]he cost of collecting clinical information on millions of claims related to thousands of different LCDs would be prohibitive.”); SEAN R. TUNIS ET AL., URBAN INSTIT., IMPROVING THE QUALITY AND EFFICIENCY OF THE MEDICARE PROGRAM THROUGH COVERAGE POLICY 1 (2011), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412392-Improving-the-Quality-and-Efficiency-of-the-Medicare-Program-Through-Coverage-Policy.pdf> (stating that even when NCDs are developed, CMS and MACs “often lack the resources to

In essence, Medicare's design delegates to physicians primary responsibility for deciding what care is provided to Medicare beneficiaries, with minimal government oversight. In giving physicians this role, "Congress surrendered direct control over the size of Medicare funding" to the physicians, who "collectively establish what the government . . . pay[s] out for medical services."⁴⁴ This delegation would not, in and of itself, be problematic if physicians acted consistently with the government's interest in spending Medicare's dollars wisely. As explained below, however, Medicare's design assures the opposite.

B. The Overtreatment of Medicare Patients

In an ideal world, medical science would provide a clear answer as to whether a particular intervention is medically appropriate for a given patient. More often than not, however, the practice of medicine involves a high degree of clinical uncertainty and ambiguous value trade-offs.⁴⁵ For many treatments, we simply lack authoritative evidence on clinical effectiveness.⁴⁶ Even when such information is available, physicians may question the potential benefits and risks for an individual patient given the substantial variation among patients.⁴⁷ In addition, medicine's inherent complexity makes assessment of appropriateness difficult, as "[t]he final

assure that the policies are implement as written"). The vast majority of claims thereby escape scrutiny. See GOV'T ACCOUNTABILITY OFF., BETTER TARGETING OF MEDICARE'S CLAIMS REVIEW COULD REDUCE IMPROPER PAYMENTS 297 (2011) (stating that less than one percent of Medicare's claims are subject to a medical record review by trained personnel).

Recovery audit contractors (RACs) also conduct post-payment claims review in order to identify improper billing of Medicare. 42 U.S.C. § 1395ddd(h)(1). However, they generally employ data mining and other analytical techniques to identify potentially improper claims that lead them to focus on a small subset of submitted claims. See Timothy P. Blanchard, *Medicare Medical Necessity: Avoiding Overpayments, Penalties and Fraud Allegations*, AM. HEALTH LAWS. ASS'N 7 (2011) (discussing RACs' claims review process).

44. Bagley, *supra* note 28, at 527.

45. See Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy and Ethics*, 64 CASE W. RES. L. REV. 455, 471–77 (2013) (discussing uncertainty and ambiguity in the clinical setting).

46. See Amitabh Chandra et al., *Who Ordered That? The Economics of Treatment Choices in Medical Care*, in 2 HANDBOOK OF HEALTH ECONOMICS 402–03 (Mark V. Pauly et al. eds., 2011) ("In many clinical situations, there are no authoritative guidelines or consensus treatment recommendations.").

47. See Jost, *supra* note 9, at 15 ("Given the infinite variability of patients and conditions, it is often quite difficult to know with any precision how useful any test or procedure will be ex ante."); Jessica Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1392, 1420 (2012) ("[A] treatment's potential clinical benefits for an individual patient often remain uncertain, with some care that, on average, is of no, or merely marginal, benefit potentially benefitting some patients.").

decision about how to manage a patient requires synthesizing all the information about a disease, the patient, signs and symptoms, the effectiveness of dozens of tests and treatments; outcomes, and values.”⁴⁸ Medical decisions also often involve difficult tradeoffs, such as balancing a treatment’s potential health benefits and risks⁴⁹ or determining whether a intervention’s potential benefits justifies its costs.⁵⁰

In navigating medicine’s vast grey zone, physicians must decide whether to err on the side of doing more versus doing less for their Medicare patients. Many choose the former, ordering expensive imaging tests, recommending aggressive treatments over watchful waiting, or hospitalizing patients rather than caring for them in outpatient settings. This bias to do more has contributed to rapid growth in Medicare spending.⁵¹ Although physicians’ professional norms and malpractice fears in part explain high utilization patterns,⁵² Medicare’s design also is to blame.

Medicare insulates beneficiaries from the full price of their medical care, so they have little incentive to consider its costs. Indeed, patients often desire all potentially beneficial care, no matter how costly or slight its benefits.⁵³ Because Medicare beneficiaries have

48. David M. Eddy, *Variation in Physician Practice: The Role of Uncertainty*, 3 HEALTH AFFAIRS 74, 83 (1984).

49. For example, a medical intervention may yield useful diagnostic information, prevent illness, cure or ameliorate a disease, increase a patient’s life expectancy, or improve a patient’s quality of life, but also may expose a patient to pain, anxiety, health complications or death. See Mantel, *supra* note 45, at 475.

50. See E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1, 25–26 (1997) (noting that medical decision-making involves value choices, including “decisions about how much money is appropriate to spend” in an effort to achieve health-related goals).

51. See *supra* notes 2–5 and accompanying text (describing the growth in Medicare expenditures).

52. See Daniel P. Kessler et al., *Effects of the Medical Liability System in Australia, the UK, and the USA*, 368 THE LANCET 240, 240 (2006) (reviewing “findings of empirical studies that estimate the effects of tort law on medical care” and concluding that there is “systematic evidence of defensive medicine” among physicians in the United States); David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2612, 2615 (2005) (stating that recent survey evidence shows “widespread” defensive medicine practices among physician in certain high-risk specialties); Wennberg et al., *supra* note 6, at 1577 (commenting that driving the frequent use of “supply-sensitive” care, or care lacking sufficient evidence on clinical effectiveness, is “the widely held assumption that more frequent intervention constitutes better care—and that whatever resources are available should be fully used in managing difficult cases.”). Elsewhere I have explained how the current medical malpractice system promotes the overtreatment of patients and suggested possible reforms that would reduce the defensive practice of medicine. See Mantel, *supra* note 42.

53. See Jost, *supra* note 9, at 15 (“[I]f the questioned test or procedure is likely to be of any benefit, the informed patient may expect or demand it.”); Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare*

the freedom to choose among physicians, physicians who fail to satisfy their patients' demands to "do everything possible" risk losing patients to those who will do so.⁵⁴ Physicians therefore face competitive pressures to provide their Medicare patients with more care, particularly expensive, technology-driven procedures.

Medicare's fee-for-service payment structure reinforces this dynamic. By paying physicians for each unit of service provided, fee-for-service rewards doing more.⁵⁵ Physicians, for example, can increase their Medicare reimbursements by scheduling their Medicare patients for repeat office visits, additional diagnostic tests, or multiple invasive procedures.⁵⁶ Fee-for-service also encourages more costly interventions by reimbursing sophisticated, labor-intensive tests and procedures at higher payment rates than less intensive interventions.⁵⁷ These higher payments also encourage physicians to become specialists,⁵⁸ who tend to favor more

Spending, 11 YALE J. ON REG. 455, 458 ("The reliance on third-party payments to finance medical care strengthens patients' own bias towards using whatever methods are available when their health is at stake.").

54. Cf. Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to "Just Say No" If an Informed Patient Demands Services That Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 358–59 (2009) (observing that pressure to sustain and increase "patient flow" causes physicians to "feel pressure to satisfy and retain patients as if they were customers in a retail business").

55. See INST. OF MED. OF THE NAT'L ACADS., *REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE* 25–26 (2007) (discussing the incentives of the Medicare fee-for-service payment system that result in overutilization); Arnold S. Relman, *Doctors as the Key to Health Care Reform*, 361 NEW ENG. J. MED. 1225, 1225 (2009), <http://www.nejm.org/doi/full/10.1056/NEJMp0907925> ("Most doctors are paid on a fee-for-service basis, which is a strong financial incentive for them to maximize the elective services they provide[,] . . . a major factor in driving up medical expenditures."). Indeed, empirical studies have documented that physicians paid on a fee-for-service basis provide more care to their patients than physicians paid under alternative payment models, such as capitation or salary. See Robert Town et al., *Market Power and Contract Form: Evidence from Physician Group Practices*, 11 INT'L J. HEALTH CARE FIN. ECON. 115, 131 (2011) ("Numerous papers have demonstrated an empirical link between [fee-for-service] payment and increased provision of services . . .").

56. See Gloria Bazzoli, *Medical Service Risk and the Evolution of Provider Compensation Arrangements*, in *UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE* 144 (Peter Hammer et al., eds., 2003) ("[A]s the agent for a patient, a physician will increase the supply of services as long as his or her marginal reimbursement exceeds marginal costs . . .").

57. See Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 JAMA 2789, 2789–90 (2011) (commenting on the impact of fee-for-service paying significantly more for procedures, rather than for evaluation and management).

58. See Hoangmai Pham & Paul B. Ginsburg, *Unhealthy Trends: The Future of Physician Services*, 26 HEALTH AFFAIRS 1586, 1590 (2007) ("[L]ow incomes for [primary care physicians] make these career paths unattractive to new physicians. Among recent medical school graduates, a falling number choose to train in primary care specialties . . ."); Bryan Vaughn et al., *Can We Close the Income Gap Between Specialists and Primary Care Physicians?*, 29 HEALTH AFFAIRS 933 (2010) (explaining that because physicians have much greater wealth potential if they choose a specialty career than if they choose a primary care career, medical students typically choose the former).

high-tech, invasive tests and procedures over less costly alternatives.⁵⁹

Finally, Medicare's coverage determination process does little to squelch providers' incentives to provide a high volume and intensity of care. As noted above, Medicare's coverage determination process is highly deferential to physicians' judgments on medical necessity,⁶⁰ making it unlikely that Medicare will question a physician's decision to do more for her patient. Moreover, lax enforcement of existing coverage rules has left Medicare administrators unsuccessful in deterring the wide-spread adoption of new and costly technologies.⁶¹ The exclusion of cost-effectiveness as a criterion for Medicare coverage also encourages the provision of marginally beneficial care.⁶²

As discussed above, regrettably, doing more for Medicare patients often does not improve their health. Studies of regional variation show that Medicare patients living in high-spending regions do not enjoy improved life expectancy or better health outcomes than those residing in low-spending regions.⁶³ Researchers also have documented that Medicare patients time and again receive inappropriate care or inefficient care.⁶⁴ Far too often, then, Medicare's dollars are spent on care of questionable value. If we wish to change this dynamic, we must motivate physicians to reduce the volume and intensity of care they provide patients.

II. LOOKING BEYOND PHYSICIANS: HOW HOSPITALS' ORGANIZATIONAL CULTURES PROMOTE OVERTREATMENT

In an effort to address physicians' overtreatment of Medicare

59. See Mantel, *supra* note 47, at 1405 (explaining how fee-for-service encourages greater specialization among physicians and expensive care).

60. See *supra* notes 40–43 and accompanying text.

61. See Tunis, *supra* note 35, at 5 (stating that “the dearth of information available to contractors” leads to missed opportunities to prevent widespread adoption of technology of questionable value, and noting that a study found that seven out of the eight selected coverage policies setting forth coverage conditions for the specified technology did not measurably change providers' use of the technology); Bagley, *supra* note 28, at 551 (arguing that in part due to lax enforcement of NCDs and LCDs, the Medicare coverage determinations process has not “deter[red] Medicare's physicians from adopting novel and unproven technologies”).

62. See Steven D. Pearson & Peter B. Bach, *How Medicare Could Use Comparative Effectiveness Research in Deciding on New Coverage and Reimbursement*, 29 HEALTH AFFAIRS 1796, 1796–98 (2010) (decrying Medicare coverage and payment policies that ignore whether a service is cost-effective because it creates “perverse incentives to develop and then overuse expensive services”).

63. See *supra* notes 18–23 and accompanying text.

64. See *supra* notes 9–17 and accompanying text.

patients, regulators have sought to align physicians' financial interests with Medicare's programmatic goal of preventing care that is medically unnecessary, inefficient, or of questionable value. Specifically, the Affordable Care Act established the Physician Value-Based Payment (VBP) Modifier,⁶⁵ which, beginning in January of 2015, links a physician or physician group's reimbursement rates to their performance on various cost and quality measures.⁶⁶ The cost measures are designed to evaluate physicians' efficiency; those who successfully lower costs receive superior performance ratings than those who do not.⁶⁷ Higher performing physicians receive an upward adjustment in their rates under the physician fee schedule,

65. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 3007, 124 Stat. 119 (2010) (codified at 42 U.S.C. § 1395w-4(p)).

66. Physicians receive two composite scores, the first based on their overall performance on the selected cost measures and the second based on their overall performance on the selected quality measures. See CTRS. FOR MEDICARE & MEDICAID SERVS., SUMMARY OF 2015 PHYSICIAN VALUE-BASED PAYMENT MODIFIER POLICIES 14-15 (2014), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf>.

Initially the Physician VBP Modifier applies only to physicians in groups of one hundred or more physicians and other "eligible professionals," but will apply to all physicians in 2017. See Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule, 77 Fed. Reg. 68991, 69306 (Nov. 16, 2012) [hereinafter Revisions to Payment Policies I]. The Medicare statute defines an "eligible professional" to include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals, audiologists, and physical, occupational, and qualified speech-language therapists. 42 U.S.C. § 1395w-4(k)(3)(B).

67. For 2015, CMS has incorporated into the Physician VBP Modifier five efficiency measures: total per capita cost and per capita costs for chronic obstructive pulmonary disease (COPD), heart failure, coronary artery disease (CAD), also known as heart disease, and diabetes. See Revisions to Payment Policies I, *supra* note 66, 77 Fed. Reg. at 69320 (explaining the Physician VBP Modifier). Total per capita cost measures the average cost of all care provided to a physician group's patients under Medicare Parts A and B, while the remaining measures calculate the average cost of all related Parts A and B care provided to a physician group's patients with the relevant condition, with adjustments made for differences in patient's risk factors and regional payment rates. See *id.*, 77 Fed. Reg. at 69315, 69317. For example, the per capita cost for diabetes measures the average cost of all diabetes-related care provided to the physician group's diabetic patients. In the future, CMS intends to incorporate additional condition-specific efficiency measures into the Physician VBP Modifier. See Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014, 78 Fed. Reg. 74230, 74229, 74786 (Dec. 10, 2013) [hereinafter Revisions to Payment Policies II].

For 2015, Medicare beneficiaries are attributed to the physician group that provides the plurality of primary care services received by a beneficiary. See Revisions to Payment Policies I, *supra* note 66, 77 Fed. Reg. at 69319. The Physician VBP Modifier thereby incentivizes primary care physicians to actively oversee and coordinate all care provided to Medicare beneficiaries in an effort to reduce the volume and intensity of care provided to their patients by other providers. For example, a primary care physician seeking to reduce per capita costs may refer her patients for fewer diagnostic tests, admit fewer patients to the hospital, and favor lower cost specialists over higher cost specialists when referring patients for specialty care. Cf. Andrew M. Ryan & Matthew J. Press, *Value-Based Payment for Physicians in*

while poorer performing physicians receive lower payments.⁶⁸ Accordingly, Medicare will pay higher rates to efficient physicians than less efficient physicians who provide similar quality care. The Physician VBP Modifier thereby aligns physicians' financial interests with the government's goal of reducing the volume and intensity of care.⁶⁹

The Physician VBP Modifier is an important step toward reducing physicians' overtreatment of Medicare patients. Nevertheless, payment reform that narrowly focuses on physicians' financial incentives overlooks a fundamental component in the overtreatment story—the impact of health care organizations' cultures on physicians' treatment decisions, particularly hospitals' organizational cultures.

As noted above, physicians frequently face uncertainty as to how best to manage their patients' care.⁷⁰ How a physician navigates medicine's grey zone is largely a function of her professional intuitive,⁷¹ which in part reflects the customs of the medical profession

Medicare: Small Step or Giant Leap?, 160 ANNALS OF INTERNAL MED. 565, 565–67 (2014) (noting that the attribution methodology under the Physician VBP Modifier “pushes primary care providers to manage patients across the continuum of care,” but noting that “[e]ven if primary care providers want to refer their patients to specialists who provide higher-value care, they may not know who those specialists are” and may “receive care from specialists to whom they were not directly referred by their primary care providers.”).

68. 42 U.S.C. § 1395w-4(p). For 2015, physicians classified as low cost/high quality, low cost/average quality, and average cost/higher quality will receive an upward adjustment in their payment rates; physicians classified as low cost/low quality, average cost/average quality, or high cost/high quality receive no adjustment in their payment rates; and physicians classified as average cost/low quality, high cost/average quality, and high cost/low quality will receive a downward adjustment in their payment rates. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 66, at 15 tbl. 4.

69. The recently enacted Medicare Access and CHIP Reauthorization Act of 2015 provides that the Physician VBP Modifier be combined with the current Physician Quality Reporting System and Electronic Health Records/Meaningful Use programs into a single Merit-based Incentive Payment System (MIPS) program beginning in 2019. Under MIPS, physicians who score highly will receive bonuses. Physicians' scores will be based on four categories: quality (thirty percent), resource use (thirty percent), meaningful use of electronic health records (twenty-five percent), and clinical practice improvement activities (fifteen percent). Medicare Access and CHIP Reauthorization Act of 2105, Pub. L. No. 114-10, § 101.

70. *See generally* Mantel, *supra* note 45, at 471–77 (describing why much of medicine involves uncertainty and ambiguity).

71. *See* JAMES L. BOWDITCH & ANTHONY F. BUONO, A PRIMER ON ORGANIZATIONAL BEHAVIOR, 45 (7th ed. 2007) (“People often use schemas, cognitive frameworks that systematize our ‘knowledge’ about . . . other people, situations, objects and phenomena.”); Mark P. Higgins & Mary P. Tully, *Hospital Doctors and Their Schemas About Appropriate Prescribing*, 39 MED. EDUC. 184, 185 (2005) (defining schemas as “ordered patterns of mental representations that encapsulate all our knowledge regarding specific objects, concepts or events”).

and a physician's personal ideals, training, and experience.⁷² However, a physician's professional judgment also is strongly influenced by the organizational culture of her affiliated hospital—its norms, values, organizational resources, and internal structures.⁷³ At times, a hospital's organizational culture encourages physicians to practice more cost-conscious care. Often, though, the opposite holds true, with a hospital's organizational culture leading to patterns of overtreatment among its affiliated physicians both within and outside the hospital's walls.

When the Physician VBP Modifier and a hospital's organizational culture work at cross-purposes, the latter may curb the former's success in reducing physicians' overtreatment of Medicare patients. Accordingly, changing physicians' practice patterns requires not only realigning physicians' financial incentives, but also adopting Medicare payment policies that promote hospital cultures of efficiency and cost-conscious care.

This Part describes how hospitals' organizational cultures influence physicians' clinical decisions. Part III then examines whether current Medicare payment policy and reform proposals adequately address hospitals' cultures of overtreatment.

A. *The Role of Hospital Leadership*

Leaders play a fundamental role in shaping an organization's culture.⁷⁴ Leaders articulate the organization's values, establish formal policies and standards of conduct, and allocate organizational rewards and status.⁷⁵ They also communicate an organization's norms and values by what issues they pay attention to, the priorities they set, and their own conduct.⁷⁶ Research in the field of organizational culture confirms that these actions strongly impact the values and behaviors of the organization's members.⁷⁷

72. See Mantel, *supra* note 45, at 484.

73. See generally *id.* at 484–505.

74. See, e.g., EDGAR SCHEIN, ORGANIZATIONAL CULTURE AND LEADERSHIP 235–58 (4th ed. 2010) (describing the ways in which leaders embed and transmit culture); A. Verbos et al., *The Positive Ethical Organization: Enacting a Living Code of Ethics and Ethical Organizational Identity*, 76 J. BUS. ETHICS 17, 22 (2007) (“Leaders’ key role in influencing ethical practices in their organizations is well established in the business ethics literature.”).

75. See SCHEIN, *supra* note 74, at 237, 247–49, 256–57 (describing how leaders shape an organization's culture through formal statements of organizational philosophy, creeds, and charters; and how they allocate rewards and status).

76. See *id.* at 236–43, 245–47 (describing various informal ways leaders shape organizational culture).

77. See M. Grojean et al., *Leaders, Values, and Organizational Climate: Examining Leadership Strategies for Establishing an Organizational Climate Regarding Ethics*, 55 J. BUS. ETHICS 223, 224

The hospital setting is no exception—hospital leaders powerfully shape their organization’s cultures, which in turn influence institutional clinical practices. As described below, a hospital’s leadership establishes the overarching values and norms that guide hospital personnel, including its affiliated physicians. They also impact physicians’ clinical judgments through various policies that bear on physicians’ self-interest. Finally, hospital administrators’ decisions regarding the amount and mix of available clinical resources strongly shape institutional patterns of care. Unfortunately, these actions often contribute to a culture of overtreatment rather than one of cost-consciousness.

1. Establishing Overarching Values and Norms

Through their words and deeds, hospital leaders shape their institutions’ overarching values and norms. Leaders committed to reducing overtreatment may voice support for a practice norm of frugality, ban from their facilities pharmaceutical and medical device representatives pushing new, costly therapies,⁷⁸ or purchase clinical decision support software that assists physicians in making cost-effective medical decisions.⁷⁹ Alternatively, hospital leaders can promote a culture of overtreatment by emphasizing “being on the cutting-edge” and “doing everything possible” for patients, directing physicians to utilize expensive technologies to boost the

(2004) (explaining how organizational leaders influence other organizational members’ perceptions and norms); Lynne L. Dallas, *A Preliminary Inquiry into the Responsibility of Corporations and Their Officers and Directors for Corporate Climate: The Psychology of Enron’s Demise*, 35 RUTGERS L.J. 1, 22 (2003) (commenting that the beliefs and values of others within an organization, particularly its leaders, are often better predictors of an individual’s behavior than the beliefs the individual brought to the organization).

78. Studies have found that physicians who interact with pharmaceutical sales representatives both prescribe drugs at a higher frequency and prescribe higher cost, lower quality drugs as compared to physicians who did not interact with pharmaceutical sales representatives. See generally THE PEW CHARITABLE TRUSTS, CONFLICTS-OF-INTEREST POLICIES FOR ACADEMIC MEDICAL CENTERS: RECOMMENDATIONS FOR BEST PRACTICES (2013), <http://www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/conflictsofinterest-policies-for-academic-medical-centers> (summarizing the findings of twenty-nine studies). Some commentators have called on hospitals to adopt policies limiting pharmaceutical and medical device representatives’ access to physicians and other personnel. See *id.*; *Managing Visits from Pharmaceutical Sales Representatives*, INST. FOR SAFE MEDICARE PRACTICES, May 22, 2008, www.ismp.org/newsletters/acutecare/articles/20080522.asp. Several hospitals have heeded these recommendations and now deny pharmaceutical and medical device representatives entry to their facilities. See George R. Gooch et al., *The Moral from Sorrell: Educate, Don’t Legislate*, 23 HEALTH MATRIX 237, 262 (2013).

79. Cf. Barrett T. Kitch et al., *Systems Model of Physician Professionalism in Practice*, 19 J. EVALUATION CLINICAL PRAC. 1, 9 (2013) (explaining that decision support software can be used in ways that “assist physicians in making cost-effective medical decisions”).

hospital's reputation,⁸⁰ or adopting clinical decision support software that encourages physicians to provide costly care of questionable value.⁸¹

These and similar managerial actions greatly influence institutional patterns of care among a hospital's physicians. Social scientists have found that an organization's individual members internalize the values, norms, attitudes, and behaviors promoted by the organization's leadership, a process that often occurs subconsciously.⁸² This suggests that if a hospital's leadership demonstrates a commitment to reducing overtreatment, physicians will internalize this norm and practice more cost-effective medicine. In contrast, if a hospital's leadership espouses that more medicine is better medicine, physicians will respond by providing more care of higher intensity.⁸³

Although few have studied this issue closely, interviews with physicians and hospital leaders in Minneapolis and Miami confirm the importance of leadership in promoting a norm of either efficiency or overtreatment. Experts have identified Minneapolis as a region providing high-quality, low-cost care to Medicare beneficiaries;

80. See Bjorn Hofmann, *Is There a Technological Imperative in Health Care?*, 18 INT'L J. TECH. ASSESSMENT HEALTH CARE 675, 685 (2002) (describing the "institutional imperative" to use technology, including hospital policies to use certain technologies as part of an overall competitive strategy or to increase the institution's status).

81. For example, Health Management Associates, Inc. (HMA), a for-profit hospital chain, allegedly used clinical software that was quick to flag emergency room patients as meeting the criteria for inpatient admission or a series of diagnostic tests. See Ruth SoRelle, *DOJ Joins Whistleblower Suits against HMA*, EMERGENCY MED. NEWS, Mar. 2014, at 1, 25–26 (describing various HMA practices that led to excessive inpatient admissions and diagnostic tests).

82. As I have explained elsewhere, this dynamic stems from individuals' powerful need for meaningful social relationships, which leads individuals to conform to the group's norms in an effort to secure continued acceptance within the group. See Mantel, *supra* note 45, at 490–91. In addition, over time an individual will come to identify with the organization, generating loyalty to and investment in the organization's values and adopting the organization's goals and interests as her own. See *id.* at 493–94.

83. Individuals who identify strongly with an organization generally are more committed to the organization and more likely to internalize its norms and values. Therefore, the impact of a hospital's organizational culture on physicians' treatment decisions likely will increase as various trends strengthen the ties between hospitals and physicians. These trends include physicians moving away from solo and small group practices and accepting salaried positions with hospitals. See Elisabeth Rosenthal, *Apprehensive, Many Doctors Shift to Jobs With Salaries*, N.Y. TIMES, Feb. 13, 2014, at A14 (noting that in 2013, sixty-four percent of job offers filled through Merritt Hawkins, one of the nation's leading physician placement firms, involved hospital employment, with the firm anticipating this trend to increase in the next two years). In addition, physicians increasingly rely on institutions to provide them capital, technology, and staff. More frequent clinical collaborations between physicians and hospitals also promote greater interdependence. See Mantel, *supra* note 45, at 495–97.

whereas Miami represents a high-cost, low-quality region.⁸⁴ Respondents interviewed in Minneapolis repeatedly noted that the policies, procedures, and public statements and actions by local hospital executives demonstrated their support for cost-effective medicine.⁸⁵ These actions promote a culture of frugality that leads to “physicians practising [sic] with an awareness of the cost of care they provide.”⁸⁶ Conversely, Miami respondents “did not report that this type of culture was present in their practice settings.”⁸⁷

Unfortunately, the culture of frugality among Minneapolis hospitals is the exception and not the rule. As discussed in detail in Part III.A, under current Medicare payment policies, a hospital’s bottom line benefits when the hospital does more, not less. With Medicare payments linked to the quantity of care, hospital administrators with an ounce of good business sense⁸⁸ aspire to treat more patients and expand the volume of services.⁸⁹ Current Medicare payment policies also skew hospitals toward more costly interventions, as more sophisticated, labor-intensive tests and procedures garner higher payment rates than less intensive interventions.⁹⁰ Consequently, hospital leaders generally promote a culture that encourages physicians to increase their “productivity” by treating more patients and performing more profitable procedures.⁹¹

2. Shaping Physicians’ Self-Interest

A hospital’s leadership also influences clinical practices through various policies that impact physicians’ self-interest. Psychologists studying cognitive motivation have found that individuals have a

84. See Kitch et al., *supra* note 79, at 3 (explaining the rationale for selecting Minneapolis and Miami as sites for the study).

85. See *id.* at 8–9 (discussing the support of leadership at Minneapolis hospitals for cost-effective care).

86. *Id.* at 6.

87. *Id.*

88. SHANNON BROWNLEE, OVERTREATED 85 (2007).

89. See Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFFAIRS 759, 761 (2008) (noting that “[u]nder current market dynamics and payment incentives, it is entirely rational for hospitals to try to fill beds and to expand services.” In doing so hospitals believe “they can protect profits best by protecting and increasing revenues.”); see also Harold D. Miller, *From Volume to Value: Better Ways to Pay for Health Care*, 28 HEALTH AFFAIRS 1418, 1418–19 (2009), <http://content.healthaffairs.org/content/28/5/1418.full.pdfhtml> (“Physicians, hospitals, and other providers gain increased revenues and profits by delivering more services to more people . . .”).

90. See Emanuel & Fuchs, *supra* note 57; see also *infra* notes 125, 127, 128.

91. See BROWNLEE, *supra* note 88, at 116 (noting that hospital administrators exert subtle pressures on physicians to “keep up their productivity by performing more profitable procedures,” especially physicians “working in profitable departments”).

subconscious tendency to form initial judgments that support conclusions that promote their own self-interest.⁹² More conscious deliberations then perform the secondary role of rationalizing the self-serving conclusion.⁹³ Accordingly, physicians may be subconsciously biased toward making clinical decisions consistent with their personal self-interest, as shaped by hospital policies.⁹⁴ For example, if a hospital rewards those physicians who admit a high volume of patients, a physician will be cognitively motivated to invoke heuristics, or mental shortcuts, that favor admitting a patient (e.g., “better safe than sorry”) or to conclude that the patient’s circumstances warrant an invasive procedure (e.g., the patient has a low-risk of complications from surgery). In contrast, if the hospital rewards frugality, a physician will be cognitively motivated to justify less aggressive care (e.g., the patient is a poor candidate for surgery).⁹⁵

The case of Health Management Associates, Inc. (HMA), the nation’s fourth largest for-profit hospital chain, illustrates this

92. See Dan M. Kahan, *The Supreme Court 2010 Term: Forward: Neutral Principles, Motivated Cognition, and Some Problems for Constitutional Law*, 125 HARV. L. REV. 1, 19 (2011) (describing “the unconscious tendency of individuals to process information in a manner that suits some end or goal”). For example, studies have found that individuals have faster reaction times when generating and endorsing memories and beliefs consistent with conclusions that promote an individual’s self-interest or desired ends. See Ziva Kunda, *The Case for Motivated Reasoning*, 108 PSYCH. BULL. 480, 483–85 (1990) (summarizing studies on biased memory search).

93. See generally DANIEL KAHNEMAN, *THINKING FAST AND SLOW* 105 (2011) (explaining that deliberative processes merely endorse individuals’ initial impressions by providing justifications for them). See also Milton C. Regan, Jr., *Moral Institutions and Organizational Culture*, 51 ST. LOUIS U. L.J. 941, 959–60 (2007) (“[W]e typically engage in moral reasoning after our judgments have been formed, and . . . we engage in that exercise in order to justify, rather than arrive at, those judgments.”). This does not mean deliberative reasoning cannot override our initial impressions—it can—but doing so requires mobilizing substantial mental focus, something individuals do infrequently, particularly when their mental capacity is otherwise taxed by the complexity of the situation or performing other tasks. See generally KAHNEMAN, *supra* note 93, at 81 (describing the “laziness” of System 2 deliberative cognitive processes). See also D. Moore & G. Lowenstein, *Self-Interest, Automaticity, and the Psychology of Conflict of Interest*, 17 SOC. JUST. RES. 189, 193 (2004) (stating that although “controlled processes can override automatic processes,” studies have found “that when mental capacity is constrained because people are under cognitive load, it is harder for them to engage in reflection and correction of automatic judgments”).

94. See Eugene C. Grochowski, *Ethical Issues in Managed Care: Can the Traditional Physician-Patient Relationship Be Preserved in the Era of Managed Care or Should It Be Replaced by a Group Ethic?*, 32 U. MICH. J.L. REFORM 619, 637–38 (1998–1999) (asserting that when making decisions in medicine’s gray area, physicians’ clinical judgments are subconsciously influenced by financial incentives); Mantel, *supra* note 45, at 498–505 (explaining how physicians’ self-interest subconsciously biases physicians to make clinical decisions consistent with their self-interest).

95. See Mantel, *supra* note 45, at 503–04 (explaining how a physician may be cognitively motivated to make patient care decisions that promote her self-interest, as shaped by an organization’s culture).

dynamic. HMA adopted various policies that made it in the self-interest of its emergency room physicians to both order multiple diagnostic tests and frequently admit patients.⁹⁶ HMA's practices included threatening to terminate physicians who did not increase hospital admissions and paying bonuses to physicians and medical directors who met benchmarks for ordering tests and admitting patients from the emergency room.⁹⁷ HMA also gave "failing grades" to physicians who regularly overrode HMA's software program when it flagged a patient as meeting the criteria for admission.⁹⁸ These practices allegedly biased the clinical decisions of HMA physicians, leading to unwarranted hospital admissions and diagnostic tests.⁹⁹

Although HMA's practices may be extreme, hospitals commonly adopt practices that align physicians' self-interest with providing high-volume, high-intensity care. The bonuses given to physicians employed by hospitals often are tied to a physician's billings, thereby encouraging the physician to order additional diagnostic tests and other services.¹⁰⁰ Hospital administrators also frequently bestow greater prestige and other perks on physicians who generate significant revenue for the hospital. For example, a heart surgeon with a robust practice may be appointed chair of the hospital's cardiology department.¹⁰¹ These and similar practices on the part of hospital administrators contribute to a culture of overtreatment.

96. See Press Release, U.S. Dep't of Justice, Government Intervenes in Lawsuits Against Health Management Associates, Inc. Hospital Chain Alleging Unnecessary Inpatient Admissions and Payment of Kickbacks (Jan. 13, 2014), <http://www.justice.gov/opa/pr/government-intervenes-lawsuits-against-health-management-associates-inc-hospital-chain> (stating that the lawsuits against HMA alleged that HMA leadership "exerted significant pressure on doctors in the emergency department to admit patients who could have been placed in observation, treated as outpatients or discharged"); SoRelle, *supra* note 81, at 25–26 (describing the HMA lawsuit).

97. See SoRelle, *supra* note 81, at 25 (describing the specific allegations contained in the lawsuits against HMA).

98. See *id.*

99. See *Hospitals: The Cost of Admission*, CBS (June 9, 2013) <http://www.cbsnews.com/news/hospitals-the-cost-of-admission-09-06-2013/> (60 Minutes television broadcast on Dec. 2, 2012 that investigated HMA's clinical practices); Complaint of Plaintiff at 19–20, 24, 27, United States *ex rel.* Meyer v. Health Mgmt. Assocs., 0:11-cv-0713-JFA (filed July 15, 2011) (alleging that HMA benchmarks for ER inpatient admissions were not based on patients' medical needs, but "were designed to boost hospital admissions rates, irrespective of the medical needs of the patient population," with the target ER benchmark admission rates for both its rural hospital patients and the elderly patient population exceeding national benchmarks, and that its ER physician protocols less to medically unnecessary tests).

100. See Rosenthal, *supra* note 83 (stating that physicians who are employees of hospitals are offered bonuses tied to how much billing they generate, and that such bonuses lead to the ordering of more tests or services such as X-rays, M.R.I. scans, and physical therapy).

101. Leadership also "stroked and pampered" the physicians in other ways, including sponsoring a golf tournament to benefit the physicians' cardiac unit and even use of the

3. Hospitals' Resources

Under Medicare's current payment policies, hospitals profit when they increase the volume and intensity of care.¹⁰² Many hospital administrators have responded to these incentives by increasing their hospital's capacity to do more—adding more inpatient beds, acquiring the latest medical technology, and recruiting more specialists.¹⁰³ Hospitals have been especially aggressive in expanding their most profitable lines of services, with many building “center[s] of excellence” for cardiology, cancer treatment, and orthopedic and spine surgeries.¹⁰⁴ Of course, such efforts would be futile if physicians did not utilize hospitals' increased capacity by admitting more patients or referring patients for more tests and procedures. Fortunately for hospitals, the *Field of Dreams* mantra generally proves true—“if you build it, they will come.”

Researchers have found a strong correlation between treatment practices among a hospital's affiliated physicians and the amount and mix of a hospital's available resources. The more acute care beds available at a hospital, the more frequently physicians admit patients to the hospital.¹⁰⁵ Physicians also are more likely to treat

hospital's emergency helicopter to fly to the golf course. Much of the care provided by the two physicians was allegedly unnecessary. See BROWNLEE, *supra* note 88, at 87 (describing the ways in which Redding Medical Center and its parent company, Tenet Healthcare, rewarded Drs. Moon and Realvasquez).

102. See *infra* Part III.A (describing Medicare's prospective payment methodology).

103. Kelly J. Devers, et al., *Changes in Hospital Competitive Strategy: A New Medical Arms Race?*, 38 HEALTH SERV. RES. 447, 456–62 (2003) (describing how in response to weaker managed care incentives hospitals redirected their efforts “toward the addition or expansion of services attractive to individual physician and patients,” particularly inpatient and outpatient specialty services such as cardiology, oncology, and orthopedics); Cara S. Lesser, et al., *Initial Findings from HSC's 2005 Site Visits: Stage Set for Growing Health Care Cost and Access Problems*, CTR. FOR STUDYING HEALTH SYS. CHANGE, Aug. 2005, at 1 (“Hospitals . . . are competing more broadly and intensely for profitable specialty services, making costly investments to expand capacity and offer the latest medical technologies . . .”); Cara S. Lesser, et al., *The End of an Era: What Became of the “Managed Care Revolution” in 2001*, 38 HEALTH SERV. RES. 337, 347 (2003) (stating that in response to a weakening of managed care, hospitals responded by focusing “on expanding services and capacity”).

104. See generally Robert A. Berenson et al., *Specialty-Service Lines: Salvos In the New Medical Arms Race*, 25 HEALTH AFFAIRS w337, w337–40 (2006) (stating that under fee-for-service, hospitals adopted strategies dedicated to increasing the flow of patients to their hospitals that resulted in a “medical arms race,” including establishing marketing specialty-services such as heart institutes, cancer centers, and orthopedic hospitals). See BERENSON & DOCTEUR, *supra* note 20; see also Paul B. Ginsberg & Joy M. Grossman, *When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medicare Care*, HEALTH AFFAIRS w5-376 (2005) (explaining that hospitals and physicians are expanding their capacity to deliver those lines of service that are most profitable under current payment mechanisms).

105. See WENNBERG ET AL., *supra* note 22, at 39, 46–49, 52 (describing the association between available resources and clinical decision-making). Although a possible explanation for the positive relationship between supply and utilization may be that regions with sicker

patients in intensive care units (ICUs) when a hospital has more ICU beds.¹⁰⁶ The availability of newer, faster, and more sophisticated imaging machines leads physicians to order more radiological images.¹⁰⁷ Similarly, an increase in the availability of catheterization laboratories leads to patients receiving angioplasty and bypass surgery at higher rates.¹⁰⁸ Likewise, when hospital systems recruit or employ more specialists, patients see specialists more frequently and receive more tests and procedures than patients in hospital systems oriented to primary care.¹⁰⁹

As these studies demonstrate, physicians adapt their practices to available resources.¹¹⁰ The more resources available, the more physicians do for their patients. Relatedly, when hospitals invest in

patients acquire more medical resources because their patients require more care, researchers at the Dartmouth Atlas Project found that the prevalence and severity of illness accounts for remarkably little of the variation in utilization rates across hospital regions. *See id.* at 9.

106. *See id.* at 39, 46–49, 52 (describing the association between available resources and clinical decision-making). The availability of ICU beds also may impact the intensity of end-of-life care. For example, a study of two academic centers found that the “resource-rich” hospital that had a 1:4 ratio of ICU-to-ward bed ratio treated patients more aggressively and had a default norm of “survival to discharge,” whereas the second academic medical center with a 1:9 ICU ratio had a norm of counseling families to withdraw life-sustaining treatment when treatment goals such as organ function recovery were not met. *See* Amber E. Barnato et al., *Norms of Decision Making in the ICU: A Case Study of Two Academic Medical Centers at the Extremes of End-of-life Treatment Intensity*, 38 INTENSIVE CARE MED. 1886 (2012) (comparing the treatment norms governing end-of-life care at two academic medical centers).

107. *See* Laurence Baker et al., *The Relationship Between Technology Availability and Health Care Spending*, HEALTH AFFAIRS w3-537, w3-542 (2003) (finding that greater availability of MRIs and CT units is associated with higher use and more spending). *Cf.* BROWNLEE, *supra* note 88, at 161–63 (summarizing the comments of a hospital’s chair of radiology, who stated that the availability of newer, faster machines “encourages physician to perform even more unnecessary tests,” thereby bolstering the hospital’s revenue).

108. *See* Baker, *supra* note 107, at w3-542–53 (finding that increases in the availability of cardiac catheterization labs are associated with increases in cardiac catheterization use and spending). Both coronary angioplasties and heart bypass surgeries are treatments for blocked arteries. Coronary angioplasties, also called percutaneous coronary interventions, involves temporarily inserting and inflating a balloon to help widen a clogged artery. *See Coronary Angioplasty and Stents*, MAYO CLINIC, <http://www.mayoclinic.org/tests-procedures/angioplasty/basics/definition/prc-20014401>. During heart bypass surgery, a blood vessel is removed or redirected from one area of the body and placed around the blocked area in order to restore blood flow to the heart. *See Heart Disease and Heart Bypass Surgery*, WEBMD, <http://www.webmd.com/heart-disease/guide/heart-disease-bypass-surgery>.

109. *See* Wennberg, *supra* note 22, at 39, 52–53 (describing the association between available resources and clinical decision-making); *see also* BROWNLEE, *supra* note 88, at 62–63 (stating that patients in hospital regions with more specialists per capita are referred to specialists more often, which in turn leads to more tests and procedures).

110. Why physicians’ treatment decisions are influenced by the supply of medical resources or specialists remains unclear. Some commentators believe that when clinical resources or specialists are readily available, this “lowers the barrier” for hospitalizing patients, ordering more tests and procedures, or referring patients to a specialist. *See* BROWNLEE, *supra* note 88, at 113, 163, 208 (stating that when hospitals buy faster imaging machines, “it lowers the barrier for physicians to order yet another unnecessary test”; that putting “a not-so-sick patient” in a hospital bed when “there is sufficient room to do so”

resources that support specialized, technology-driven care, physicians provide their patients higher intensity care. Hospital administrators thereby contribute to a culture of overtreatment when they expand their hospital's capacity, especially its capacity to provide high-intensity care.

B. The Influence of Physicians' Organizational Peers

Organizational role models and peers also strongly influence individuals' norms, values, attitudes, and behavior.¹¹¹ Physicians are no different, with commentators long observing that an individual physician's clinical decisions generally reflect the practice style and philosophy of her colleagues.¹¹² As I have explained in previous work, there are several reasons why physicians hold sway over one another, particularly in situations of clinical uncertainty. Adopting the practices of role models or peers provides reassurance that the physician chose the correct course of treatment.¹¹³ In addition, following the clinical practices of others takes less time and effort than independently evaluating treatment alternatives.¹¹⁴ Physicians also

requires less "time and trouble" for the referring physician than caring for the patient in other settings; and that "a readily available catheterization laboratory also lowers the barrier for other doctors to refer patients to an interventional cardiologist for an angiogram, because they know the patients won't have to wait weeks or months to get an appointment").

Physicians also may be subconsciously motivated to utilize available resources in order to bolster their hospital's financial position. As I have explained elsewhere, over time, individual members of an organization come to identify with the organization, which in turn generates loyalty to the organization and internalization of the organization's goals as one's own. *See* Mantel, *supra* note 45, at 493–94. Physicians therefore may be subconsciously motivated to bolster a hospital's revenues by filling its beds, sending patients to its catheterization laboratory, ordering more imaging procedures, and keeping its specialists busy. Using the available resources also may further the physician's self-interest. For example, interventional cardiologists may appreciate that if the hospital's catheterization laboratory sits empty, the hospital will shut it down, denying the interventional cardiologists access to the equipment and other resources essential to their practices. Consequently, when hospitals expand their capacity, physicians may be cognitively motivated to clinically justify doing more for patients rather than less. *See generally supra* notes 93–95 and accompanying text (explaining how physicians' self-interest subconsciously impacts their clinical judgment).

111. *See generally* Dallas, *supra* note 77.

112. *See, e.g.*, Catherine Borbas et al., *The Role of Clinical Opinion Leaders in Guideline Implementation and Quality Improvement*, TRANSLATING GUIDELINES INTO PRACTICE, 24S, 26S (2000) (noting that interpersonal relationships among physicians are the most important facts in determining physicians' adoption of medical innovations and refinements of medical practice, with local, informal medical opinion particularly important); Rita Mano-Negrin & Brian Mittman, *Theorizing the Social within Physician Decision Making*, 15 J. MGMT. MED. 259, 261 (2001) (discussing the importance of peer influences on physician behavior).

113. *See* Mantel, *supra* note 45, at 491–93 (explaining why physicians model their peers, including role models).

114. *Id.*

may hope that by modeling clinical leaders, they can obtain for themselves similar prestige and professional advancement. Finally, physicians may conform to group norms in order to secure others' approval.¹¹⁵ For example, in a survey of cardiologists, some physicians acknowledged having ordered cardiac catheterizations that were not clinically indicated in order to meet peer expectations.¹¹⁶

Emerging empirical research demonstrates the effect of organizational peers on physicians' treatment. A physician's propensity to perform a procedure increases as others with admitting privileges at the same hospital increasingly perform the procedure.¹¹⁷ For example, a study of surgeons affiliated with a multi-hospital system found that surgeons' use of blood products in cardiac operations varied widely across facilities, but surgeons practicing at the same hospital had similar blood transfusion rates.¹¹⁸ In fact, the study's authors estimated that only thirty percent of the variation among surgeons could be explained by differences among individual surgeons, with *seventy percent* of the variance explained by the influence of hospital culture.¹¹⁹ Studies looking at physician drug prescribing practices have likewise found that the likelihood of a physician prescribing a new drug increases as a physician's workplace colleagues increasingly prescribe the drug.¹²⁰

Studies of physicians who admit patients to two or more hospitals similarly show the effect of organizational culture on treatment practices. Among those physicians who admit patients to two or more hospitals, the number of days a physician keeps a patient in the hospital generally conforms to the usual practice at the hospital where the patient is admitted.¹²¹ In other words, rather than follow

115. *Id.*

116. See Frances Lee Lucas et al., *Variation in Cardiologists' Propensity to Test and Treat: Is It Associated with Regional Variation in Utilization?*, 3 CIRCULATION: CARDIOVASCULAR QUALITY & OUTCOMES 253, 253 (2010) (reporting results of a survey of cardiologists).

117. See Mary A. Burke et al., *Geographical Variations in a Model of Physician Treatment Choice with Social Interactions* (Fed. Reserve Bank Bos., Working Paper No. 09-4, 2009) (reporting results of study comparing a physician's propensity to perform certain procedures to rates of use within the physician's social network).

118. See Ruyun Jin et al., *Effect of Hospital Culture on Blood Transfusion in Cardiac Procedures*, 95 ANNALS THORACIC SURGERY 1269, 1269 (2013) (surgeons' use of blood products in cardiac operations varied widely across the facilities, but surgeons practicing at the same hospital had similar blood transfusion rates).

119. See *id.*

120. See Shu-Jou Lin et al., *Colleague Interactions and New Drug Prescribing Behavior: The Case of the Initial Prescription of Antidepressants in Taiwanese Medical Centers*, 73 SOC. SCI. & MED. 1208 (2011) (confirming the findings of prior studies showing that the likelihood of a physician adopting a new drug is influenced by the adoption rate for the drug among the physician's colleagues).

121. See Judith D. de Jong et al., *Variation in Hospital Length of Stay: Do Physicians Adapt Their Length of Stay Decisions to What is Usual in the Hospital Where They Work?*, 41 HEALTH SERV.

a consistent practice style across hospitals, a physician admits her patients for longer periods of time in the hospital with the longer average length of stay and discharges her patients sooner from the hospital with the shorter average length of stay even after controlling for differences in patient characteristics.¹²²

These studies reveal that physicians do not make clinical decisions in a vacuum, but that hospitals' organizational cultures shape physicians' professional judgments. Over time, institution-specific patterns of care emerge as individual physicians conform to their organizational peers' "way of doing things."

* * * * *

In sum, hospitals' organizational cultures play a large role in shaping physicians' treatment patterns, including their treatment of Medicare patients. Far too often these patterns of care reflect a cultural bias toward overtreatment. Importantly, hospitals' organizational cultures influence physicians' judgments not only within the acute care setting, but also outside the inpatient hospital walls. For example, the decision whether to admit a Medicare patient for inpatient care frequently occurs in the physician office. Similarly, the decision to refer a patient to the hospital's heart center and the decision to perform an invasive cardiology procedure all take place in the outpatient setting.

Reducing the volume and intensity of care provided to Medicare patients therefore requires a fundamental shift in hospitals' organizational cultures: a shift from cultures of overtreatment to cultures of efficiency. Accordingly, a comprehensive regulatory approach for combatting overtreatment of Medicare patients must encourage hospitals to address the various ways their cultures promote overtreatment of patients both inside and outside the hospital setting. Unfortunately, current Medicare payment policies fail in this task, as they do too little in holding hospitals accountable for excessive care.

RES. 374 (2006) (comparing lengths of stays for U.S. physicians admitting patients to two or more hospitals); see also G.P. Westert et al., *Variation in Duration of Hospital Stay Between Hospitals and Between Doctors Within Hospitals*, 37 Soc. Sci. & MED. 833 (1993) (similar study looking at Dutch physicians).

122. *Id.*

III. PAST AND PRESENT PAYMENT REFORMS— AN ORGANIZATIONAL FOCUS

Hospitals' influence over patterns of care has not escaped policy-makers' notice. Particular attention has been given to how hospitals are paid under Medicare. The hope has been that payment reforms that reward hospitals for lower utilization would cause hospitals to pressure physicians to practice in a more cost-conscious manner.¹²³ Although these payment reforms have had some success in slowing the rate of growth in Medicare spending, the problem of overtreatment continues to plague the Medicare program. This Part describes current Medicare hospital payment policies, and explains why they have not addressed hospitals' cultures of overtreatment.

A. Prospective Payment

Medicare initially paid hospitals their reasonable costs for each discrete service provided to inpatients.¹²⁴ Paying hospitals in this manner rewarded resource-intensive care that kept patients in the hospital for longer periods of time. Recognizing the inflationary pressures of reasonable cost reimbursement, in the mid-1980s Medicare shifted to prospective payment, under which hospitals are paid a fixed payment for each inpatient admission. Specifically, under the Medicare Inpatient Prospective Payment System (IPPS), acute care hospitals receive a pre-determined rate for each inpatient admission based on the diagnosis-related group (DRG) classification.¹²⁵ To ensure that the costs of treating a Medicare patient remained below the fixed payment amount, hospitals

123. Phyllis Floyd, *Roadmap for Physician Compensation in a Value-Based World*, PHYSICIANLEADERS.ORG (2014) (stating that as payment models evolve to value-based, risk-sharing accountable care contracts, current models of compensating physician-employees of hospitals and health systems must shift from one based primarily on productivity to a more complex model with incentives to "bend the cost curve"); Anna Wilde Mathews, *Hospitals Prescribe Big Data to Track Doctors at Work*, WALL ST. J., July 12, 2013, at A1 (stating that in response to payment changes that place hospitals under pressure to cut costs, hospital administrators must "lean on doctors" to provide less costly care); Christopher Moriates, et al., *Development of a Hospital-Based Program Focused on Improving Healthcare Value*, 9 J. HOSP. MED. 671 (2014) (describing the efforts of one hospital to address wasteful practices among its hospitalist group in response to value-based purchasing programs).

124. Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 102, § 1814(b), 79 Stat. 303.

125. 42 U.S.C. § 1395ww(d)(1). Each case is assigned to a DRG based on the Medicare beneficiary's principal diagnosis, secondary diagnoses such as comorbidities and complications, and patient characteristics such as gender and age. 42 C.F.R. § 412.60(c)(1). Each DRG is assigned a payment weight based on the average resources used to treat Medicare patients in that DRG relative to patients assigned to other DRGs. 42 U.S.C.

responded to IPPS by discharging patients sooner and, to a lesser extent, reducing the intensity of care.¹²⁶ Prospective payment thereby flipped hospitals' incentives, with hospitals profiting by doing less rather than more.

Following implementation of IPPS, Congress expanded prospective payment to other patient care settings, including the outpatient hospital setting.¹²⁷ The outpatient prospective payment system (OPPS) pays hospitals a fixed rate for outpatient services, such as outpatient surgical procedures or emergency care, based on the ambulatory payment case (APC) to which the service is assigned.¹²⁸ Ancillary, supportive, and adjunctive items such as routine supplies and clinical laboratory services are bundled into the payment for the primary outpatient service.¹²⁹

Although prospective payment succeeded in slowing the growth in Medicare costs,¹³⁰ its success in reducing overutilization has been incomplete. Importantly, prospective payment only encourages hospitals and other providers to reduce the cost of treating an episode of care, such as an inpatient admission; it does not create incentives to avoid the episode itself.¹³¹ For example, IPPS does nothing to deter admitting Medicare patients with chronic conditions to the hospital rather than treating them in outpatient settings. Nor does

§ 1395ww(d)(4)(B). The fixed payment rate paid to the hospital is also adjusted for geographic differences in labor and other costs. 42 U.S.C. § 1395ww(b)(4)(B)(ii).

126. See Robert F. Coulam & Gary L. Gaumer, *Medicare's Prospective Payment System: A Critical Appraisal*, HEALTH CARE FIN. REV. 45 (1992) (summarizing studies finding a decline in the average length of stay for Medicare patients admitted to the hospital during the year following implementation of IPPS as well as a decrease in the intensity of care of certain services); Frank A. Sloan et al., *Medicare Prospective Payment and the Use of Medical Technologies in Hospitals*, 26 MED. CARE 837, 837 (1988) (finding a decline in the number of routine tests per inpatient following implementation of the IPPS).

127. In addition to the inpatient and outpatient hospital settings, Medicare pays for the following services on a prospective basis: inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. 42 U.S.C. §§ 1395ww(j), (m), and (s); and 1395yy(d)(1). Home health agencies similarly receive a fixed payment for each sixty-day episode of care. 42 U.S.C. § 1395(b).

128. 42 U.S.C. § 1395l(t). Individual services within an APC are clinically similar and similar in costs. *Id.* § 1395l(t)(2)(B).

129. As with IPPS payment rates, payments rates under OPPS are adjusted for geographic differences in labor and other costs. *Id.* § 1395l(t)(2)(D).

130. See Cristina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades*, 22 HEALTH AFF. 230, 235 (2003) (finding a "dramatic" decline in the growth of costs for both Medicare and the private sector following implementation of IPPS); Chapin White, *Why Did Medicare Spending Growth Slow Down?*, 27 HEALTH AFF. 793, 796 (2008) ("[T]he implementation of the inpatient PPS coincided with a substantial and sustained reduction in excess spending growth in Medicare hospital spending.").

131. Initially some hospitals responded to IPPS by shifting certain services from the inpatient setting to outpatient settings that were not subject to prospective payment. See Coulam & Gaumer, *supra* note 126, at 57–58. This strategy, however, became less tenable as Medicare adopted prospective payment for institutional outpatient settings.

OPPS deter outpatient services of questionable value, such as expensive cancer treatments that, at best, offer minimal clinical benefit. Moreover, because prospective payment reimburses higher intensity care at higher rates, it encourages providers to select higher intensity care over lower intensity alternatives.¹³² Indeed, the shift to prospective payment led many hospitals to *increase* their capacity to provide technology-driven care, as discussed previously.¹³³ Prospective payment thus continues to reward overtreatment.

B. Affordable Care Act Reforms

In recognition of the failures of prospective payment, the ACA ushered in a new era in Medicare payment policy. This Subpart discusses three payment reforms enacted under ACA—the Hospital Value-Based Purchasing Program, the Bundled Payments for Care Improvement Initiative, and the Shared Savings Program.

1. Hospital Value-Based Purchasing

Under Medicare's Hospital Value-Based Purchasing (VBP) Program, hospitals performing well on selected measures enjoy higher Medicare reimbursement rates under IPPS, while those performing poorly face downward adjustments in their reimbursement rates.¹³⁴

132. Under the IPPS, each DRG is assigned a payment weight based on the average resources used to treat Medicare patients in that DRG relative to patients assigned to other DRGs. *See id.* Consequently, if higher than average resources are used to treat patients within a particular DRG, the DRG is assigned a higher weight, resulting in higher payments for patients assigned to that DRG. Moreover, as hospitals adopt a new technology for the treatment of patients assigned to a DRG, overtime the DRG's relative weight will reflect the higher costs associated with the new technology. Similarly, because the OPSS assigns individual services in an APC in part based on costs, *see* 42 U.S.C. § 1395l(t)(2)(D), using a new technology will lead to a service being assigned to a higher-paying APC. Hospitals also have continued to adopt new technology in an effort to attract physicians away from competing hospitals. *See* Bagley, *supra* note 28, at 542 (discussing hospitals adoption of new technology). Consequently, prospective payment failed to put the brakes on providers adopting new technology that may be of limited value.

133. *See supra* notes 102–104 and accompanying text.

134. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 3001(a), 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 1395ww(o)). The Hospital VBP Program began in October of 2012. Hospitals performing poorly had their payment rates for inpatient acute care services reduced by up to 1.0 percent, with the percentage reduction gradually increasing to 2.0 percent for fiscal year 2017. 42 U.S.C. § 1395ww(o)(7)(C).

Other so-called value based purchasing programs that link hospitals' payments to outcomes include the Medicare Readmission Reductions Program and the Medicare Hospital-Acquired Condition Reductions Program. The Medicare Readmission Reductions Program reduces inpatient payments to hospitals with a high rate of discharged patients re-admitted to

The initial VBP measures focused on the quality of care provided to hospital inpatients, rather than efficiency considerations. For example, for fiscal year 2014, over half of the measures evaluated how often a hospital delivered a specific clinical service at a specific point in time,¹³⁵ such as the percentage of Acute Myocardial Infarction (AMI) (or heart attack) patients receiving fibrinolytic medication within thirty minutes of arriving at the hospital.¹³⁶ Other quality measures evaluate hospitals' clinical outcomes, such as the thirty-day mortality rate for patients with a heart attack, heart failure, or pneumonia diagnosis,¹³⁷ or patients' perspective on the quality of care received.¹³⁸ The Hospital VBP Program thereby encourages hospitals to improve the quality of care delivered to inpatients, as doing so will raise their IPPS payments.

Improving the quality of inpatient care also can lead to efficiency gains by preventing costly complications and hospital readmissions.¹³⁹ The hospital VBP quality measures, however, do little to reduce overutilization of medically unnecessary or excessive care. For example, measures evaluating whether surgical patients receive appropriate care immediately before or after surgery do not address whether the surgery itself was appropriate. Nor do VBP measures assessing hospital inpatients' satisfaction with their care assess whether their admission to the hospital was warranted in the first place.

the hospital. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 3025, 124 Stat. 119 (2010) (codified at 42 U.S.C. § 1395ww(q)). The Medicare Hospital-Acquired Condition Reductions Program reduces inpatient payments to the lowest-performing quartile of hospitals with regard to hospital-acquired conditions (*i.e.*, conditions that patients did not have upon admission to the hospitals but developed during the hospital stay). *Id.* § 3008 (codified at 42 U.S.C. § 1395www(p)).

135. See U.S. Dep't of Health & Human Servs., *The Total Performance Score Information*, MEDICARE.GOV, <http://www.medicare.gov/HospitalCompare/Data/total-performance-scores.html> (listing the three domains that comprise hospitals' Total Performance Score).

136. See U.S. Dep't of Health & Human Servs., *Clinical Process of Care Domain*, MEDICARE.GOV, <http://www.medicare.gov/HospitalCompare/Data/Clinical-Process-of-Care.html> (listing the performance measures comprising the clinical process of care domain).

137. See U.S. Dep't of Health & Human Servs., *Outcome Domain*, MEDICARE.GOV, <http://www.medicare.gov/HospitalCompare/Data/outcome-domain.html> (listing the performance measures comprising the outcome domain).

138. See U.S. Dep't of Health & Human Servs., *Patient Experience of Care Domain*, MEDICARE.GOV, <http://www.medicare.gov/HospitalCompare/Data/Patient-Experience-Domain.html> (listing the eight performance measures comprising the patient experience of care domain). For example, the patient experience of care measures include the percentage of patients reporting that their nurses "always" communicated well and the percentage of patients reporting that hospital staff were "always" responsive to their needs.

139. See Richard F. Averill et al., *Achieving Cost Control, Care Coordination and Quality Improvement Through Incremental Payment System Reform*, 33 J. AMBULATORY CARE MGMT. 2, 10 (2009) ("For inpatient care, the 2 most significant manifestations of poor quality that increase payment are postadmission complications and readmissions.").

Recognizing that quality measures are of limited value in targeting overtreatment, CMS has turned its attention to measures that evaluate a hospital's efficiency. For fiscal year 2015, the Hospital VBP Program will include a new efficiency measure that compares a hospital's overall efficiency relative to the median hospital—the Medicare Spending per Beneficiary (MSPB) measure.¹⁴⁰ The MSPB measure captures Medicare-covered services performed by the hospital and other providers¹⁴¹ for the period beginning three days before an inpatient admission through thirty days after the patient is discharged.¹⁴² Hospitals with lower per capita costs receive higher efficiency scores, while those with higher per capita costs may receive lower efficiency scores.¹⁴³ For fiscal year 2015, twenty percent of a hospital's overall VBP score will be based on the MSPB measure, with the remaining eighty percent based on its performance

140. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEASURE INFORMATION FORM COLLECTED FOR: CMS EFFICIENCY MEASURES (CLAIMS BASED), <https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Search/SearchResults&keywords=MSPB&rowNum=11> (Medicare Spending Per Beneficiary, 1) [hereinafter MEASURE INFORMATION FORM] (explaining the MSPB measure).

141. The MSPB measure captures all Medicare Part A and Part B claims provided to the relevant time period, but excludes Part D claims. See *id.* at 2.

142. See *id.* CMS has explained that the MSPB measure includes care provided during the thirty days post-discharge because variations in practice patterns post-discharge often reflect differences in hospitals' practices during the inpatient stay and the transition to non-inpatient settings. See *id.* at 1, 3 (explaining the rationale for including the time period thirty days post-discharge).

To calculate a hospital's MSBP score, CMS first standardizes Medicare payments by eliminating geographic payment adjustments and payments to hospitals for graduate indirect medical education (IME) and for serving a disproportionate population of poor and uninsured (*i.e.*, disproportionate share hospital payments) (DSH)). See *id.* at 3 (explaining CMS's price standardization methodology). CMS then sums the payment-standardized costs for all claims submitted to Medicare, beginning three days before the inpatient admission and ending thirty days after discharge. CMS next adjusts this amount to account for differences in patients' risk factors by dividing the aggregate costs by the sum of the expected costs from the risk-adjustment model. This ratio is then multiplied by the national average MSPB episode cost for all hospitals to determine the "MSPB amount at the hospital level." The individual hospital's MSPB amount is then divided by the national medical MSPB amount to determine a ratio, or percentage, which is the hospital's MSPB measure rate. See Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule & Other Revisions to Part B for CY 2014, 78 Fed. Reg. 43282, 43494 (July 19, 2013) [hereinafter Revisions to Payment Policies III] (describing CMS's calculation of hospitals' MSPB measure rate).

143. A hospital's efficiency score is based on the higher of its achievement score or improvement score. The achievement score is based on the hospital's performance on the MSBP measure as compared to other hospitals, and its improvement score is based on the extent to which a hospital improves its performance on the MSBP measure over its prior performance. Accordingly, hospitals that have lower per capita costs will have higher achievement scores, which translates into higher efficiency scores. Hospitals with higher per capita costs will have lower achievement scores, and thus lower efficiency scores absent significant improvement over their past performance. See *Hospital Value-Based Purchasing*, MEDICARE.GOV, <https://www.medicare.gov/hospitalcompare/data/hospital-vbp.html>.

on the VBP quality measures.¹⁴⁴ Inefficient hospitals thus may be penalized with lower reimbursement rates.

CMS also invited public input on whether to adopt additional efficiency measures that would evaluate hospitals' success in controlling costs for six specific conditions: (1) kidney/urinary tract infection, (2) cellulitis, (3) gastrointestinal hemorrhage, (4) hip replacement/revision, (5) knee replacement/revision, and (6) lumbar spine fusion/refusion.¹⁴⁵ These episode-based efficiency measures would capture Medicare-covered services provided by the hospital and other providers for the period beginning three days before an inpatient admission through thirty days following discharge, but would be limited to those services clinically related to the specified health condition.¹⁴⁶ For example, the kidney/urinary tract infection measure would be based on the average cost of all care provided to a hospital's patients for treatment of a kidney/urinary tract infection. Hospitals with lower per capita costs for the selected conditions would receive higher efficiency scores, while those with higher per capita costs would receive lower efficiency scores.

The inclusion of efficiency measures under the Hospital VBP Program is an important step in giving hospitals financial incentives to address overtreatment. Yet the MSBP measure and episode-based measures suggested by CMS have significant shortcomings. First, because these measures are triggered by an inpatient admission, they do not create incentives to avoid the initial hospitalization.¹⁴⁷ For example, a measure evaluating a hospital's efficiency in caring for patients receiving a lumbar spine fusion would not address overutilization of the surgical procedure itself.¹⁴⁸ Second, because the time period captured by the MSBP measure and proposed episode-based measures is limited to three days before hospitalization and

144. See CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET: UNDERSTANDING THE FISCAL YEAR (FY) 2015 HOSPITAL VALUE-BASED PURCHASING (VBP) PERCENTAGE PAYMENT SUMMARY REPORT 2 (July 2014), <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228774324777> (explaining the methodology for calculating hospitals' VBP scores).

145. See Medicare Program: Hospital Inpatient Prospective Payment Systems, 79 Fed. Reg. 27978, 28122–23 (May 15, 2014) [hereinafter Hospital IPPS] (discussing the possibility of adding new episode-based payment measures to the Hospital VBP program).

146. See *id.*

147. See Peter S. Hussey et al., *Episode-Based Performance Measurement and Payment: Making it a Reality*, 28 HEALTH AFF. 1406, 1412 (2009) (commenting that hospital-based episodes “do not create an incentive to avoid the initial hospitalization, since episodes are based around admissions”).

148. Experts contend that orthopedic surgeons are performing too many lumbar spine fusion surgeries on patients with chronic back pain. See, e.g., Richard A. Deyo et al., *Spinal-Fusion Surgery—The Case for Restraint*, 350 NEW ENG. J. MED. 722 (2004).

thirty days after discharge, the measures do not capture excessive outpatient care provided outside this window. As discussed previously, however, hospitals may subtly encourage their affiliated physicians to perform certain outpatient procedures at excessive rates, such as by building centers of excellence or subsidizing the purchase of costly technology used in the outpatient setting.¹⁴⁹ At best, then, the current Hospital VBP Program serves as a partial and imperfect tool for addressing hospitals' cultures of overtreatment.

2. Bundled Payments and Shared Savings

Medicare's Bundled Payments for Care Improvement Initiative ("Bundled Payments Program") and Shared Savings Program also depart from the fee-for-service model of paying providers separately for each unit of care provided. CMS established the Bundled Payments Program under its new authority "to test innovative payment and service delivery models to reduce program expenditures"¹⁵⁰ The initiative tests four bundled payment models that jointly pay providers for a defined set of services, known as an episode of care.¹⁵¹ For example, under the fourth model, CMS makes a single bundled payment to a hospital for all care provided to a patient by the hospital, physicians, and other practitioners during an inpatient stay and any related readmission within thirty days of the initial discharge.¹⁵² Providers profit when the cost of treating an episode of care falls below the bundled payment amount. Bundled payments thereby encourage more cost-conscious care.

Despite the promise of bundled payments to deter overtreatment, the Bundled Payments Program as currently designed has significant deficiencies. Under each of the four payment models, an episode of care is triggered by an inpatient admission.¹⁵³ Like the

149. See *supra* note 104 and accompanying text.

150. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 3021, § 1115(a)(1), 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 1316(a)).

151. See CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEETS: BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE (Jan. 31, 2013) [hereinafter FACT SHEETS: BUNDLED PAYMENTS] (providing an overview of the Bundled Payments for Care Improvement Initiative). The four different bundled payment models vary by the types of health care providers involved and the services included in the bundle. See *id.*

152. See *id.*

153. The first model defining an episode of care as an inpatient admission, the second defining an episode as the inpatient admission plus thirty, sixty, or ninety days after discharge, the third defining an episode as thirty, sixty, or ninety days after discharge, and the final model defining an episode as the inpatient admission plus any related readmissions within thirty days after discharge. See Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Announces New Initiative to Improve Care and Reduce Costs for Medicare (Jan. 31,

Hospital VBP Program, the Bundled Payment Program does not deter unnecessary or excessive hospital admissions. Nor do the four bundled payment models address overtreatment of patients never admitted as inpatients. All four payment models also narrowly define the relevant time periods for an episode of care, capping the timeframe at ninety days after discharge.¹⁵⁴ Consequently, the payment models do not reach excessive outpatient care provided outside these narrowly defined episodes. Finally, the Bundled Payments Program has limited reach, as it is a voluntary program restricted to approximately five hundred organizations.¹⁵⁵ The vast majority of hospitals thus do not participate in the program.¹⁵⁶

The ACA also launched the Medicare Shared Savings Program.¹⁵⁷ Under the Medicare Shared Savings Program, hospitals participating in accountable care organizations (ACOs)¹⁵⁸ that successfully lower the aggregate annual cost of caring for their Medicare patients receive a percentage of the savings, provided the ACO also satisfies certain quality metrics.¹⁵⁹ After completing their initial term in the program, hospitals and other providers participating in

2013), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-01-31.html>.

154. *Id.*

155. *See id.* "Organizations" includes institutions other than hospitals, such as physicians' groups. *Id.*

156. *See id.*; *see also Fast Facts on US Hospitals*, AM. HEALTH ASS'N (2015), <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml> (noting that there are 4,974 community hospitals in the United States, not including Veterans Administration hospitals, prison hospitals and acute care facilities like psychiatric hospitals).

157. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 3022, § 1899, 124 Stat. 119 (2010).

158. ACOs are local organizations comprised of primary care physicians and also may include specialists, hospitals, and/or other providers. Providers participating in an ACO agree to be jointly accountable for the cost and quality of care delivered to a patient population. *See Boland, supra* note 9, at 12 ("An ACO is generally defined as a local health care organization with a network of providers such as primary care physicians, specialists, and hospitals that are accountable for the cost and quality of care delivered to a particular population.").

159. Under the shared savings payment model, the ACO continues to receive fee-for-service based payments, but Medicare also rewards an ACO that meets or exceeds its targeted cost savings with a bonus equal to a percentage of the savings. *See Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule*, 76 Fed. Reg. 67,802, 67,927 (Nov. 2, 2011), <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> [hereinafter Medicare Shared Savings Program]. The Shared Savings Program also includes economic incentives for ACOs to improve quality by tying a portion of an ACO's reimbursement to its performance on quality benchmarks. For example, an ACO that performs poorly on the relevant quality measures may be ineligible for any bonus payment under the shared savings or shared savings and risk payment models, even if the ACO lowers the cost of care. *See* 42 C.F.R. § 425.100(b) (2012) (stating that ACOs participating in the Medicare shared savings program are eligible for shared savings only if they meet the minimum quality performance standards, among other requirements).

an ACO will continue to receive a percentage of any Medicare savings, but also will be penalized with a downward adjustment in their Medicare reimbursement rates if the ACO does not meet targeted cost savings.¹⁶⁰ CMS has stated that in the future it may pay ACOs on a capitated basis, with participating organizations receiving a single payment for each Medicare patient under their care.¹⁶¹

The Shared Savings Program avoids many of the pitfalls of prospective payment, the Hospital VBP Program, and the Bundled Payments Program. Importantly, the Shared Savings Program bases bonuses and penalties on the cost of all care provided to Medicare beneficiaries across all patient settings for the entire year.¹⁶² By tying hospital and other ACO participants' incomes to the total annual resources used to treat their patient population, the Shared Savings Program encourages ACO providers to care for their patients in the most efficient manner possible. For example, the program deters admitting to the hospital patients that could be effectively treated in the outpatient setting. Similarly, it discourages costly procedures that are no better than less expensive alternatives. Unfortunately, the voluntary nature of the Shared Savings Program has hampered its effectiveness as a tool against overtreatment, as most hospitals are not participating in the program.¹⁶³

160. See 42 C.F.R. § 425.100(c). ACOs also may elect to enroll in the shared savings and risk model during their initial term. See Medicare Shared Savings Program, *supra* note 159, at 67,904.

161. See Medicare Shared Savings Program, *supra* note 159, at 67,805 (discussing the possibility of CMS in the future paying ACOs based on a capitation payment model). In addition to the Shared Savings Program, CMS has established the Pioneer ACO Model (Pioneer Program) for organizations with experience operating as ACOs. Under this program, participating ACOs will receive higher levels of reward and assume greater financial risk than ACOs participating in the Shared Savings Program. See CTRS. FOR MEDICARE & MEDICAID SERVS., PIONEER ACCOUNTABLE CARE ORGANIZATION MODEL: GENERAL FACT SHEET (2011), <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/PioneerACO-FactSheet.html>. In addition, in year three of the Pioneer Program, CMS will begin testing a capitated payment model, with eligible ACOs receiving a monthly per-beneficiary amount in lieu of part or all of the ACO's fee-for-service payments. See *id.*

162. In calculating the savings to the Medicare program, if any, generated by the ACO, CMS estimates the ACO's average per capita Medicare expenditures for its Medicare beneficiaries and compares this to the ACO's benchmark per capita Medicare expenditures. This calculation considers *all* services provided to the beneficiary for the performance year that are covered under Medicare Parts A and B, regardless of whether provided by the ACO or another provider. 42 C.F.R. §§ 425.604, 425.606 (setting for the rules for calculating savings under the one-sided and two-sided models).

163. In 2014, 338 ACOs participated in the Shared Savings Program, with an additional twenty-three ACOs participating in the Pioneer Program. Collectively these ACOs provide care to 5.6 million Medicare beneficiaries. Among the 338 ACOs participating in the Shared Savings Program, thirty percent reported that they were hospitals/professional partnerships and nineteen percent were hospitals employing physicians. CTRS. FOR MEDICARE & MEDICAID SERVS., FAST FACTS: ALL MEDICARE SHARED SAVINGS PROGRAM AND MEDICARE PIONEER ACOs 1

In theory, the current limitations of the Bundled Payment and Shared Savings Programs could be removed. The Bundled Payment Program could define episodes of care more broadly to capture longer time periods and all outpatient care. Congress also could mandate that hospitals and other providers participate in the Bundled Payment Program or Shared Savings Program. In practice, however, mandatory participation in these programs would be unwise at this time because many providers have yet to achieve the administrative and operational infrastructure necessary for success under these programs.

Before accepting bundled payments or shared savings/losses, hospitals and their affiliated providers must be capable both of managing the associated financial operations and coordinating care across care settings. Hospitals and affiliated providers must agree on how to allocate the bundled payments, shared savings, and shared losses.¹⁶⁴ They also must identify an entity capable of acting as a third-party administrator—collecting the bundled payments and shared savings; distributing payments among participating providers; and identifying patients' clinical needs.¹⁶⁵ In addition, participating providers must “break down provider silos”¹⁶⁶ and “establish linkages”¹⁶⁷ that allow them to efficiently deliver high quality care.¹⁶⁸ Finally, participating providers must be capable of assuming the financial risk inherent in the Bundled Payments and Shared Savings Programs.¹⁶⁹ Unfortunately, at present many hospitals and

(Apr. 2015), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/shared-savings-program/Downloads/PioneersMSSPCCombinedFastFacts.pdf>. Participation in the Shared Savings Program continues to grow, as CMS has announced that in 2015, 424 ACOs serving over 7.8 million beneficiaries will participate in the Shared Savings and Pioneer Programs. See *ACOs Moving Ahead*, THE CMS BLOG (Dec. 22, 2014), <http://blog.cms.gov/2014/12/>.

164. See Cheryl L. Damberg et al., *Exploring Episode-Based Approaches for Medicare Performance Measurement, Accountability and Payment* 9 (HHS Working Paper, Feb. 2009) (noting the challenge of how to divide bundled payments among multiple providers); AM. HOSP. ASS'N COMM. ON RESEARCH, BUNDLED PAYMENT: AHA RESEARCH SYNTHESIS REPORT 9–10 (2010) (same).

165. See AM. HOSP. ASS'N COMM. ON RESEARCH, *supra* note 164, at 10 (describing the administrative challenges of bundled payments).

166. BERENSON AND DOCTEUR, *supra* note 20, at 8.

167. AM. HOSP. ASS'N COMM. ON RESEARCH, *supra* note 164, at 9.

168. See *id.* at 10 (stating that there must be an entity that can undertake the function of care coordination, that is an entity that can work effectively with all participating providers and hold them accountable for the quality and cost of care provided).

169. See Peter S. Hussey et al., *The Prometheus Bundled Payment Experiment: Slow Start Shows Problems in Implementing New Payment Models*, 30 HEALTH AFF. 2116, 2188 (2011) (noting concerns that providers accepting bundled payments “will not be capable of managing the increased financial risk or reducing care costs for their patient populations”). In contrast to fee-for-service, where the insurer bears the financial risk of costly care, bundled payments and shared risk shifts some or all of this financial risk to providers.

their affiliated physicians are not yet ready to undertake these functions, as they lack the necessary infrastructure and collaborative relationships.¹⁷⁰

In the near term, then, reformers should focus on making incremental changes to Medicare payment policy that would encourage hospitals and other providers to build the infrastructure that would support their assuming financial risk under bundled payment or shared savings payment arrangements.¹⁷¹ Part IV therefore proposes a new, transitional payment policy that would accomplish this goal while encouraging providers to reduce their overtreatment of Medicare patients.

IV. REGULATING OVERTREATMENT THROUGH THE HOSPITAL VALUE BASED PURCHASING PROGRAM

As discussed above, the Medicare payment system must evolve from one that rewards the provision of high volume, high intensity care to one that rewards efficient care. Incorporating efficiency measures under the Hospital VBP Program is an important step in that direction, but in its current form the program does too little to deter the overtreatment of patients outside the acute care setting. This Part therefore sets forth a proposal that would rectify this deficiency—adopting under the Hospital VBP Program efficiency measures based on broadly defined episodes of care. The proposal also includes safeguards that would protect Medicare patients from undertreatment and suggests a process for resolving complex technical issues before full implementation of the new efficiency measures.

A. *Linking Hospital's Payments to Broadly Defined Episode-Based Efficiency Measures*

As discussed in Part III.B.1, the Hospital VBP Program rewards hospitals that perform well on selected quality and efficiency measures with higher payments for inpatient care, while lower

170. See AM. HOSP. ASS'N COMM. ON RESEARCH, *supra* note 164, at 10 (commenting that few health care entities “have the infrastructure and influence to undertake” the functions necessary for accepting bundled payments); Damberg et al., *supra* note 164, at 72 (commenting that a “significant barrier” to accountable entities such as ACOs is the lack of integration between group members).

171. See generally Damberg et al., *supra* note 164 (discussing the merits of a building block approach to payment reform).

performing hospitals are penalized with lower payments. The program presently includes a single efficiency measure, the MSPB measure, although CMS has invited public input on six condition-specific efficiency measures.¹⁷² For the reasons noted previously, these measures are of limited effectiveness in deterring overtreatment, as they are built around inpatient admissions and a narrowly defined timeframe. Consequently, they create no incentive for hospitals and their affiliated physicians to avoid the initial hospitalization; nor do they curb excessive ambulatory care provided outside the measures' narrow time window.¹⁷³

These defects can be remedied by incorporating into the Hospital VBP Program broadly defined episode-based efficiency measures built around specific medical conditions. Like the six episode-based measures suggested by CMS, broadly defined episode-based efficiency measures would compare the relative efficiency of hospitals and their affiliated physicians in treating patients with particular conditions. Hospitals with higher-than-average costs in treating the selected conditions would score poorly on the measures, while those with less-than-average costs would score higher. However, under my proposal, the episode-based efficiency measures would differ from the six episode measures proposed by CMS in two important respects.

First, the selected episodes would not necessarily require a hospitalization, but instead would be triggered by the patient having the selected condition. In other words, patients attributed to a hospital would include both patients with the condition that are admitted to the hospital and those with the condition treated entirely on an outpatient basis.¹⁷⁴ For example, an efficiency measure for heart disease would include the cost of treating patients with heart disease who are hospitalized and those who are not. Because inpatient care typically costs more than outpatient care, hospitals whose affiliated physicians regularly treat patients in the inpatient setting would have higher per capita costs for the selected conditions than hospitals whose physicians favor the outpatient setting. Consequently, hospitals with cultures that encourage unwarranted inpatient admissions would score poorly on the episode-based efficiency measures.

Second, the selected episodes would include all related care provided to patients over an extended period of time (e.g., six months

172. See *supra* note 145 and accompanying text.

173. See *supra* Part III.B.1.

174. See *infra* note 205 for a discussion of possible methodologies for attributing patients to a particular hospital.

or one year), rather than ending thirty days after a patient's discharge from the hospital.¹⁷⁵ For example, a measure for heart attack that captures all related care for a one year period would include not only the emergency room and inpatient care provided at the condition's onset but also all follow-up care provided during the one year period. The measure thus would capture the invasive cardiology procedures often performed on heart attack patients during the months following their discharge.¹⁷⁶ Because the efficiency measures would include care provided over an extended period of time across all patient care settings, hospitals whose affiliated physicians provide a high volume and intensity of care both inside *and outside* the acute care setting would have higher per capita costs under the selected measures.

Unlike the current Hospital VBP program, this Article's proposal recognizes the far-reaching influence of hospitals' organizational cultures beyond the acute care setting. In capturing a wide range of services, broad episode-based efficiency measures provide a comprehensive picture of the volume and intensity of services provided by a hospital and its affiliated physicians *across all patient care settings*. Hospitals with a culture of overtreatment would have higher per capita costs for the selected conditions, and thus would have lower VBP efficiency scores. As a result, hospitals with a culture of overtreatment would be paid less under Medicare than their more efficient counterparts. My proposal thereby holds a hospital accountable when its organizational culture leads to excessive care both inside and outside the acute care setting.

To illustrate, contrast the narrow lumbar spine fusion/refusion episode measure suggested by CMS with a broader episode-based efficiency measure for chronic lower back pain. Providers caring for patients with chronic back pain employ a wide range of high-tech and low-tech treatment options across patient care settings, including bed rest, drug therapy, physical therapy, chiropractic care, steroid injections, transcutaneous electrical nerve stimulation, spinal fusion surgery, and other forms of surgery.¹⁷⁷ The lumbar spine

175. See Revisions to Payment Policies III, *supra* note 142, at 43502 (explaining episodes of care).

176. See generally NATIONAL QUALITY FORUM, ENDORSING COST AND RESOURCE USE MEASURES: TECHNICAL REPORT 4 (2014) (explaining episodes built around acute illnesses).

177. See *Low Back Pain Fact Sheet*, NAT'L INSTS. OF HEALTH (Dec. 2014), http://www.ninds.nih.gov/disorders/backpain/detail_backpain.htm (describing the available treatments for chronic lower back pain). There is wide variation in the care provided to patients with chronic back pain that is not explained by differences in patient characteristics and co-morbidities. See THE DARTMOUTH INST. FOR HEALTH POL'Y & CLINICAL PRACTICE, *supra* note 11 (reporting regional variation in the treatment of chronic back pain not explained by patient needs or preferences).

fusion/refusion episode measure proposed by CMS only captures the inpatient care associated with a spinal surgical procedure and the follow-up care provided through thirty days post-discharge. Consequently, it does not address overutilization of the surgical procedure itself or excessive outpatient care provided outside the narrow time window. A broad episode measure for chronic back pain, however, would bundle together *all* services related to managing the condition for an extended period of time. This means hospitals and their affiliated providers who aggressively treat back pain patients with costly interventions, including inpatient surgery, will have higher per capita costs than their more conservative peers, and thus have a lower VBP efficiency score. So unlike the narrower lumbar spine fusion/refusion episode measure, a broader measure for chronic back pain would penalize those hospitals that, together with their affiliated physicians, perform unnecessary or excessive surgeries or other costly interventions when treating chronic back pain. In contrast, hospitals that lower the cost of treating chronic back pain patients would achieve a higher VBP efficiency score, which could translate into higher Medicare payments.

As this example illustrates, incorporating broad episode-based efficiency measures into the Hospital VBP Program financially incentivizes hospitals to reduce the overtreatment of Medicare patients across all patient care settings. In response to these incentives, hospital management would support efforts to reduce the volume and intensity of care. For example, they could closely monitor the appropriateness of inpatient admissions, surgeries, and other costly procedures; tie physician bonuses to their reducing costs rather than rewarding “productivity;” and encourage greater adherence to practice guidelines targeting the overuse of certain services.¹⁷⁸ Hospitals also might think twice before building centers of excellence or investing in expensive technology that encourages overutilization. Clinical leadership roles could be filled by individuals with conservative practice styles, who in turn would influence others within the organization to practice cost-conscious care. Similarly, hospitals may prefer affiliations with more efficient physicians

178. Under the ABIM Foundation’s Choosing Wisely campaign, over fifty national organizations representing medical specialists have identified commonly overprescribed tests and procedures. Each list is based on evidence-based recommendations intended to facilitate better decisions as to the appropriateness of the test or procedure for a particular patient. See Roni Caryn Rabin, *Doctor Panels Recommend Fewer Tests for Patients*, N.Y. TIMES, Apr. 4, 2012, at A10 (discussing the efforts by medical specialty boards to reduce unnecessary care); CHOOSING WISELY: AN INITIATIVE OF THE ABIM FOUNDATION, <http://www.choosingwisely.org> (discussing the Choosing Wisely campaign).

and hesitate to grant staff privileges to physicians who overtreat patients. In time, a new culture of cost-consciousness would emerge within the hospital organization, with hospitals and their physicians utilizing fewer and less costly resources.

This Article's proposal also nudges the health care industry toward collaborative arrangements that eventually would support providers assuming greater financial risk under Medicare bundled payments, shared savings and risk, and capitated payment arrangements.¹⁷⁹ To successfully reduce unnecessary or excessive care, a hospital must work closely with its affiliated physicians. Together they must identify gaps between their existing patient care practices and efficient practices, and then address those gaps through training and the development of new patient care protocols.¹⁸⁰

Experienced hospital administrators also can assist physician groups in implementing more cost-effective patient care models outside the hospital setting. For example, hospital administrators can share their expertise and data analytics, support greater coordination among the various physicians caring for a patient, and provide health information systems.¹⁸¹ These initial collaborations would support hospitals and physicians transitioning to ACOs or other organizations that can assume the financial risk inherent in bundled payment and shared savings programs.

Moreover, because the Hospital VBP Program applies to most hospitals participating in Medicare,¹⁸² this Article's proposal incentivizes integration across the entire hospital industry, and not simply among those hospitals voluntarily participating in the Bundled Payments and Shared Savings Programs.

179. Cf. Damberg et al., *supra* note 164, at 9 (stating that a "building block" that begins with adjustments to fee-for-service payments, such as pay for performance financial incentives, would support later moves toward a prospective payment approach for episodes (such as bundled payments paid on a prospective basis)).

180. Cf. Mantel, *supra* note 47, at 1413–18 (discussing how collaborations such as ACOs can support efforts to improve both efficiency and quality).

181. See generally Mantel, *supra* note 45, at 470 (explaining that health care organizations, such as hospitals, "can provide the capital, technology, and staff needed to support today's practice of medicine . . .").

182. IPPS and the Hospital VBP Program apply to "subsection (d) hospitals." Subsection (d) hospitals includes hospitals located in the fifty states or the District of Columbia other than psychiatric hospitals, rehabilitation hospitals, pediatric hospitals, hospital with an average inpatient length of stay greater than twenty-five days, and hospital involved extensively in treatment for or research on cancer. 42 U.S.C. § 1395ww(d)(1)(B).

B. Deterring the Undertreatment of Patients

As with all financial incentives that reward providers for lowering costs, introducing episode-based efficiency measures into the Hospital VBP Program might lead hospitals and their affiliated physicians to reduce not only excessive care, but also appropriate care.¹⁸³ As discussed below, the risk that financial incentives will lead to substandard care is real, although often overstated. For this reason, it is necessary to incorporate into this Article's proposal safeguards that would protect Medicare patients from undertreatment.

Although many health care providers sincerely believe that financial incentives do not affect their professional judgment,¹⁸⁴ empirical research shows otherwise.¹⁸⁵ For example, physicians paid on a capitated basis prescribe fewer drugs, see their patients for fewer physician visits, limit the number of diagnostic procedures done, make fewer referrals for elective surgery, and hospitalize their patients less often.¹⁸⁶ The theory of cognitive motivation suggests the reason for this.¹⁸⁷ As explained previously in Part II.B.2, physicians may be subconsciously biased to make clinical decisions consistent with their personal self-interest, despite their strong commitment to their patients' welfare.¹⁸⁸ Consequently, if hospitals looking to lower costs reward physicians for doing so, physicians may be cognitively motivated to justify the delay or withholding of beneficial care.

Nevertheless, the risk that hospitals and their affiliated physicians will provide substandard care may be small. Psychologists have

183. Cf. AM. HOSP. ASS'N COMM. ON RESEARCH, *supra* note 164, at 9 ("One potential unintended consequence [of bundling payments for episodes of care] is that necessary care may also be reduced.")

184. See Kevin Grumbach, et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1518–19 (1998) (reporting that although the majority of physicians reported pressure from managed care organizations to limit referrals, only seventeen percent stated that such pressure compromised patient care); James D. Reschovsky et al., *Effects of Compensation Methods and Physician Group Structure on Physicians' Perceived Incentives to Alter Services to Patients*, 41 HEALTH RES. & EDUC. TRUST 1200, 1209 (2006) (reporting that the majority of physicians with financial incentives to reduce services nevertheless believe they can provide high quality care to their patients and make clinical decisions in the best interest of patients).

185. See Carine Chaix-Couturier et al., *Effects of Financial Incentives of Medical Practice*, 12 INT'L J. FOR QUALITY IN HEALTH CARE 133 (2000) (summarizing results from studies finding that financial incentives impact physicians' utilization and referral rates).

186. See *id.* at 135–37.

187. See generally Roy F. Baumeister & Kathleen D. Vohs, *Motivated Cognition*, in ENCYCLOPEDIA OF SOCIAL PSYCHOLOGY 594 (Roy F. Baumeister & Kathleen D. Vohs eds., 2007) (explaining cognitive motivation).

188. See *supra* Part III.A.2.

found that when individuals consciously construct a justification for their self-serving, subconscious judgments, they “attempt to be rational and to construct a justification for their desired conclusion that would persuade a dispassionate observer.”¹⁸⁹ This means individuals’ capacity for reaching a self-serving conclusion “is constrained by their ability to construct seemingly reasonable justifications for these conclusions.”¹⁹⁰ So although providers may be able to justify delaying or denying discretionary care falling within medicine’s grey zone, it would be difficult to justify the withholding of care backed by strong evidence of medical efficacy. For this reason, it is unlikely that hospitals and physicians would withhold or delay care that clearly is medically appropriate, even if doing so serves their financial interest.¹⁹¹ Indeed, several studies have found that when physicians are given financial incentives to lower costs, they only reduce care of questionable or uncertain clinical benefit, and *not* care of known clinical benefit.¹⁹²

Additional considerations also may counteract a hospital’s financial incentives to undertreat patients under a Hospital VBP Program that rewards lower costs. Fear of malpractice lawsuits may deter a hospital and its affiliated physicians from denying patients care of clear clinical value.¹⁹³ Hospitals and their affiliated physicians also may fear that they will lose patients to competitors if they develop a reputation for providing low quality care.¹⁹⁴ Relatedly,

189. Kunda, *supra* note 92, at 482–83.

190. *Id.* at 480.

191. See Mantel, *supra* note 45, at 504–05.

192. See Sean P. Elliott et al., *Reduction in Physician Reimbursement and Use of Hormone Therapy in Prostate Cancer*, 102 J. NAT’L. CANCER INST. 1826 (2010) (finding that reductions in reimbursement rates for ADT was associated with a reduction in overtreatment without a reduction in needed services); Vahakn B. Shahinian et al., *Reimbursement Policy and Androgen-Deprivation Therapy for Prostate Cancer*, 363 NEW ENG. J. MED. 1822 (2010) (finding that reductions in reimbursement for androgen-deprivation therapy (ADT) was associated with a reduction in inappropriate and discretionary use of ADT, but not of use considered appropriate); Joannie Shen et al., *The Effects of Payment Method on Clinical Decision-Making*, 42 MED. CARE 297 (2004) (finding that capitated payment lead physicians to reduce health care resource expenditures on discretionary care of relatively small or questionable benefits to the patient, but not on care that offered large, undeniable benefits to patients).

193. See Mehlman, *supra* note 13, at 858 (“The fear of malpractice is probably the most effective pressure on providers to refrain from denying nonwasteful technology to patients.”).

194. Although the difficulties faced by patients in evaluating the care they receive may limit their ability to make informed choices among providers, some providers nevertheless are motivated to provide high quality care in order to protect their reputations. See DEP’T OF JUSTICE & FED. TRADE COMM’N, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* 17 (2004) (stating that although there exists informational and payment barriers to effective competition, competition can play an important role in enhancing quality of care); Anne Frølich et al., *A Behavioral Model of Clinician Responses to Incentives to Improve Quality*, 80 HEALTH POL’Y 179, 187 (2007) (discussing a study of Wisconsin hospitals finding that public reporting of

private payors may be unwilling to contract with hospitals and physicians that provide lower quality care.¹⁹⁵ Finally, payors offering a tiered provider network plan may assign poor performing providers to tiers with higher cost-sharing.¹⁹⁶

Despite these considerations, the financial incentives inherent in this Article's proposal may lead some hospitals and their affiliated physicians to inappropriately stint on the care they provide patients in an effort to raise their VBP efficiency scores. To guard against this, the Hospital VBP Program should include episode-based quality measures for the clinical conditions selected for the efficiency measures.¹⁹⁷ For example, an efficiency measure for heart disease could be paired with quality measures for heart disease, such as measures evaluating the incidence of heart attacks among heart disease patients or mortality rates for heart disease patients. Because hospitals performing poorly on the VBP quality measures are penalized with lower Medicare payment rates, marrying episode-based efficiency measures with quality measures will counteract incentives to withhold or delay beneficial care.¹⁹⁸

quality performance made hospitals more likely to adopt quality improvement programs); David Hyman, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 957 n.364 (2005) (stating that one motive of providers for improving quality may be concern for their reputation).

195. See *infra* note 218. Managed care plans also are limiting their enrollees to a single or select hospitals for particular procedures, with hospitals selected based on their provision of high-quality care and willingness to discount their prices. See James C. Robinson & Kimberly MacPherson, *Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers*, 31 HEALTH AFF. 2028, 2029–30 (2012) (explaining centers-of-excellence contracting).

196. See Paul Fronstin, *Tiered Networks for Hospital and Physicians Health Care Services*, EBRI ISSUE BRIEF NO. 206, 3 (2003), <http://www.ebri.org/pdf/briefspdf/0803ib.pdf> (explaining that payors with tiered networks may assign providers to tiers based on their quality of care).

197. See NATIONAL QUALITY FORUM, *supra* note 176, at 6 (stating that the NQF supports using measures on resource use in conjunction with quality measures, because using the former alone “may lead to adverse unintended consequences in the health care system”); Tom MaCurdy et al., ACUMEN, OPTIMAL PAY-FOR-PERFORMANCE SCORES: HOW TO INCENTIVIZE PHYSICIANS TO BEHAVE EFFICIENTLY USING EPISODE-BASED MEASURES 37 (Feb. 2011) (stating that a pay-for-performance system that only rewards providers for cost efficiency “ignores the potential tradeoffs between cost efficiency and quality of care,” and that one option for addressing this “is to integrate quality or outcome measures into the [pay-for-performance] scheme”). Cf. Hussey et al., *supra* note 169, at 2118 (stating that bundled payments for episodes requires “robust quality measurement to guard against the potential adverse effects of bundled payment, such as stinting on care”).

198. Posting on Medicare's Hospital Compare web site each hospital's score on the episode-based quality measures would further safeguard patients from subpar care, because poor performance on the quality measures would harm a hospital's reputation with both patients and private payors.

C. Transitioning to Episode-Based Efficiency Measures

Before incorporating episode-based efficiency measures into the Hospital VBP Program, CMS should implement a hospital feedback program modeled after the Medicare Physician Feedback Reporting Program described below.

The design and implementation of episode-based efficiency measures raise numerous technical challenges.¹⁹⁹ Medicare patients often receive treatment for multiple medical conditions, so care associated with the measured condition must be separated from care related to other conditions. Typically the process of assigning care to specific episodes is done using episode grouper software, with the software's algorithms determining which services will be bundled together in a particular episode.²⁰⁰ CMS would need to ensure the validity of the software's logic so that care related to a particular episode is in fact captured while unrelated care is excluded.²⁰¹ In addition, CMS would need to determine how broadly or narrowly to define the selected episodes²⁰² and how best to address patients with multiple co-occurring conditions.²⁰³ Other critical issues

199. See generally NATIONAL QUALITY FORUM, *supra* note 176 (highlighting some of the challenges in designing and implementing episode-based efficiency measures); ROBERT WOOD JOHNSON FOUNDATION, MEDICARE'S VALUE-BASED, PHYSICIAN PAYMENT MODIFIER: IMPROVING THE QUALITY AND EFFICIENCY OF MEDICAL CARE (2012) (same); Damberg et al., *supra* note 164 (same); Hussey et al., *supra* note 147 (same).

200. See NATIONAL QUALITY FORUM, *supra* note 176, at 6. Although most episode grouper software sort claims data into episodes of care, future software may use data contained in electronic health records rather than claims records. See *id.*

201. For example, for a diabetic patient that suffered pneumonia, the episode grouper software should attribute to the diabetes episode all care related to the patient's diabetes, while attributing to the pneumonia episode all care related to the patient's pneumonia.

202. Patients with a given clinical condition could be grouped into a single, broad episode or grouped into subgroups based on severity or comorbidities. See Damberg et al., *supra* note 164, at xix (explaining that patients can be grouped broadly or into separate categories "based on the degree of advancement of their disease and other existing comorbidities"). For example, AMI patients could be grouped into a single major episode, or could be stratified into subgroups based on whether they received certain procedural interventions, such as a percutaneous coronary intervention or coronary artery bypass graft.

203. When patients have multiple comorbidities, or co-occurring conditions, the conditions can be lumped together in a single episode or separated into two or more separate episodes. See Hussey et al., *supra* note 147, at 1412–13 ("Consideration needs to be given as to how to account for the multiple comorbidities of many [Medicare] beneficiaries and whether to lump related and co-occurring conditions together or to address them separately."). For example, if an AMI patient also has hypertension, the treatment of the latter could be included in the AMI episode or separated into a distinct episode for hypertension. The question proves challenging for two reasons: First, co-morbid conditions often interact so that the presence of a second condition (*e.g.*, hypertension) may affect the cost of managing the primary condition (*e.g.*, AMI). See NATIONAL QUALITY FORUM, *supra* note 176, at 15 (discussing interactive episodes). Second, accurately attributing services to separate episodes can be difficult. As explained by two commentators:

include the selection of a risk-adjustment methodology²⁰⁴ and the process for assigning an episode to a specific hospital (a process called “attribution”).²⁰⁵

A transitional approach similar to the approach adopted on the physician payment side would allow CMS to work through the implementation challenges described above. The Physician VBP Modifier builds on the Medicare Physician Feedback Reporting Program. Under the Physician Feedback Reporting Program, CMS provides to physicians confidential reports (called physician quality and resource use reports (QRURs)) comparing their resource use in treating Medicare beneficiaries.²⁰⁶ Beginning in 2013, CMS used its newly developed episode grouper to issue QRURs to certain physician groups comparing their episode-based costs for certain conditions.²⁰⁷ The reports also show resource use by type of

[F]or a patient who has congestive heart failure, diabetes, and renal failure and is hospitalized for uncontrolled diabetes, there is considerable uncertainty in identifying precisely which services are related to the diabetes care rather than the care of the heart failure or renal failure (*e.g.*, a posthospitalization emergency department visit for syncope could be related to the heart failure rather than diabetes).

Averill et al., *supra* note 176, at 15.

204. Risk adjustment is a statistical process that adjusts for patient characteristics. Risk adjustment would ensure that differences among patients do not unfairly impact a hospital's performance on episode-based efficiency measures. See ROBERT WOOD JOHNSON FOUNDATION, *supra* note 199, at 13 (discussing risk adjustment). Risk adjustment is necessary because patient characteristics that are beyond the health care provider's control, such as age and comorbidities, impact the amount of resources used to treat patients. Because older, sicker patients typically require a higher intensity of care, hospitals treating older and sicker patients would have higher per capita costs relative to other hospitals in the absence of risk adjustment.

205. For example, an episode first could be assigned to the physician group or individual physician providing a plurality of the physician services included in the episode, and then be assigned to the hospital at which the physician group or physician provides the majority of their hospital-based services. Alternatively, for episodes that include a hospitalization, the episode could be attributed to the hospital billing for the plurality of hospital services. See *generally* Damberg et al., *supra* note 164, at 71–72 (describing various attribution methodologies).

206. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 3003, 124 Stat. 119 (2010). The Physician Feedback Reporting Program was initially established by section 131 of the Medicare Improvements for Patients and Providers Act of 2008. Medicare Improvement for Patients and Providers Act of 2008, Pub. L. No. 110-275, 122 Stat. 2494. To facilitate CMS's providing feedback to physicians about their costs, the ACA also requires CMS to develop episode grouper software. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 3003, § 1848(n)(9)(A)(ii), 124 Stat. 119 (2010). CMS developed a prototype episode grouper in 2012. See Revisions to Payment Policies II, *supra* note 67, at 74785. In 2012, CMS also awarded a contract to Brandeis University for the development of a public domain grouper for Medicare. See NATIONAL QUALITY FORUM, *supra* note 176, at 4 (discussing the Medicare Public Grouper).

207. The 2013 QRURs compared physician groups' episode-based costs for pneumonia, AMI, coronary artery disease, coronary artery bypass grafting (CABG), and percutaneous coronary intervention. See Revisions to Payment Policies III, *supra* note 142, at 43500, 43502

service,²⁰⁸ allowing physicians to compare their practice patterns to other physicians and identify services potentially being overutilized. The knowledge CMS gained from the Physician Feedback Reporting Program supported its implementation of the Physician VBP Modifier.

CMS similarly should establish a hospital feedback reporting program, with the hospital reports comparing hospitals' (and their affiliated physicians') per capita costs for the selected episodes.²⁰⁹ As with the physician QRURs, providing similar reports to hospitals would allow CMS to test various approaches to constructing broad episode measures before linking them to IPPS payments under the Hospital VBP Program.²¹⁰ Hospitals and others in the health care industry also could provide valuable feedback to CMS on the measures included in the reports,²¹¹ which would both ensure the episode measures' validity and mitigate hospitals' resistance to their subsequent use in the Hospital VBP Program.²¹²

(discussing the supplemental QRURs issued in 2013). More recent reports compare per capita costs for beneficiaries with chronic obstructive pulmonary disease (COPD), heart failure, coronary artery disease (CAD), and diabetes. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., 2012 QUALITY AND RESOURCE USE REPORT AND PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT, Exhibit 7 (2013) (sample QRUR report), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2012-GPRO-QRUR-Sample.pdf>. CMS plans to include additional clinical episodes in future QRURs. Additional clinical conditions under consideration by CMS include congestive heart failure, cardiac arrhythmias, hip fracture, osteoarthritis, cataract, glaucoma, chronic obstructive lung disease, and respiratory failure. *See* Revisions to Payment Policies II, *supra* note 67, at 74786.

208. The QRURs show per capita costs by service type across all Medicare beneficiaries, rather than by specific conditions. The services include inpatient hospital care, outpatient hospital care, evaluation and management services, procedures, emergency services, ancillary services (lab, imaging, and durable medical equipment), and post-acute care (skilled nursing facility, home health, psychiatric, rehabilitation). *See id.* at Exhibits 9, 10.

209. CMS could establish a hospital feedback reporting program under its broad authority to "test innovative payment and service delivery models to reduce program expenditures." 42 U.S.C. § 1315a(a)(1).

210. *See* Hussey et al., *supra* note 147, at 1413 ("Testing the face validity of various approaches to defining an episode with providers will serve to highlight potential implementation barriers and can be used to refine definitions.").

211. CMS worked closely with physicians and others in developing the episode measures included in the physician QRURs and, ultimately, the Physician VBP Modifier. *See* Revisions to Payment Policies II, *supra* note 67, at 74786 (commenting that CMS develops the physician QRURs in an iterative manner, working with and soliciting feedback from specialty societies, professional associations and others).

212. *Cf.* Hussey et al., *supra* note 147, at 1413 (stating that soliciting physicians' input while defining episodes "will ensure the clinical integrity of the episodes and help mitigate resistance to their use among providers").

D. The Possibility of Unintended Consequences

Notwithstanding the advantages of this Article's proposal, it raises two important concerns. First, rather than incentivize hospitals to reduce overtreatment of Medicare patients, economic theory suggests that inefficient hospitals may respond by *increasing* the volume and intensity of care they provide to patients. Second, inefficient hospitals penalized under my proposal with lower Medicare payments may offset their losses by raising the prices they charge privately insured patients. This subpart discusses these concerns, and concludes that ultimately they do not render the proposal unworkable.

1. Higher Volume and Intensity of Care

Part IV.A argues that linking a hospital's payment rates to its performance on episode-based efficiency measures will encourage hospitals and their affiliated physicians to reduce the volume and intensity of care they provide to patients. Critics, however, may argue that the opposite will occur. In an effort to maintain their overall revenue, inefficient hospitals penalized with lower payment rates may *increase* their volume of services and/or shift their mix of services to more highly compensated care.²¹³ In other words, rather than utilize fewer high cost resources in an effort to raise their VBP efficiency scores, inefficient hospitals and their affiliated physicians may hospitalize even more patients, perform more invasive cardiology procedures, treat more chronic back pain patients surgically, and so on. For the reasons discussed below, however, business considerations will lead most hospitals to focus not on increasing their volume and intensity of care, but on shifting from cultures of overtreatment to cultures of efficiency.

Hospitals can induce demand for their services through their affiliated physicians. Whereas the demand for most non-medical services and products is driven largely by consumers, vulnerable patients with limited information rely heavily on their physicians' guidance. This allows physicians to shape the demand for both their own services and hospitals' services, a phenomenon known as

213. See MaCurdy et al., *supra* note 1197, at 29 ("Inefficient providers whose reimbursements are cut may perform more episodes to make up for lost income."); Chapin White & Tracy Yee, *When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care*, 32 HEALTH AFF. 1789, 1789 (2013) (stating that hospitals might react to Medicare price cuts by "increas[ing] the volume of Medicare services they provide to make up for the lower per service price").

“supplier-induced demand.”²¹⁴ For example, for patients suffering from chronic back pain, treating physicians may induce demand for hospital care by recommending spinal fusion surgery over bed rest, drug therapy, physical therapy, or other outpatient treatments. In theory, then, an inefficient hospital penalized with lower Medicare payments under my proposal could offset its lost revenue by inducing demand for more care or care of higher intensity, a behavior known as volume and intensity offsetting.²¹⁵

In practice, however, offsetting lower Medicare payments through induced demand may not be a realistic strategy for many hospitals. Profit-maximizing hospitals already may be maximizing the volume and intensity of care provided to Medicare patients.²¹⁶ For hospitals not currently maximizing their volume and intensity of care, it is by no means certain that the additional revenue from any induced demand would fully negate the lost revenue from lower Medicare payment rates. The ability of providers to induce demand for more care of higher intensity has limits. Professional norms, the threat of malpractice liability, and the possibility of non-payment deter the provision of clinically inappropriate care. In addition, hospitals and physicians that induce demand for care of questionable value may find themselves subject to a fraud investigation by federal prosecutors for overtreatment.²¹⁷ Many hospitals may therefore conclude that increasing the volume and intensity of care provided to Medicare beneficiaries is not economically feasible, and that their efforts would be better spent improving their performance on the VBP efficiency measures through reduced utilization.

Various market pressures also may motivate hospitals to improve their VBP efficiency scores. Hospitals that perform poorly on the

214. See REXFORD E. SANTERRE, HEALTH ECONOMICS: THEORIES, INSIGHTS, AND INDUSTRY STUDIES 226 (1996) (explaining “The Supplier-Induced Demand Theory”); John Wennberg et al., *Professional Uncertainty and the Problem of Supplier-Induced Demand*, 16 SOC. SCI. & MED. 811, 811–12 (1982) (same).

215. See Christopher S. Brunt, *Medicare Part B Intensity and Volume Offset*, HEALTH ECON. 1 (July 22, 2014) (defining and explaining volume and intensity offsetting).

216. It may be that the approximately seventy-eight percent of hospitals that are either nonprofit or government-owned do not consistently maximize profit, as they are guided in part by their charitable missions. See Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 111 (2011) (“[N]onprofit hospitals can be guided by vague missions and influenced by stakeholders with different objectives. Consequently, they may not consistently maximize anything.”). If this is indeed the case, some hospitals may have the ability to increase the volume and intensity of care they provide.

217. See Isaac D. Buck, *Caring Too Much: Misapplying the False Claims Act to Target Overtreatment*, 74 OHIO ST. L.J. 463, 467–68 (2013) (explaining that federal enforcement agencies increasingly are using the False Claims Act against providers who have administered too much care).

episode-based efficiency measures may find themselves at a competitive disadvantage when contracting with private payors. Health insurers increasingly are adopting narrow networks comprised of lower cost providers, with enrollees receiving care from “out of network” providers paying significantly higher cost-sharing or footing their bill entirely.²¹⁸ Health insurers also are making greater use of tiered provider networks, with plan enrollees paying lower cost-sharing when they select efficient, high-value providers and higher cost-sharing when treated by less efficient providers.²¹⁹ Consequently, hospitals with a poor track record for lowering costs risk losing patients to other hospitals, as plans may exclude them from their networks or preferred tiers.²²⁰

In distinguishing efficient hospitals from inefficient ones, private payors likely would consider hospitals' efficiency scores under the Hospital VBP program.²²¹ Health providers' operations, including their clinical patterns of care, typically are consistent across all patients, whether insured privately or by a government payor.²²² Accordingly, hospitals that, together with their affiliated physicians, provide a higher volume and intensity of care to Medicare patients generally do the same with their privately insured patients. Private payors therefore would disfavor hospitals that perform poorly on Medicare's VBP efficiency measures, believing that such hospitals

218. See Joseph Burns, *Narrow Networks Found to Yield Substantial Savings*, MANAGED CARE (2012) (summarizing comments from health insurance executives, who described adopting narrow networks built around cost-effective, high-quality providers); Merrill Goozner, *Building Narrow Networks that Work*, 43 MODERN HEALTHCARE 26 (2013) (same); see also AMERICA'S HEALTH INSURANCE PLANS, ISSUE BRIEF: HIGH-VALUE PROVIDER NETWORKS 3 (Dec. 2013) (describing trends of insurers adopting smaller provider networks comprised of providers with a track record of providing high-quality, cost-efficient care).

219. See Fronstin, *supra* note 196, at 3 (explaining tiered provider networks). Providers also may be assigned to tiers based on their charges and/or quality. See *id.*

220. See AM. HOSP. ASS'N, HOSPITALS IN PURSUIT OF EXCELLENCE: A COMPENDIUM OF ACTION GUIDES 27 (2013), www.hpoe.org/2013_HPOE_Compendum.pdf (explaining that less efficient providers may “be excluded from the narrow and tiered networks that are being formed nationwide”); Suzanne Delbanco, *The Payment Reform Landscape: Benefit and Network Design Strategies to Complement Payment Reform*, HEALTH AFF. BLOG (Nov. 4, 2014), <http://healthaffairs.org/---reform-landscape-benefit-and-network-design-strategies-to-complement-payment-reform/> (stating that higher cost providers “do not make it into the preferred tiers”); Brian A. Liang, *Deselection Under Harper v. Healthsource: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 799–803 (1997) (explaining that deselection is driven by managed care plan's desire to minimize costs).

221. Medicare's Hospital Compare web site currently posts data on hospitals' performance on the measures selected under the Hospital VBP program. See *Hospital Compare*, MEDICARE.GOV, <https://www.medicare.gov/hospitalcompare/search.html>.

222. See Austin B. Frakt, *The End of Hospital Cost Shifting and the Quest for Hospital Productivity*, 49 HEALTH SERVS. RES. 1, 3 (2014).

similarly overtreat their privately insured patients. Hospitals that increase the volume or intensity of care in response to lower Medicare reimbursement rates thus risk hurting their competitive position in the private sector.

In addition, hospitals that focus on increasing utilization, rather than transitioning to a culture of efficiency, will be ill-prepared for a new world that ties providers' payments to performance. Like Medicare, the private sector is in the midst of a historic shift away from fee-to-service to value-based and other risk-based payment methodologies, including bundled payments, shared savings, and capitation.²²³ Success under these new payment models will require a culture that emphasizes efficiency over volume, as "getting to appropriate utilization is critical."²²⁴ Hospitals unable to make this shift risk financial stress under these new payment models.

Physicians and investors also may penalize hospitals with high utilization rates. As physicians increasingly face their own financial incentives to lower costs under the Medicare Physician VBP Modifier and their contracts with private payors, they may spurn higher

223. See AVAILITY, PROVIDER ATTITUDES TOWARD VALUE-BASED PAYMENT MODELS 8 (Apr. 2014), <http://www.availity.com/wp-content/uploads/2014/05/provider-attitudes-research-availity-may2014.pdf> (survey of providers finding that although only twenty percent of providers' current revenue derives from value-based purchasing arrangements, most expect value-based purchasing to become the dominant payment model, reaching sixty percent by 2017); HEALTHCARE FIN. MGMT. ASS'N, VALUE PROJECT: PHASE 2, DEFINING AND DELIVERING VALUE 11 (2012) (2012 survey reporting that survey participants anticipate growth in value-based payment mechanisms); TOM MAIN & RICK WEIL, THE VIEW FROM HEALTHCARE'S FRONT LINES: AN OLIVER WYMAN CEO SURVEY 2, http://www.oliverwyman.com/content/dam/oliverwyman/global/en/files/archive/2011/The_View_from_Healthcares_Front_Lines_An_Oliver_Wyman_CEO_Survey.pdf (reporting that in their interviews with industry executives, executives were "virtually unanimous in believing that the system is on the verge of a shift from a volume-based to a value-based model over the next decade"); MCKESSON HEALTH SOLS., THE STATE OF VALUE-BASED REIMBURSEMENT AND THE TRANSITION FROM VOLUME TO VALUE IN 2014 22 (2014), <http://mhsinfo.mckesson.com/rs/mckessonhealthsolutions/images/MHS-2014-Signature-Research-White-Paper.pdf> (reporting that survey participants expect fee-for-service to comprise less than one-third of providers' total reimbursements five years from now); MOODY'S INVESTORS SERVICE, VALUE OVER VOLUME: RISKS, PITFALLS AND OPPORTUNITIES 3 (2013) (commenting that the health care sector has begun "a historic shift to value-based reimbursement after decades of volume-based incentives").

224. HURON HEALTHCARE, INNOVATION IN ACTION: INSIGHTS ON ACHIEVING HEALTHCARE TRANSFORMATION 15 (2013), http://www.huronconsultinggroup.com/Insights/Perspective/Healthcare/~media/Insights-Media-Content/PDF/Healthcare/Innovation_In_Action_Report.pdf (summarizing comments of Andrew A. Ziskind, M.D.). Similarly, in a recent survey of 200 industry executives, seventy-three percent either "agreed completely" or "somewhat agreed" with the statement that providers "need to immediately begin shifting their focus from volume to value." See *Forbes Insights Study Signals Imminent Health Care Shift Toward Value-Based Purchasing (VBP)*, FORBES (June 5, 2012), <http://www.forbes.com/sites/forbespr/2012/06/05/forbes-insights-study-signals-imminent-health-care-shift-toward-value-based-purchasing-vbp/>.

cost hospitals in favor of their more efficient competitors. In addition, non-profit hospitals that fail to reduce costs may have difficulty obtaining bond financing to support their capital projects because lenders may consider them poor risks in a market moving toward value-based payments and risk-based payments that shift financial risk from payors to providers.²²⁵ Accordingly, inducing demand in response to lower Medicare payment rates would be a short-sighted strategy that would adversely impact a hospital's long-term interests.

Studies examining provider responses to past reductions in Medicare payment rates support the above analysis. Whereas earlier studies found that lower Medicare payment rates were in fact associated with increases in volume,²²⁶ more recent studies find no evidence of volume-offsetting.²²⁷ Indeed, one study reported that "a 10 percent reduction in Medicare prices [for inpatient care] was associated with a 4.6 percent *reduction* in discharges among the elderly" as well as with reduced inpatient bed capacity.²²⁸ These more recent findings coincide with the expansion of managed care in the

225. See MOODY'S INVESTORS SERVICE, DOING MORE WITH LESS: CREDIT IMPLICATIONS OF HOSPITAL TRANSITION STRATEGIES IN ERA OF REFORM I (2012) ("Hospitals that can manage well during this transition [in payment methodologies] should be able to maintain if not improve their credit ratings. Conversely, hospitals that cannot navigate the payment reductions or reduce their expense structures quickly enough to mitigate the impact may see rating pressure.").

226. See Gloria J. Bazzoli et al., *The Balanced Budget Act of 1997 and U.S. Hospital Operations*, 41 INQUIRY 401 (2004) (finding that hospitals increased their Medicare admissions following reductions in Medicare inpatient rates after passage of the Balanced Budget Act of 1997); Brunt, *supra* note 215, at 3 (summarizing earlier studies finding that reductions in physicians' fees were associated with increased volume in physician services).

227. See Brunt, *supra* note 215, at 3, 16 (summarizing studies finding either a *positive* relationship between Medicare fees and volume or no significant effect, and reporting results of the authors' own study finding "little to no evidence of volume offsetting").

228. White & Yee, *supra* note 213, at 1789, 1794. *But see* Daifeng He & Jennifer M. Mellor, *Hospital Volume Responses to Medicare's Outpatient Prospective Payment System: Evidence from Florida*, 31 J. HEALTH ECON. 730, 730 (2012) (finding that Medicare payment cuts lead to a lower volume at hospitals with a low percentage of Medicare patients, but volume *increases* at hospitals with a high percentage of Medicare patients). White and Yee cautioned that although lower Medicare payments for inpatient care under IPPS led to lower *inpatient* admission rates, it is not known whether these price reductions spurred an increase in *outpatient* care. *See* White and Yee, *supra* note 213, at 1794. In other words, when faced with lower IPPS payments, providers might have offset reductions in their inpatient care revenue by increasing their volume and intensity of outpatient care. Even if providers did in fact respond to past reductions in IPPS payment rates by inducing demand in the outpatient setting, they nevertheless are unlikely to do so under my proposal. As explained in Part IV.A, broadly defined episode-based efficiency measures link hospitals' inpatient payment rates to the volume and intensity of care provided in *both* the inpatient and outpatient settings. So whereas in the past hospitals that induced demand for outpatient care suffered no financial consequences under Medicare for doing so, my proposal would penalize such hospitals with lower inpatient payment rates.

private sector, suggesting that managed care has constrained hospitals' ability to induce demand.²²⁹ To the extent the shift to value-based and risk-based contracts imposes similar pressures on hospitals to lower costs, this will further limit hospitals' ability to pursue a strategy of inducing demand rather than reducing utilization.

Nevertheless, some hospitals performing poorly on the VBP efficiency measures may pursue higher utilization over cost reduction. Private payors generally must include in their plan networks dominant or "must have" hospitals, that is hospitals with significant prestige or large market share. Dominant hospitals therefore need not fear exclusion from plans' provider networks or preferred tiers, and can resist payors' push for value-based and risk-based contracts.²³⁰ Consequently, the market pressures described above that constrain hospitals' ability to induce demand may be weak with respect to dominant hospitals. Some dominant hospitals, then, might respond to lower Medicare payments by increasing their volume and intensity of care.²³¹

Because of the possibility that some hospitals penalized with lower Medicare payment rates under my proposal would induce demand, penalized hospitals (and their affiliated physicians) should be monitored for evidence of abuse.²³² Should such monitoring reveal a pattern of induced demand, Congress could enact legislation

229. Cf. He & Mellor, *supra* note 228, at 738 (finding that in response to Medicare payment reductions for outpatient care, hospitals increased the number of procedures provided to privately insured patients covered by *traditional fee-for-service arrangements*, but no evidence that hospitals did so for privately insured patients enrolled in *managed care plans*, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs)).

230. See generally Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012) ("[M]ust have' providers—meaning providers that health plans must include in their networks to attract employers and consumers—have used their clout to raise prices."); Chapin White et al., *Understanding Differences Between High- and Low-Priced Hospitals: Implications for Efforts to Rein in Costs*, 33 HEALTH AFF. 324, 325, 329–30 (testing whether high-priced hospitals "might enjoy 'must have' status in negotiations with private insurers because of the hospitals' market share, . . . reputation, or unique services or geographic services area," and finding that "some hospitals have market power that allows them to negotiate high prices with private health plans and operate under little pressure to contain costs").

231. That being said, we should be careful not to overstate the likelihood that dominant hospitals penalized with lower Medicare payment rates under my proposal would increase the volume or intensity of care. Dominant hospitals that are already maximizing their volume and intensity of care would be unable to offset reduced Medicare payments through induced demand. In addition, as noted previously, providers' ability to induce demand is not infinite—at some point more care of higher intensity is clinically inappropriate.

232. For example, CMS could monitor the total per capita costs for the hospital's affiliated physicians. As explained previously, the total per capita cost measure included in the Physician VBP Modifier captures *all* care provided to a Medicare beneficiary and paid for under Medicare Parts A and B. See *supra* note 67 and accompanying text. Physicians whose patients on average receive a high volume and/or intensity of care will have higher total per capita costs than those who successfully reduce utilization. Consequently, any increase in

imposing additional penalties against hospitals that do so. For example, imposing steeper reductions in Medicare payment rates for hospitals that induce demand may deter doing so, as even dominant hospitals may be unable to fully offset such reductions given the inherent limits on inducing demand. Imposing additional penalties thereby would encourage hospitals to focus on improving their performance on the episode-based efficiency measures, rather than increasing their volume and intensity of care.

2. Cost-Shifting

Some commentators also may express concern that inefficient hospitals penalized with lower Medicare payment rates under this Article's proposal will engage in "cost-shifting." Cost-shifting occurs when hospitals facing reductions in their Medicare reimbursements raise the prices they charge privately insured patients in an effort to maintain their overall revenue.²³³ Although my proposal may lead a few hospitals to engage in cost-shifting, for the reasons discussed below, most hospitals will be unable to do so.

In general, hospitals' capacity to engage in cost-shifting is circumscribed by factors similar to those that check their ability to induce demand. Hospitals facing the prospect of exclusion from plans' networks or preferred tiers can ill afford to raise the prices they charge private payors;²³⁴ nor can they negotiate for higher payments under value-based and risk-based contracts.²³⁵ Similarly, hospitals that already fully exploit their market power would have limited ability to extract even higher prices from payors.²³⁶ Recent

utilization or intensity by a hospital and its affiliated physicians would be reflected in the total per capita cost measure.

233. See White and Yee, *supra* note 213, at 1789–90 (explaining cost-shifting).

234. See Frakt, *supra* note 216, at 122 (suggesting that plans "are better able to resist price increases due to network-based contracting").

235. Cf. James Robinson, *Hospitals Respond to Medicare Payment Shortfalls By Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30 HEALTH AFF. 1265, 1269 (2011) ("Hospitals in competitive markets will be less able than those in concentrated markets to raise prices . . .").

236. As explained by one commentator:

Market power cannot be profitably wielded indefinitely, however. Once a hospital has fully exploited its market power, it has exhausted its ability to extract additional revenue from further price increases. That is, an even higher price would drive away enough customers (plans) that revenue would decrease, not increase.

Frakt, *supra* note 216, at 109; see also Frakt, *supra* note 222, at 1, 3 (concluding that in today's marketplace, cost shifting by hospitals "now appears to be largely infeasible[,] . . . [as] hospitals may have already exploited their market power and lack further leverage to raise private prices").

empirical studies support these predictions, finding that “the vast majority of public payers’ [sic] shortfalls are accommodated by cost *cutting*, not cost *shifting*.”²³⁷ In addition, the studies found that although cost-shifting may occur in markets where hospitals have market power, the resulting price increases are small and do not fully offset the reductions in government payment rates.²³⁸ With hospitals’ ability to cost-shift largely constrained, hospitals at risk of performing poorly on the VBP efficiency measures would be motivated to lower utilization in an effort to avoid reduced revenues.

* * * * *

In sum, incorporating into the Hospital VBP Program efficiency measures based on broadly defined episodes of care would address the problems that plague current and proposed Medicare payment policies. Importantly, this Article’s proposal provides a powerful inducement for hospitals to embrace a culture of cost-consciousness and minimize patterns of overtreatment among their affiliated physicians. In addition, the proposal would push hospitals to work more collaboratively with their affiliated physicians, laying the groundwork for hospitals and physicians to someday assume financial risk under bundled payment, shared savings and risk, and capitated payment arrangements.

Fortunately, CMS is well-positioned to implement this proposal. Adopting the proposal would not require Congress to enact new legislation, as current law affords CMS broad discretion in selecting the efficiency measures incorporated into the Hospital VBP Program.²³⁹ In addition, CMS could build on the experience and insights gained from its use of episode-based efficiency measures under the Medicare Physician Feedback Reporting Program and Physician VBP Modifier. Finally, CMS could test possible episode-based efficiency measures through a hospital feedback program before their inclusion in the Hospital VBP Program to ensure their validity.

237. Frakt, *supra* note 216, at 93.

238. *See generally id.* (summarizing research on cost-shifting); Frakt, *supra* note 222 (same).

239. 42 U.S.C. §§ 1395ww(o)(2)(A), (B)(ii) (delegating to the Secretary of the Department of Health and Human Services broad authority to select the measures under the Hospital VBP Program, including efficiency measures).

CONCLUSION

Medicare's relentlessly rising costs pose a significant threat to the nation's long-term finances. Medicare's cost problem stems in part from physicians doing too much for their Medicare patients—providing care that is medically unnecessary, inefficient, or of unknown value. The challenge for Medicare, then, is how to encourage physicians to reduce their overtreatment of patients.

The obvious solution is to reform how Medicare pays physicians by financially rewarding physicians who reduce the volume and intensity of care and penalizing those who do not. The Affordable Care Act does exactly that by giving CMS the authority to link physicians' payment rates to their performance on various efficiency measures. Yet simply refashioning how Medicare pays physicians is not enough, as it ignores the profound influence of hospitals' organizational cultures on physicians' clinical decision-making. Medicare payment policy therefore also must hold hospitals accountable when their affiliated physicians overtreat patients.

To some extent, existing and proposed Medicare reforms achieve this goal by penalizing hospitals when their physicians overtreat patients. These reforms, however, do either too little or too much. One group of reforms focuses narrowly on overtreatment in the inpatient hospital setting, failing to recognize that hospitals' organizational cultures also impact practice patterns in the outpatient care setting. Other reforms require hospitals and their affiliated physicians to have an administrative and operational infrastructure that, for many, exceeds their current capacity.

This Article sets forth a novel policy that would avoid these shortcomings—incorporating into the Medicare Hospital VBP Program broadly defined efficiency measures that would tie a hospital's Medicare payment rates to its success in lowering the cost of treating patients across all patient care settings. Reforming the Hospital VBP Program in this manner would incentivize hospitals to reduce the volume and intensity of care provided to patients across the health care system. Importantly, because providers' practice patterns are similar for Medicare and privately insured patients, this culture of cost-consciousness would not only ensure that Medicare dollars are spent more wisely, but also would deter the overtreatment of privately insured patients. My proposal thus would lead to real savings for both Medicare and private payors by helping to ensure both the future viability of Medicare and lower premiums and out-of-pocket spending for privately insured individuals.

