Medicare's Design Flaw

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Nicholas Bagley, Bedside Bureaucrats: Why Medicare Reform Hasn't Worked, 101 **Geo. L.J.** 519 (2013).

Medicare is a behemoth. But the legal literature on it is almost negligible by comparison. Only a few scholars tackle Medicare broadly, like Ted Marmor, Tim Jost, and David Hyman. Most articles (like Jacqueline Fox's two must-read articles on coverage decisions), tackle discrete problems with Medicare. And there is no shortage of those.

It takes a fair bit of pluck to confront Medicare's design flaws, as Nicholas Bagley does in *Bedside Bureaucrats*. Bagley applies administrative law sensibilities to argue that Medicare can't implement its programmatic goals in large part because it relies on decentralized administration by private insurance contractors and, more importantly, by hundreds of thousands of private physicians as "street-level bureaucrats."

One of the article's major contributions is observing that private physicians run Medicare on the ground: they judge whether treatments are eligible for reimbursement; they certify whether Medicare will pay for hospital stays; and they diagnose conditions that determine how much Medicare pays for treatment. In administrative law terms, each participating physician is an "adjudicator"—making judgments about which Medicare beneficiaries need which care under which circumstances. But the Medicare statute, according to Bagley, "deprived federal administrators of the conventional roster of legal and management tools typically used to control frontline bureaucrats."

Deference to private physicians highlights a persistent tension in Medicare. The very first words in the 925-page Medicare statute declare that "Nothing … shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine…." As Bagley notes perceptively, these words from the original 1965 statute describe the root of Medicare's biggest problems: cost and quality controls. Bagley argues—and many agree—that fixing Medicare requires us to "adjust physician practice patterns." But Medicare's design creates a conflict between competing public values: Medicare was designed to preserve physician autonomy and patient choice; but those two values now hamstring our efforts to rein in costs and impose quality controls.

Not surprisingly, Bagley observes, four decades of reforms have not changed Medicare's basic administrative design. Instead, they skate the periphery. For example, in 1972, Congress tried to influence physician practice patterns and combat Medicare fraud by creating peer review organizations. But these were controlled by private physicians. Then, to battle overbilling under fee-for-service payments, Congress adopted a physician fee schedule. But instead of allowing Centers for Medicare and Medicaid Services (CMS) to make hard choices, Congress outsourced the duty to a committee run by the American Medical Association. When Congress experimented with Medicare managed care, it turned to private insurers. But Medicare Advantage and its precursors are considered to be colossally expensive failures. Finally, when Medicare decides whether to cover new technologies, it largely defers to local coverage determinations (LCDs) made by private contractors who do not have the capacity or incentives to enforce them.

Instead of equipping CMS to manage Medicare more effectively, Congress has preferred outsourcing administration to private organizations. If CMS is Medicare's centrifuge, it is a weak one. Again, this is by design. Bagley emphasizes that outsourcing administration "absolves the federal government of direct responsibility for controlling physicians and, in bypassing agency officials, mutes public concerns with government interference." What makes Medicare palatable also makes it unsustainable.

Another important contribution here is emphasizing the administrative importance of scale. Medicare spends more on

private sector services ($502 billion) than all other federal contracts for goods and services combined ($450 billion). It pays for services provided by hundreds of thousands of physicians to almost 50 million beneficiaries, processing 4.8 million claims *per day*, and 1.2 billion per year. The task of managing anything of this scope is hard to imagine.

CMS is a small, virtually unknown agency, "with a staff about the same size as that of the Smithsonian Institution," managing "a Medicare budget that exceeds the size of Argentina's economy." In turn, Medicare is good at doing one thing: providing prompt payment. It is not good at meaningful oversight, or, more importantly, influencing physician practice patterns. Instead, physicians define and legitimate Medicare, not the other way around, as it is with most agencies (here, Bagley invokes Jerry Mashaw).

Congress designed Medicare to protect private prerogatives, and now genuine reform efforts are hamstrung because of it. Bagley appreciates that Congress cannot simply turn CMS into a massive bureaucracy that suddenly micromanages hundreds of thousands of physicians. Nor can Congress simply morph Medicare into the National Health Service without sacrificing Medicare's political legitimacy.

Bagley's answer is politically pragmatic and not entirely obvious: leverage private providers even more. Medicare reforms, Bagley argues, should encourage physicians to join integrated delivery systems, which are better positioned than CMS or private contractors to "adjust physician practice patterns" through things like treatment protocols, disease-specific checklists, and bundled payment systems. Bagley mentions the much-hailed integrated delivery systems of Intermountain, Geisinger, and the Mayo Clinic.

But didn't these integrated delivery systems inspire several reforms in the Affordable Care Act? And doesn't the Act contemplate most of these things? Bagley says these reforms will fall short, again because of Medicare's core design. For example, the Independent Payment Advisory Board (IPAB) is more likely to prefer temporary, short-term spending cuts rather than structural, longer-term ones. Similarly, the new Center for Medicare and Medicaid Innovation will encourage experiments with new payment and delivery models, but CMS still lacks the resources to scale them up as the ACA envisions. The Patient-Centered Outcomes Research Institute (PCORI) is tasked with comparing the clinical effectiveness of alternative treatments, but its recommendations ("Gee, that new treatment costs a lot and adds zero benefits over existing therapies!") are non-binding. And "Accountable Care Organizations" (ACOs), designed to generate "shared savings," are not true bundled payment systems.

Bagley argues that Medicare needs bold change, but even the bold changes contemplated by the ACA probably need even further authorization by Congress. Eventually, we will have to reform Medicare again. And when Congress does, it should consider Medicare's design flaws.

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