

Medicare Governance And Provider Payment Policy

Dramatic and sustainable payment reform may require reforming decision making in Medicare.

by **Hoangmai H. Pham, Paul B. Ginsburg, and James M. Verdier**

ABSTRACT: Medicare’s decision-making processes leave policies on provider payment vulnerable to “micromanagement” by Congress and the White House. If they continue as they are, they could jeopardize delivery system changes central to current health reform proposals. Ad hoc intervention in response to pressure from narrow interests can result in policies that do not serve the broader priorities of beneficiaries and taxpayers and that are unsound economically. Establishing a new Medicare policy board, as proposed by the Obama administration and Congress; transforming the Medicare agency into an independent agency or new department; and conducting analyses of congressionally proposed payment policy changes before they are voted on could further insulate payment decisions from political interference. [Health Aff (Millwood). 2009;28(5):1382–94; 10.1377/hlthaff.28.5.1382]

CONGRESS AND THE OBAMA ADMINISTRATION envision broad changes to the health care delivery system, many enacted through the Medicare program. The American Recovery and Reinvestment Act (ARRA) of 2009 (the so-called stimulus bill) mandates that Medicare offer payment incentives to providers to adopt electronic health records.¹ The Senate Finance Committee articulated priorities regarding the creation of “accountable care organizations” as groups of providers who could be held jointly responsible for the care outcomes of Medicare beneficiaries.² Proposed legislation calls for specific reforms to Medicare’s payments for physicians, including revisions to the resource-based relative value scale (RBRVS) and payments to primary care practices to serve as patients’ “medical homes.”³

Implementation of these reforms is likely to be an iterative process. Congress cannot legislate the most promising reforms at the level of detail necessary to create an operational program, particularly when interactions between multifaceted changes may be difficult to anticipate. In reality, new programs and policies will require many midcourse corrections.

The challenge for policymakers is to ensure that the crafting and refinement of

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reforms, particularly those affecting payment for providers, is driven as much as possible by data rather than politics. Unfortunately, political factors often hinder data-driven decisions in Medicare, particularly when those decisions create economic losers among influential special interests. Both President Obama and members of Congress have recognized this concern by proposing ways of better insulating Medicare decision making from political pressures. In recent years, Congress has legislated many detailed program decisions, usually made by Medicare administrators under long-standing authority. Severely constrained resources for program management will also impair the ability of the Centers for Medicare and Medicaid Services (CMS) to implement politically sensitive reforms.⁴ Given the extraordinary fiscal pressures now facing federal policymakers, taxpayers' interests would seem to merit higher priority than those of narrow constituencies.

This paper focuses on how governance issues may undermine reform efforts in Medicare, by impairing decision making on provider payment. We present a framework for analyzing options for reformed decision-making structures, summarize the advantages and disadvantages of specific options, and describe the features of two illustrative models.

Whisper-Down-The-Lane: The Translation Of Medicare Policies

The Medicare statute requires the program to pay providers for services based on either their “reasonable costs” or “customary charges.”⁵ The CMS crafts regulations to reflect its judgment of what constitutes reasonable payment. Over time, major changes (for example, cost- or charge-based payments for providers) have largely occurred at the direction of Congress, sometimes to provide the CMS with the political cover to take action it already had the authority to take. Major advances in Medicare’s payment structures have served new policy priorities, such as prospective payment and a pay-for-reporting (on quality) program for hospitals, a physician fee schedule, and a “global” payment for dialysis centers to cover a set of related services.

It is thus appropriate for political debate to drive major policy directions in Medicare—such as when hospital prospective payment replaced cost reimbursement. But constituencies such as particular subgroups of hospitals can exert disproportionate influence, in turn spurring detailed legislation or rule making that is inconsistent with broader policy goals. Whether through Congress, the White House, or directly through lobbying CMS staff, such activity can undermine the integrity, equity, and predictability that new and complex payment reforms require to garner buy-in from stakeholders and work effectively.

■ **Intrusion of politics in legislation.** Congress has legislated specific decisions that favor narrow groups of providers or suppliers, such as which area’s geographic adjuster should be used for a given hospital.⁶ Congress urged the CMS to delay its 2006 overhaul of diagnosis-related group (DRG) payment for inpatient care and

then disregarded judgments by the Medicare actuary on how to account for projected coding changes under an expanded DRG system.⁷ Similarly, the results of a demonstration convinced the CMS that competitive bidding for suppliers of durable medical equipment would generate substantial savings without affecting beneficiaries' access. Congress initially agreed, authorizing implementation of a competitive bidding program for durable medical equipment in 2003. But when suppliers protested because they anticipated lower payments, Congress postponed the program.⁸

Intervention by the White House on issues such as payment rates for the facility component of imaging services may be as common but has been more difficult to document because such activity is less transparent than congressional action. Lobbying efforts by providers and suppliers with CMS staff are poorly documented but widely acknowledged.⁹ After careful review of market prices by the Medicare Payment Advisory Commission (MedPAC), Congress ordered reductions in payments to physicians for the cost of chemotherapy drugs. But the White House and the CMS decided instead to pay oncologists substantial amounts for reporting quality data, to mitigate the payment reduction.¹⁰

■ **Resources and influence.** Resources for program management have been another problem. Resources flow outside the appropriations process to pay for beneficiary services, but program administration is not an entitlement and instead is based on appropriations. Thus, CMS administrative resources compete with those for other federal agencies. Medicare has not fared well in this process. In 1977 Medicare spent \$21 billion on twenty-six million beneficiaries. Today it spends \$425 billion on forty-five million beneficiaries. Yet the CMS has 4,500 full-time-equivalent workers, compared to the 4,000 who worked at its predecessor agency in 1977.^{11, 12} Studies by the U.S. Government Accountability Office (GAO) show how resources for activities such as claims review would save many times their cost.¹³ Private insurers spend much more on comparable activities than Medicare does.

Although chronic underfunding plagues many agencies, adequate resources are particularly critical for the efficient management of Medicare. For example, survey data on physician practice expenses have become far out of date, leading to disparities in the profit margins that physicians earn for different services and to the dramatic rise in volume of favored services.¹⁴ Instead of funding a new survey covering all physicians in a consistent manner, Congress ordered the CMS to use surveys sponsored by physician specialty societies to update the data, with the unintended consequence that specialties without the funds to field a survey could not generate data to support increases in their fees.

Undue influence by specific constituencies characterizes many areas of Medicare policy. We focus on provider payment policy because it is central to many proposals for delivery system reform; it affords a useful platform for examining governance issues; and its design and implementation require technical skills (for example, measurement of relative costs). Our analysis may be applicable to other policy areas that are beyond the scope of this paper.

Framework To Assess Decision-Making Structures

Neither policymakers nor stakeholders have reached clarity on what level of congressional or White House involvement constitutes appropriate oversight versus unconstructive micromanagement. However, models for reform could be crafted with explicit goals that counter current shortcomings in decision-making structures to produce, in the ideal, the following: (1) Payment policies that are consistent across time and different facets of the program. Although it is desirable that broad program directions shift over time, sudden or multiple changes waste resources and add uncertainty to health care markets. (2) Segregation of macro-level decisions, which should be steered by political debate, from micro-level decisions. An example of the former is determining the proper level of emphasis to place on value-based purchasing. An example of the latter is specifying the details of how to structure a pay-for-performance (P4P) program for physicians. (3) Policies that are driven by data and economically sound. We interpret “data” broadly to include information from program tracking that may prompt policy adjustments. For example, the CMS should be able to adjust payment systems in response to adverse developments, such as rapid growth in the volume of imaging services or shortages of primary care physicians, without having those decisions overridden as a result of lobbying by affected providers or suppliers. (4) Decision making that is open, is transparent, and allows for input from experts and constituencies. The Administrative Procedure Act allows such input for formal regulations. For decisions based on input from formal advisory committees, there should be strict conflict-of-interest guidelines. Routine and clear reporting of communications between special interests and decisionmakers at the CMS, elsewhere in the executive branch, and in Congress would provide taxpayers and oversight bodies with an auditable trail of contacts. (5) Predictable and improved financing for Medicare administration. The unpredictability of funding makes it difficult for the CMS to make longer-term investments that could improve both payment policies and Medicare policy making more broadly. For example, the CMS lacks the multiyear commitment of funds, information systems, and in-house technical expertise to modernize claims processing.¹⁵⁻¹⁷ Many provider payment reforms discussed in Congress in 2009 would require substantial resources for the CMS to implement. With these goals in mind, we turn to existing models of decision making to assess their applicability to Medicare.

A Spectrum Of Existing Models For Decision Making

There is a long history in American government of concern about the undue intrusion of politics into administrative activities.¹⁸ Analysts have sought to identify areas in which insulation from political influence may be especially appropriate. Alan Blinder, a former member of the President’s Council of Economic Advisers, suggests that these include areas that are highly technical, require longer time ho-

rizons than political pressures normally afford, or have broad impacts that are more important than their impacts on particular constituencies.¹⁹ He cited as examples setting monetary policy (Federal Reserve Board), and closing military bases (Defense Base Closure and Realignment Commission).

■ **Decision-making mechanisms.** Several approaches have been used to try to achieve varying degrees of insulation from political pressures (see Exhibit 1).

Governance mechanisms alone might not be sufficient to provide insulation from political pressures if an agency’s work adversely affects identifiable and organized constituencies who think they can seek remedy from Congress, the White House, or the agency’s leadership. James Q. Wilson emphasizes that the framers of our Constitution intended for such checks and balances to result from their separation of governmental powers.²⁰

■ **Factors contributing to autonomy.** The experience of agencies that have been more successful in keeping at least part of their activities free from political micromanagement suggests that several factors contribute to such relative autonomy: (1) a relatively straightforward mission or set of tasks (such as sending out Social Security checks, collecting taxes);²¹ (2) highly technical responsibilities that do not have easily discernible impacts on narrow, well-organized constituencies (setting monetary policy); and (3) skillful leadership that anticipates political concerns and responds to them without undermining the agency’s core activities and goals (at different times and to varying degrees, the Social Security Administration, Federal Reserve Board, and Internal Revenue Service).

■ **Spectrum of models for financing.** Congress is understandably reluctant to give up funding authority. Even when administrative expenses are funded from dedicated taxes, premiums, or user fees, appropriations action by Congress is usually re-

EXHIBIT 1
Current Mechanisms For Insulating Decision Making In Federal Agencies From Political Influence In Agencies That Employ Them

	Fixed terms for agency heads and governing boards that extend beyond presidential terms	Governance by boards/commissions rather than a single political appointee	Large professional staffs that are apolitical and highly qualified technically	Expert advisory boards with strict conflict-of-interest guidelines
Social Security Administration	●		●	●
Federal Reserve Board	●	●	●	●
Federal Trade Commission	●	●	●	
Internal Revenue Service			●	●

SOURCE: Authors’ analysis.

quired before the funds can be spent.²²

Although the CMS’s administrative functions have not been funded adequately, Congress has provided additional funding when it considered an activity to be a high enough priority. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorized \$1 billion in additional CMS funding for implementation of Part D and other aspects of MMA.

There are several ways of providing agencies with some degree of adequacy, predictability, and insulation from political pressures in their administrative funding (Exhibit 2). The Federal Reserve Board has the greatest degree of autonomy through financing administrative activities from revenue it earns on holdings of government securities and from charges for bank regulation and other services. Agencies that can assess fees or otherwise charge for services (such as the U.S. Postal Service) have greater funding autonomy than agencies that rely only on annual appropriations, as the CMS must.

Lessons For Medicare

From the preceding review, we glean several critical factors in decision-making structures with relevance for payment policy. First, broad policy decisions such as overall payment levels are appropriate matters of congressional and White House

EXHIBIT 2 Current Mechanisms For Encouraging Adequacy And Predictability Of Funding For Administrative Activities

	Funding from agency’s own operations; no separate appropriation	Funding from agency’s own operations; permanent appropriation with oversight	Partially funded from own operations; appropriation required	Appropriation request submitted directly to Congress, with limited presidential revision
Federal Reserve Board	Yes: interest earned on U.S. government securities acquired through open market operations, and charges for services	No	No	No
Comptroller of the Currency	No	Yes: mandatory assessments on regulated institutions	No	No
Food and Drug Administration	No	No	Yes; user fees from review of drugs and medical devices	No
U.S. Postal Service	Yes: revenue from postal delivery services	No	No	No
Social Security Administration	No	No	No	Yes

SOURCE: Authors’ analysis.

concern. The period of time over which changes are phased in may also be an appropriate matter for political input. Indeed, flexibility here may be a way to allay concerns that may otherwise impede reforms. Problems arise, however, with decisions that have identifiable adverse effects on specific geographic areas or subgroups of providers. These provisions are likely to be especially vulnerable to second-guessing and micromanagement by Congress or the White House.

Second, agencies headed by an individual rather than boards or commissions tend to generate more cohesive policies, especially if the agency has day-to-day decision-making responsibilities.²³ Having a single head also tends to increase an agency's visibility and public accountability. Boards and commissions are more effective at careful deliberation on a limited number of issues with representation of multiple perspectives. When an agency is governed by a board, it may better weather political pressures if the chair functions as its public face.²⁴ Boards that include distinguished members and achieve respect through their conduct may earn greater deference from Congress, just as the prestige of the Congressional Budget Office (CBO) has resulted in the substantial influence of its budget analyses.

Third, fixed terms of office for agency heads and board members that extend beyond four years may provide some insulation from White House influence, if less so from congressional influence. However, preventing any replacement of agency heads and board members for fixed periods also limits a new president's ability to establish new policy directions for an agency.

Fourth, advisory boards can anticipate and alleviate external concerns about controversial issues that might lead to ad hoc interventions, especially if they include directors who understand constituencies' perspectives. Such boards can demonstrate that key concerns are being taken into account in developing policy.

Fifth, Congress is more likely to defer to agency expertise when the task is essentially a technical one without detectable adverse impacts on specific constituencies. Case-mix adjustment for nursing home payments is one example. But policies that adversely affect identifiable geographic areas will likely garner congressional scrutiny no matter how well they are done technically. Similarly, payment adjustments that have clear adverse impact on well-organized providers or suppliers may be politically challenged, even if the adjustments are technically solid and broader provider groups may benefit from the new system. Actual losers tend to care more about these issues than potential winners do.

Lastly, the governance structures of other agencies, such as the Federal Reserve Board, were consciously designed when the agency was established, to provide political insulation. "Retrofitting" an existing agency to achieve a similar degree of insulation presents a much greater political challenge, as policymakers and constituencies have grown accustomed to their current influence. Nevertheless, such a goal has particular merit if achieving new decision-making structures can help ensure that the effort and resources required to legislate and implement broad delivery system reforms will have lasting and positive impact.

Assessing Options For A New Decision-Making Structure

We identify specific design parameters involved in creating a new decision-making structure in Medicare and the options for each parameter. The list is not intended to be exhaustive, but rather to focus on major parameters to lay a foundation for debate (see Exhibit 3).

Design parameters include the following: (1) Medicare’s relationship with the U.S. Department of Health and Human Services (HHS). (2) The locus of program authority: responsibility for payment policy could remain with the CMS administrator (or new Cabinet secretary), or be vested in a new body (Medicare Policy Board). (3) The cohesion of program decisions. Whether responsibility for all pol-

EXHIBIT 3
Options For Reformed Decision-Making Structures In Medicare

Feature	Options	Advantages	Disadvantages
Relation to HHS	CMS remains in HHS CMS as independent agency or as new Dept. of Health Care Services	Politically simple Increases visibility and accountability for decisions	Limited advocacy for agency Resistance from Congress, HHS secretary, and other stakeholders
Locus of authority	CMS administrator or new Cabinet secretary Medicare policy board with large staff	Increases visibility; effective for guiding many complex decisions Balanced stakeholder representation; prestige limits micromanagement	No increased insulation from political pressures Less visibility and accountability than single agency head
Cohesion of program decisions	Single body oversees all policy and operations One body leads operations; two other bodies lead coverage/payment policy Begin with second option, but evolve to first option	Maximizes the cohesiveness of policies May lessen early political opposition Allows decision-making body time to prove its effectiveness	Resistance to Congress ceding control over coverage/payment decisions Requires mechanism for coordination (leader on coverage as ex officio member of body on payment) Greater effort required to keep policies cohesive during transition period
MedPAC’s role	Retain current role Review Medicare legislation for impacts on costs, quality, and access	Could also inform decisions by CMS/department head or policy board Needed especially in absence of a policy board to protect agency/department head	– Congress may resist new burdens on legislation; would expand MedPAC staff
Board composition	Board size ^a Full-time directors ^b Expertise on technical issues versus constituency perspectives ^c Staggered terms of five or more years; president appoints chair from existing directors	Larger board could better cover areas of necessary expertise Fewer conflicts of interest than part-time director Majority of technical directors ensures expertise, positions board as above politics Longer terms for technical directors than constituency directors broadens representation	Larger board may make decision making unwieldy Fewer qualified candidates would be willing to serve full time than part time Lack of directors whom constituencies trust could increase resistance to board decisions Substantial commitment for directors

EXHIBIT 3
Options For Reformed Decision-Making Structures In Medicare (cont.)

Feature	Options	Advantages	Disadvantages
Financing mechanisms	Fixed/trended percentage of benefits outlays without review	Maximizes funding autonomy for Medicare agency or dept.	Congressional resistance to complete autonomy for agency or dept.
	Fixed/trended percentage of benefits outlays with review	Increases autonomy greatly while retaining congressional review	Leaves Medicare administration vulnerable to budgetary pressures
	Administrative expenses appropriated in all new Medicare bills	Helps avoid "unfunded mandates" from Congress	Burdensome for congressional members; does not ensure resources for program "maintenance"
	Current process	Politically simple	Continued poor funding

SOURCE: Authors' analysis.

NOTES: HHS is U.S. Department of Health and Human Services. CMS is Centers for Medicare and Medicaid Services. MedPAC is Medicare Payment Advisory Commission.

^aAn appropriate balance may fall between eight and ten directors. Regardless of the number of directors, a strong, politically savvy, and very visible chair will increase board's prestige and influence.

^bA middle path could be to have a mix of full- and part-time directors.

^cSome potential directors with stellar reputations for objectivity also engender confidence among certain constituencies.

icies and operations (for example, managing contracts) would lie with a single or multiple bodies. (4) MedPAC's role. (5) The composition of any new decision-making body (Medicare Policy Board), whether focused on payment policies alone or on all areas of Medicare policy. We recognize several dimensions to board composition: size; whether directors serve full or part time; their appointment and lengths of term; and their backgrounds. (6) Mechanisms for financing administrative activities of the CMS or a new decision-making body.

Two Models For New Medicare Decision-Making Structures

Assessing the options outlined above, we describe features of two illustrative models for reform. We do not assert that these or any decision-making structures can, or should, completely insulate decisions from politics. Rather, reforms might strive to provide some measurable relief from the status quo.

■ **A new Medicare payment policy board.** This model emphasizes insulation from political pressures, adherence to data-driven policies, and structured opportunities for input from constituencies. This approach would remove provider payment policy activities from the CMS and create an entity modeled after independent federal commissions, such as the Federal Trade Commission, to set such policies. The entity would need its own staff, largely drawn from current CMS staff devoted to payment policy activities. The board would be governed by a combination of directors representing specific areas of expertise as well as constituency perspectives (providers, suppliers, beneficiaries) but with a preponderance of those not linked to specific constituencies (for example, former government officials, academics). Directors would be appointed by the president and confirmed by the Senate. The CMS administrator would be an ex officio director, to facilitate coordination among the

board, CMS, and HHS. Terms would be fixed and staggered, but an incoming president could select a new chairperson from among existing directors, who would then serve as the public face of the board. As with independent commissions, directors would serve full time. And as is the practice at MedPAC, directors chosen on the basis of their understanding of constituencies would be expected to speak for themselves rather than as representatives of a trade group, which fellow directors would enforce through peer pressure. Contacts between directors and external groups or experts would be meticulously documented.

It would be important to maintain adequate oversight of the board's activities, as not a quasi-independent body but rather one granted authority to implement broad policy directions established by the president and Congress. From this perspective, presidential appointment and Senate confirmation provide the first layer of oversight. Annual review by Congress of the board's major decisions and planned activities would allow meaningful debate without undue political influence over detailed decisions. MedPAC could continue advising Congress on payment policy decisions. Existing oversight mechanisms could be brought to bear from the GAO and through congressional oversight hearings. Rule making by the board would be subject to the same public review and comment procedures that Medicare uses now.

This model departs from that of the Defense Base Closure and Realignment Commission, in which Congress took an up-or-down vote on a large grouping of decisions by the commission. Base closings require the multiyear implementation of a broad strategic decision, whereas developing payment policy is a continuous process that could be greatly slowed by grouping of decisions for periodic review.

Lastly, funding for the board's activities could be set by a formula, such as a trended percentage of benefits outlays—recognizing that funding for program administration need not grow as rapidly as aggregate benefit payments. This would provide for more predictable operating budgets than is now the case.

Versions of this approach have recently gained prominence in the health care reform debate. Two objectives have been paramount. One has been to provide assurance that long-term cost savings will be achieved. Tools include ways of resisting actions by Congress that would further raise costs, and the ability to take steps to reduce costs without obtaining specific authority from Congress. The other has been to develop long-term reform of provider payment without the need to have each step endorsed by Congress.

A proposal (S 1380) by Sen. Jay Rockefeller (D-WV) would reconstitute MedPAC as a new executive-branch agency (the Medicare Payment and Access Commission) with eleven full-time members. It would have the authority to determine provider payments and coverage policies in Medicare unless blocked by a resolution of 60 percent of the membership of either house of Congress.²⁵ President Obama has similarly proposed an Independent Medicare Advisory Council (IMAC). IMAC would have the authority to recommend annual payment updates

and Medicare reforms (including on provider payment). The president would have thirty days to review the package of recommendations; if approved, they would take effect unless Congress passed a joint resolution rejecting the package. This proposal is closer to the process used to close military bases but is consistent with the model we outlined in buffering the process from both the president and Congress.

Advantages of this model. This model has several advantages. It builds on existing frameworks at other federal agencies, by allowing the board to serve as an agent of Congress and the White House with some insulation from political considerations. The board would function as a professional body with greater assurance of longitudinal consistency in its decisions. The model would also improve the equitable representation of different constituencies in a transparent decision-making process. And it would provide more predictable and realistic financing for the implementation of increasingly complex payment policies. If the board successfully managed payment policy, it might serve as a model for a similar board to address other areas in Medicare, such as coverage policy. Alternatively, Congress could expand the responsibilities of the payment board to other areas, to minimize the fragmentation of decision making.

Shortcomings of the model. The model also has shortcomings. It would not preclude political interference, but we believe that politicians would be less inclined than under current circumstances to reverse decisions by a highly respected board that operates transparently. Second, policymakers might object to the lack of explicit expectations for efficient spending of administrative dollars. However, oversight bodies could provide incentives for the board to operate efficiently—for example, by setting target spending levels that Congress could compare to actual spending during its annual review. Not least, for the board to be established, Congress would have to decide (and the president agree) to not engage in minor policy decisions. Congress has resisted intervening to set relative values for specific physician services or DRGs, perhaps because lawmakers recognized the potential for getting consumed by such issues.

■ **Cabinet status for CMS and MedPAC review of Medicare payment legislation.** This second model builds on the existing system by elevating the head of the CMS to a Cabinet-level position and requiring MedPAC to analyze the implications of legislation that affects payment policy before it can be voted on.

This could be done in two ways: (1) establishing a new Cabinet-level Department of Health Care Services with responsibility for the Medicare program; and (2) requiring that all legislation affecting Medicare payment policy be accompanied by a MedPAC report analyzing its implications for Medicare spending, quality of care, and access for beneficiaries, just as spending legislation must be accompanied by a report from the CBO on its budget impact.

A new department. With a new Cabinet-level department, the CMS would be separated from HHS. In terms of budget outlays, the proposed Department of Health

Care Services would be the largest Cabinet agency—larger than the Department of Defense. In terms of staffing, unless its resource shortfalls are addressed, it would be one of the smallest—approximately equivalent to the Department of Education. Giving the new department head Cabinet status would enable its secretary to deal directly with the White House, the Office of Management and Budget (OMB), and Congress on Medicare policy, management, and funding issues. The new secretary would have more visibility and accountability than the CMS administrator does. The secretary would also likely carry more authority in executive-branch and congressional deliberations and be better positioned to argue for sound payment policy and agency funding.

Requiring MedPAC analysis of Medicare payment legislation. MedPAC is authorized to review Medicare payment policies and make recommendations to Congress, including on factors affecting cost, efficiency, payment methodologies, and their relationship to access and quality of care for beneficiaries.²⁵ This authority could be extended to require MedPAC analysis of the implications for costs, access, and quality of any legislation directly affecting Medicare payment policy that is reported from committees of either House, just as the CBO provides budget cost estimates on spending legislation.²⁶⁻²⁸ Having a report by an authoritative entity such as MedPAC before a piece of legislation is voted on by the full House or Senate might concentrate public attention on payment issues in a way that is rarely possible currently. This model also has disadvantages. A Department of Health Care Services would be more vulnerable to pressure from the White House than a board would be. Coordination with other programs in HHS could also be more difficult. Although we have considered both elements (Cabinet-level department and MedPAC reviews) to be part of a single model, either mechanism could be an initial step in reform.

DEBATES ON HEALTH REFORM PROVIDE an opportunity to reexamine the underlying structures for decision making that, if uncorrected, could undermine even well-designed policy changes. Provider payment is an example of both the current vulnerability of Medicare policy to political influence and the opportunity for alternative models to better support the ambitious delivery system reforms that policymakers have proposed.

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