

GAUGING THE COST OF LOOPHOLES: HEALTH CARE PRICING AND MEDICARE REGULATION IN THE POST-ENRON ERA

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I. INTRODUCTION

Tax loopholes are an accepted, almost sacred part of government taxation. Rational taxpayers seek to minimize the amount that they owe to the government by learning the intricacies of the tax code, including the loopholes.¹ Complex regulatory programs, such as Medicare, Medicaid, and other public benefits programs similarly are characterized by intricate regulations inevitably containing loopholes that program participants may use to their advantage.² As a matter of individual wealth or profit

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1. See, e.g., David Cay Johnston, *The Loophole Artist*, N.Y. TIMES MAG., Dec. 21, 2003, at 18 (discussing Jonathan Blattmachr, a partner at Milbank, Tweed, Hadley & McCloy, whose career is built on finding tax code loopholes); Allan Sloan, *Tax Tricks: No Matter How Many Tax Loopholes Get Closed, Corporate America Always Seem to Find New Ones; This Time It's 'Cash Rich Split-offs'*, NEWSWEEK BUS., Oct. 26, 2004 (“When it comes to creating the most-efficient manufacturing plants or fuel-efficient cars, we in the United States still lag behind other countries. But when it comes to creating tax-efficient corporate transactions, we continue to lead the world.”), at <http://www.msnbc.msn.com/id/6337705/site/newsweek>; Kaja Whitehouse, *Learn the Ropes, and Loopholes, for Gifts to Family*, WALL ST. J., Dec. 17, 2003, at D2 (recommending that “[i]f you plan to give assets to family members this holiday season, keep in mind the tax rules and loopholes that can guide your giving”); Welcome to Diane Kennedy’s Tax Loopholes (advertising that the “full service CPA firm develops legal tax solutions for your unique circumstances that will dramatically reduce your taxes”), at <http://www.taxloopholes.com> (last visited Nov. 21, 2005).

2. See, e.g., Sarah Lueck, *Creative Accounting for Medicaid: Bush Budget Proposal Targets Loopholes That States Use to Garner More Federal Funds*, WALL. ST. J., Feb. 24, 2005, at A4 (quoting the head of the Alabama Medicaid program who suggested that the state’s success in garnering federal funding by

maximization, it seems irrational for a taxpayer, health care provider, or welfare beneficiary not to take advantage of regulatory loopholes as long as the potential gains outweigh the potential losses or liability. But widespread use of loopholes may come to be regarded as unfair or “cheating.” In addition, allowing individuals and businesses to take advantage of unintended loopholes can distort regulatory incentives and result in misallocation of government resources.

The public and government respond to the existence of loopholes inconsistently. Sometimes loopholes remain open and become accepted as part of the regulatory scheme, along with the affirmative regulations. Other times, public pressure, shifting priorities, policy trends, or reform efforts drive the government to crack down on longstanding “sacred cows.”³ Because individuals and businesses come to rely on loopholes as part of the institutional structure under which they operate, regulators should take care and apply the same measured, rational, cost-benefit analysis in closing longstanding loopholes as applied in promulgating new rules. When regulators do not approach closing loopholes deliberately but instead react to public perceptions of “cheating,” the response may exacerbate rather than remedy the perceived problem.

This Article provides a detailed case study, in the Medicare

taking advantage of Medicaid loopholes “is exactly what all of us do when we do our income taxes every year: We looked at the law and used the law to our advantage.”); Robert Pear, *Health Secretary Calls for Medicaid Changes*, N.Y. TIMES, Feb. 2, 2005, at A12 (quoting new Health & Human Services Secretary Michael O. Leavitt who announced sweeping changes to Medicaid and observed that “[r]ight now, many older Americans take advantage of Medicaid loopholes to become eligible for Medicaid by giving away assets to their children”); Ellen E. Schultz & Theo Francis, *U.S. Drug Subsidy Benefits Employers*, WALL ST. J., Jan. 8, 2004, at A3 (describing a “little-noticed provision,” or loophole, in the new Medicare prescription drug law that allows employers to collect a federal subsidy based on both employer and retiree expenditures); *see also* Editorial, *The Real Tenet Scandal*, WALL ST. J., Dec. 31, 2002, at A14 (discussing the pervasiveness of Medicare loopholes); Editorial, *Tenet’s Shareholder Ills*, WALL ST. J., Jan. 9, 2003, at A10 (“After all, Tenet wasn’t doing anything illegal in profiting from Medicare’s infinite flaws, and it could have continued to do so in the many months it will take for the bureaucracy to churn out yet a new regulation.”).

3. *See* Jonathan Fuerbringer, *Gauging the Cost of a Loophole*, N.Y. TIMES, Nov. 14, 2004, at B8 (observing that tax reform will likely require the administration to attack two “sacred cows,” namely deductions for mortgage interest and charitable contributions or “do an exceptional job of removing almost every other loophole”); *see also* Lueck, *supra* note 2, at A4 (“When the nation’s governors go to the White House on Monday, they are likely to deliver a blunt message to President Bush: Keep your hands off our Medicaid loopholes.”).

context, of public pressure to close loopholes distorting market incentives and regulatory program design and proposes certain measures to prevent similar results in the future. Drawing on behavioral law and economics literature, this Article examines the post-Enron experience of Tenet Healthcare Corporation, a prominent for-profit health care provider. Before Enron, market watchers generally praised Tenet for its efficiency and innovations in for-profit health care delivery, a model that was becoming increasingly important as health care policymakers urged privatization as a way to address skyrocketing health care costs. But after Enron, the public grew suspicious of profitability and looked for alternative explanations for high earnings. In Tenet's case, the alternate explanation was a special payment adjustment under the Medicare program—the outlier “loophole.”

II. RISK PERCEPTION AND REGULATION

In the unique post-Enron culture, the public may have overestimated the risks posed by corporate competition and strategic conduct, including use of longstanding loopholes. The result, particularly in the health care context, damaged the industry and ultimately harmed consumers. The phenomena of the public's judgment errors and other misperceptions of relevant risks distorting government priorities are well documented.⁴ In particular, people may overestimate the threat posed by a particular business practice or private conduct. They may clamor for new regulations or legislative changes based on high-profile, especially salient, or readily “available” examples of a perceived problem. But the public may inaccurately perceive the risk and fail to comprehensively appreciate the consequences of government intervention.⁵ The resulting legislation may be “bad policy” in terms

4. The literature on behavioral law and economics, casting doubt on the classical “rational actor” economic model, is ample. See, e.g., Christine Jolls et al., *A Behavioral Approach to Law and Economics*, in BEHAVIORAL LAW & ECONOMICS 14 (Cass R. Sunstein ed., 2000) [hereinafter Jolls et al., in SUNSTEIN] (noting that there are “three important ‘bounds’ on human behavior [i.e., bounded rationality, bounded willpower, and bounded self-interest] that draw into question the central ideas of utility maximization, stable preferences, rational expectations, and optimal processing of information”); Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1476 (1998) [hereinafter Jolls et al., *A Behavioral Approach*] (noting, before Sunstein's book, that “[t]he task of behavioral law and economics, simply stated, is to explore the implications of *actual* (not hypothesized) human behavior for the law. How do ‘real people’ differ from *homo economicus*?”).

5. See Timur Kuran & Cass R. Sunstein, *Availability Cascades and Risk Regulation*, 51 STAN. L. REV. 683, 685 (1999) (defining “availability heuristic” as “a pervasive mental shortcut whereby the perceived likelihood of any given

of promoting efficiency or reducing risks.⁶ Scholars propose various solutions to problems of judgment-error risk regulation, including “rationalizing” bureaucracy and creating a group of civil servants insulated from public pressure with special expertise and authority to work across agency lines.⁷

A clear example of the public’s judgment errors distorting regulatory agendas and potentially producing more harm than good occurred in late 2000 and early 2001 following the widely reported sagas of Enron, WorldCom, Adelphia, Tyco, and other unprecedented corporate accounting scandals, management malfeasance, and bankruptcy filings.⁸ The public’s post-Enron

event is tied to the ease with which its occurrence can be brought to mind,” describing “availability cascades,” and stating that “resulting mass delusions may last indefinitely and . . . produce wasteful or even detrimental laws and policies”); see also Michael Abramowicz, *Information Markets, Administrative Decisionmaking, and Predictive Cost-Benefit Analysis*, 71 U. CHI. L. REV. 933, 966 (2004) (describing Kuran and Sunstein’s availability theory as that “which refers to the tendency of people to think that events are more likely to occur than the statistics suggest because they can recall past examples of such events”). See generally Christopher R. Drahozal, *A Behavioral Analysis of Private Judging*, 67 LAW & CONTEMP. PROBS. 105 (2004) (discussing the effect of judgment errors in arbitral decisionmaking).

6. See STEPHEN BREYER, *BREAKING THE VICIOUS CIRCLE: TOWARD EFFECTIVE RISK REGULATION* 10-11 (1993) (suggesting that regulatory priorities are not based on rational cost-benefit analysis but plagued by judgment errors, principally tunnel vision, random agenda selection, and inconsistency); Jolls et al., *A Behavioral Approach*, *supra* note 4, at 1518 (“When beliefs and preferences are produced by a set of probability judgments, made inaccurate by the availability heuristic, legislation will predictably become anecdote-driven.”); Cass R. Sunstein, *Cognition and Cost-Benefit Analysis*, 29 J. LEGAL STUD. 1059, 1059 (2000) (advocating cost-benefit analysis to not only promote economic efficiency but also correct judgment errors).

7. See, e.g., BREYER, *supra* note 6, at 55-63 (proposing to attack the “vicious circle at its weakest point, the regulatory link, and to change the circle’s dynamics”).

8. See, e.g., Ken Brown, *Company Blowups Abound, Rebounds Rare*, WALL ST. J., Jan. 2, 2003, at R2 (noting that “in 2002, with every major sector . . . down, the standouts are the train wrecks, such as WorldCom Inc., Tyco International Ltd., and Adelphia Communications Corp”); Verne Kopytoff, *Year in Review, Annus Horribilis; Corporate Scandals, Lingering Recession Made 2002 Truly Horrible Year*, S.F. CHRON., Dec. 29, 2002, at G1 (listing business episodes during 2002); see also Larry E. Ribstein, *Market vs. Regulatory Responses to Corporate Fraud: A Critique of the Sarbanes-Oxley Act of 2002*, 28 J. CORP. L. 1, 2 (2002) (noting that the “spectacular crashes and frauds of Enron, WorldCom, and other companies, including Sunbeam, Waste Management, Adelphia, Xerox, and Global Crossing” have reinvigorated debate about government regulation of corporations and efficient market theory); Note, *The Good, the Bad, and Their Corporate Codes of Ethics: Enron, Sarbanes-Oxley, and the Problems with Legislating Good Behavior*, 116 HARV. L. REV.

enthusiasm for regulation of private industry invigorated lawmakers, who passed new laws, such as the Sarbanes-Oxley Act.⁹ Regulators responded to the mounting public pressure by adjusting enforcement priorities, attacking previously overlooked loopholes, and fast-tracking new policies. The resulting quick fixes, however, failed to fully consider long-term market risks and, in some cases, deterred otherwise beneficial business innovations and practices.

Health care providers were not spared from the post-Enron corporate clean-up campaign. Long-recognized practices and notorious loopholes suddenly came under scrutiny, causing health care providers to react and retool existing business models and strategies in ways that reduced their own revenue and, ultimately, the availability of medical services generally.¹⁰ The American health care system is an instructive context for examining the problems of agencies regulating in response to public pressure instead of deliberately weighing the costs and benefits of a particular policy.¹¹ Health care regulation in the United States is tricky because of the dual markets for medical care. Health care is paid for by both private dollars, through employer health plans and private

2123, 2123 (2003) [hereinafter Note, *The Good, the Bad*] (listing recent corporate governance scandals).

9. Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, 116 Stat. 745 (codified in scattered sections of 11, 15, 18, 28, and 29 U.S.C.); see Larry E. Ribstein, *SarbOx: The Road to Nirvana*, 2004 MICH. ST. L. REV. 279, 293 (2004) (describing the panic that led to the passage of Sarbanes-Oxley as an example of “Sudden Acute Regulatory Syndrome” that follows market bubble bursts, in which “investor heuristics . . . support unreasonable pessimism about markets and optimism about regulation” and noting that “[f]raud becomes the media story of the day, magnified through the ‘availability’ heuristic”).

10. See, e.g., Nina Owcharenko, *Congress Should Get Serious About Medicaid*, HERITAGE FOUND. POL’Y RES. & ANALYSIS (Mar. 30, 2005), available at <http://www.heritage.org/Research/HealthCare/wm705.cfm>

11. See BREYER, *supra* note 6, at 57 (noting that, among other factors, the “[c]ongressional tendency to respond quickly and directly to public perceptions . . . all work[s] against the development of a more systematic, coordinated approach to regulating risks”); Abramowicz, *supra* note 5, at 966 (suggesting that cost-benefit analysis “prevents bad policies, which are policies whose costs, if enacted, would exceed their benefits”); Kuran & Sunstein, *supra* note 5, at 737 (noting that resisting public pressure, at times, is consistent with the ideal of deliberative democracy as “[a] principal point of the original Constitution was to ensure that representatives ‘refine and enlarge’ popular sentiment, rather than automatically translate it into law”); Sunstein, *supra* note 6, at 1065-66 (suggesting that, given the public’s judgment errors, “a highly responsive government is likely to blunder” and that “cost-benefit analysis should be taken not as undemocratic but, on the contrary, as a means of fortifying (properly specified) democratic goals, by ensuring that government decisions are responsive to well-informed public judgments”).

insurance, and government dollars, through programs like Medicare and Medicaid.¹² An intricate web of regulations and incentives define the government health care programs. Tugging on a strand to close one loophole risks unraveling another strand of regulations and private market incentives elsewhere in the system, compromising the overall scheme.¹³ Program changes must be made deliberately, not reactively, to avoid unintended results that endanger the nation's overall health care system.

Traditional law and economics theory operates from the premise that individuals act rationally to further their own individual self-interest and, by so doing, increase the overall level of wealth in society.¹⁴ Behavioral law and economics questions the traditional

12. The United States government is the single largest purchaser of health care services in the country. *See, e.g., Waste, Fraud, Abuse, and Mismanagement: Hearings Before the Task Force on Health of the House Comm. on the Budget*, 106th Cong. 178 (2000) [hereinafter *OIG Statement*] (prepared statement of the Office of Inspector General, Dep't of Health & Human Servs.) (stating that the Health Care Financing Administration is largest health care purchaser in the world); *see also* Thomas R. McLean, *Crossing the Quality Chasm: Autonomous Physician Extenders will Necessitate a Shift to Enterprise Liability Coverage for Health Care Delivery*, 12 HEALTH MATRIX: J. L.-MED. 239, 255 (2002) (noting that the federal government is the largest purchaser of health care services). The federal government also pays for health care for the Federal Employees Health Benefits Program ("FEHBP") and Department of Veterans Affairs ("VA"). States may also cover state employees' health insurance and provide other welfare programs, including the State Children's Health Insurance Program ("CHIP").

13. *See, e.g., Stephenson v. Shalala*, 87 F.3d 350, 356 (9th Cir. 1996) ("Medicare and Medicaid are enormously complicated programs. The system is a web; a tug at one strand pulls on every other."); *cf. Am. Lithotripsy Soc'y v. Sullivan*, 785 F. Supp. 1034, 1036 (D.D.C. 1992) ("The Court lacks the expertise to decide whether or not agency action, especially in fields as arcane and specialized as Medicare law and medical procedures, is reasonable, unless it has the benefit of adversarial discussion in the rulemaking record. Similarly, the agency itself cannot function properly without having the benefit of such comments before it makes any final decisions.").

14. Modern microeconomic theory suggests that, as individuals or firms undertake to increase their own self-worth, they increase wealth for society overall. *See* James M. Buchanan, *Rent Seeking and Profit Seeking*, in *TOWARD A THEORY OF THE RENT-SEEKING SOCIETY* 1, 4 (James M. Buchanan et al. eds., 1980) ("Since Adam Smith, we have known that the profit-seeking activity of the butcher and baker ensures results beneficial to all members of the community."); ADAM SMITH, *THE WEALTH OF NATIONS* bk. IV, ch. II, 484-85 (Edwin Cannan ed., The Modern Library 2000) (1776) (noting that the individual "neither intends to promote the public interest, nor knows how much he is promoting it[,] . . . and[,] by directing that industry in such a manner as its produce may be of the greatest value, he intends only his own gain, and he is in this, as in many other cases, led by an invisible hand to promote an end which was no part of his intention").

assumptions, drawing on empirical evidence demonstrating how people “really” act.¹⁵ That evidence suggests that people do not always act rationally, seeking to maximize utility from a stable set of preferences, based on optimal information and other inputs.¹⁶ The literature identifies three “bounds” on human behavior—bounded rationality, bounded willpower, and bounded self-interest—to explain how “real people” differ from the paradigmatic rational actor.¹⁷ The public’s over-reaction and regulators’ flawed responses in the wake of Enron and similar high-profile episodes demonstrate the first bound—bounded rationality.

Bounded rationality describes the obvious limits on human cognitive abilities. We are not omnipotent or perfectly intellectually adept. Given our limited brain power, we rely on mental shortcuts and rules of thumb, which are rational strategies in terms of economizing thinking time. But those remedies can lead to judgments that differ markedly from what would be expected under the rational actor model.¹⁸ One shortcut, or heuristic, involves estimating the likelihood of a particular event based on how easy it is to recall similar instances, i.e., the availability of other examples of the same event.¹⁹ The “availability heuristic” causes people to conclude that an event is more likely to occur if they have recently witnessed a similar occurrence than if they do not have a recent example to draw on.²⁰ But still, the likelihood of an event occurring based on availability may differ markedly from predictions based on

15. See Jolls et al., *A Behavioral Approach*, *supra* note 4, at 1471 (noting that “[e]conomic analysis of law usually proceeds under the assumptions of neoclassical economics. But empirical evidence gives much reason to doubt these assumptions.”); see also BREYER, *supra* note 6, at 35-36 (describing several examples that psychologists have identified as impeding rational understanding); Abramowicz, *supra* note 5, at 966-97 (summarizing Sunstein’s identified “predictable problems in individual and social cognition,” meaning the “heuristics that cognitive psychologists have identified as producing systematic biases in human decisionmaking, as well as the social dynamics that can cause group decisionmaking to err”). See generally Jolls et al., *in* SUNSTEIN, *supra* note 4, at 13-58 (providing an overview of the behavioral approach).

16. Jolls et al., *A Behavioral Approach*, *supra* note 4 at 1476 (summarizing Gary Becker’s description of standard economic principles).

17. *Id.* at 1476-77 (noting that each bound “represents a significant way in which most people depart from the standard economic model” and recognizing that “[a]ll three bounds are well documented in the literature of other” disciplines but not economics).

18. *Id.* at 1477-78; see also BREYER, *supra* note 6, at 35 (suggesting that rules of thumb and other departures from “rational” decisionmaking “may have helped us survive as we lived throughout much of prehistory, in small groups of hunter-gatherers, depending upon grain, honey, and animals for sustenance”).

19. Jolls et al., *A Behavioral Approach*, *supra* note 4, at 1477.

20. *Id.*

unbiased information. Drawing on “availability” to predict risks can produce judgment errors.²¹ People “overestimate the number of deaths from highly publicized events (motor vehicle accidents, tornados, floods, botulism) but underestimate the number from less publicized sources (stroke, heart disease, stomach cancer).”²² Those availability errors can be costly for society by directing resources and regulation toward the perceived risks, away from the risks that are, in reality, more serious.

As individuals interact in society, their judgments and biases tend to influence others’ perceptions. When one person communicates, through words or actions, his or her individual risk assessment of an event, he or she provides information on which others may base their judgments. As more and more people rely on that data to develop and express their perceptions, the availability of the example in the public’s mind increases, leading to an “availability cascade.”²³ The classic example of an availability cascade is the Love Canal example, in which residents expressed concerns about the health effects from a nearby hazardous waste dump to their neighbors, others in the region, and the nation through media and other widely disseminated reports. The perceived Love Canal threat led to mass relocations and, eventually, passage of the Superfund statute, despite the absence of any good scientific evidence validating residents’ initial safety concerns.²⁴

The social processes that produce availability cascades include informational and reputational cascades. When people lack adequate private information about a particular danger or risk, they rely heavily on information and data communicated from others.

21. *Id.* at 1477-78.

22. Sunstein, *supra* note 6, at 1065.

23. See Kuran & Sunstein, *supra* note 5, at 685 (suggesting that the availability heuristic “interacts with identifiable social mechanisms to generate *availability cascades*—social cascades, or simply cascades, through which expressed perceptions trigger chains of individual responses that make these perceptions appear increasingly plausible through their rising availability in public discourse”); see also Abramowicz, *supra* note 5, at 966-67 (describing the availability cascade as “a vicious cycle in which an event leads individuals to overestimate a risk, in turn affecting public discourse, which then exacerbates the initial overestimation”).

24. See Abramowicz, *supra* note 5, at 967 (describing Kuran and Sunstein’s Love Canal example, “in which residents’ concerns about environmental contamination from a toxic waste dump snowballed” despite the “relatively small risk” actually posed by toxic waste dumps); Kuran & Sunstein, *supra* note 5, at 691-98 (detailing the Love Canal episode as an example of costly availability error and describing others, e.g., Alar pesticide, which led to the plummeting demand for apples, and the TWA Flight 800 crash, which led to the creation of the White House Commission on Aviation, Safety, and Security).

For example, if someone living close to a hazardous waste site perceives an increased risk of cancer associated with the site, a person living far away, lacking direct experience with hazardous waste, may go along with the belief.²⁵ As more and more people come to accept a certain belief simply because they think other people accept it, an informational cascade results. Reputational concerns also affect how people perceive and express their beliefs. The desire to earn social approval or avoid disapproval may lead a person to express certain popularly held views while not sharing dissenting views.²⁶ An individual may be reluctant to express doubts about the perceived risk in the face of a consensus because the dissenter fears being seen as indifferent or uncaring if most others are upset, or being seen as cowardly or confused if most others are unconcerned.²⁷

Availability cascades may be stoked by “availability entrepreneurs.” Availability entrepreneurs are individuals, government officials, media, nonprofit organizations, businesses, and other interested parties who understand the dynamics of availability cascades and attempt to trigger cascades to advance their own interests.²⁸ By drawing the public’s attention to a particular problem, event, or example, availability entrepreneurs attempt to drum up support for specific reforms. For example, environmental organizations drew attention to examples such as Love Canal or Chernobyl to gather support for environmental legislation, such as Superfund.²⁹ Similarly, competitors or consumers could point to Enron and similar incidences of managerial malfeasance to gather support for new corporate

25. See Kuran & Sunstein, *supra* note 5, at 720 (describing informational cascades and noting that most people form risk judgments and policy preferences through very limited information); Sunstein, *supra* note 6, at 1066 (describing the process by which one person’s statement creates an “informational externality,” or signal, that proves relevant data to others and leads to an informational cascade).

26. See Kuran & Sunstein, *supra* note 5, at 727-30 (discussing reputational and other social pressures that cause individuals to tailor public expressions to public expectations); Sunstein, *supra* note 6, at 1067 (noting that reputational concerns, fueled by the availability heuristic, may lead the public to demand regulation for risks that are relatively low while ignoring relatively high magnitude risks).

27. Sunstein, *supra* note 6, at 1067 (“If many people are alarmed about some risk, you may not voice your doubts about whether the alarm is merited, simply in order not to seem obtuse, cruel, or indifferent. And if many people believe that a certain risk is trivial, you may not disagree through words or deeds, lest you appear cowardly or confused.”).

28. Kuran & Sunstein, *supra* note 5, at 687.

29. *Id.* at 687-88 (describing availability entrepreneurs).

responsibility laws, such as Sarbanes-Oxley. Availability campaigns may benefit society by focusing attention on long-festering but ignored problems; however, they also can be harmful by redirecting societal resources to relatively trivial concerns.

As the Superfund example illustrates, setting regulatory priorities based on available examples and availability cascades, instead of on unbiased data on the actual probability of certain occurrences, may result in resource misallocation, or “bad policies.”³⁰ Superfund is “bad policy” in the sense that critics view it as one of the most expensive and least effective environmental statutes, given the relatively small risk posed by toxic waste.³¹ In addition to producing too much or inappropriate regulation, availability cascades may produce legislation that fails to reduce, or actually increases, the same type of risks sought to be reduced or exacerbates problems elsewhere.³²

Similarly, public perceptions and regulatory responses that led to Sarbanes-Oxley and similar laws passed in the post-Enron era demonstrate the “bad policy” that judgment biases and cascade effects tend to produce. In an already falling market, highly salient and widely publicized examples of corporate fraud led the public to overestimate the relevant risks and push for legislation that further cooled the economy.³³ As one critic noted, “[r]evelations of corporate fraud coincided with public anxiety over the economy and populist sentiments condemning the insiders who took great wealth out of now-fallen companies.”³⁴ Just like the Love Canal example, the media contributed to the cascade effect by continuously reporting and reinforcing the available examples of corporate fraud, even

30. See Abramowicz, *supra* note 5, at 966 (defining “bad policies” as “policies whose costs, if enacted, would exceed their benefits”).

31. See *id.* at 967 (noting critics’ views of Superfund); Kuran & Sunstein, *supra* note 5, at 697-98 (noting the negligible health risk posed by Superfund sites, compared with other risks, and suggesting that had resources devoted to Superfund been devoted to other risks, “there could have been major benefits as measured in, say, life-years saved”).

32. See Sunstein, *supra* note 6, at 1068-70 (noting the problem of “health-health trade-offs,” deriving from the fact that the public and regulators tend to “bracket” risks rather than appreciating systemic effects and recommending cost-benefit analysis as solution); see also BREYER, *supra* note 6, at 22 (discussing several examples of regulators ignoring the external effect of one intervention on another problem and suggesting the need for inter-program coordination).

33. See Ribstein, *supra* note 8, at 46-48 (discussing the role of the availability heuristic in shaping public perceptions, ultimately leading to the passage of Sarbanes-Oxley Act).

34. *Id.* at 46.

suggesting a unifying, ongoing saga to draw in readers.³⁵ Availability entrepreneurs, including the targeted corporations' competitors, market analysts, fund managers, lawyers, regulators, and other interest groups also played a role, directing the public's attention and scrutiny toward unusually profitable companies or firms that continued to thrive even in the post-bubble market. Reacting to public outrage and seeking distance from unseemly Wall Street profiteers, Congress quickly passed new laws and regulators announced sweeping new fraud initiatives. But in so doing, lawmakers failed to adequately balance the costs and benefits of the reforms, including long-term market effects.³⁶

Tenet's experience in the aftermath of Enron provides a clear example of the confluence of judgment errors, availability cascades, and misguided policy reform. Enron and other companies provided readily available examples of apparently innovative and highly successful companies that, upon further examination, turned out to have derived their remarkably high profits not from astute business practices but rather from fraudulent schemes or questionable transactions. Likewise, the public and market analysts had viewed Tenet as a productive model of private, for-profit medicine. But that positive perception shifted rapidly in the post-Enron era. In the context of Enron and other corporate scandals, the public easily accepted the intimations of availability entrepreneurs that Tenet derived its high revenues not from legitimate market strategies but from shady dealings—in particular, exploiting Medicare loopholes.

To the extent that the public was already leery of the idea of a company making a profit from providing medical treatment, Tenet's aggressive strategies and robust earnings confirmed suspicions and drew scrutiny. But the risks associated with competition and profit-motivation in health care delivery may not be as great as the public perceived. The reforms demanded of health care providers, generally, and Tenet, in particular, in the post-Enron era squelched some private market innovations. Those strategies could have offered solutions to persistent problems of access, quality, efficiency, and cost containment in health care delivery. Under the Bush Administration's trend toward privatization of traditional welfare

35. *Id.* at 47 (suggesting that “media’s profit incentive to sell the story of corporate fraud as a continuing saga of wrongdoing that readers or viewers follow everyday rather than as discrete events”).

36. *See id.* at 47 (noting that “the hasty adoption of the Sarbanes-Oxley Act in the midst of a stock market crash was even less conducive to careful weighing of costs and benefits than the circumstances surrounding typical legislation”); Ribstein, *supra* note 9, at 293 (suggesting that “voters and politicians looking for a quick fix to market ills may ignore regulation’s long-term risks to markets”).

programs, the existence of the reliable, competitive, private market strategies on which to draw as models for government programs will be essential to the success of any reforms.³⁷

III. TENET CASE STUDY

Tenet Healthcare achieved market prominence through a variety of innovative and successful strategies. Aspects of Tenet's business model also allowed the company to collect special payments from Medicare, the federal health care program for the elderly and disabled.³⁸ Although Tenet does not appear to have violated Medicare program rules or guidance in collecting those special payments, the post-Enron public distrusted profitability and pointed to the special Medicare payments as an alternate, illegitimate source of Tenet's success. Tenet's rise and fall highlights the costly effects of regulating the complex American health care delivery system based on public risk perceptions.

Public outrage over the Medicare loophole and other perceived abuses pushed Tenet to abandon various successful business strategies. Regulators scrambled to respond to the public by cracking down on providers garnering extra revenue through a well-known, longstanding loophole in the Medicare payment system. Society paid dearly in both administrative resources expended and in the loss of potentially instructive health care delivery innovations. Instead, had health care regulators been given space to deliberate and assess the systemic effects of any proposed changes, more pressing regulatory flaws may have been identified and addressed to the benefit of the overall system.

Tenet is the second largest hospital holding company in the United States, after Hospital Corporation of America, or HCA.³⁹ When the Enron story hit newsstands, Tenet owned 114 facilities across the country, concentrated in the West and Southwest.⁴⁰

37. See Jackie Calmes, *In Bush's 'Ownership Society,' Citizens Would Take More Risk*, WALL ST. J., Feb. 28, 2005, at A1 (describing President Bush's "ownership society" that would fundamentally alter New Deal and Great Society welfare reforms by requiring citizens to bear greater financial risk and responsibility, including moving Medicare and Medicaid to the "share-the-risk model of group insurance . . . in which individuals shop for health care much like anything else, seeking the best prices and products among competing providers").

38. Reed Abelson, *U.S. to Review Big Payments for Medicare*, N.Y. TIMES, Nov. 13, 2002, at A1.

39. See Neil Weinberg, *Healing Thyself*, FORBES, Mar. 17, 2003, at 64 (discussing the two corporations' relative market shares).

40. Press Release, Tenet Healthcare Corporation, Tenet Receives Subpoenas Regarding Relocation Agreements (July 15, 2003), at <http://>

Tenet rose to market prominence by employing aggressive, competitive, for-profit strategies that were relatively unfamiliar to medical services providers.⁴¹ By all accounts, Tenet was a model for-profit health care company, in the classic model of a rational profit-maximizing firm. For a time, analysts and policymakers touted Tenet specifically, and proprietary hospitals generally, as the salve for the broken American health care system.⁴² Eventually, however, Tenet and hospitals employing similar strategies were “vilified as greedy and corrupt.”⁴³ Tenet’s once-touted practices drew scrutiny and renewed underlying discomfort and skepticism about the appropriateness of profiting off of sickness, death, and need.

A. *Tenet’s Rise*

Until October 2002, by all objective measures, Tenet was “a Wall Street darling,”⁴⁴ hailed as a successful, efficient competitor that employed savvy business strategies to generate remarkable

www.tenethealth.com/TenetHealth/PressCenter/PressReleases/Tenet+Receives+Subpoenas+Regarding+Relocation+Agreements.htm.

41. See, e.g., Brown, *supra* note 8, at R2 (noting that Tenet “had been an investor’s darling because of its solid fundamentals and strong growth”); Weinberg, *supra* note 39, at 64 (noting that “HCA was a free-market crusader, growing feverishly by acquisition and dazzling Wall Street”). Cf. Bernard Wysocki Jr., *To Fix Health Care, Hospitals Take Tips From Factory Floor*, WALL ST. J., Apr. 9, 2004, at A1 (discussing trend of hospitals’ adopting production techniques from automotive assembly lines).

42. Laurence Darmiento, *Prescription for Profit: Tenet Healthcare Boosts Revenues, Influence by Adding Patient Services*, L.A. BUS. J., Apr. 15-21, 2002, at 1 (quoting the chief of staff whom Tenet recruited away from a neighboring non-profit hospital regarding Tenet’s “bare bones” efficiency demands: “They run it like a business and in this day medicine has to be run like a business.”); Rhonda L. Rundle, *Tenet Healthcare, After Cleaning House, Seeks Purchases: Company Now Posting Record Cash Flow, Is a Bidder on Four Big Hospitals*, WALL ST. J., Mar. 22, 2001, at B6 (noting that Tenet sought to acquire hospitals in financial trouble, “a plight that characterizes more than a third of the nation’s 5,000 hospitals” and that “hospitals’ woes come at a time when ‘we [Tenet] have a lot of capital to put to work’”) (quoting Tenet officer in charge of acquisitions); Charles Yoo, *Tenet Stopping Bleeding at South Fulton Medical*, ATLANTA J.-CONST., Feb. 11, 2002, at E6 (“For now, the bleeding has stopped at South Fulton, thanks to privatization—the CPR that brought back the hospital from the brink of death.”).

43. Weinberg, *supra* note 39, at 64 (regarding HCA); *id.* at 65 (discussing allegations against Tenet for over-billing federal health care programs); see, e.g., Kopytoff, *supra* note 8, at G1 (“Revelations about Tenet Healthcare painted a picture of a company that specialized in high prices.”).

44. Darmiento, *supra* note 42 (describing Tenet as “the envy of the industry” and “a Wall Street darling”); Yoo, *supra* note 42, at 1 (quoting an Emory University health policy professor: “[Tenet] ha[s] been Wall Street’s darlings. Their revenues are way up.”).

growth⁴⁵ in an otherwise weak economy.⁴⁶ Tenet focused on core operations in acute-care hospitals.⁴⁷ The company abandoned its old vertical integration model by reducing satellite operations, such as dialysis, home health, physician practices, and health plans.⁴⁸ The strategy shifted to horizontal integration in key markets by acquiring struggling hospitals,⁴⁹ including community hospitals,⁵⁰

45. *Tenet's Profit Rises 30%, Beating Forecasts*, L.A. TIMES, Jan. 5, 2001, at C2 [hereinafter *Beating Forecasts*] (quoting bank analyst: "The quarter was truly spectacular by any measure"); Barbara Kirchheimer, *Greater Expectations: Tenet Says It Will Beat Street's Earnings Estimates*, MODERN HEALTHCARE, June 18, 2001, at 46 (quoting Advest analyst regarding Tenet's particularly strong quarterly increase in admissions: "It's a pleasant surprise, but not a shock The company has been doing very well for quite a while."); Andy Pasztor, *Tenet Profit Climbs 41% to \$280 Million, and Full-Year Forecast Is Boosted Again*, WALL ST. J., Apr. 3, 2002, at B10 (quoting a Lehman Brothers analyst's observation that "Tenet shares still 'continue to have a lot of sizzle' because of the company's reputation for tight management"); *The Money Gang: Stock of the Day: Tenet Healthcare* (CNNfn television broadcast) (Oct. 2, 2002) [hereinafter *The Money Gang*] ("This is where we tap dance about Tenet Healthcare."); see also James Bandler, *Jump in Operating Profit Linked to Stronger Pricing*, WALL ST. J., Oct. 4, 2001, at B9 ("Tenet . . . expected earnings per share to significantly exceed analysts' expectations.").

46. See Don Lee, *Tenet Says Earnings Will Top Estimates*, L.A. TIMES, Sept. 24, 2002, at C2 (noting that Tenet "has outperformed the overall hospital sector" and "has been beating analysts' expectations"); Jeff D. Opdyke & Michelle Higgins, *Will You Get a Bonus This Year? Surprisingly, Some Companies Are Paying More Than Last Year, But Wall Street and Tech Suffer*, WALL ST. J., Oct. 22, 2002, at D1 (noting that Tenet already paid higher bonuses than previous year "after racking up profits of more than \$1 billion for fiscal 2002, . . . an increase of more than 50% from a year ago"); *The Money Gang*, *supra* note 45 (summing up investors' attitude toward Tenet as: "I want to own this stock. Because most everything on Wall Street I don't want to own right now.").

47. Pasztor, *supra* note 45, at B10 (quoting Tenet CEO Jeffrey C. Barbakow as saying that Tenet is reaping the benefits of "years spent developing a strong portfolio of hospitals and honing our internal processes"); *The Money Gang*, *supra*, note 45 (attributing strong performance, in part, to the "shift in [Tenet's] business mix to acute care services" and "divest[ing] non-core businesses").

48. Darmiento, *supra* note 42 (noting that Tenet "got out of a half dozen sidelights . . . [to] focus on its core business of running hospitals"); *The Money Gang*, *supra* note 45 ("This is a company that's benefited in a significant way from paring the non-core businesses, the physician practices, the health plans, home health operations, etc cetera [sic].").

49. Darmiento, *supra* note 42 (noting that Tenet opened a competing heart hospital near a lagging facility with a second-rate cardiology program, recruited a competitor's cardiology chief of staff, and eventually purchased the competitor outright); Rundle, *supra* note 42, at B6 (noting that target hospitals are all in financial trouble, facing operating losses or break-even results, labor costs due to nursing shortage, and a lack of capital to invest in improved facilities and new technology).

non-profit facilities,⁵¹ and academic medical centers. With these takeovers, Tenet was praised for its turnaround successes,⁵² emphasis on efficiency,⁵³ and improved staff relations.⁵⁴ Horizontal integration also allowed Tenet to increase its market share,⁵⁵ which strength the company parlayed into favorable contract negotiations with commercial insurers and managed care companies.⁵⁶ Tenet was able to command “strong”⁵⁷ and “robust”⁵⁸ prices because of its market control and the overall high demand for its services.

50. Yoo, *supra* note 42 (discussing Tenet’s acquisition of vital community hospital for three growing cities and noting that “[n]ow that the hospital is no longer tax-exempt, it has become a new source of income for [one of the cities]”).

51. Darmiento, *supra* note 42 (noting that one physician was worried about going from non-profit to for-profit setting); *id.* (discussing a University of Southern California professor’s concern that Tenet’s take-over of a not-for-profit hospital would compromise charity care but concluding that “Tenet is not quite the bad operator he feared”); Rundle, *supra* note 42 (according to a UBS Warburg analyst: “Tenet’s low-key takeover of the Philadelphia system shows that the relationship between not-for-profits and the investor-owned companies is less adversarial than it was five years ago.”).

52. Yoo, *supra* note 42 (noting that Tenet is “known for buying ailing hospitals and turning them around”).

53. Darmiento, *supra* note 42 (noting Tenet’s “reputation as a cost cutter and consolidator”).

54. Yoo, *supra* note 42 (citing improved morale among doctors and nurses and quoting a physician staff president: “I think the main challenge [for Tenet] is that you have to create trust. You have to say that we’re here for a long run and we’re here to turn this place around, getting back to top quality care.”); *The Money Gang*, *supra* note 45 (concluding that Tenet has been “on the forefront of aggressively managing labor trends” and “getting at employee turnover and nurse satisfaction”). *But see* Darmiento, *supra* note 42 (discussing labor troubles from a nurses union and quoting a union representative’s concern that “Tenet’s well known hostility to registered nurses and hospital staff forming unions hurts patients and workers alike”).

55. Rundle, *supra* note 42 (quoting Tenet’s chief corporate officer in charge of acquisitions: “We need to grow our share in markets that we’re in”); *The Money Gang*, *supra* note 45 (noting that Tenet “did a number of very astute things,” including “building these multi-facility networks and single markets that’s really contributed to substantial market concentration”).

56. *Beating Forecasts*, *supra* note 45 (observing strong growth in revenue, including increases in admissions and revenue-per-patient admission); Darmiento, *supra* note 42 (noting that Tenet “sought to gain regional market share that would give it bargaining power to extract higher payments from managed care insurers”); *The Money Gang*, *supra* note 45 (assessing that market concentration has “really turned into pricing power”).

57. Kirchheimer, *supra* note 45, at 46 (quoting CEO Barbakow on “the continuing phenomenon of strong pricing trends combined with strong admissions trends” as a “potent combination”).

58. Bandler, *supra* note 45 (noting that Tenet is “spurred by robust price increases”); Anne Marie Chaker, *Converse Tech Sets Lower Estimates for*

Tenet was also a savvy investor, pumping capital earnings back into physical facilities and new technology at its existing and newly acquired hospitals, thereby improving the quality of care.⁵⁹ Tenet took advantage of its strong cash flow to significantly reduce its debt.⁶⁰ Market prominence and ownership of multiple facilities in the same location allowed the company to improve efficiency and reduce duplication of services⁶¹ through bulk purchasing of supplies and acquiring new high-technology equipment for one hospital to serve several facilities in the same geographic region.⁶² Tenet's strategy also included product differentiation, in particular, focusing on high reimbursement services, such as cardiology, orthopedics, and neurology.⁶³ Commitment to acute-care facilities and high technology services positioned Tenet to meet the demands of the growing "baby boomer" sector of health care consumers.⁶⁴ Improved

Quarter, Year: Tenet Healthcare Corp., WALL ST. J., July 12, 2001, at B6 (noting that Tenet attributed earnings "to robust price increases and admissions").

59. Pasztor, *supra* note 45 (noting Tenet's "continued heavy investment to upgrade recently acquired hospitals"); Yoo, *supra* note 42 (noting Tenet's acquisition of South Fulton Medical Center followed by \$30 million worth of repairs and improvements, including replacing ceilings, painting walls, replacing duct-taped carpet with tile, buying new equipment for various medical departments, and expanding the emergency department); *The Money Gang*, *supra* note 45 (noting that Tenet expects to reinvest \$1 billion in its hospitals this year).

60. Kirchheimer, *supra* note 45, at 46 (noting that Tenet paid off debt of \$689 million for the fourth quarter and \$1.5 billion for year); Lee, *supra* note 46, at C2 (attributing strong growth to reduced costs, including lower debt and interest payments).

61. Darmiento, *supra* note 42 (noting that Sister Carolita Hart, director of health affairs for the Los Angeles Archdiocese, became "convinced that [Tenet's] centers of excellence strategy make sense in an era of competitive and costly health care. 'You really cannot afford to have services duplicated.'").

62. Darmiento, *supra* note 42 (observing that Tenet "uses its heft to significantly lower purchasing costs for both routine supplies and advanced equipment, such as \$1 million CT scanners").

63. *Id.* (describing the strategy of establishing networks of hospitals that specialize in these services, dubbed regional "centers of excellence"); Kirchheimer, *supra* note 45, at 46 (noting a focus on these specialties); Rhonda L. Rundle, *Tenet's Net More Than Doubles; Earnings Projections are Boosted*, WALL ST. J., Oct. 3, 2002, at D5 (noting that Tenet attributed its continued strong performance to various factors, including a "shift in its business mix to special acute-care services, such as cardiology, orthopedics and neurology," which "generate higher revenue, and account for as much as one-half of unit revenue growth").

64. Darmiento, *supra* note 42 (noting that while these services "are expensive to set up, the future payoff is assured, given the 83 million baby boomers are aged 37 to 54" and quoting Barbakow's observation: "In your 50s you start using [cardiology, neurology, and orthopedic services] more than when

customer service was also part of the strategy.⁶⁵ Increased hospital admissions demonstrated that Tenet was providing services that the market strongly demanded.⁶⁶

B. Weakley Report

Perceptions of Tenet shifted radically based on a single Wall Street analyst's report. On October 28, 2002, Kenneth Weakley, a UBS Warburg health care analyst, raised questions about one aspect of Tenet's government health care program reimbursement and downgraded the stock from "hold" to "reduce."⁶⁷ Weakley's report demonstrated that Tenet's revenue share attributable to a special payment under the Medicare program—the outlier adjustment—was considerably higher than the company's competitors.⁶⁸ As discussed more fully below, the Medicare reimbursement methodology provides an add-on or "bonus" for the cost of caring for unusually expensive patients.⁶⁹ Weakley did not suggest that Tenet's earnings were overstated but expressed concern that the company was overly dependent on Medicare outlier adjustments.⁷⁰ In the prevailing climate of corporate scandals, accounting audits, congressional probes, and record-setting bankruptcy filings,⁷¹ Weakley's report was sufficient to initiate a

you are younger and it goes on from there."); Rundle, *supra* note 42 ("Tenet says its hospital admissions in the critical 51-to-60-year-old age group rose 12% in the second half of last year."); *The Money Gang*, *supra* note 45 ("Admission's [sic] growth was highest among baby boomers age groups.").

65. Kirchheimer, *supra* note 45, at 46 (noting a new "customer service initiative"); Yoo, *supra* note 42, at E6 (quoting an analyst's observation that Tenet committed capital "in improving services and facilities overall to make them more appealing").

66. *Beating Forecasts*, *supra* note 45, at C2 (noting analysts' observations that significant investments in facilities and equipment helped attract patients to Tenet's hospitals); Lee, *supra* note 46, at C2 (attributing strong revenue growth to "rising demand for more sophisticated and costly hospital services"); Rundle, *supra* note 42, at B6 (listing patient volumes and pricing as the two biggest revenue drivers); see also *The Money Gang*, *supra* note 45.

67. Laurence Darmiento, *Questions about Billings, Medicare Charges Have Tenet Stock in a Dive*, L.A. BUS. J., Nov. 4, 2002, at 3; Don Lee, *Tenet Shares Tumble 14% After Downgrade; An Analyst's Report Raises Questions About the Hospital Company's Medicare Reimbursement and Whether it Can Sustain its Stellar Growth*, L.A. TIMES, Oct. 29, 2002, at C1.

68. See Darmiento, *supra* note 67.

69. See *infra* Part IV (describing Medicare payment methodology and outlier adjustments).

70. See Darmiento, *supra* note 67; see also Lee, *supra* note 67; Rhonda Rundle & Anna Wilde Mathews, *Medicare Payments to Tenet Come Under Federal Scrutiny*, WALL ST. J., Nov. 7, 2002, at D4.

71. See Brown, *supra* note 8, at R2 (indicating that seven of the twelve

cascade of market and regulatory responses. Tenet's investors fled,⁷² and pending merger partners became skittish.⁷³ Tenet's stock value had reached a fifty-two-week high of \$52.20 on October 3, 2002.⁷⁴ By November 9, 2002, the price had dropped to \$14.90, a seventy-one percent decline in value.⁷⁵

In response to Weakley's report, Tenet officials admitted that the company received higher-than-average Medicare outlier payments but maintained that the payments were legal.⁷⁶ The outlier issue brought the company's aggressive pricing strategy under scrutiny because a key element of the special payment formula is the amount that hospitals charge for various services. Also, outlier payments tend to correlate with high-reimbursement specialty services, such as cardiology, orthopedics, and neurology. In addition, Tenet's market control and ability to negotiate high rates with commercial insurers had the side effect of driving up the company's charges across the board, including charges to the government. Higher charges produced higher Medicare outlier payments.⁷⁷

Weakley's report and the resulting scrutiny of Medicare outlier payments were not Tenet's only concerns. The company was attracting government and public attention on other issues around the same time. Two physicians in Tenet's Redding, California, facility were suspected of performing medically unnecessary heart

largest American bankruptcies occurred in 2002); see also Kopytoff, *supra* note 8, at G1; Note, *The Good, the Bad*, *supra* note 8, at 2123 (listing the era's bankruptcy filings).

72. See Brown, *supra* note 8, at R2.

73. See Paul Bartels, *Hospital Examining Tenet Troubles*, NEW ORLEANS TIMES-PICAYUNE, Nov. 13, 2002, at B1 [hereinafter Bartels, *Examining*] (regarding Tenet's bid to takeover Slidell Memorial Hospital); see also Rhonda L. Rundle, *Tenet Healthcare Says SEC to Look Into Stock Trades*, WALL ST. J., Nov. 19, 2002, at A3 (discussing Slidell deal); see also Paul Bartels, *Hospital Board's Chairman Resigns: SMH Sale Rejected by Huge Margin*, NEW ORLEANS TIMES-PICAYUNE, Apr. 8, 2003, at B1 (reporting on local voters rejecting the sale of a community hospital and the hospital board chairman's subsequent resignation).

74. Rhonda L. Rundle & Anna Wilde Mathews, *Tenet Reaped Outsize Gains From Flaw in Medicare System*, WALL ST. J., Nov. 11, 2002, at A1.

75. *Id.*; Karl Stark & Josh Goldstein, *Tenet's Lucrative Medicare Billing Seen at 3 Hospitals*, PHIL. INQUIRER, Nov. 9, 2002, at C1.

76. See Rundle & Mathews, *supra* note 74 (reporting that Tenet expected to receive 23.5% of its Medicare revenue from outlier payments, compared to HCA's expected 5%); Stark & Goldstein, *supra* note 75.

77. Rundle & Mathews, *supra* note 74, at A1; Carolyn Said, *Profiting from Health Care: Hospital Chain's Steep Prices Blamed for Raising Costs for All*, S.F. CHRON., Nov. 14, 2002, at A1.

surgeries.⁷⁸ Around the same time, a Latino advocacy group accused Tenet of overcharging uninsured patients.⁷⁹ By January 2003, the government had issued two investigatory subpoenas, one related to Medicare outlier payments and another for an earlier fraud initiative on “upcoding,” a strategy for boosting Medicare reimbursement by selecting higher reimbursement diagnoses on patients’ billing forms.⁸⁰ The government also was looking into allegations that management at a Tenet hospital in San Diego, California, offered physicians kickbacks for referring patients.⁸¹ Meanwhile, the Securities and Exchange Commission was investigating high trading volume preceding some Tenet public announcements, including statements regarding Medicare outlier payments.⁸² Later, in the post-Enron furor, a United States Senate committee opened a probe of the company’s corporate governance practices, suggesting that the company may be “ethically and

78. Rundle, *supra* note 73; Ronald D. White, *Pressure on Tenet Chief to Resign*, L.A. TIMES, Nov. 13, 2002, at C1; see Rhonda L. Rundle, *Tenet Healthcare Agrees to Pay \$54 Million to Settle U.S. Case*, WALL ST. J., Aug. 7, 2003, at B2 (discussing Tenet’s agreement to settle government allegations of unnecessary procedures and surgeries at Redding Medical Center).

79. Andrew Pollack & Reed Abelson, *Chief Faces Questions Again After Restoring Tenet Once*, N.Y. TIMES, Nov. 11, 2002, at C2; see also Rhonda L. Rundle, *Tenet Healthcare Faces Lawsuits by Latinos Alleging Overcharging*, WALL ST. J., Feb. 15, 2002, at B6; Said, *supra* note 77, at A1; Carolyn Said, *Tenet Plans to Ease Up on Uninsured Patients; Hospitals to Cut Prices, Stop Suing Jobless*, S.F. CHRON., Jan. 29, 2003, at A1 (noting Tenet’s voluntary policy change regarding billing uninsured patients).

80. Katherine Vogt, *Tenet Shaking Up Board, Management*, AM. MED. NEWS, Apr. 28, 2003 (discussing upcoding allegations), available at http://www.ama-assn.org/sci-pubs/amnews/pick_03/bisc0428.htm; see also Ronald D. White, *Tenet Profit Jumps, but Forecast Dims; Hospital Chain Cuts Fiscal 2003 Earnings Outlook as it Reduces the Amount it Charges Medicare*, L.A. TIMES, Jan. 14, 2003, at C1 (discussing same upcoding allegations).

81. Andrew Pollack, *Tenet to Sell or Shut Hospitals and Cut Jobs*, N.Y. TIMES, Mar. 19, 2003, at C3 (regarding San Diego’s Alvarado Hospital Medical Center); Rhonda L. Rundle, *CEO at Tenet Hospital Faces Charges on Payments to Doctors*, WALL ST. J., June 9, 2003, at B2 (reporting that federal prosecutors charged the Alvarado CEO with making illegal payments to induce physicians to refer patients); *Tenet Administrator Surrenders to Judge Amid Federal Probe*, WALL ST. J., Sept. 25, 2003, at B6 (reporting that an associate administrator of Alvarado, accused of receiving personal payments for arranging relocation agreements, surrendered to federal arrest warrant).

82. See Rundle, *supra* note 73 (reporting that the SEC opened an “informal file” on Tenet); see also Press Release, Tenet Shareholder Committee, LLC, Tenet Shareholder Committee Asks Government to Investigate New Claims of Securities Law Violations (Jan. 6, 2003) (announcing Tenet shareholders’ request that SEC initiate formal investigation), at <http://www.tenetshareholdercommittee.org/Press5.htm>.

morally bankrupt” and “among the worst corporate wrongdoers.”⁸³

With respect to outlier payments, at least, Wall Street and other observers failed to appreciate the inevitable and not entirely unintended or objectionable correlation between Tenet’s competitive strategies and the lucrative outlier revenue stream under the Medicare program. Congress created a limited pool of Medicare payments to reimburse health care providers for serving patients who are extraordinarily costly to treat. Tenet did not shy away from the expensive cases but, rather, welcomed them as a part of its business strategy. Tenet’s aggressive pricing, focus on high-reimbursement services, and investment in new technology attracted the high-cost cases and allowed its hospitals to secure a significant share of the special outlier payments. In particular, Tenet astutely focused on delivering complex services in high demand by aging health care consumers. The high demand for, and complexity of, these services allowed Tenet to increase its charges to commercial and private payors. As it turned out, Tenet’s ability to deliver specialized services and command high prices also tended to generate Medicare outlier payments.

But after Enron and other episodes, Tenet’s high earnings attracted scrutiny. Drawing on the widely reported scandals as examples, the public began to view strong earnings as an indication not of legitimate business prowess, but possible wrongdoing and questionable operations. Wall Street combed financial reports for an indication that a company’s profits could be explained by “cheating” rather than “fair” competition.⁸⁴ The American Institute of Certified Public Accountants’ auditing standards expressly identify “[r]apid growth or unusual profitability, especially compared to that of other companies in the same industry” as a fraud risk factor.⁸⁵ The public began to doubt the market’s ability to self-regulate desirable corporate conduct,⁸⁶ and regulators responded. In July 2002,

83. Rhonda L. Rundle, *Senate Panel is Investigating Tenet*, WALL ST. J., Sept. 8, 2003, at B10 (quoting the contents of four-page letter sent to Trevor Fetter, Tenet’s acting CEO).

84. *See, e.g.*, Ribstein, *supra* note 8, at 49.

85. *See* Am. Inst. of Certified Public Accountants, Appendix to SAS No. 99, Fraud Risk Factors, available at <http://www.aicpa.org/antifraud/risk/38.htm>; *see also* Jonathan Weil, *Did Ernst Miss Key Fraud Risks at HealthSouth?* WALL ST. J., Apr. 10, 2003, at C1 (discussing the AICPA standards in context of Ernst & Young’s auditing work for HealthSouth Corp.’s “massive accounting fraud”).

86. *See, e.g.*, PETER C. FUSARO & ROSS M. MILLER, WHAT WENT WRONG AT ENRON 150 (2002) (suggesting that some view Enron’s collapse as “the market’s way of enforcing its standards for honesty,” while “[o]ther companies, fearing the wrath of the market, were immediately forced to become more forthcoming without any deliberative action from the accounting profession or the government,” and concluding that “[t]he true lesson of Enron is that one who

Congress passed the Sarbanes-Oxley Act⁸⁷ specifically to address to the widely reported incidents of corporate malfeasance.⁸⁸ Scrambling to dispel the increasingly negative public attention, companies like Tenet revised and abandoned various business plans and strategies that generated unusually high, and now presumptively illegitimate, earnings.

lives by the market can also die by the market”); *see also* FRANK PARTNOY, *INFECTIOUS GREED 2* (2003) (arguing that “conventional wisdom” that “markets would remain under control, that the few bad apples would be punished” is wrong); Arthur Levitt, Jr. & Richard C. Breeden, *Our Ethical Erosion*, WALL ST. J., Dec. 3, 2003, at A16 (former SEC chairmen discussing the importance of investors’ trust and realizing that, since Enron, that trust has been abused and taken for granted). *But see* Susan Lee, *The Dismal Science: Enron’s Success Story*, WALL ST. J., Dec. 26, 2001, at A11 (concluding that “no matter how one views the purposes or operations of a competitive market, the history of Enron proves that the market works pretty much as expected. And thus the story of Enron is, so far, a success story.”).

87. Pub. L. No. 107-204, 116 Stat. 745 (2002) (codified in scattered sections of 11, 15, 18, 28, and 29 U.S.C.). A proprietary health care company, HealthSouth Corp., was the first company to be sanctioned by the SEC under the new Sarbanes-Oxley corporate disclosure and certification requirements. *See* Kate Kelly, *Sealed, Delivered but Not Yet Signed by CEOs*, WALL ST. J., July 25, 2003, at C1; *see also* Patti Bond, *A Fraud Squad Dream: HealthSouth Case to Test New Law*, ATLANTA J.-CONST., May 11, 2003, at Q1.

88. *See* Erica Beecher-Monas, *Corporate Governance in the Wake of Enron: An Examination of the Audit Committee Solution to Corporate Fraud*, 55 ADMIN. L. REV. 357, 358 (2003) (noting that “Congress reacted to the Enron fiasco by enacting the Sarbanes-Oxley Act and directing the [SEC] to engage in rulemaking to address the perceived problems”); Kathryn Stewart Lehman, *Executive Compensation Following the Sarbanes-Oxley Act of 2002*, 81 N.C. L. REV. 2115, 2115-18 (2002) (describing various corporate scandals and noting that “[w]ith this legislation [the Sarbanes-Oxley Act] Congress intended to calm a volatile market, inspire investor confidence, and stop the flood of corporate scandals”); Robert Prentice, *Enron: A Brief Behavioral Autopsy*, 40 AM. BUS. L.J. 417, 440 (2003) (indicating that “Congress responded to Enron and similar scandals by passing the Sarbanes-Oxley Act” and identifying the Act’s attempts to address some suboptimal, behavioral tendencies); Lawrence M. Solan, *Statutory Inflation and Institutional Choice*, 44 WM. & MARY L. REV. 2209, 2211 (2003) (indicating that Sarbanes-Oxley was “enacted in response to the financial scandals of Enron, WorldCom, and other major corporations”); Harvey L. Pitt, *How to Prevent Future Enrons*, WALL ST. J., Dec. 11, 2001, at A18 (outlining the SEC’s regulatory response); Michael Schroeder, *Levitt Calls for New Laws on Accounting*, WALL ST. J., Jan. 25, 2002, at A4 (quoting former SEC Chairman Arthur Levitt calling Enron “a wake-up call,” and “the smoking gun [that] has exploded”); *see also* Holman W. Jenkins Jr., *Agency, Interrupted*, WALL ST. J., Jan. 12, 2005, at A11 (suggesting that the SEC’s recent hands-on approach to regulating markets, rather than trusting efficient market hypothesis is “telling us something. They’re letting us know the pressures and expectations of society are finally getting to them.”).

C. Tenet's Fall

As Tenet's earnings and practices came under scrutiny, Wall Street's darling became Wall Street's pariah. Tenet's "robust" and "strong" pricing trends were recharacterized as "cowboy medicine,"⁸⁹ "Wall Street medicine,"⁹⁰ "turbocharging,"⁹¹ "too aggressive,"⁹² and "unusually hearty profits."⁹³ At first, Tenet staunchly maintained that it had done nothing illegal under the Medicare program.⁹⁴ Even if Tenet's strategy was not technically illegal, the investing public remained uneasy. One commentator suggested: "The firm picked its markets, concentrated on lucrative surgeries, and milked Medicare for extra 'outlier' payments. That may meet the law, but the results victimize both patients and taxpayers."⁹⁵ Analysts and observers renewed questions about the basic compatibility of profit-orientation and health care delivery.⁹⁶ Praise for Tenet's turn-around successes and unprecedented growth was replaced by doubts about the company's integrity and fairness.⁹⁷ Tenet's own shareholders

89. Editorial, *Time to Rein In "Cowboy Medicine,"* S.F. CHRON., Nov. 11, 2002, at A30 [hereinafter *Cowboy Medicine*] (describing high-pressure tactics at Tenet's Redding hospital).

90. See Katherine Vogt, *Suit Claims Unnecessary Surgeries at Tenet*, AM. MED. NEWS, May 19, 2003 (quoting opposing counsel's comment: "We believe that the Tenet health system practices what we call 'Wall Street Medicine;' They practice bottom-line medicine to drive their stock prices up."), available at http://ama-assn.org/sci-pubs/amnews/pick_03/bisc0519.htm.

91. See Said, *supra* note 77 (quoting a Service Employees International Union representative).

92. See Bartels, *Examining, supra* note 73 (quoting the Slidell Memorial Hospital board's consultant regarding Tenet's pursuit of outlier payments); see also Pollack & Abelson, *supra* note 79, at C2 (noting that government "inquiries are raising concerns about whether Tenet was too aggressive in raising prices").

93. See Said, *supra* note 79 (noting a UCLA bankruptcy law professor's assessment that aggressive collection practices may have been one of the reasons for Tenet's success).

94. Press Release, Tenet Healthcare Corporation, An Open Letter to Shareholders of Tenet Healthcare Corporation (Nov. 18, 2002) available at <http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases/An+Open+Letter+to+Shareholders+of+Tenet+Healthcare+Corporation.htm>.

95. *Cowboy Medicine, supra* note 89.

96. See Pollack & Abelson, *supra* note 79 (noting that Tenet's troubles raise questions about "whether its quest for profits threatens its quality of care"); Rundle & Mathews, *supra* note 77 (quoting a Tenet investment firm representative's query "whether Tenet managers 'prefer revenue to quality of care'"); Said, *supra* note 7 (noting that "Tenet's approach to pricing is not necessarily illegal" but that "a range of observers, including ordinarily profit-focused Wall Street analysts, have begun to question the ethics behind charging so much for health care"); Vogt, *supra* note 90.

97. See, e.g., Stark & Goldstein, *supra* note 75 (quoting a health care analyst's assessment that Tenet "has left itself open to boundless questions of

prepared a report estimating the company's potential fraud liability for Medicare outlier abuses at \$6 billion.⁹⁸

Attempting to restore investor confidence and avoid other reputational sanctions, Tenet took various steps. Specifically, the company dismantled its management structure, revised its pricing policy, and voluntarily reduced the amount of Medicare reimbursement it claimed by voluntarily modifying key features of the outlier payment formula long before regulators proposed similar changes.⁹⁹ Less than two weeks after Weakley issued his report, Tenet announced the departure of two high-level executives just below chairman and chief executive officer Jeffery C. Barbakow.¹⁰⁰ One was Thomas B. Mackey, the chief operating officer credited with developing the company's aggressive pricing strategy.¹⁰¹ A month before the government launched a nationwide inquiry into Medicare outlier payments across all hospitals, Tenet initiated a self-audit of its pricing policy and outlier payments.¹⁰² The self-audit revealed substantial and dramatically increased outlier payments in recent years. Barbakow expressed surprise at the findings and asserted that he had never focused on outlier payments until

integrity"); *see also* *Cowboy Medicine*, *supra* note 89 (urging that "there must be sharp oversight of the public dime and the common good"); Pollack & Abelson, *supra* note 79 (discussing various opinions about Tenet CEO Barbakow's integrity); Said, *supra* note 77 (quoting a nonprofit research group representative as saying that "Tenet is driving up the cost of health care in California for everyone").

98. Glenn Singer, *Tenet Healthcare Could Face \$6 Billion in Liability for Medicare, Panel Says*, SUN-SENTINEL, Apr. 8, 2003, at D1 (reporting the shareholder committee's findings that Tenet increased outlier charges "in a manner that lacks any connection to increases in the cost of its services" and could be liable for treble damages and civil fines under the False Claims Act).

99. Press Release, Tenet Healthcare Corp., Tenet Volunteers to Adopt New Outlier Policy (Jan 6, 2003) at <http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases/Tenet+Volunteers+to+Adopt+New+Outlier+Policy.htm>.

100. *See* Rhonda L. Rundle & Anna Wilde Mathews, *Tenet to Restructure Amid Scrutiny*, WALL ST. J., Nov. 8, 2002, at A3 (discussing the departures of Chief Corporate Officer David L. Dennis and Chief Operating Officer Thomas B. Mackey).

101. *See* Rundle & Mathews, *supra* note 74, at A1 (stating that "Mr. Mackey developed a policy to raise so-called chargemaster prices, a kind of health-care equivalent of the sticker price at car lots").

102. *See* Rundle & Mathews, *supra* note 100, at A3 (reporting that a Tenet "internal study found that sharp rises in certain prices at its hospitals . . . have led to increasingly large collections from Medicare of so-called outlier payments"); *see infra* note 187 and accompanying text (describing CMS program memoranda issued to local Medicare contractors in late 2002 and early 2003).

Weakley began asking questions.¹⁰³ Barbakow's "Ken Lay-esque"¹⁰⁴ response of denying awareness of a scheme purportedly devised by lower management did little to calm investors.¹⁰⁵ Before long, Barbakow was ousted from his posts, first as board chairman,¹⁰⁶ and eventually as CEO.¹⁰⁷

Tenet made other changes aimed at restoring legitimacy and improving accountability. For example, Tenet placed a physician in charge of its California division,¹⁰⁸ a geographical region drawing a considerable share of the negative attention. The company also replaced several board members and appointed a former auditor to the board.¹⁰⁹ Trevor Fetter, the interim CEO who succeeded Barbakow, was made permanent CEO.¹¹⁰ Later, Tenet's chief in-house legal counsel and chief corporate officer, Christi R. Sulzbach, resigned under pressure and concerns regarding her ability to resolve the various government investigations and other problems.¹¹¹ Tenet replaced Sulzbach with Peter Urbanowicz, outgoing deputy general counsel of the Department of Health and Human Services,

103. Rundle & Mathews, *supra* note 74, at A1 (reporting that Barbakow said he "never focused on the financial impact of the outlier payments until sometime in the week of Oct. 14 when Mr. Weakley . . . called").

104. See Mitchell Pacelle & Rebecca Smith, *Enron's Lay Resigns as Chairman, CEO*, WALL ST. J., Jan. 24, 2002, at A3 (stating that Lay "has indicated he wasn't fully aware of the details of the controversial partnerships whose disclosure led to major financial losses").

105. See White, *supra* note 78 (noting that Barbakow "said he was unaware of the extent of Tenet's use of the Medicare billing program," which led investors, analysts, and observers to ask: "If Barbakow didn't know, why didn't he? And if he did know, why didn't he address it?").

106. See Rhonda L. Rundle, *Tenet's CEO Plans to Leave Board*, WALL ST. J., Apr. 8, 2003, at A2; see also Debora Vrana, *Group Urges Tenet to Split Top 2 Jobs*, L.A. TIMES, Mar. 28, 2003, at C2 (reporting on the American Federation of State, County and Municipal Employees Pension Plan's proposal and Barbakow's offer to resign from board in the fall of 2002, when issues surfaced).

107. See Rhonda L. Rundle, *Tenet CEO Quits After Board Meets*, WALL ST. J., May 28, 2003, at A3 (reporting Barbakow's early departure, planned for July 2003, and replacement by Trevor Fetter, brought in as president in November 2002).

108. See James F. Peltz, *Doctor to Head Tenet California Operations*, L.A. TIMES, Mar. 18, 2003, at C3 (regarding the promotion of Dr. Stephen L. Newman to the newly created post of chief executive of Tenet California).

109. See Ronald D. White, *Tenet Adds Former Deloitte CEO to Board*, L.A. TIMES, Apr. 25, 2003, at C2 (regarding the board appointment of Edward A. Kangas, former chief executive of Deloitte Touche Tohmatsu); Vogt, *supra* note 90, (reporting replacing one-third of board and appointment of new chair).

110. See Rhonda L. Rundle & Joann S. Lublin, *Tenet Names Fetter Permanent CEO*, WALL ST. J., Sept. 17, 2003, at A6.

111. Rhonda L. Rundle, *Tenet Healthcare's Sulzbach Resigns Amid Critics' Pressure*, WALL ST. J., Sept. 29, 2003, at B6.

the agency that oversees the Medicare program.¹¹² Still re-tooling, Tenet specifically recruited replacement executives from outside the health care industry, including energy-industry veteran Robert S. Shapard, as chief financial officer.¹¹³

Tenet also adopted a new pricing philosophy that de-emphasized list charges,¹¹⁴ discounted charges to uninsured and under-insured patients, and relaxed debt collection efforts.¹¹⁵ Those changes facilitated settlement of various unfair pricing lawsuits.¹¹⁶ In announcing the new policies, Tenet expressed a commitment to “fair treatment of uninsured patients,”¹¹⁷ echoing the public’s new focus on corporate fairness over profitability. Tenet’s voluntary pricing and other policy changes preceded agency regulations on charges to uninsured patients.¹¹⁸

112. Rhonda L. Rundle, *Tenet Healthcare Taps HHS Lawyer as Top Counsel*, WALL ST. J., Dec. 23, 2003, at B4.

113. See *Who’s News: Tenet Selects Utility Executive As Its Chief Financial Officer*, WALL ST. J., Feb. 22, 2005, at B10 (noting that, in addition to “utility executives, Tenet considered candidates at banks, insurers and information-services giants. Among the targeted high-tech providers were ones that provide a lot of services to the federal government.”).

114. See Rhonda L. Rundle, *Tenet Unveils Pricing Approach, Slashes Estimates*, WALL ST. J., Dec. 4, 2002, at A2 (describing Tenet’s “restrained pricing philosophy” that deemphasized “gross charges, which rarely bear any resemblance to what hospitals are actually paid for the services they provide”); Ronald D. White & Don Lee, *Tenet Cuts Earnings Forecast for 2 Years*, L.A. TIMES, Dec. 4, 2002, at C1 (reporting Tenet’s new pricing strategy “that includes discounts for uninsured patients” and is “mov[ing] away from reimbursements based on gross retail charges set by hospitals in favor of fixed daily fees”).

115. See Said, *supra* note 79 (reporting on Tenet’s new policy to discount prices to the uninsured and to restrain collection practices, including placing liens on patients’ homes).

116. See Rundle, *supra* note 79 (discussing allegations by Consejo de Latinos Unidos); Said, *supra* note 79 (reporting on the settlement of ten lawsuits brought by uninsured Latino patients in Los Angeles).

117. Said, *supra* note 79.

118. The practice of hospitals billing full charges to uninsured patients was a nationwide problem. In a letter to HHS Secretary Tommy Thompson, American Hospital Association members identified their understanding that HHS regulations prohibit offering discounts to uninsured patients and require active collection practices. Thompson responded that “[n]othing in the Medicare program rules or regulations prohibit such discounts.” News Release, Dep’t of Health & Human Servs., Text of Letter from Tommy G. Thompson, Secretary of Health & Human Services, to Richard J. Davidson, President, American Hospital Association (Feb. 19, 2004), at <http://www.hhs.gov/news/press/2004pres/20040219.html>. The OIG also issued guidance to hospitals regarding discounts to uninsured and underinsured patients, asserting that the agency “fully supports hospitals’ efforts in this area.” DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., HOSPITAL DISCOUNTS OFFERED TO PATIENTS WHO CANNOT AFFORD TO PAY THEIR HOSPITAL BILLS 1 (2004) [hereinafter HHS,

Regarding Medicare outlier payments, Tenet took an unprecedented step by voluntarily and anticipatorily modifying federal Medicare regulations. Specifically, Tenet changed certain key features of the formula for calculating outlier adjustments on its own records several months before the government issued final regulations implementing similar amendments.¹¹⁹ Company officials announced the damages, publicly declaring a desire to align with the government's new outlier initiative:

We want to be part of CMS'[s] [Centers for Medicare & Medicaid Services] solution to the outlier issue and we support across-the-board modifications. To that end, we are willing to step forward and adopt what we anticipate may become central components of CMS'[s] new outlier rule as though the agency had put it into effect Jan. 1, 2003.¹²⁰

Tenet faced an estimated \$700 million reduction in Medicare payments as a result of the voluntary changes.¹²¹ At first, the announcement had minimal impact on Tenet's already gutted share value,¹²² but three months into the voluntary outlier policy, Tenet reported quarterly losses of \$55 million, or twelve cents per share.¹²³

HOSPITAL DISCOUNTS], available at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf>. See generally Lucette Lagnado, *HHS Chief Scolds Hospitals for their Treatment of Uninsured*, WALL ST. J., Feb. 20, 2004, at A2 (quoting Legal Aid Society attorney Elisabeth Benjamin: "This finally puts to rest the hospital's tired and inaccurate argument that the government made them charge uninsured and underinsured people these crazy inflated prices.").

119. See Editorial, *Tenet's Shareholder Ills*, *supra* note 2 (describing Tenet's self-policing modifications); see also Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems; Final Rule, 68 Fed. Reg. 34,494 (June 9, 2003) (to be codified at 42 C.F.R. pt. 412) (revising various aspects of the Medicare outlier payment formula).

120. Press Release, *supra* note 99 (quoting Tenet President Trevor Fetter); see *infra* notes 141-94 and accompanying text (describing Medicare outlier payments and loopholes). In particular, Tenet vowed to rely on up-to-date cost and charge data and abandon use of the statewide average RCC in submitting Medicare outlier claims. See Andy Pasztor, *Tenet Voluntarily Cuts Amount of Hospital Medicare Payments*, WALL ST. J., Jan. 7, 2003, at B7 (describing Tenet's plans to "halt[] all outlier payments based on 'statewide average' calculations" and to "rely on the latest available cost data to determine the level of reimbursement sought from Medicare").

121. See Pasztor, *supra* note 12; Ronald D. White, *Tenet to Alter Billing*, L.A. TIMES, Jan. 7, 2003, at C1 (noting that \$700 million was "the worst-case scenario" and CMS Administrator Scully's estimate that Tenet may have received \$500 million in outlier overpayments).

122. See Pasztor, *supra* note 120, at B7 (noting that "[i]nvestors took the

As financial prospects worsened, Tenet sought to further reduce costs by selling assets, including fourteen of its 114 hospitals, firing non-patient care staff, and restricting corporate travel expenses.¹²⁴ At the beginning of 2004, Tenet remained on financially shaky ground, evidenced by continued restructuring, asset divestiture, and revised earnings reports.¹²⁵ Management reorganization and government investigations continued as well.¹²⁶ By the end of 2004, Tenet expected to report a loss, including write-downs on the estimated current value of its hospitals and goodwill.¹²⁷ The company also reported declining patient volumes due to increased competition from outpatient surgery centers and declining physician referrals.¹²⁸ The announcement sent Tenet shares down 8.1% to \$11.07 by the year's end.¹²⁹

announcement in stride, with Tenet shares falling only 10 cents, to \$16.68”).

123. Rhonda L. Rundle, *Tenet Posts Loss; Outlier Payments from U.S. Plunge*, WALL ST. J., Apr. 11, 2003, at B6 (indicating the loss was due to a reduction in outlier payments as well as asset write-downs and “soaring medical malpractice expenses”); *see also* Rhonda L. Rundle, *Tenet Healthcare, Hurt by Charges, Swings to Loss*, WALL ST. J., Aug. 8, 2003, at B4 (describing Tenet’s plummeting outlier revenues).

124. *See, e.g.*, Stephanie Patrick, *Tenet Healthcare Predicting Local Layoffs*, DALLAS BUS. J., Mar. 28, 2003, (noting the layoffs “as the health care giant attempts to eliminate \$100 million in expenses amid federal investigations into its business practices”); Pollack, *supra* note 81, at C3; Rhonda L. Rundle, *Tenet Healthcare to Cut Expenses, Revamp Hospitals*, WALL ST. J., Mar. 19, 2003, at B3; *Tenet to Sell Twelve Oaks Medical Center*, HOUSTON BUS. J., Mar. 19, 2003, (noting the sale as part of Tenet’s strategy “to reduce operating expenses and sharpen its strategic focus”).

125. Rhonda L. Rundle, *Tenet Remains on Tenuous Ground*, WALL ST. J., Jan. 27, 2004, at C3 (summarizing an analyst’s assessment that “a return to normalcy’ at Tenet is ‘quite remote’”); Rhonda L. Rundle, *Tenet Healthcare to Sell Hospitals and Take Charge of \$1.4 Billion*, WALL ST. J., Jan. 28, 2004, at A3 (reporting Tenet’s plans to sell twenty-seven hospitals, including nineteen in its largest markets).

126. *See, e.g.*, Rhonda L. Rundle, *Tenet Healthcare May Relocate Corporate Office*, WALL ST. J., Mar. 25, 2004, at B5 (quoting Tenet President Trevor Fetter’s memo to employees: “it’s clear to everyone that the Santa Barbara headquarters location was originally created for the personal convenience of the top executives”); Rhonda L. Rundle, *Tenet is Target of New Round of Inquiries*, WALL ST. J., Apr. 15, 2004, at A9 (summarizing an analyst’s suggestion that the new inquiries could be “‘isolated incidents,’ but ‘you never know when one of these could mushroom into something bigger’”).

127. *See* Rhonda L. Rundle, *Tenet Warns of Slow Recovery, Says it May Post Loss Next Year*, WALL ST. J., Dec. 14, 2004, at A6.

128. *Id.*

129. *Id.* (discussing various challenges to Tenet’s slow financial recovery, including ongoing government investigations).

IV. MEDICARE PAYMENT METHODOLOGY

To appreciate how the public misperceived the risks posed by Tenet's conduct, it is necessary to understand some basics about the Medicare payment system. The outlier adjustment was a well-known loophole that regulators had previously reviewed and adjusted but elected to leave open. Even assuming Tenet developed a business plan specifically to take advantage of that loophole, it is not clear that the company did anything wrong. But in the face of Enron and other highly salient examples of corporate fraud and wrongdoing, public perceptions of corporate responsibility and fairness changed, prompting changes in regulatory priorities. For the health care industry, the government's response to public pressure produced "bad policies" that were poorly considered and unnecessarily disruptive to the intricate Medicare payment structure and incentives.

When the Medicare program was enacted in 1965, the government reimbursed hospitals on a cost basis for all expenses incurred in treating Medicare patients. Hospitals were paid a per diem, determined retrospectively from the hospitals' actual total Medicare allowable costs.¹³⁰ The obvious incentive under a payment system like that is to spend as much as possible and order as many services as possible because the greater the hospital's actual expenditures, the greater the hospital's Medicare reimbursement.¹³¹ Not surprisingly, medical costs soared after Medicare implementation as both the number of people insured and hospital spending increased.¹³²

130. See Timothy Stoltzfus Jost & Sharon L. Davies, *The Empire Strikes Back: A Critique of the Backlash Against Fraud and Abuse Enforcement*, 51 ALA. L. REV. 239, 250 (1999) ("Over the past three decades, Medicare has become much more sophisticated in paying for health care goods and services—developing its own per case, per diem, and per service payment systems.").

131. See Randall A. Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965, 970 (1981) (noting that the "critical incentive" under cost-based reimbursement "is that an institution is typically paid more for raising its costs and less if it holds down its costs"); Jost & Davies, *supra* note 130, at 251 (observing that cost-based, or fee-for-service, payment "creates incentives for providers to (1) maximize the volume of profitable goods and services for which they bill and (2) maximize profit per service by billing for the highest payment rate available for a service, while at the same time minimizing the amount expended in providing the service").

132. See VICTOR R. FUCHS, WHO SHALL LIVE?: HEALTH, ECONOMICS AND SOCIAL CHOICE 173 (1998) (observing that unintended consequences of Great Society Medicare and Medicaid programs were increased health care costs and physician incomes). See generally RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 16-17 (1997) (noting that the "enactment of Medicare and Medicaid coincided with the beginning of a spectacular escalation

To contain costs and reverse the incentives for over-spending and over-utilization, Congress, in 1983, dramatically changed the way that hospitals are paid under Medicare.¹³³ Under the new inpatient Prospective Payment System (“PPS”), hospitals receive a predetermined amount for treating Medicare patients, determined from the patients’ diagnosis at the time of discharge.¹³⁴ Payment is based on the diagnosis-related group (“DRG”) to which a patient is assigned at discharge.¹³⁵ A hospital receives the same DRG payment regardless of the number of procedures or services provided, supplies used, or length of stay for the particular patient. The PPS methodology is intended to promote efficiency by reducing the incentive to provide unnecessary services or supplies.¹³⁶ The obvious, and intended, incentive is to spend as little as possible, for if the hospital’s actual costs come in under the fixed payment amount, it retains the excess.

Under PPS, reimbursement levels are based on average rates across all hospitals, and the particular hospital’s actual costs or charges for treating patients are largely irrelevant.¹³⁷ Therefore, little opportunity remains to impact Medicare reimbursement by increasing costs or charges. In a few areas, actual costs do matter and may affect a hospital’s reimbursement level. First, hospitals may influence the DRG payment amounts to some degree because those rates are derived from participating providers’ actual cost reports, which regulators review annually to determine the average cost of treating a particular disorder.¹³⁸ Also, certain adjustments to the basic DRG payments—including outliers, graduate medical

in national health care spending” and attributing part of the blame to provider-dominated, cost-based payment system).

133. See H.R. REP. NO. 98-25, at 132 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 351.

134. *Id.*

135. *Id.*

136. See, e.g., *id.* (noting that PPS “is intended to improve the medicare [sic] program’s ability to act as a prudent purchaser of services” and “[m]ore important, it is intended to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost/effective hospital practices”); S. REP. NO. 98-21, at 47 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 193 (noting that PPS promotes efficiency by allowing hospitals to retain payment amounts that exceed actual costs and requiring them to absorb costs that exceed standard payment rates); see also *Methodist Hosp. v. Shalala*, 38 F.3d 1225, 1227-28 (D.C. Cir. 1994) (discussing PPS legislative history).

137. See Barry R. FURROW ET AL., *HEALTH LAW* § 13-10, at 121-22 (1995).

138. See *id.* (discussing history of Medicare cost-based reimbursement and PPS implementation); ROSENBLATT ET AL., *supra* note 132, at 469-70, 484-85 (noting the same).

education, and new technology payments—may be based on actual costs.¹³⁹ Finally, the outlier adjustment that hospitals receive for unusually expensive cases is based on actual charges for treating the patient.¹⁴⁰

A. *Medicare Outlier Payments*

At the time PPS was implemented, Congress left open a tiny, retrospective, cost-based “loophole”—the outlier adjustment—to cover costs of cases that fall far outside the fixed, average diagnosis-related payment amounts. Congress recognized that “there will be cases within each [DRG] that will be extraordinarily costly to treat, relative to the other cases within the DRG, because of severity of illness or complicating conditions, and are not adequately compensated for under the DRG payment methodology.”¹⁴¹ The concern was that hospitals might avoid treating the “hard” cases—the sickest and neediest Medicare patients—because they would be under-reimbursed for those cases.

Accordingly, PPS calls for Medicare regulators to set aside a limited pool of so-called “outlier” payments to defray the extra costs hospitals incur in treating these expensive cases.¹⁴² By statute, Medicare outlier payments may not be less than five or more than six percent of total standard DRG payments that CMS projects it will make under PPS for any federal fiscal year (“FFY”).¹⁴³ CMS must reduce total standard DRG payments by the proportion of

139. *See, e.g.*, 42 C.F.R. § 412.80(a)(2) (2004) (providing an extra payment for outlier cases if the “hospital’s charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios”); *id.* § 412.88(a)(2) (providing for an extra payment under inpatient PPS for discharges involving new medical services or technologies and providing one calculation method based on actual costs for the new service or technology); *id.* § 412.105(f) (providing an extra payment for hospitals that incur indirect costs for graduate medical education programs, based, in part, on actual number of “full-time equivalent” residents for a cost reporting period).

140. *Id.* § 412.84(k)-(m).

141. S. REP. NO. 98-21, at 51 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 191.

142. *Id.*

143. *See* 42 U.S.C. § 1395ww(d)(5)(A)(iv) (2000). “Total standard DRG payments” means the DRG amounts plus add-on payments for new technology, IME, and DSH. Medicare regulations establish the outlier pool, or target annual outlier payments, at 5.1% of standard DRG payments. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 49,982, 50,122 (Aug. 1, 2002) (codified at 42 C.F.R. pt. 405); Medicare Program; Changes to the Inpatient Hospital Prospective Payment Systems and Fiscal Year 1989 Rates, 53 Fed. Reg. 38,476, 38,503-04 (Sept. 30, 1988) (codified at 42 C.F.R. pts. 405, 412, 413, 489).

estimated outlier payments to be made during the same FFY.¹⁴⁴ In other words, outlier payments are budget-neutral and do not detract from Medicare funds allocated to cover “typical,” non-outlier cases. Therefore, even if Medicare providers collected more than their fair share of the limited pool of outlier payments, those payments would not endanger coverage for standard DRG cases. Another feature of the fixed pool is non-retroactive adjustment. The outlier pool is based on estimated, not actual payments, meaning that CMS is not required to recalculate and adjust outlier payment levels at the end of the fiscal year, even if the actual amount paid out to providers at the end of the year comes in below five percent or above six percent.¹⁴⁵

1. *Outlier Payment Methodology*

Initially under PPS, hospitals could receive extra payment for two types of cases: “day outliers”—extraordinarily long lengths of stay—and “cost outliers”—extraordinarily expensive cases.¹⁴⁶ Day outlier adjustments were available for cases in which the patient’s length of stay exceeded the mean length of stay for the assigned DRG by a fixed number of days.¹⁴⁷ Cost outlier adjustments were available for cases in which the charges for the case, adjusted to cost, exceeded a fixed multiple of the applicable DRG, or other fixed dollar amount.¹⁴⁸ Under the original PPS scheme, day outliers were calculated first, with cost outliers as a back-up method for reimbursing high-cost cases that did not qualify for an outlier payment based on length of stay.¹⁴⁹

Over time, the provision for day outliers was phased out because the loophole was too obvious. Day outlier payments were easy to “game” simply by keeping a patient in the hospital past the fixed day-outlier cutoff. The loophole was particularly lucrative because the later days of a patient’s stay tend to be cheaper than days at the beginning of the admission. Therefore, the hospital

144. 42 U.S.C. § 1395ww(d)(5)(A); 42 C.F.R. §§ 412.80, 412.84 (2004).

145. *See* County of L.A. v. Shalala, 192 F.3d 1005, 1019 (D.C. Cir. 1999) (concluding that retrospective review and adjustment of Medicare outlier payments are not required by statute and would result in undue administrative burdens).

146. *Id.* at 1009.

147. *See* 42 U.S.C. § 1395ww(d)(5)(A)(i).

148. *See id.* § 1395ww(d)(5)(A)(ii).

149. *Id.* §§ 1395ww(d)(5)(A)(i)-(ii) (providing that the Secretary “shall” provide an additional payment for day outliers and that providers “may request” an additional payment for cost outliers); *see* S. REP. NO. 98-21, at 51 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 191; H.R. REP. NO. 98-21, at 135 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 354.

derived a bonus payment from relatively low additional costs. Certain government-commissioned studies of health care reimbursement revealed that hospitals were being overpaid, and, in many cases, profiting from day outlier payments.¹⁵⁰ Regulators also were concerned that day outlier payments disadvantaged hospitals that received a high number of transfer cases.¹⁵¹ Although a transfer case may be costly to treat, the transferee hospital might not meet the day outlier length of stay threshold because the initial days of the admission occurred at a different hospital.¹⁵² Accordingly, Congress phased out day outliers over a three-year period, beginning in 1993.¹⁵³

But cost outlier payments remain. Just as providers could increase their day outlier payments by keeping patients in the hospital longer, providers can influence their cost outlier payments through a different strategy. However, the loophole is less obvious. The complicated formula for calculating the cost outlier adjustment includes a hospital's actual costs and charges for medical treatment.¹⁵⁴ Therefore, by increasing charges—the “list price”—for treatment, hospitals can increase cost outlier payments.

150. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1993 Rates, 57 Fed. Reg. 23,618, 23,640 (June 4, 1992) (codified at 42 C.F.R. pts. 412, 413) (summarizing a RAND Corporation study showing that hospitals, on average, were being paid twenty-five percent more than the marginal cost of care for day outlier cases during the outlier portion of their stays).

151. *Id.* (discussing the RAND study showing that 38.2% of day outlier cases were profitable, after the outlier payment was included, and that later days of stay are considerably cheaper than earlier days for both medical and surgical DRGs).

152. H.R. REP. NO. 103-213, at 749 (1993) (Conf. Rep.), *reprinted in* 1993 U.S.C.C.A.N. 1430, 1438 (noting that “the Prospective Payment Assessment Commission has expressed concern that the Secretary’s outlier policy penalizes hospitals that receive a large number of transfer cases”).

153. 42 U.S.C. § 1395ww(d)(5)(A)(v) (1994) (providing for a three-year phase-out by which “the day outlier percentage for fiscal year 1995 shall be [seventy-five] percent of the day outlier percentage for fiscal year 1994,” fifty percent for fiscal year 1996, and twenty-five percent for fiscal year 1997); *see* H.R. REP. NO. 103-66, at 509 (1993), *reprinted in* 1993 U.S.C.C.A.N. 738, 741 (mentioning a proposed amendment that would require phase-out of “payments for day outlier cases beginning in fiscal year 1995 and ending in fiscal year 1998”); H.R. REP. NO. 103-213, at 749 (1993) (Conf. Rep.), *reprinted in* 1993 U.S.C.C.A.N. 1430, 1438. Day outlier payments were phased out completely for discharges occurring after September 30, 1997. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1995 Rates, 59 Fed. Reg. 45,330, 45,367 (Sept. 1, 1994) (codified at 42 C.F.R. pt. 412).

154. *See* Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752, 39,777 (Sept. 1, 1983) (codified at 42 C.F.R. pts. 405, 409, 489).

Under the outlier statute, cost outlier payments were based on the difference between the hospital's "adjusted costs" for the case and a cost outlier threshold.¹⁵⁵ Adjusted costs are derived from a ratio of the provider's covered charges compared to costs ("RCC"). The RCC is designed to account for the tendency of costs and charges to accelerate at different rates.¹⁵⁶ Initially, a single, uniform RCC, derived from nationwide cost and charge data, was applied to all hospitals.¹⁵⁷ During the earlier years of PPS, the Health Care Financing Agency ("HCFA"), CMS's predecessor agency, dismissed providers' objections to the nationwide RCC.¹⁵⁸ Providers suggested that the nationwide RCC failed to account for regional and other differences in costs and charging practices and urged the agency to implement regional, provider-specific, or hospital department-specific RCCs to yield more accurate outlier payments.¹⁵⁹ CMS consistently declined to amend the formula, citing administrative ease and consistency with reliance on nationwide data elsewhere in the payment methodology.¹⁶⁰

But eventually, the agency shifted to provider-specific RCCs. In explaining the policy change, HCFA acknowledged that nationwide RCCs were having an undesirable distributive effect of transferring payment away from struggling hospitals to already profitable, efficiently operated hospitals.¹⁶¹ Hospitals with lower costs per case under the basic DRG rates have lower RCCs and, thus, stand a better chance of exceeding the threshold and generating a greater outlier adjustment than hospitals with higher costs per case. Accordingly, HCFA amended the outlier regulations to require provider-specific RCCs, calculated annually.¹⁶² With this shift to

155. *Id.*

156. *See* Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services, 49 Fed. Reg. 234, 265 (Jan. 3, 1984) (codified at 42 C.F.R. pts. 405, 409, 489).

157. *Id.*

158. *Id.*

159. *Id.* at 264-65.

160. *See, e.g.,* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 57 Fed. Reg. 39,746, 39,784 (Sept. 1, 1992) (codified at 42 C.F.R. pts. 412, 413); Medicare Program; Changes to the Inpatient Hospital Prospective Payment Systems and Fiscal Year 1989 Rates, 53 Fed. Reg. 38,476, 38,503-04 (Sept. 30, 1988) (codified at 42 C.F.R. pts. 405, 412, 413, 489); Prospective Payments, 49 Fed. Reg. at 265; Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752, 39,777 (Sept. 1, 1983) (codified at 42 C.F.R. pts. 405, 409, 489).

161. *See* Changes, 53 Fed. Reg. at 38,507 (explaining the effects of nationwide RCCs).

162. *See id.* at 38,503 (implementing provider-specific RCCs).

provider-specific RCCs, HCFA planted the seeds for the Medicare outlier payment “abuses” that drew scrutiny of Tenet and other hospitals.

Calculating outlier payments using a provider’s actual costs and charges retains an element of retrospective, cost-based reimbursement in an otherwise prospective, fixed-payment system. PPS was intended to eliminate inefficiencies and incentives to overcharge and over-treat by reducing reliance on providers’ actual costs and charges. But the cost outlier adjustment remains as a tiny loophole inviting charge inflation.

2. *Outlier Loophole*

Almost from the beginning of PPS implementation, Medicare authorities were aware of the potential for hospitals to increase cost outlier payments by increasing charges. But year after year, they dismissed concerns and left the outlier loophole in place. The agency believed that the incentive to inflate charges would be checked by other aspects of the Medicare payment system, state regulation, or private insurance competition.¹⁶³

The most common way for a hospital to increase the level of Medicare outlier payments is to increase the list prices for medical services more rapidly than the hospital’s actual costs are increasing. The amount that a hospital receives for an outlier case is a percentage of the amount by which the provider’s adjusted costs for the case exceed the outlier threshold.¹⁶⁴ “Adjusted costs” are

163. See *infra* note 175 and accompanying text (quoting regulatory preamble).

164. The cost outlier threshold in the original PPS implementing regulation was \$12,000. Hospitals received sixty percent of the difference as the outlier adjustment. Prospective Payments, 48 Fed. Reg. at 39,776-77. For FFY 2004, the threshold was \$50,645. Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems; Final Rule, 68 Fed. Reg. 34,494 (June 9, 2003) (to be codified at 42 C.F.R. pt. 412) (revising various aspects of the Medicare outlier payment formula). Under current regulations, hospitals receive eighty percent of the amount by which adjusted costs exceed the outlier threshold. 42 C.F.R. § 412.84(k) (2004). For a detailed description and example of the Medicare outlier payment formula, which includes separate calculations for capital and operating costs, see Change in Methodology, 68 Fed. Reg. at 34,495. CMS has been increasing the outlier threshold rapidly in recent years in an attempt to maintain the percentage of outlier payments within the statutorily required five-to-six percent of standard DRG payments. See *supra* notes 143-45 and accompanying text (discussing outlier pool). The higher the threshold the fewer the cases that qualify for an outlier adjustment. In FFY 1998, the outlier threshold was \$11,500. Change in Methodology, 68 Fed. Reg. at 34,496. By FFY 2001, the threshold had increased to \$17,550. *Id.* The FFY 2002 threshold

calculated based on the provider-specific RCC.¹⁶⁵ The “costs” that are adjusted are the current year’s costs, as reported on the provider’s Medicare cost report for the year for which reimbursement is sought. But the cost and charge data used to calculate the provider-specific RCC may be from an earlier year’s cost report.¹⁶⁶ That anomaly occurs because regulations require the RCC to be calculated using a “final” cost report. Typically, CMS takes several years to finalize a hospital’s cost report.

After a provider files its annual cost report, private contractors, or fiscal intermediaries (“FIs”), audit and finalize the reports.¹⁶⁷ Overburdened FIs may be two or more years behind in completing audits and making final adjustments to providers’ cost reports.¹⁶⁸ In addition, even after a cost report is finalized, the FI may delay additional months before implementing the adjusted RCC for a particular provider. In the meanwhile, the provider’s out-of-date RCC, based on an earlier, and typically lower, charge structure, continues to be used. By increasing charges in the current year, while the RCC against which the charges are compared remains constant, a hospital may generate larger outlier payments for qualifying cases and cause more cases to qualify for outlier adjustments than if the RCC were based on the current year’s

was \$21,025, representing a twenty-four percent increase. *Id.* The FFY 2003 increase to \$33,560 represents approximately a sixty percent increase in one year. *Id.*

165. *See supra* notes 139-45 and accompanying text (summarizing outlier payment formula).

166. *See, e.g.*, Medicare Program; Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System, 68 Fed. Reg. 10,420, 10,423 (Mar. 5, 2003) (codified at 42 C.F.R. pt. 412) (discussing lag-time in calculating the provider-specific RCC).

167. CMS delegates responsibility for administering the Medicare program and determining reimbursement amounts at the local level to private contractors. Local contractors for Medicare Part A, which includes inpatient hospitalization, are known as fiscal intermediaries, or FIs. Local contractors for Medicare Part B, which covers outpatient services, are known as carriers.

168. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1994 Rates, 58 Fed. Reg. 46,270, 46,347 (Sept. 1, 1993) (codified at 42 C.F.R. pts. 412, 413) (“Because we use the latest available cost-to-charge ratios (which may be as much as 2 years old) to convert billed charges to costs for purposes of estimating cost outlier payments, we may be overestimating outlier payments in setting the thresholds.”); Press Release, Center for Medicare & Medicaid Services, CMS Takes Steps to Crack Down on Inappropriate Hospital Outlier Claims (Feb. 28, 2003) (noting that “the longer the lag between the historical data and the current charges—currently two years—the less accurate the estimate will be”), at <http://www.cms.hhs.gov/media/press/release.asp?counted=715>.

charges.¹⁶⁹ In CMS's recent outlier initiative, the agency specifically identified the "lag-time" in updating provider-specific RCCs as creating an opportunity for providers to "game" the system by increasing charges more rapidly than costs.¹⁷⁰

Another way that providers can increase outlier payments is by taking advantage of a regulation that requires FIs to use a statewide average RCC instead of the provider-specific RCC under certain circumstances. If the provider-specific RCC is more than three standard deviations, plus or minus, from the mean RCC for all hospitals, fiscal intermediaries are required to revert to a statewide average RCC.¹⁷¹ If the statewide RCC is more favorable, in terms of generating outlier payments, than the provider-specific RCC, a provider may inflate charges to throw its own RCC below the three

169. See Proposed Change, 68 Fed. Reg. at 10,423 (noting that "[i]f the rate-of-charge increases . . . exceeds the rate of the hospital's cost increases during that time, the hospital's cost-to-charge ratio [RCC] based on its [earlier] cost report will be too high, and applying it to current charges will overestimate the hospital's costs per case during [the current year]").

170. CENTERS FOR MEDICARE & MEDICAID SERVICES, PROGRAM MEMORANDUM INTERMEDIARIES, NOTICE REGARDING COST-TO-CHARGE RATIOS AND INPATIENT OUTLIER PAYMENTS, TRANSMITTAL NO. A-02-122 (2002) [hereinafter CMS, NOTICE], available at http://www.cms.hhs.gov/manuals/pm_trans/A02122.pdf ("Analysis of hospital charges since 1999 reveals that some hospitals' charges have grown at a much higher rate than the national average. Although these extraordinary increases will eventually result in lower CCRs [cost-to-charge ratios, i.e., ratio of cost-to-charges, or RCCs], the lag [time] between when charges are increased and the availability of cost reports results in higher outlier payments than is the case if the CCRs were updated more timely. . . . The CMS believes that some hospitals may be attempting to 'game' the current payment systems for the purposes of maximizing payment."); see also Proposed Change, 68 Fed. Reg. at 10,424 (noting that "a hospital has the ability to increase its outlier payments during this lag time through dramatic charge increases"); Press Release, Centers for Medicare & Medicaid Services, CMS Issues Final Rule for Outlier Payments to Hospitals (June 5, 2003) (quoting CMS Administrator Thomas Scully: "Last year, CMS discovered that a small number of hospitals—a few hundred—had been manipulating the outlier formula by aggressively increasing their charges compared to their costs."), at http://www.cms.hhs.gov/manuals/pm_trans/A02122.pdf.

171. 42 C.F.R. § 412.84(h) (2004) ("[S]tatewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth [these] parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates . . ."); see Change in Methodology, 68 Fed. Reg. at 34,496 (describing three standard deviations to the rule); Medicare Program; Changes to the Inpatient Hospital Prospective Payment Systems and Fiscal Year 1989 Rates, 53 Fed. Reg. 38,476, 38,503 (Sept. 30, 1988) (codified at 42 C.F.R. pts. 405, 412, 413, 489) (implementing use of statewide RCCs when hospital-specific RCCs fall outside reasonable parameters).

standard deviations range.¹⁷² Tenet was accused of “gaming” the outlier adjustment through both the RCC lag-time and statewide average RCC methods.¹⁷³

CMS has long been aware of the outlier loophole and potential for charge inflation. As early as 1989, in implementing the switch from the single, nationwide RCC to provider-specific RCCs, regulators identified and discussed at some length the potential for charge inflation as a means of increasing outlier payments.¹⁷⁴ But they elected not to address the problem, believing that market or other factors would mitigate any improper incentives.¹⁷⁵ The agency concluded: “[T]his incentive to manipulate charges is not new; in fact, any measure of cost (including length of stay) that is based on an indicator that is within the control of the provider provides an incentive to manipulate that indicator.”¹⁷⁶ HCFA left the outlier

172. See Proposed Change, 68 Fed. Reg. at 10,423 (explaining the vulnerability of the standard deviation rule)

173. See, e.g., Pasztor, *supra* note 120, at B7 (describing Tenet’s plans to “halt[] all outlier payments based on ‘statewide average’ calculations” and “rely on the latest available cost data to determine the level of reimbursement sought from Medicare”).

174. See, e.g., Changes to the Inpatient Hospital Prospective Payment Systems, 53 Fed. Reg. at 38,509.

175. The preamble to the formal rulemaking noted:

Since both the cost-to-charge ratio (whether national or hospital-specific) and the threshold are constant for the payment period, the payment received by the hospital can be increased by increasing charges. In addition, hospitals can conceivably change their charge structures, just as is the case at present, to maximize their outlier payments.

Although concern over this type of incentive is appropriate, we believe that there are several factors that will mitigate its effects. First, increases in a hospital’s overall charges relative to costs will be reflected in the cost-to-charge ratio assigned to the hospital in the future. This is one of the strong arguments for the use of the hospital-specific cost-to-charge ratios. Second, many hospitals are restricted in their ability to arbitrarily increase their charges by the fact that they must deal with other third-party payers, some of which base their payments on charges. Also, several States place restrictions on hospital charge increases. Third, a general acceleration in hospital charge increases can be incorporated into the setting of thresholds in future years, which would limit the potential benefit to hospitals.

Fourth, outlier payments comprise a small percent of total hospital payments under the prospective payment system, diluting the incentive for hospitals to disrupt their operations by drastically and continually manipulating charges.

Id.

176. *Id.*

loophole open but vowed to “continue to investigate potential improvements in the measurement of case level costs.”¹⁷⁷

CMS repeatedly declined to implement specific reforms to the outlier payment methodology to address the identified loophole.¹⁷⁸ CMS annually reviews all aspects of PPS and updates the payment rates and formulas, including the outlier threshold, through notice and comment rulemaking. As recently as September 2002, when CMS issued the fiscal year 2003 annual inpatient PPS update, the agency again declined to address the outlier loophole.¹⁷⁹ The agency identified two factors contributing to a rise in outlier payments in recent years: first, a trend of hospital charge increases; and, second, Medicare contractors’ delays in updating provider-specific RCCs.¹⁸⁰ According to CMS, those factors resulted in a higher than expected number of cases qualifying for outlier payments.¹⁸¹ To address the unexpected increase and maintain the statutorily required five-to-six-percent outlier pool, CMS increased the outlier threshold by as much as sixty percent from 2002 to 2003.¹⁸² A higher threshold results in fewer cases qualifying for outlier payments. In CMS’s view, hospitals’ “inappropriate” charge inflation “caused” the threshold to increase.¹⁸³ But the agency declined to directly regulate hospital charges.¹⁸⁴

177. *Id.*

178. CMS, NOTICE, *supra* note 170 (providing instructions on mitigating vulnerability but not making any changes).

179. See CMS, PROGRAM MEMORANDUM INTERMEDIARIES, FISCAL YEAR (FY) 2003 PROSPECTIVE PAYMENT SYSTEM (PPS) HOSPITAL, SKILLED NURSING FACILITY (SNF) AND OTHER BILL PROCESSING CHANGES, TRANSMITTAL A-02-084 (2002) (outlining changes but not addressing outlier loophole), *available at* http://www.cms.hhs.gov/manuals/pm_trans/A02084.pdf.

180. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 49,982, 50,124 (Aug. 1, 2002) (codified at 42 C.F.R. pt. 405). *Id.* Specifically, CMS’s data showed that the average covered charge per case was \$15,215 in 1999, \$16,376 in 2000, and \$18,015, in 2001. The charge per case increased, on average, by 7.63% from 1999 to 2000, and by ten percent from 2000 to 2001. *Id.*

181. *See id.*

182. *See supra* note 180 (listing recent years’ outlier threshold amounts and percentage increases). CMS proposed to increase the threshold from \$33,560 for FFY 2003 to \$50,645 for FFY 2004. Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems; Final Rule, 68 Fed. Reg. 34,494, 34,496 (June 9, 2003) (to be codified at 42 C.F.R. pt. 412).

183. “Because the fixed-loss threshold is determined based on hospitals’ historical charge data, hospitals that have been inappropriately maximizing their outlier payments have caused the threshold to increase dramatically for FY 2003, and even more dramatically for the proposed IPPS FY 2004 outlier

3. *Outlier Initiative*

In late 2002, about a year after Enron filed for bankruptcy and over a decade after Medicare authorities first acknowledged the unintended loophole in the cost outlier formula, CMS announced an initiative to identify “problematic” hospitals, meaning hospitals that, in recent years, received particularly high levels of outlier payments or rapidly increased charges.¹⁸⁵ The identified hospitals included many of Tenet’s 114 facilities. Through strongly worded public statements, audits of hospital billing and charging practices, and other tactics, regulators pressured hospitals to rein in their charges and implement other self-policing measures.¹⁸⁶

CMS announced the Medicare outlier payment initiative through a series of informal instructions to local Medicare FIs.¹⁸⁷ The program memoranda instructed FIs to identify providers that either received outlier payments representing specified, relatively high percentages of overall Medicare DRG payments or increased charges by specified percentages.¹⁸⁸ The identified “problematic” hospitals then would be subject to closer scrutiny from FIs or the Office of Inspector General through review of charge structures and case-by-case audits of randomly selected patient files.¹⁸⁹ In sharp contrast to the agency’s previous hands-off approach to the potential

threshold of \$50,645.” Change in Methodology, 68 Fed. Reg. at 34,496. Another revision intended to rein in outlier payments was to adjust the outlier formula for inflation using providers’ charges rather than costs. Changes to the Hospital Inpatient Prospective Payment Systems, 67 Fed. Reg. at 50,124.

184. See Medicare Program; Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System, 68 Fed. Reg. 10,420, 10,425 (Mar. 5, 2003) (codified at 42 C.F.R. pt. 412).

185. See CMS, NOTICE, *supra* note 170.

186. See, e.g., CENTERS FOR MEDICARE & MEDICAID SERVICES, PROGRAM MEMORANDUM INTERMEDIARIES, INSTRUCTIONS REGARDING HOSPITAL OUTLIER PAYMENTS, TRANSMITTAL NO. A-02-126 (2002) [hereinafter CMS, INSTRUCTIONS] (instructing intermediaries to perform comprehensive field audits and medical reviews), available at http://www.cms.hhs.gov/manuals/pm_trans/A02126.pdf; Press Release, *supra* note 168 (announcing proposed regulation designed to halt “gaming” of the outlier system).

187. See CMS INSTRUCTIONS, *supra* note 186; see also CMS NOTICE, *supra* note 170; CENTERS FOR MEDICARE & MEDICAID SERVICES, PROGRAM MEMORANDUM INTERMEDIARIES, CALCULATING PROVIDER-SPECIFIC MEDICARE OUTPATIENT COST-TO-CHARGE RATIOS (CCRs) AND INSTRUCTIONS ON COST REPORT TREATMENT OF HOSPITAL OUTPATIENT SERVICES PAID ON A REASONABLE COST-BASIS, TRANSMITTAL NO. A-03-004 (2003) [hereinafter CMS, CALCULATING] (providing guidelines for determining cost-to charge ratios), available at http://www.cms.hhs.gov/manuals/pm_trans/A03004.pdf.

188. CMS, NOTICE, *supra* note 170.

189. CMS, INSTRUCTIONS, *supra* note 186.

for charge inflation under PPS, CMS took an aggressive stance under this new initiative. In the words of CMS Administrator Thomas Scully: "Any hospital billing very high outlier rates better be absolutely sure that they are right or they are likely to be very sorry."¹⁹⁰ CMS vowed to scrutinize "all operations of the targeted hospitals" for any "improper conduct," including "any billing trends or other indications of inappropriate reimbursement."¹⁹¹ Separately, a congressional committee sent letters to hospitals suspected of overcharging and publicized the list of hospitals that received the letter.¹⁹²

CMS's outlier initiative culminated in formal rulemaking that amended certain aspects of the outlier payment regulations.¹⁹³ In particular, the new regulations addressed the RCC lag time by authorizing fiscal intermediaries to update providers' RCCs without waiting on final, audited cost reports. Fiscal intermediaries were further authorized to make year-end, retrospective adjustments to outlier payments based on hospitals' most recently settled but not final cost reports.¹⁹⁴ Those year-end adjustments allowed fiscal intermediaries to capture any provider charge inflation that occurred during the current payment period.¹⁹⁵ The final rule also

190. Press Release, Centers for Medicare & Medicaid Services, CMS to Clamp Down on Hospitals for Overcharging for Complex Cases (Dec. 3, 2002), at <http://www.cms.hhs.gov/media/press/release.asp?Counter=661>.

191. *Id.*

192. Committee News Release, The Committee on Energy and Commerce, Tauzin, Greenwood Investigate Hospital Billing Disparities for the Uninsured (July 16, 2003) (regarding the problem of billing full charges to uninsured patients), at http://energycommerce.house.gov/108/News/07162003_1040print.htm; see *infra* notes 207-09 and accompanying text (discussing the uninsured charges issue).

193. See Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems; Final Rule, 68 Fed. Reg. 34,494 (June 9, 2003); Medicare Program; Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System, 68 Fed. Reg. 10,420, 10,425 (Mar. 5, 2003) (codified at 42 C.F.R. pt. 412) (providing an abbreviated 30-day, instead of statutory 60-day, comment period); see also CENTERS FOR MEDICARE & MEDICAID SERVICES, PROGRAM MEMORANDUM INTERMEDIARIES, CHANGE IN METHODOLOGY FOR DETERMINING PAYMENT FOR OUTLIERS UNDER THE ACUTE CARE HOSPITAL INPATIENT AND LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEMS, TRANSMITTAL NO. A-03-058 (2003) (providing the first set of instructions to fiscal intermediaries implementing the revised outlier regulations), available at http://www.cms.hhs.gov/manuals/pm_trans/A03058.pdf.

194. Change in Methodology, 68 Fed. Reg. at 34,509.

195. *Id.* at 34,499 (establishing a new regulation, 42 C.F.R. § 412.84(i)(1),

eliminated the reversion to the statewide average RCC for hospitals falling below the lower limit.¹⁹⁶ Providers with RCCs exceeding the upper limit and providers without historical cost and charge data could still revert to the statewide RCC to calculate outlier adjustments.¹⁹⁷

B. Health Care Pricing

The one aspect of the outlier payment methodology that CMS did not address in informal memoranda, press releases, or the formal outlier regulations is the one feature that CMS expressly identified as the root of the problem—hospital charge inflation. The most likely explanation for this omission is that CMS lacks authority to regulate charges. As the preamble to the new outlier regulations expressly states: “Hospitals set their own level of charges and are able to change their charges, without review by their fiscal intermediaries.”¹⁹⁸ This statement confirms CMS’s historical understanding that the agency has no authority to regulate hospital pricing or charge structures.

1. Medicare Regulation of Pricing

A fundamental principle of the Medicare program is regulatory noninterference with health care providers’ business activities, including establishing charges for services and supplies. The preamble to the Social Security Act, provides: “Nothing in this title [of the Social Security Act] shall be construed to authorize any Federal officer or employee . . . to exercise any supervision or control over the administration or operation of any such institution, agency, or person.”¹⁹⁹ A key function of hospital administration is to establish and update charges for medical supplies and services. Therefore, a reasonable interpretation of the statutory provision suggests that the government lacks authority to supervise or control hospitals’ charging practices or price increases.²⁰⁰

authorizing CMS to instruct fiscal intermediaries to use updated, non-final data and allowing providers to request use of the same data); *id.* at 34,504 (establishing a new section, 412.84(i)(3), regarding year-end reconciliation, and indicating that CMS would issue further instructions to fiscal intermediaries through program memoranda).

196. *See supra* note 171 and accompanying text (describing former regulation).

197. Change in Methodology, 68 Fed. Reg. at 34,500 (implementing revisions at section 412.84(h), (i)(1)).

198. Proposed Change in Methodology, 68 Fed. Reg. at 10,425.

199. Social Security Act § 1801, 42 U.S.C. § 1395 (2000).

200. For the most part, the federal government has complied with this directive. Attempts to regulate hospital charges were either short-lived or

Out of apparent respect for that principle, federal regulators traditionally accorded Medicare providers considerable discretion in setting charges and updating prices. No Medicare regulations or instructions require hospitals to establish particular prices or limit the amount by which they may increase charges. In fact, Medicare program instructions specifically prohibit the agency from regulating charges: “[T]he Medicare program cannot dictate to a provider what its charges or charge structure may be”²⁰¹ But certain Medicare reimbursement principles and regulations could provide a hook for CMS to crack down on charge inflation under the outlier payment initiative.

One potential hook CMS might use to regulate charges appears in the old Medicare cost reimbursement regulations. Prior to PPS implementation, hospitals were paid the lower of their reasonable costs or customary charges (“LCC”).²⁰² The LCC regulations defined “customary charges” as “the regular rates that providers charge both beneficiaries and other paying patients for the services furnished to them.”²⁰³ Similarly, Medicare program instructions interpreted the LCC regulation to mean that “customary charges” are charges actually “imposed uniformly on most patients.”²⁰⁴ The Medicare instructions provide further that “customary charges” must “actually be collected from a substantial percentage of patients liable for payment on a charge basis.”²⁰⁵ The intent of those requirements was to prevent providers from gouging the government with high prices while offering discounts or write-offs to commercial payors. In practice, however, commercial insurers typically negotiate discounted or special rates, and the government pays based on DRGs or fee schedules. Accordingly, the only “[p]atients liable for payment on a charge basis” are self-pay or

never enacted. For example, President Nixon’s Economic Stabilization Program (“ESP”), which was in place from November 1971 to April 1974, implemented national wage and price controls, including hospital rate controls. See ROSENBLATT ET AL., *supra* note 132, at 481-83; see also PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 423 (1982) (noting that providers responded to price controls by increasing volume and, after ESP was repealed, increased fees to compensate for the losses). In 1977, President Carter proposed to limit hospital rate increases to 1.5% of the gross consumer price index and to cap such increases at nine percent annually, but the proposal failed. See ROSENBLATT ET AL., *supra* note 132, at 484; STARR, *supra*, at 412.

201. HEALTH CARE FINANCING ADMIN., U.S. DEPT’ OF HEALTH & HUMAN SERVS., PROVIDER REIMBURSEMENT MANUAL § 2203 (1997) [hereinafter MANUAL].

202. 42 C.F.R. § 413.1(b) (2004).

203. *Id.* § 413.13(a).

204. MANUAL, *supra* note 201, § 2604.3.

205. *Id.* (internal quotation marks omitted).

uninsured patients.²⁰⁶ Read together, the LCC regulations and interpreting instructions create an incentive for aggressive collection practices against uninsured patients.²⁰⁷

Also, Medicare cost-reimbursement principles emphasize uniformity, meaning that providers must charge the same rates to all payors—commercial insurers, government health care programs, and self-pay patients. The principle of uniform charges created a pitfall, however, because hospitals interpreted the principle as requiring them to charge all patients, including the uninsured, the same list price and disallowing price adjustments, discounts, or sliding-scales based on patients' ability to pay.²⁰⁸ Accordingly, Tenet's practice of charging its full, "strong" or "robust" prices to uninsured patients arguably was necessary to comply with Medicare rules. But that practice of demanding full charges from uninsured patients attracted public scorn and lawsuits alleging price-gouging.²⁰⁹

Other regulations, no longer applicable under PPS, echo the uniformity principle and suggest additional limits on providers' discretion in establishing charges. According to cost reimbursement regulations, charges should be "reasonable" and bear some relation to the actual cost of care.²¹⁰ In their annual cost reports, providers must distinguish between reimbursable costs, meaning costs attributable to serving Medicare patients, and excluded costs, meaning costs attributable to treating non-Medicare patients.²¹¹ The regulations and instructions regarding this "cost apportionment" process provide: "Charges means the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as

206. *See id.* § 2604.3(B)(1).

207. CMS, in other contexts, has similarly addressed incentives to collect from uninsured patients, specifically encouraging providers to pursue collection practices. For example, in proposing changes to reduce the amount of extra Medicare payments available to hospitals for "bad debt," the agency noted that the current liberal bad-debt policy "provides an incentive to the provider to forego effective collection efforts in return for the certainty of Medicare payments." Medicare Program; Provider Bad Debt Payment, 68 Fed. Reg. 6,682, 6,684 (Feb. 10, 2003) (codified at 42 C.F.R. pt. 413).

208. *See supra* note 118 and accompanying text (describing Health & Human Services' and the Inspector General's responses to hospitals' pricing practices towards the uninsured).

209. *See supra* note 79 and accompanying text (describing lawsuits and Tenet's response).

210. 42 C.F.R. § 413.9 (2004).

211. *Id.* §§ 413.9, 413.20.

the basis for apportionment is the objective that charges for services be related to the cost of the services.”²¹²

Medicare instructions interpreting the regulation specify that “each facility should have an established charge structure which is applied uniformly to each patient” and “which is reasonably and consistently related to the cost of providing the services.”²¹³ Although CMS could rely on those provisions to regulate hospital charges, the provisions are phrased in precatory rather than mandatory terms, which leave room to argue that charges “should” be, but are not necessarily required to be, uniform.

A final reference to hospital charges appears in the Social Security Act and Medicare regulations pertaining to the Office of Inspector General’s (“OIG”) enforcement authority.²¹⁴ The OIG is authorized to impose civil and criminal fines and exclude providers from participating in the Medicare program for particular misconduct.²¹⁵ Specifically, the OIG may exclude a provider that has “[s]ubmitted, or caused to be submitted, bills or requests for payments under Medicare . . . containing charges or costs for items or services furnished that are substantially in excess of such individual or entity’s usual charges or costs for such items or services.”²¹⁶ Less strongly worded than the LCC and cost apportionment regulations, the OIG regulations do not require uniform charges or charges that bear relation to costs. The OIG provision requires only that the provider’s charges to the government are usual and not “substantially in excess” of amounts charged to other payors.²¹⁷

CMS is gradually abandoning charge-based payment in many areas of the Medicare program, but the OIG provision has recently been given new teeth. Recent agency guidance now clarifies that the OIG has discretion in imposing sanctions, including program exclusion, for providers submitting claims for amounts “substantially in excess” of usual charges and notes a statutory good cause exception.²¹⁸ Also, the OIG proposed amendments that would

212. *Id.* § 413.53(b)(2)(ii).

213. MANUAL, *supra* note 201, § 2203.

214. *See generally* Social Security Act §§ 1128-1129A, 42 U.S.C. §§ 1320a-7 to 1320a-8b (2000); 42 C.F.R. §§ 1001-08 (2004).

215. *See* Social Security Act §§ 1128A-11298B, 42 U.S.C. §§ 1320a-7a to 1320a-7b; 42 C.F.R. §§ 1001, 1003.

216. 42 C.F.R. § 1001.701(a)(1); *see also* Social Security Act § 1128(b)(6), 42 U.S.C. § 1320a-7(b)(6) (regarding the OIG’s permissive exclusion authority for excessive charges).

217. *See* Social Security Act § 1128(b)(6), 42 U.S.C. § 1320a-7(b)(6); 42 C.F.R. § 1001.701(a)(1).

218. *See* HHS, HOSPITAL DISCOUNTS, *supra* note 118, at 1-2 (addressing

explicitly define the key terms “substantially in excess” and “usual charges.”²¹⁹ In the preamble to the proposed rule, the OIG expressed concern over charge inflation and noted the continued relevance of charges, even after PPS implementation. Specifically, the notice identifies that Medicare Part B and “[o]ther Medicare payment provisions, such as the inpatient outlier payment methodology, also depend in whole or part on a provider’s costs or charges.”²²⁰ The renewed attention to the OIG regulations suggests the direction in which authorities may be headed in regulating hospital charges, despite the historical hands-off approach.

In addition to concern over outlier payments, the uninsured charges issue and the Tenet pricing abuse lawsuits prompted CMS to issue various guidance statements on hospital practices. The agency disavowed any interpretation of Medicare regulations that would require hospitals to demand full charges or engage in aggressive collection practices against uninsured patients. The agency asserts that the recent statements “reflect[] no change to existing policy.”²²¹ Despite CMS’s announced policy on hospital charges and uninsured patients, Medicare providers still may rationally fear both informal and formal sanctions for violating the uniform charges and other provisions.²²² First, Medicare regulations are notoriously indeterminate.²²³ In addition, CMS has a history of regulatory indifference followed by unexpected, zealous

providers’ concerns that offering discounts to uninsured patients would violate various program laws and guidance).

219. *See id.* at 2; Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53,939, 53,940-43 (Sept. 15, 2003) (codified at 42 C.F.R. pt. 412).

220. Clarification of Terms, 68 Fed. Reg. at 53,940.

221. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDLEARN MATTERS: INFORMATION FOR MEDICARE PROVIDERS, REMINDER: HOSPITAL DISCOUNTS PERMITTED FOR INDIGENT, UNINSURED, AND UNDERINSURED PATIENTS, NO. SE0405, *available at* <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0405.pdf>.

222. *See id.*; News Release, *supra* note 118 (“Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that as a result, the uninsured are forced to pay ‘full price’ for their care. That suggestion is not correct and certainly does not accurately reflect my policy.”). *See generally* CENTERS FOR MEDICARE & MEDICAID SERVICES, QUESTIONS ON CHARGES FOR THE UNINSURED (Feb. 17, 2004) (discussing various implications of CMS and OIG regulations on charges to uninsured patients and providing that discounts to uninsured patients do not affect a provider’s RCC as long as full charges are listed on the Medicare cost report), *available at* http://cms.hhs.gov/FAQ_Uninsured.pdf.

223. *See, e.g.*, Clarification of Terms, 68 Fed. Reg. at 59,340.

enforcement.²²⁴ Informal sanctions might include audits and investigations of hospital charges, such as the audits announced in the outlier program memoranda. Moreover, the government has authority to impose formal sanctions, including steep fines and loss of all Medicare revenue through program exclusion, for health care fraud and abuse.²²⁵ Finally, CMS followed a similar strategy to reduce overcharges in an analogous context—prescription drug prices under Medicare and Medicaid.

2. Prescription Drug Pricing Analogy

Another Medicare and Medicaid loophole, similar to the outlier loophole, allows providers to increase reimbursement by increasing charges for pharmaceutical products. Under Medicare Part B, the Medicaid program, prescription drugs were reimbursed according to formulas based on the drugs' average wholesale price ("AWP").²²⁶ Pharmaceutical manufacturers and suppliers were free to set the AWP, just as hospitals were free to set hospital charges.²²⁷ Until recently, drug pricing issues under Medicare were limited to a narrow class of Part B outpatient drugs because drugs prescribed to patients during inpatient hospital stays are included in the bundled DRG payments.²²⁸

The recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA")²²⁹ dramatically overhauled Medicare coverage, adding a broad prescription drug benefit for outpatient drugs. The legislation codifies the Medicare noninterference policy and expressly prohibits the government from negotiating with pharmaceutical companies on

224. See, e.g., *infra* notes 236-39 and accompanying text (describing the prescription drug pricing crack-down).

225. See David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen,"* 30 J. LEGAL STUD. 531, 550 (2001) (describing a history of inconsistent enforcement and potential for steep sanctions when regulatory priorities change).

226. See 42 U.S.C. § 1395u(o)(1) (2000).

227. See *supra* notes 200-01 and accompanying text.

228. See *supra* notes 134-40 and accompanying text (describing Medicare PPS and DRG payment structure for inpatient hospital care). The cost of drugs and biologics supplied to hospital inpatients, under Medicare Part A, are bundled into the DRG payment. Drugs and biologics furnished to an inpatient for use outside the hospital, i.e., post-discharge or as a hospital outpatient, other than a limited supply necessary to facilitate discharge, generally are not covered under Part A. See HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICARE CARRIERS MANUAL, Part 3, Claims Process § 3101(3)(E) (1984) [hereinafter CARRIERS MANUAL].

229. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

the price of drugs purchased for Medicare beneficiaries, despite the fact that the sheer volume of drugs purchased and other factors give the government a strong bargaining position. Drug pricing under the new Part D benefit is worked out between private insurance companies sponsoring the drug benefit²³⁰ and pharmaceutical manufacturers. Specifically, the MMA provides:

In order to promote competition under this part and in carrying out this part, the Secretary—(1) may not interfere with the negotiations between drug manufacturers and pharmacies and [prescription drug plan] sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs.²³¹

The decision under MMA to give free rein on prescription drug pricing to the pharmaceutical and insurance industries drew strong public objection and accusations that the lawmakers drafting the MMA were “captured” by politically powerful lobbying groups.²³² Although such criticism may be overstated, the MMA contains not merely a loophole but an open invitation for pricing abuses. Regulations implementing the new Part D prescription drug benefit took effect on March 22, 2005, and the drug pricing issue promises

230. These are referred to as Pharmacy Benefits Managers or “PBMs.” See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 303.

231. *Id.* § 101 (describing “noninterference”).

232. See, e.g., Ceci Connolly, *New Drug Law’s Cost Impact Debated; Some Question Whether Insurance Companies Will Get Lower Prices*, WASH. POST, Apr. 9, 2004, at A3 (noting that the government could have cut drug costs in half by using its purchasing power to negotiate lower prices, the way the VA does, and quoting Senator Edward Kennedy as stating, “[t]he single most irresponsible provision in the Medicare bill is the prohibition that prevents Medicare from negotiating lower-priced prescription drugs”); Editorial, *Give Medicare Power to Bargain on Drug Costs*, TENNESSEAN, Jan. 12, 2004, at 6A (“The anti-bargaining provision only makes sense from the perspective of pharmaceutical makers, who want full price for their wares, or private health-care companies, that will now have a competitive edge against Medicare.”); Judith A. Stein, *Don’t Give Medicare Away to Private Plans*, HARTFORD COURANT, Feb. 10, 2004, at A9 (noting that the “new Medicare law includes another certain prescription for skyrocketing costs. Adding insult to injury, it explicitly prohibits the government from negotiating discounted prices with pharmaceutical companies on behalf of the 41 million Medicare beneficiaries.”); John O’Neil, *Medi-SCARE*, NEA TODAY, Mar. 1, 2004, at 34 (listing among the problems in the new law, “[n]o controls on runaway drug costs. . . . [I]n the face of fierce lobbying by the drug industry, the new law specifically forbade the federal government from negotiating with suppliers to rein in drug costs.”).

to remain a central point of controversy as the program takes effect.²³³

Past experience with drug pricing under government health care programs suggests that lawmakers' current acquiescence to the industry's price setting may not persist. Regulators responded to public pressure and attacked the AWP loophole through price reviews and threatened enforcement action, despite any clear authority to regulate drug prices. Under Medicare Part B, pharmacies and other suppliers received the lower of billed charges or ninety-five percent of the AWP.²³⁴ Under Medicaid, most states reimburse pharmacies the AWP, less a percentage discount.²³⁵ Although the government lacks clear authority to regulate charges, it nevertheless scrutinized and threatened sanctions against providers for alleged prescription drug overcharges.²³⁶

CMS recently conducted a nationwide review of pharmacy pricing and concluded that the Medicare and Medicaid programs were being significantly overcharged for prescription drugs because the AWP is not the actual price that pharmacies pay for drugs.²³⁷

233. See Medicare Program: Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194 (Jan. 28, 2005) (to be codified at 42 C.F.R. pts. 400, 403, 411, 417, 423).

234. 42 C.F.R. § 405.517(b) (2004) (explaining the payment for drugs and biologics are not paid on a cost or prospective payment basis). Medicare Part B provided limited prescription drug coverage for certain drugs and biologics furnished to outpatients, e.g., clotting agents for hemophilia, Social Security Act § 1861(s)(2)(I), 42 U.S.C. § 1395x(s)(2)(I) (2000); immunosuppressive drugs for organ transplant recipients, Social Security Act § 1861(s)(2)(J), 42 U.S.C. § 1395x(s)(2)(J); oral cancer chemotherapy drugs, Social Security Act §§ 1861(s)(2)(Q), (t)(2), 42 U.S.C. §§ 1395x(s)(2)(Q), (t)(2); hepatitis B vaccines for certain individuals, Social Security Act § 1861(s)(2)(V)(10)(B), 42 U.S.C. § 1395x(s)(2)(V)(10)(B); and flu vaccines furnished under state law, CARRIERS MANUAL, *supra* note 228, § 2049(4)(B)(3). See also 42 C.F.R. § 419.64(d) (2004) (stating that outpatient reimbursement is ninety-five percent of AWP minus the ambulatory payment classification ("APC") amount). Under the Medicare outpatient prospective payment system ("OPPS"), APCs are fixed payment categories analogous to DRGs under inpatient PPS. See *id.* § 419.31.

235. See generally U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., MEDICAID PHARMACY—ACTUAL ACQUISITION COST OF GENERIC PRESCRIPTION DRUG PRODUCTS, REP. NO. A-06-01-00053 (2002) [hereinafter HHS, GENERIC] (describing prescription drug reimbursement under states' Medicaid programs); see also U.S. DEP'T HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., MEDICAID PHARMACY—ACTUAL ACQUISITION COST OF BRAND NAME PRESCRIPTION DRUG PRODUCTS, REP. NO. A-06-00-00023 (2001) [hereinafter HHS, BRAND NAME] (describing prescription drug reimbursement under states' Medicaid programs).

236. See *supra* Part IV.B.1 (discussing CMS's authority to regulate charges).

237. See generally HHS, GENERIC, *supra* note 235; HHS, BRAND NAME, *supra* note 235; see also *Medicare Payments for Currently Covered Prescription Drugs:*

The AWP is the pharmaceutical manufacturer's "list price" for the drug, similar to a hospital's list price or full charges for medical treatment. But like hospitals, drug manufacturers typically offer discounts to certain buyers, such as pharmacies and other wholesale purchasers.²³⁸ As a result, the only purchaser being charged the full AWP or list price for drugs was the government. The government alleged that manufacturers' "manipulation of AWPs" caused the significant overpayments and, accordingly, sought to bring reimbursement levels "more in line with the actual acquisition costs."²³⁹

CMS further suggested that the practice of inflating AWPs for purposes of increasing government health care program reimbursement could be actionable under the federal civil False Claims Act ("FCA").²⁴⁰ Medicare-participating hospitals are aware of the high stakes for exploiting loopholes, even if the conduct is not clearly prohibited. Medicare regulators previously have turned to the FCA and other laws to sanction conduct that previously seemed tacitly, if not openly, acceptable but later became an enforcement

Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 107th Cong. 9-13 (2002) (statement of CMS Administrator Thomas A. Scully regarding Part B overpayment for drugs).

238. *See generally* HHS, BRAND NAME, *supra* note 235.

239. HHS, GENERIC, *supra* note 235, App. 3 (reprinting CMS Administrator Scully's letter to Inspector General Janet Rehnquist); *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., MEDICAID PHARMACY—ADDITIONAL ANALYSES OF THE ACTUAL ACQUISITION COST OF PRESCRIPTION DRUG PRODUCTS, REP. NO. A-06-02-00041 (2002) (proposing a four-tiered reimbursement methodology). As with the outlier formula, the potential for providers to increase drug reimbursement levels by increasing charges was not a new revelation for federal regulators. As early as 1975, the Secretary of Health, Education, and Welfare ("HEW") attempted to control Medicare and Medicaid drug costs, under the Maximum Allowable Cost initiative. *See* Limits on Payments for Drugs, 40 Fed. Reg. 34,512, 34,516 (Aug. 15, 1975); Limitations on Payment or Reimbursement for Drugs, 40 Fed. Reg. 32,283, 32,284 (July 31, 1975).

240. *See* Draft OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 67 Fed. Reg. 62,057, 62,060 (Oct. 3, 2002) (explaining that the federal government sets reimbursement rates for pharmaceuticals "with the expectation that the data provided are complete and accurate," that manufacturers' reported prices "should accurately take into account price reductions, rebates, up-front payments, coupons, goods in kind, free or reduced price services, grants or other price concessions or similar benefits offered to some or all purchasers," and that submission of "false, fraudulent, or misleading information" is actionable under the False Claims Act). The False Claims Act prohibits knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval. *See* 31 U.S.C. § 3729(a)(1) (2000).

priority.²⁴¹ The FCA carries steep sanctions, including treble damages and civil monetary penalties up to \$11,000 per claim,²⁴² meaning each individual patient record, of which there could be thousands for a particular medical provider.²⁴³

Similar to the AWP issue, the government could employ a strategy of accusation and innuendo to rein in hospital charges under the Medicare outlier payment initiative.²⁴⁴ Specifically, enforcement authorities could allege that hospital charge structures are grossly inflated and bear no relation to the actual prices that commercial insurers and others pay for inpatient services and supplies. Then, they could allege that claims for Medicare outlier bonus payments based on inflated charges amount to a false claim in violation of the FCA. Despite the lack of authority over hospital charges and a historical policy of noninterference toward hospital administration, federal authorities could resort to the open-ended language of FCA to sanction perceived abuses under the Medicare outlier adjustment.²⁴⁵ In light of those possibilities, health care providers may weigh the risks associated with the loophole heavily and alter otherwise beneficial pricing and other business strategies to avoid the potentially steep monetary and reputational sanctions.

Before regulators embark on a campaign of closing Medicare loopholes, including the outlier adjustment, the collateral economic effects of stifling private market competition and innovation should be considered. The dual government and private health care delivery systems are not coordinated and may offer competing incentives. The current trend in health care reform is to increase reliance on privatization, competition, and market-based strategies as ways of reducing costs and improving quality and efficiency. Therefore, it is especially important that regulators implement any

241. See Hyman, *supra* note 225, at 550-52 (discussing problems of “speakeasy” enforcement of health care fraud and abuse under an over inclusive, highly indeterminate FCA provision).

242. 31 U.S.C. § 3729(a)(7) (listing civil monetary penalties under the FCA); 42 C.F.R. § 1003.103(c) (2004) (stating that the “OIG may impose a penalty of not more than \$11,000 for each payment for which there was a failure to report required information”) (footnote omitted).

243. See Hyman, *supra* note 225, at 536 (noting that “[b]ecause most health care providers typically submit a large number of modest claims, this structure means that statutory penalties generally dwarf actual damages and quickly rise to staggering levels”); Jost & Davies, *supra* note 131, at 247-48 (noting that “[h]ealth care providers tend to file large numbers of small claims, often amounting to thousands of claims over the course of a year” and that “penalties . . . can literally run into hundreds of millions of dollars”).

244. See While & Lee, *supra* note 114 (quoting CMS Administrator Scully: “If you have true costs, great. If not, we are going to come looking for you.”).

245. See *supra* notes 240-43 and accompanying text.

changes to the Medicare program only after fully considering the risks posed by historical loopholes and secondary effects of closing them on both the overall regulatory scheme and private market. In Tenet's case, CMS's Medicare outlier initiative deterred potentially innovative market strategies that might have provided useful guidance in forthcoming health care policy discussions.

V. ANALYSIS

In the current health care environment of declining reimbursement and rising costs, hospitals—and not just for-profit hospitals like Tenet, but also non-profit, community, and teaching hospitals—look for ways to offset losses in losing cost centers by increasing revenue or reimbursement in other areas. “Cost-shifting” is standard operating procedure for hospitals in the current health care market squeeze. Accordingly, hospitals may identify regulatory incentives, including loopholes, as potentially lucrative sources of additional income.

The easy answer to the problem of Medicare loopholes is simply to close them and thereby eliminate the temptation. But loopholes are inevitable and pervasive in complex regulatory schemes like the tax code and Medicare reimbursement methodology.²⁴⁶ Regulators may lack resources to quickly spot and close the loopholes. On the other hand, regulators may be fully aware of loopholes but may rationally weigh the costs and benefits of closing the loopholes and make a conscious choice not to leave them open, as occurred for many years with the Medicare outlier payment formula. But public pressure or concern over “cheating” may cause regulators to re-prioritize and reconsider settled issues.²⁴⁷ The standard approach to closing loopholes through statutory or regulatory amendment may be slow or cumbersome because formal legislative or administrative channels must be navigated. Public pressure for speedy response may drive regulators to employ shortcuts and informal methods of tightening loopholes or otherwise addressing the Medicare “pollutant of the month.”²⁴⁸ In addition, the impatient public may

246. Editorial, *See The Real Tenet Scandal*, *supra* note 2 (regarding the inevitability of loopholes in Medicare regulatory system). *Cf.* Uwe E. Reinhardt, *Medicare Can Turn Anyone Into a Crook*, *WALL ST. J.*, Jan. 21, 2000, at A18 (noting the “unrivaled” regulatory complexity of the Medicare program and tendency of “spooked” hospital executives to cave to enforcement actions rather than litigate).

247. *See* Hyman, *supra* note 225, at 550 (observing that “when administrative priorities change, conduct that everyone in the industry thought was acceptable can suddenly become exhibit A in a criminal and civil case”).

248. “In the context of environmental legislation, it encourages the well-known ‘pollutant of the month’ syndrome, where regulation is driven by recent

not wait for official response, applying a range of informal sanctions against identified wrongdoers.²⁴⁹ Social norms and informal sanctions, in some cases, may compliment government enforcement.²⁵⁰ But those approaches more often will lead to over-deterrence or misguided responses by the sanctioned actors. Without the deliberative, albeit slow, process that characterizes administrative policy changes, society's attempted "cure" may be much more harmful than the perceived "cancer" sought to be eliminated.

A. *Gauging the Cost of Loopholes*

The Medicare program, by design, contains payment incentives directing health care providers' operations.²⁵¹ For example, in implementing inpatient PPS, regulators intended providers to limit unnecessary services and inflationary spending. Moreover, by restricting payment for inpatient care under PPS, while outpatient

and memorable instances of harm." Jolls et al., *A Behavioral Approach*, *supra* note 4, at 1518 (regarding anecdote-driven environment legislation and noting that reliance on "how 'available' other instances of the harm in question are" is a fully rational judgment error that nevertheless can lead to systemic errors); see also Kuran & Sunstein, *supra* note 5, at 691-701 (discussing the Love Canal, Alar pesticide, and other examples).

249. Decentralized enforcement through social norms may offer a faster, more responsive approach than centralized enforcement to police private conduct. See Robert D. Cooter, *Decentralized Law for a Complex Economy: The Structural Approach to Adjudicating the New Law Merchant*, 144 U. PA. L. REV. 1643, 1655 (1996) (describing alternative views that social norms are either hard to change because a procedure for reform does not exist or easy to change because reform does not require formal procedures). Cf. Eric A. Posner, *Law, Economics, and Inefficient Norms*, 144 U. PA. L. REV. 1697, 1700-01 (1996) (refuting the notion that decentralized rulemaking is more effective and streamlined than centralized rulemaking).

250. See ROBERT C. ELLICKSON, *ORDER WITHOUT LAW* 127 (1991) (describing norms as rules emanating from social forces and laws as rules emanating from government); Richard H. McAdams, *The Origin, Development, and Regulation of Norms*, 96 MICH. L. REV. 338, 340 (1997) (defining norms as "informal social regularities that individuals feel obligated to follow because of an internalized sense of duty, because of fear of external non-legal sanctions, or both"); Richard A. Posner & Eric B. Rasmusen, *Creating and Enforcing Norms, with Special Reference to Sanctions*, 19 INT'L REV. L. & ECON. 369, 369 (1999) (providing examples, including table manners, grammar rules, country club regulations, standard business practices, and lying, which may be independent of, or overlap with, laws).

251. See Jost & Davies, *supra* note 131, at 250 (noting that "payment systems unavoidably provide incentives for certain kinds of provider behavior—for example, the provision, of more, or of higher quality, or of more cost-effective health care goods and services. Payment systems are often consciously designed to promote such goals.").

care remained under the old, potentially more lucrative cost-based reimbursement program, regulators intended for hospitals to divert resources to outpatient treatment.²⁵² Responding to that incentive, hospitals closed some acute care inpatient units and opened new, long-term care units, which were reimbursed as outpatient services.²⁵³

Since PPS implementation, providers have identified various unintended incentives, or loopholes, to increase Medicare reimbursement under the fixed DRG payments.²⁵⁴ For example, providers quickly recognized that by “upcoding,” or classifying patients’ conditions as more complex or acute than medically indicated, they could collect higher DRG payment amounts.²⁵⁵ The

252. See Stephenson v. Shalala, 87 F.3d 350, 355 (9th Cir. 1996) (noting that after inpatient PPS implementation “permitting outpatient charges to rise is consistent with Congress’ goal of encouraging a diversion of resources toward outpatient treatment. . . . By increasing the rate of return to outpatient vis-à-vis inpatient procedures, Congress effectively increased the incentive to supply outpatient services.”).

253. See Theodore M. McDowell, Jr., *Physician Self Referral Arrangements: Legitimate Business or Unethical “Entrepreneurialism”*, 15 AM. J.L. & MED. 61, 64 (1989) (noting that providers responded to PPS implementation by shifting services to non-hospital settings). Cf. George Anders, *A Plan to Cut Back On Medicare Expenses Goes Awry; Costs Soar: Hospitals Rush to Remodel To Offer Subacute Care – And Get Paid Twice*, WALL ST. J., Oct. 3, 1996, at A1, reprinted in ROSENBLATT ET AL., *supra* note 132, at 486-87 (suggesting that “incomplete and imperfect efforts to contain [Medicare] costs” fall on elderly and disabled because hospitals identify alternative reimbursement strategies rather than reduce costs).

254. As one commentator summarized:

Health-care providers have been gaming Medicare since that federal insurance program evolved into a system of Soviet-style price controls in the 1980s. Medicare pays a fixed amount for a treatment, regardless of costs, and in turn companies search for loopholes in the system’s 100,000 pages of regulations to make up the difference. Sooner or later Medicare discovers the “loophole,” closes it and the cycle starts all over.

Editorial, *The Real Tenet Scandal*, *supra* note 2, at A14; see also Editorial, *Tenet’s Shareholder Ills*, *supra* note 2, at A10 (“As we’ve said before, Tenet’s mistake wasn’t in getting what it could from Medicare loopholes, but that it didn’t let shareholders know that the windfall couldn’t last.”). See generally Richard M. Cooper, *Objectionable Conduct*, NAT’L L.J., Oct. 20, 2003, at 16 (noting that “[m]arket forces respond to incentives; and in virtually all markets, even the unlawful ones, the government significantly affects the incentives to which buyers and sellers respond” and discussing regulatory incentives in Medicare prescription drug reimbursement policy). Cf. Hyman, *supra* note 225, at 542 (suggesting that, under cost-contained health care payment systems, physicians may believe that the only way to provide high-quality care is to manipulate reimbursement rules).

255. See, e.g., David Wessel, *Medicare Cures: Easy to Prescribe, Tricky to*

Medicare outlier adjustment was another incentive built into PPS regulatory framework. Day outlier payments created an incentive to keep patients in the hospital extra days. Cost outlier payments also created incentives—an intended incentive to treat the sickest and most needy Medicare patients and an unintended incentive for charge inflation.

As a matter of basic microeconomics, perhaps none of those strategies was unexpected or irrational. In each instance, hospitals were acting as rational profit-maximizing firms. But as a normative matter, many of us would consider at least some of the conduct objectionable.²⁵⁶ Practices such as upcoding or extending lengths of stay may be consistent with individual wealth maximization but may misallocate societal resources if a provider receives reimbursement that greatly exceeds the actual costs of caring for the patient. The Medicare program is supported by a limited pool of federal funds, derived from general revenue and federal payroll tax,

Predict, WALL ST. J., June 30, 2003, at A1 (describing a pneumonia upcoding probe to crack-down on improper coding of “high-risk pneumonia” and reporting that a 1993 government study of 17,000 pneumonia cases found that only 3.3% were classified as “low-risk,” a much lower figure than medical evidence suggests); *see also supra* note 80 and accompanying text (describing Tenet’s settlement of pneumonia upcoding charge settlement). Several other strategies have been the focus of government enforcement initiatives, such as “Operation Bad Bundle,” which targeted hospitals’ attempts to collect higher reimbursement for certain laboratory tests by billing the tests individually, or “unbundled,” rather than as a panel or “bundle” of tests as required by regulations. The Physicians at Teaching Hospitals (“PATH”) audits, targeted improper billing for services provided by supervising physicians at academic medical centers. The “72-Hour DRG Payment Window” initiative involves a Medicare regulation that requires hospitals to include services furnished to inpatients within seventy-two hours before or after admission as part of the bundled DRG payment, rather than billing separately for hospital outpatient services. Another DRG-related issue involves billing hospital transfers as discharges so that each hospital receives the full DRG amount. Medicare regulations provide that only the transferee hospital receives the DRG payment, while the transferring hospital receives a per-diem amount. *See Hyman, supra* note 225, at 555 (listing OIG enforcement initiatives aimed at hospital billing practices); *Jost & Davies, supra* note 131, at 255-57 (describing national health care fraud and abuse enforcement initiatives).

256. *See, e.g., Said, supra* note 77, at A1 (describing a health care analyst as saying, “I don’t know any other way to put it. They [Tenet] have a duty not to manipulate their strategies to game the system. They just did not act as good corporate citizens.”). *But see Jost & Davies, supra* note 131, at 254 (describing a continuum of “beneficial to inexcusable” provider responses to incentives in government health care programs and identifying upcoding as an “enthusiastic” response to incentives, i.e., “responses that the designers of the incentive system perhaps did not contemplate, but they are not yet beyond the bounds of either reasonableness or manageability”).

with some additional contributions by Medicare beneficiaries in the form of premiums, deductibles, and copayments.²⁵⁷ But the pool of funds is largely fixed, meaning that excessive payments to one participating provider deplete funds available to pay other providers. Federal dollars account for almost one-third of health care providers' income.²⁵⁸ Providers that lose out to loophole exploiters may be forced to close their operations, potentially endangering the overall availability of health care services. Moreover, taxpayers face increased tax burdens if the government has to generate additional dollars to maintain existing Medicare enrollment and benefit levels. Therefore, basic fairness, fiscal concerns, and market practicalities suggest some need to police loopholes, even if the conduct is not clearly unlawful.

Under traditional principles of profit-maximization, firms will cheat as long as it is economically efficient to do so; that is, as long as the potential gains from cheating outweigh the potential risks.²⁵⁹ Potential gains might include capturing a market advantage or remaining competitive in a tight market.²⁶⁰ Potential risks include

257. 42 U.S.C. §§ 1395i, 1395s (2000).

258. See OIG Statement, *supra* note 12 (citing statistics regarding government health care purchasing).

259. See, e.g., James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 218 (1996) (noting that illegal conduct is "rampant and countenanced by law enforcement officials because" fraud and abuse laws and enforcement are "so out of sync with the conventional norms and realities of the marketplace"); Kimberly D. Krawiec, *Accounting for Greed: Unraveling the Rogue Trader Mystery*, 79 OR. L. REV. 301, 308-09 (2000) (discussing incentives and observing that traders' motivations to hide losses and fabricate profits "are so great that to fail to attempt such evasion is arguably irrational"); Cooper, *supra* note 254, at 16 (noting that where the "risk of detection of improper conduct or of strong enforcement action against it appears to be small, competitors will cheat, even at some risk of running afoul of laws with substantial penalties"); see also Eric A. Posner, *The Jurisprudence of Greed*, 151 U. PA. L. REV. 1097, 1122 (2002) (noting that "[g]reed is a problem for the state because greedy people are too hard to control" because they are "either so myopic and extreme that they do not care about legal sanctions, or they are so cold and calculating that they exploit all legal loopholes to their own benefit and to the harm of others"). Cf. Jost & Davies, *supra* note 131, at 268 (noting that complete deterrence requires a penalty that equals or exceeds any potential gain from wrongful conduct); Dan M. Kahan, *Social Influence, Social Meaning, and Deterrence*, 83 VA. L. REV. 349, 349 (1997) (noting that standard economic conception of deterrence assumes that "[i]ndividuals commit crimes . . . when the expected utility of law-breaking exceeds the expected disutility of punishment").

260. See Krawiec, *supra* note 259, at 335 (concluding that "market forces will not eliminate rouge trading" because self-interested trading benefits traders, management, and, to some extent, shareholders); Cooper, *supra* note 254, at 16

formal and informal sanctions. Therefore, even if certain business strategies or conduct are not actually unlawful, firms may recognize efficiency or other rational economic reasons to resist regulatory loopholes. Society may impose informal sanctions against conduct that violates widely held values, beliefs, or norms, including standards of fairness and morality.²⁶¹ Informal sanctions include guilt, shame, stigmatization, gossip, ostracism, disapproval, contrition, and vengeance.²⁶² The government may impose legal sanctions, including fines, incarceration, and, in the Medicare context, exclusion from participation in government health care programs.²⁶³ But lack of coordination among official and unofficial “regulators” may lead to under-enforcement, with the questionable conduct going unchecked. Alternatively, over-zealous enforcement may deter competition and produce inefficient responses by

(“In current circumstances, companies competing in the market have to choose either to exceed the limits or suffer a competitive disadvantage.”).

261. See Posner, *supra* note 249, at 1720 (discussing morality and norms that “reflect nonefficiency and, more generally, non-consequentialist values”); see, e.g., Kahan, *supra* note 259, at 357-59 (noting that “individuals tend to adapt their moral convictions to those of their peers” and are more likely to violate or evade laws if they perceive their peers are doing so). See generally Posner, *supra* note 259, at 1099-1102 (distinguishing “self-interest,” in consumer choice theory, from “greed,” which describes “excessive bodily appetites or an excessive longing for purchasing power” and “carries with it a moral charge”).

262. See ELLICKSON, *supra* note 250, 213-19 (outlining gradual escalation of force against norm violators, from notice, to gossip, to physical seizure and destruction of measured amount of deviant’s assets); Cooter, *supra* note 249, at 1668-69 (“Informal sanctions like gossip and ostracism are cheap pain” which “increase the expected cost of violating the norm, which increases conformity to it.”); Dan M. Kahan, *What Do Alternative Sanctions Mean?*, 63 U. CHI. L. REV. 591, 631-49 (1996) (listing and discussing various shaming penalties); Posner & Rasmusen, *supra* note 250, at 370-72 (describing six types of sanctions for violating norms, including automatic sanctions, guilt, shame, informational sanctions, bilateral costly sanctions, and multilateral costly sanctions); see also John B. Owens, *Have We No Shame?: Thoughts on Shaming, “White Collar” Criminals, and the Federal Sentencing Guidelines*, 49 AM. U. L. REV. 1047, 1047-53 (2000) (evaluating Kahan’s arguments in favor of “shaming” sanctions for white collar criminals).

263. Kahan, *supra* note 262, at 591 (listing forms of punishment for violating laws and noting overwhelming societal preference for incarceration); Posner, *supra* note 249, at 1699 (defining a “norm” as “a rule that distinguishes desirable and undesirable behavior and gives a third party the authority to punish a person who engages in the undesirable behavior” and noting that “a private person sanctions the norm violator, whereas a state actor sanctions the law violator”); Posner & Rasmusen, *supra* note 250, at 369-70 (noting further that public institutions use “well-defined deliberative” processes to promulgate laws, and states’ enforcement ultimately carries a “threat of violence”).

regulated firms.²⁶⁴ In theory, a combination of formal and informal sanctions could provide an effective strategy for policing complex, regulated industries, such as the American health care market.²⁶⁵ Industry insiders or competitors may be better or faster at identifying problems and imposing sanctions than government regulators.²⁶⁶ Moreover, regulators may be entrenched or impeded by bureaucratic red tape, factors which hamper their ability to effectively or quickly address changing industry practices and close problematic loopholes.

Without waiting on formal action by regulators, the public responded to the Weakley report identifying the outlier issue by imposing informal sanctions, including shaming, gossip, ostracism, and disapproval on Tenet. News reports and commentators cited Tenet's questionable practices, explained (often erroneously) the correlation between charges and outlier payments, and questioned

264. See Cooper, *supra* note 254, at 16 (“Sometimes, even objectionable conduct simply should be tolerated”); Posner, *supra* note 249, at 1708 (noting, in variant of Coase’s theorem, that inefficient laws may be superseded by efficient norms, “transferring the entitlement to the party who values it most”); *id.* at 1728-29 (discussing strategies for eliminating inefficient norms by creating incentives for violating them); Posner, *supra* note 259, at 1132 (describing the role of judges in condemning “socially valuable if unsavory” behavior and “sow[ing] confusion for litigants and the public”); Posner & Rasmusen, *supra* note 250, at 380-81 (discussing interplay of government sanctions and norms and noting “that government should be careful about interfering with norm sanctions. Sometimes just staying out of the way is the best policy.”).

265. See ELLICKSON, *supra* note 250, at 5-6 (discussing pervasiveness of social norms and noting that “[p]eople may supplement, and indeed preempt, the state’s rules with rules of their own”); Kahan, *supra* note 262, at 593 (describing the ways that alternative sanctions may complement traditional criminal punishments, such as imprisonment and fines); Posner & Rasmusen, *supra* note 250, at 380 (suggesting that norms may be “more important than laws in deterring theft”); see also Krawiec, *supra* note 259, at 332-33 (describing the process of norm creation and role of “norm entrepreneurs” and summarizing Ellickson’s view that a new norm arises with an individual change agent); Posner, *supra* note 249, at 1708 (“Norms are usually enforced not just by the victim, but by third parties, such as the local villagers who impose sanctions (gossip, ostracism) on those who break the rules.”); Posner & Rasmusen, *supra* note 250, at 379 (regarding norm innovators and other influences on norm enforcement).

266. See ELLICKSON, *supra* note 250, at 177 (identifying characteristics of close-knit groups that tend to promote efficient norm production, including possessing information about norms and violations, reciprocal power, and ready sanctioning opportunities); see also Cooter, *supra* note 249, at 1643-47 (introducing a theory of decentralized law, “which percolates up from the bottom”); Krawiec, *supra* note 259, at 325-32 (describing the development of financial traders’ norms).

the company's morality.²⁶⁷ Potential merger partners and investors grew wary. Tenet's own shareholders perpetuated the shaming and gossip by gathering to discuss the company's wrongdoing. Compromising their own portfolio values, the shareholders published a report tabulating Tenet's potential liability for health care fraud at \$6 billion.²⁶⁸ As a consequence, investors dumped their shares, resulting in additional informal sanctions in the form of ostracism and refusal to do business.

After years of declining to police the outlier loophole or hospital charges, CMS responded to the post-Enron public pressure to crackdown on corporate "cheating." The agency reprioritized its enforcement agenda and initiated investigations of previously overlooked practices.²⁶⁹ Aiming to act quickly, the government relied on many of the same informal sanctions that the public had already begun imposing. For example, CMS and Congress perpetuated the gossip and stigma on Tenet and other providers suspected of collecting high outlier payments by issuing strongly worded press releases and memoranda listing suspect factors for outlier abuse, publishing names of possible offenders, and initiating informal audits and investigations. The government possesses additional enforcement methods unavailable to the public including civil fines and other formal sanctions for perceived outlier abuses. Although the government's authority to regulate hospital administration and charging practices is questionable,²⁷⁰ providers took the threats seriously, knowing the agency's precedent for broadly interpreting the FCA to bring enforcement actions and potentially steep sanctions, including fines and program exclusion.²⁷¹

267. See generally Laura B. Benko, *On the Lookout; CMS Studies Outlier Billing Practices*, MODERN HEALTHCARE, Dec. 9, 2002, at 14.

268. See *supra* note 98 and accompanying text (describing a meeting that estimated liability at \$6 billion). Cf. Vikramaditya S. Khanna, *Should the Behavior of Top Management Matter?*, 91 GEO. L.J. 1215, 1223 (2003) (suggesting that "corporate liability seems, on some level, unfair because it reduces the wealth of shareholders who themselves have rarely done anything wrong directly"); Editorial, *Tenet's Shareholder Ills*, *supra* note 2, at A10 ("Tenet Healthcare presented a shiny red apple to Medicare on Monday, hoping to get back in teacher's good graces. Too bad the fruit came from its shareholders' tree.").

269. See Hyman, *supra* note 225, at 550 (observing that "when administrative priorities change, conduct that everyone in the industry thought was acceptable can suddenly become exhibit A in a criminal and civil case").

270. See *supra* part IV.B.1 (discussing CMS's authority, or lack thereof, regarding health care providers' and suppliers' pricing).

271. Program exclusion results in loss of all Medicare revenue and publication of the excluded providers' names in the Federal Register. See *supra* notes 240-43 and accompanying text (discussing regulators' use of FCA to

Faced with persistent non-legal sanctions and credible threats of costly legal sanctions, Tenet took various steps to dispel the negative attention. Tenet's response included press releases, Web site postings, and media interviews.²⁷² At first, the company denied any wrongdoing with respect to outliers but later expressed contrition and overhauled its corporate policies and practices.²⁷³ Specifically, Tenet attempted to reduce stigma and restore investor confidence by self-auditing its Medicare claims, restructuring management, and revamping pricing policies and outlier computation methodologies.²⁷⁴

As a rational corporate actor, Tenet weighed the suddenly increased potential costs of taking advantage of the outlier loophole against the benefits and reacted accordingly. However, after the Enron dust settled, it appears that Tenet may have overreacted and self-policed itself into a marginal market position. Ultimately, Tenet might have brought outlier payments in line with agency rules and guidance through corrective measures less debilitating than the concessions and changes that the public demanded through informal sanctions. Enron and other readily available examples of corporate cheating and "creative accounting" caused the public to misperceive the threat posed by the Medicare outlier loophole. The changes eventually implemented through formal amendment to the outlier regulations were not as radical or detrimental to providers' operations than the changes driven by informal sanctions, self-policing, and other fast-track regulatory initiatives. Had regulators been insulated from the public's emotional reaction and retributive desires, the agency could have conducted rational, deliberative corporate reform, preserving Tenet as a useful model for efficient, private, market health-care delivery.

B. Costly Availability Errors

Public reaction to news of Tenet's disproportionately high outlier payments produced costly availability errors similar to the effects described in other regulatory contexts.²⁷⁵ Just as the public

sanction excess prescription drug prices).

272. See, e.g., Press Release, *supra* note 99; Interview by Cory Johnson, CNBC correspondent, with Trevor Feter, President and CEO of Tenet Healthcare (Sept. 17, 2003).

273. See Press Release, *supra* note 99.

274. See *Tenet's Shareholder Ills*, *supra* note 2, at A10.

275. See Kuran & Sunstein, *supra* note 5, at 691-703 (describing the Love Canal, Alar pesticide, and TWA Flight 800 episodes and regulatory responses); see also Jolls et al., *A Behavioral Approach*, *supra* note 4, at 1518-22 (describing anecdote-driven environmental legislation, with special reference to Superfund).

latched onto the Love Canal example to conclude that hazardous waste sites represented the nation's top environmental problem—above pesticides, smoking tobacco, water pollution, work-site chemicals and other threats²⁷⁶—the public latched onto the outlier loophole and for-profit medicine as the major flaw in the American health care system, rather than a whole host of other problems. Moreover, just as in the environmental context, consumers, investors, and the media failed to understand the range of factors, incentives, and risks associated with the complex regulatory scheme. The public did not comprehend the intricate Medicare reimbursement methodology or the carefully balanced regulatory and private market incentives underlying hospital pricing and other business operations. Drawing on widely publicized examples outside of the health care context such as Enron, Adelphia, and HealthSouth, the public pushed regulators to close the Medicare outlier loophole.²⁷⁷ The enforcement program drew resources away from other priorities and concerns to a relatively minor wrinkle in the reimbursement methodology, of which regulators were well aware and had repeatedly and rationally declined to iron out.

Until the fall of 2001, Tenet rationally could have concluded that the potential exposure for targeting Medicare outlier payments was relatively low, even as a part of a deliberate strategy rather than just fortunately tapping into that revenue stream through robust pricing and product differentiation. Medicare authorities had repeatedly acknowledged the flaws in the outlier formula. They knew that hospitals could and were increasing outlier claims by increasing hospital charges. However, regulators expressly declined to impose sanctions or close the outlier loophole.²⁷⁸ In 2002, Kenneth Weakley first identified the correlation between Tenet's hospital charges and Medicare outlier payments. Weakley served as an "availability entrepreneur," offering the outlier formula as a ready explanation for Tenet's unusually high profits.²⁷⁹ The media and the public, lacking independent understanding of hospital pricing and Medicare payments, readily adopted and perpetuated Weakley's explanation initiating a cascade effect.

The public failed to independently review relevant information before passing judgment and signaling others to adopt the same view. At Weakley's suggestion, the public focused its disapproval on

276. See Kuran & Sunstein, *supra* note 5, at 696-98 (describing the public's persistent misperception regarding the threat posed by toxic waste sites, compared to other environmental risks).

277. See Ribstein, *supra* note 8, at 2.

278. See *supra* note 179 and accompanying text.

279. See Kuran & Sunstein, *supra* note 5, at 687-88.

Tenet's high prices and the outlier formula. Highly publicized lawsuits and news reports regarding hospitals charging full list prices and sending collection agents after indigent patients confirmed skeptics' worst fears about for-profit "cowboy" medicine. In the post-Enron climate, the public scrutinized aggressive competitive strategies and unusually high profits for alternative explanations. In Tenet's case, the outlier loophole was as good an explanation as any other. But the public's visceral, emotional reaction was based on an incomplete understanding of the Medicare reimbursement methodology and the government's historical noninterference policy, not to mention the complex interplay of private market incentives. The availability cascade that Weakley's report initiated, the media stoked, and the public carried forward, produced widespread availability errors.

First, the public did not comprehend the pressures driving health care pricing. In the current managed care era, hospital charges, or list prices, bear little relevance to how either private insurers or the government pay for health care services provided to their enrollees. Private insurance companies typically negotiate fixed, prospective, bundled, or otherwise discounted payments with hospitals. Charges serve as a reference point for negotiating the discounts or payment structures and, to that extent, reflect what the market will bear. Likewise, government health care programs use special payment methodologies—such as PPS based on DRGs—that are largely divorced from actual costs or charges.²⁸⁰ As a result, the only patients left exposed to full, non-discounted prices are the self-insured and uninsured. At the surface, the idea of the government and private insurance companies negotiating steep discounts while indigent patients are saddled with full charges seems to be the height of callous private market greed.

But the public failed to understand the Medicare regulations driving Tenet and other hospitals to increase charges and undertake to actually collect payment from indigent patients. In particular, Medicare uniform charges and other cost reimbursement principles, combined with the outlier loophole, created the incentive.²⁸¹ Nothing in the Medicare program rules prevented Tenet from increasing charges. Moreover, the government lacks authority to interfere with hospital administration, including pricing.²⁸² In addition, hospital

280. See FURROW, *supra* note 137, at 574.

281. See *supra* notes 202-05 and accompanying text (explaining regulations requiring hospitals to establish uniform charges for all payors and using "charges actually imposed" or "collected" as the basis for Medicare reimbursement).

282. See *supra* notes 199-200 and accompanying text (citing the statute and

administrators understood that offering discounts or sliding-scale fees to uninsured patients could violate Medicare “uniform charges” rules and invite potentially steep FCA sanctions.²⁸³ For charges to be considered “actual charges” for purposes of calculating Medicare payment for outliers and other cost-based adjustments under PPS, hospital administrators rationally believed that they actually had to attempt to collect payment from patients. CMS recently issued guidance rebutting that interpretation of the regulations, but the view had been widely accepted in the industry.²⁸⁴

Hospitals, such as those owned by Tenet, rationally responded to the regulatory incentives in establishing their charge structures. Because charges are largely irrelevant for determining private or government reimbursement, there was no market or regulatory consequence for increasing charges, even if those prices were inflated or fictional. List prices could be super-competitive with no associated decline in demand because no one was actually paying list prices. Contrary to the public’s perceptions, Tenet’s pricing strategy was not a clear example of naked greed, “turbocharging,” or price gouging. A complex mix of private market and regulatory factors created incentives for Tenet’s strong and robust charges. Nevertheless, under pressure of informal sanctions and agency audit and enforcement activity, Tenet voluntarily altered various business strategies and internal policies, including its price structure and outlier calculation. The damages compromised the company’s market advantage and contravened other Medicare rules and policies.²⁸⁵

Another judgment error that the public and media perpetuated

describing the traditional non-interference policy).

283. Offering discounts, in particular, could also be considered “illegal remuneration” offered to induce a patient referral under the anti-kickback statute, if the patient was a federal health care program enrollee. *See* 42 U.S.C. § 1320a-7b (2000). But because the indigent patients in question generally had no form of health insurance, including government insurance, this statute likely would not be implicated.

284. CMS addressed the uninsured charges issue through informal policy statements, rather than formal amendments, because the agency believed the statements reflected the existing rules, not a rule change. *See supra* note 221 and accompanying text.

285. In addition to arguably violating the uniform charges principle by discounting prices to uninsured patients, Tenet’s voluntary outlier formula modifications arguably violate the rule that only Medicare FIs have authority to revise a provider-specific RCC. *See supra* note 167. Federal regulations expressly require FIs—not providers—to calculate the provider-specific RCCs annually. Until recently, there was no allowance for mid-year updates, adjustments, or provisions for using data from tentative or non-final cost reports. 42 C.F.R. § 412.84(h) (2004).

was the repeated criticism that Tenet collected a “disproportionate” share of Medicare outlier payments.²⁸⁶ By “disproportionate,” critics had in mind the five-to-six percentage target level of outlier payments specified in the Medicare statute. Specifically, the Act requires annual program-wide outlier payments to represent five-to-six percent of all standard, DRG payments to all Medicare providers in the aggregate.²⁸⁷ The target does not refer to individual providers.²⁸⁸ The fact that Tenet’s outlier payment percentage was higher than the statutory five-to-six-percent range—as high as twenty-five percent²⁸⁹—misapprehends the meaning and purpose of the statutory provision. The statutory range is a target for the percentage of the total Medicare budget allocated to outlier cases.²⁹⁰ Relying on that provision to suggest that Tenet received a “disproportionate” share of outlier payments because it received more than six percent represents a fundamental misunderstanding of the statute.

The outlier payment methodology does not anticipate equitable distribution, with all providers receiving roughly proportional shares of the limited pool of outlier dollars. It is both possible and expected that some hospitals will receive no outlier adjustments while other hospitals will claim a high proportion of outlier cases relative to non-outlier, or standard DRG cases. In particular, certain facilities, such as research-oriented teaching hospitals and large urban trauma centers, tend to have relatively high numbers of cases qualifying for outlier adjustments because they provide sophisticated, resource-intensive services.²⁹¹ Those services result in higher costs per case than cases at small, rural hospitals, or hospitals not offering high-technology, specialty care. The tendency of one type of hospital to receive more outlier cases than another does not necessarily suggest improper conduct by the hospital.

286. See, e.g., Bartels, *Examining*, *supra* note 73 (“Tenet hospitals have received an unusually large share of such extra [Medicare outlier] payments.”); Editorial, *The Real Tenet Scandal*, *supra* note 2 (“We’re told that Tenet came under regulatory scrutiny only when competitors, worried they weren’t getting their fair share of outliers, snitched.”); see also CMS, INSTRUCTIONS, *supra* note 186.

287. 42 U.S.C. § 1395ww(d)(5)(A)(iv) (2000).

288. *Id.*

289. See, e.g., White, *supra* note 121 (noting that Tenet’s “special payments” accounted for as much as twenty-five percent of the company’s total Medicare revenue for the previous year, compared to “average for major hospital chains [which] has been estimated to be in the 5%-to-6% range”).

290. 42 U.S.C. § 1395ww(d)(5)(A)(iv).

291. See, e.g., Abelson, *supra* note, at C1 (stating that teaching hospitals and other large hospital chains generally receive more outlier payments because of kinds of cases they typically treat).

Tenet facilities, in particular, had a high case mix of complex cases because they targeted the market for specialized, high-technology treatment.²⁹² But the public misunderstood both the statutory provision and the correlation between the type of treatment offered at a particular hospital and the likelihood of outlier cases resulting.

In addition, contrary to public perceptions, Tenet's strategy of targeting complex cases was legal and consistent with Medicare program rules and regulations. Congress specifically authorized payment adjustments for extraordinarily expensive cases because policymakers recognized that certain cases, "because of severity of illness or complicating conditions," would not be adequately compensated under the DRG payment methodology.²⁹³ Congress was concerned that providers might avoid treating the Medicare program's sickest and neediest patients and approved extra payment to correct the disincentive. Tenet's hospitals did not avoid treating the hard cases but actively sought them out, consistent with regulatory incentives.

Moreover, the public failed to understand the nuances of the Medicare budget and limited outlier pool. The overall Medicare budget is not depleted just because one hospital receives a higher percentage of outlier cases than another hospital. Outlier payments represent a fixed, budget-neutral item under the Medicare program. By statute, they will not exceed six percent of the total annual Medicare inpatient budget.²⁹⁴ Even if one Medicare provider, such as Tenet, collects a relatively high percentage of outlier payments, there is no impact on overall Medicare program costs or depletion of Medicare funds allocated to standard DRG payments. Inferring wrongdoing from the fact that Tenet hospitals' outlier payments exceeded six percent of standard DRG cases reflects the public's fundamental misunderstanding of the controlling law and regulatory incentives.

But in the wake of Enron, the public suddenly demanded that CMS shift regulatory priorities without regard to the actual risks posed by the outlier problem or secondary effects of closing the loophole. In addition to widespread availability errors that distorted the regulatory agenda, the public exacerbated the problem by

292. See, e.g., Carolyn Said, *Bay Area Pays Dearly for Tenet, Other Hospitals Charge About Half As Much, Data Show*, S.F. CHRON., Nov. 15, 2002, at A1 (quoting Tenet spokesman Greg Harrison: "We're treating more-complex cases or sicker patients and more of them. . . . That accounts for some of the disparity.").

293. S. REP. NO. 98-23, at 51 (1983) ("The committee amendment, therefore, requires the Secretary to provide additional payment for cases which are extraordinarily costly to treat, relative to other cases within the DRG.").

294. *Id.*

applying informal sanctions, which inappropriately raised the stakes for providers that had been setting prices under the outlier loophole, with little risk over many years. Tenet adjusted its risk-reward calculus to respond to public perceptions and informal sanctions but, in doing so, compromised the availability of highly demanded medical services.²⁹⁵ Tenet's business strategy for innovative products provided high-quality specialty care to a targeted sub-market of health care consumers and offered valuable models for market-based health care delivery. Tenet's dramatic decline in the wake of Enron demonstrates the dangers of allowing the public to set regulatory priorities based on incomplete information and inaccurate judgments.

C. *Virtues of Bureaucracy*

Regulations reflect reasoned policy decisions developed through formal, deliberative processes. Administrative agencies are specialists at obtaining and processing information. Institutional structures guide the process and ensure that all relevant information is collected and considered. Virtues, such as rationalization, expertise, insulation, and authority are inherent in the regulatory scheme.²⁹⁶ Specifically, under notice and comment rulemaking, agencies like CMS publish proposed rules; solicit, review, and respond to public comments by the public; assess and report on the budgetary impact of any changes; and incorporate and revise interested constituents' proposals before issuing a final program regulation or amendment.²⁹⁷ In particular, CMS annually

295. See Khanna, *supra* note 268, at 1225 (discussing the rationale for corporate liability standards and suggesting that for socially appropriate amount of particular good to be produced, the price of the good should reflect its true social costs, including potential liability).

296. See BREYER, *supra* note 6, at 61-63 (describing four virtues of administrative systems and advocating a group of special civil servants to bring uniformity and rationality to decisionmaking in highly technical areas); Kuran & Sunstein, *supra* note 5, at 746-57 (advocating "comprehensive rationality" and describing institutional safeguards against harmful cascades, including new governmental structures to insulate civil servants from mass demands for regulatory changes).

297. See Steven L. Schwarcz, *Private Ordering*, 97 Nw. U. L. REV. 319, 335-36 (2002) (describing administrative law theory justifications for legitimacy of administrative agency rulemaking, including the requirements that agencies stay within the bounds of statutory delegations and engage in reasoned decisionmaking by soliciting public comments, carefully considering issues raised, and rationally justifying policy choices) (quoting Johnathan Weinberg, *ICANN and the Problem of Legitimacy*, 50 DUKE L.J. 187, 221-22 (2000)). See generally 5 U.S.C. § 553 (2000) (Administrative Procedure Act rulemaking provision).

updates inpatient PPS rates, incorporating price and cost changes, utilization patterns, treatment methods, and inflation factors.²⁹⁸ The agency also regularly reviews every aspect of the Medicare payment system, updates prices for all Medicare-reimbursed services, and considers other changes to improve program operations, efficiency, and payment accuracy.²⁹⁹

Medicare authorities on several previous occasions evaluated comments identifying various flaws in the outlier payment methodology. Through the institutional structures of formal rulemaking, the agency carefully considered the issues and potential flaws in the outlier formula. Over the years, the agency accepted some suggested changes and rejected others, each time rationally justifying its policy decisions. The essential elements of the outlier regulations, including reference to hospitals' actual charges and unfettered discretion to set charges, were retained.³⁰⁰ But in late 2001 and early 2002, after years of acquiescence, Medicare authorities responded to public pressure after Enron and imposed informal sanctions.³⁰¹ Regulatory priorities were set by availability entrepreneurs, such as Kenneth Weakley, and availability cascades that resulted from the Enron fall-out led to the public's identifying the outlier loophole to explain Tenet's remarkable profitability, without fully understanding the regulatory and market incentives that drove Tenet's business strategies.

Without citing any laws or regulations that might be violated, CMS in late 2002 announced an outlier initiative, conducted primarily through sub-regulatory enforcement and policy setting.³⁰² The agency issued memoranda, guidance statements, and informal audits suggesting that providers should reduce in their charges and otherwise adjust practices with respect to the outlier loophole.³⁰³ The agency's strategy of informal action rather than formal rulemaking resulted in unpredictability and inefficient self-policing by targeted providers like Tenet. In 2003, CMS eventually amended the outlier regulations through formal rulemaking, a process that reconciled the controlling law, justified the changes, and balanced competing incentives.³⁰⁴ The changes called for by CMS's final

298. 42 C.F.R. § 412.8(b) (2004).

299. *Id.* § 412.60(e).

300. *See supra* notes 179-84 and accompanying text (describing several years' annual PPS updates and discussion of outlier adjustment).

301. *See* CMS, NOTICE, *supra* note 170.

302. *See supra* Section IV.A.3 (discussing the CMS outlier initiative).

303. *See* CMS, INSTRUCTIONS, *supra* note 186; CMS, NOTICE, *supra* note 170.

304. *See* Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment

outlier regulations were far less radical than the response the public demanded through informal sanctions.³⁰⁵

Unfortunately, by the time formal regulations were issued, Tenet had already reacted to public pressure and adjusted its business practices to comply with emerging corporate norms favoring fairness and self-restraint over aggressive competition and profit-maximization. The changes Tenet implemented compromised the company's strong market position. Tenet executives who had been most closely identified with the outlier issue were removed, without regard to their overall contributions and talents, apart from Medicare reimbursement strategies.³⁰⁶ The company appointed new officers and board members, including a physician and a former auditor, with expertise suggesting renewed commitment to professionalism and accountability.³⁰⁷ Tenet preemptively adopted a revised approach to calculating its own Medicare outlier claims, resulting in a substantial payment reduction, even though CMS had not yet implemented any changes to the payment formula.³⁰⁸ The company also changed its pricing and debt-collection policies for charges incurred by uninsured and underinsured patients.³⁰⁹ All of those changes reflected contrition more than rational business decisions.³¹⁰ Tenet's self-corrective policies caused a dramatic, persistent decline in share value.³¹¹ As it turned out, many of the changes would not have been required under the final outlier amendments.

The formal amendments narrowed but did not entirely close the loophole. In particular, CMS declined any changes to the rules regarding hospital charges or the fixed outlier pool.³¹² The agency's

Systems; Final Rule, 68 Fed. Reg. 34,494, 34,496 (June 9, 2003) (to be codified at 42 C.F.R. pt. 412).

305. See *supra* notes 193-97 (describing final outlier amendments).

306. Debora Vrana & Ronald D. White, *Tenet Names Kangas as Chairman*, L.A. TIMES, July 23, 2003, at C1; Ronald D. White, *Tenet's Top Legal Counsel Resigns*, L.A. TIMES, Sept. 27, 2003, at C1.

307. Andrew Pollack, *Tenet Vows Improvements in Patient Care*, N.Y. TIMES, July 24, 2003, at C5; Vrana & White, *supra* note 307.

308. Pasztor, *supra* note 120, at B7.

309. Lisa Girion, *Tenet Set to Discount Charges to Uninsured*, L.A. TIMES, Mar. 3, 2004, at C1.

310. See Pasztor, *supra* note 173, at B7 (quoting an analyst's observation that Tenet officials are "trying to show they are good public citizens"); White, *supra* note 290, at 2D (indicating that Administrator Scully was "pleasantly surprised" by Tenet's actions and said that the company took a "pretty honorable step").

311. See *supra* notes 74-75 and accompanying text (detailing Tenet's market decline).

312. See Medicare Program; Changes to the Hospital Outpatient Prospective

restraint respects the government's limited authority under the Medicare statute as well as the competing regulatory and private incentives driving health care markets. The amendments instead focused on problems associated with RCC lag time and statewide average RCC. Specifically, the regulations authorized FIs to use updated but non-final cost report data to reduce RCC lag-time and eliminated reversion to the statewide RCC for hospital-specific RCCs falling below the established parameters.³¹³

Separately, the agency issued statements affirming the understanding that Medicare LCC, cost apportionment, and other regulations do not "require" hospitals to charge and collect full list prices from indigent patients.³¹⁴ Offering discounts or sliding-scale rates based on ability to pay is fully consistent with Medicare policy, according to CMS. Nevertheless, CMS did not impose Medicare price controls or cap the level of Medicare outlier payments that a particular hospital could claim. Those regulations, if implemented, would not only violate CMS's noninterference policy but also impair hospitals' ability to negotiate competitive prices in the private market and develop specialized, targeted health care services. Post-Enron public perceptions frowned on profitability and favored self-restraint. But agency regulations retained a measured view of health care markets and did not trample efficient profit-maximization incentives. Hospitals remain free to establish charges based on what the market will bear. The recently enacted MMA, which includes the most significant changes to Medicare since the program's inception, affirms the traditional noninterference policy on health care pricing.³¹⁵ That MMA provision, like the outlier loophole, has attracted considerable criticism as naked rent-seeking by pharmaceutical and insurance industries.³¹⁶ The criticism may be

Payment System and Calendar Year 2004 Payment Rates, 68 Fed. Reg. 63,398, 63,460 (Nov. 7, 2003) (codified at 42 C.F.R. pts. 410, 419).

313. See *supra* notes 193-97 and accompanying text (summarizing changes to outlier payment methodology).

314. See *supra* notes 221-22 and accompanying text.

315. See *supra* notes 230-31 and accompanying text (describing the Medicare Part D prescription drug benefit).

316. See *supra* notes 231-32 and accompanying text (discussing the MMA's noninterference provision); see also DAVID D. FRIEDMAN, *LAW'S ORDER* 33 (2000) (noting that the "term [rent-seeking] was coined to describe competition for government favors"); RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 41 n.3 (5th ed. 1998) ("The tendency of an expected gain to be translated into costs through competitive efforts is called rent-seeking. . ."); MAXWELL L. STEARNS, *PUBLIC CHOICE AND PUBLIC LAW: READINGS AND COMMENTARY* 120-24 (1997) (describing the interest group theory of rent seeking); James M. Buchanan, *Rent Seeking and Profit Seeking*, in *TOWARD A THEORY OF THE RENT-SEEKING SOCIETY* 4 (James M. Buchanan et al. eds., 1980) ("The term *rent seeking* is

warranted, but any changes to the policy should be conducted through rational bureaucratic processes, shielded from public emotions and judgment errors.

The proliferation of corporate wrongdoing and accounting scandals beginning with Enron in late 2001, drove the public to identify Tenet's high prices and debt collection practices as "unfair" or cheating under an identifiable Medicare loophole. Without fully considering the costs of its informal enforcement campaign, the public imposed sanctions and pressured hospitals to dramatically alter practices that previously drew tacit approval or even praise. By contrast, CMS comprehensively evaluated the various competing regulatory and market incentives underlying hospital prices, product and service differentiation, patient mix, and other factors influencing the level of outlier cases that a particular hospital receives. The Medicare program is notoriously complex, and the outlier adjustment is just one small strand in an intricate web. The formal administrative rulemaking process that eventually occurred allowed the agency to assess the impact of tugging on one strand of the Medicare web on the overall health care system. That formal approach to closing Medicare loopholes is preferable to the availability cascade and informal reactions to Tenet and the outlier issue.

Perhaps closing the outlier loophole would have been the most direct and efficient regulatory response. Eliminating the outlier adjustment altogether removes the questionable incentive for charge inflation. Closing the loophole would also enhance predictability for the Medicare program and participating providers, who would receive only the fixed DRG amount, even for extraordinarily expensive cases. Just as Medicare authorities eliminated the day outlier adjustment, they could eliminate the cost outlier adjustment. Congress' concern that eliminating cost outliers would result in hospitals avoiding the hard cases would likely not occur because the system contains other payment adjustments and enforcement mechanisms to check that incentive. First, outlier cases tend to occur with greater frequency at teaching hospitals, urban hospitals that treat a disproportionate share of underinsured patients, and sophisticated trauma centers, facilities that already receive Medicare adjustments to make up for their added costs.³¹⁷ Also,

designed to describe behavior in institutional settings where individual efforts to maximize value generate social waste rather than social surplus."); Robert D. Tollison, *Rent Seeking*, in 3 THE NEW PALGRAVE DICTIONARY OF ECONOMICS AND THE LAW 315 (Peter Newman ed., 1998) ("Rent seeking is the socially costly pursuit of wealth transfers . . .").

317. See 42 C.F.R. § 412.105 (2004) (regarding special payment for hospitals

regulators update the average DRG payment amounts annually, using hospitals' actual cost and charge data,³¹⁸ meaning that the increased costs of treating particular cases or types of cases eventually become incorporated as average rather than extraordinary reimbursement levels. Moreover, regulators have discretion to create new DRGs and could do so to provide additional payment for certain categories of high-cost cases. Finally, regulatory quality-of-care standards³¹⁹ and common law tort liability,³²⁰ to some extent, already police the incentive to avoid or under-serve needy patients.

Medicare authorities may have opted to narrow but not close the loophole because closing it would require statutory amendment,³²¹ a typically slower, more cumbersome process than revising regulations. Or the agency may have determined that the extra payment continues to be a necessary incentive to avoid treating the hard cases. As CMS continues to monitor the outlier issue and assess regulatory priorities and incentives, authorities may determine that the burdens of pursuing statutory amendment are worth the benefits of increased predictability and reduced program costs. Formal institutions, administrative expertise, inter-

that incur indirect costs of graduate medical education), *id.* § 412.106(d) (regulations regarding special payment for hospitals that treat disproportionate share of low-income patients). In particular:

The indirect medical education adjustment recognizes that there are additional costs that teaching hospitals incur in connection with the presence of graduate medical education programs. Congress was concerned that teaching hospitals might be adversely affected by the implementation of [PPS] because these hidden costs would not be reflected in [PPS] payment rates as costs were standardized and the system moved toward a national payment rate applicable to all hospitals.

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1986 Rates, 50 Fed. Reg. 35,646, 35,681 (Sept. 3, 1985) (codified at 42 C.F.R. pts. 405, 412).

318. *See supra* notes 299-300 and accompanying text (describing annual inpatient PPS updates).

319. *See, e.g.*, 42 C.F.R. § 424.13 (listing inpatient hospital Medicare conditions of participation), *id.* § 424.5(a)(ii) (excluding from coverage "services not reasonable and necessary").

320. Under the common law, hospitals may be held liable for an individual physicians' failure to provide adequate or appropriate medical treatment or other medical malpractice. *See, e.g.*, *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987) (describing theories of hospitals' vicarious liability, including enterprise liability, apparent authority, and non-delegable duty); *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (describing hospitals' independent duty to monitor physicians).

321. The Medicare outlier adjustment is found in 42 U.S.C. § 1395ww(d)(5)(A)(i) (2000).

branch coordination, other processes insulated from public misperceptions and judgment errors will allow lawmakers to address Medicare loopholes through measured, deliberative analysis of relevant risks.³²²

VI. CONCLUSION

In complex regulatory programs like Medicare, loopholes are inevitable. Regulators may lack the resources to keep up and to quickly and tightly close loopholes as they become apparent. But without the risk of sanctions, the potential rewards for exploiting loopholes increase. Accordingly, among rational actors, we can predict that the incidence of questionable conduct also will increase. Therefore, public pressure and informal sanctions could potentially enhance formal regulations. In the aftermath of Enron, however, the public latched on to the Medicare outlier loophole as yet another readily available example of corporate fraud and “creative accounting” without fully understanding the complex interplay of private market and regulatory incentives for health care. Public perceptions created an availability cascade, focused on the outlier loophole as the key problem needing to be addressed. The cascade of blame led to informal sanctions. Tenet and other targeted health care providers internalized the sanctions and dismantled promising models for private market health care delivery. The chain reaction eventually pressured regulators to respond with investigations, enforcement initiative, and hastily implemented reforms.

In that climate, health care providers could not rationally evaluate the risks of engaging in certain conduct and adjust practices to conform, short of ceasing altogether or drastically overhauling core strategies and operations. The unfortunate result of the post-Enron health care public reactions and administrative reforms was the dismantling of a promising private market model for health care delivery. Health care pricing and third-party reimbursement is a highly technical web of incentives that requires a coordinated agency response. Moreover, the current trend in health care reform emphasizes privatization and market competition to increase efficiency and reduce health care costs. Those measures are doomed if widespread judgment errors, based on the latest news report of Wall Street executives gone bad and

322. See BREYER, *supra* note 6, at 61-63 (describing the “virtues of bureaucracy”); Kuran & Sunstein, *supra* note 5, at 746-59 (discussing institutional safeguards against harmful cascades). See generally Sunstein, *supra* note 6, at 934 (advocating cost-benefit analysis to correct cognitive errors, including availability cascades). Cf. Abramowicz, *supra* note 5 (analyzing whether informational markets could improve agency decisionmaking).

incomplete understanding of the complex health care system, are allowed to drive regulatory responses. Instead, agencies should be insulated from public pressures and given the space to develop and deliberate over rational policies for policing loopholes, while carefully assessing the risks of privatizing or market-based strategies to improve the nation's health care system.