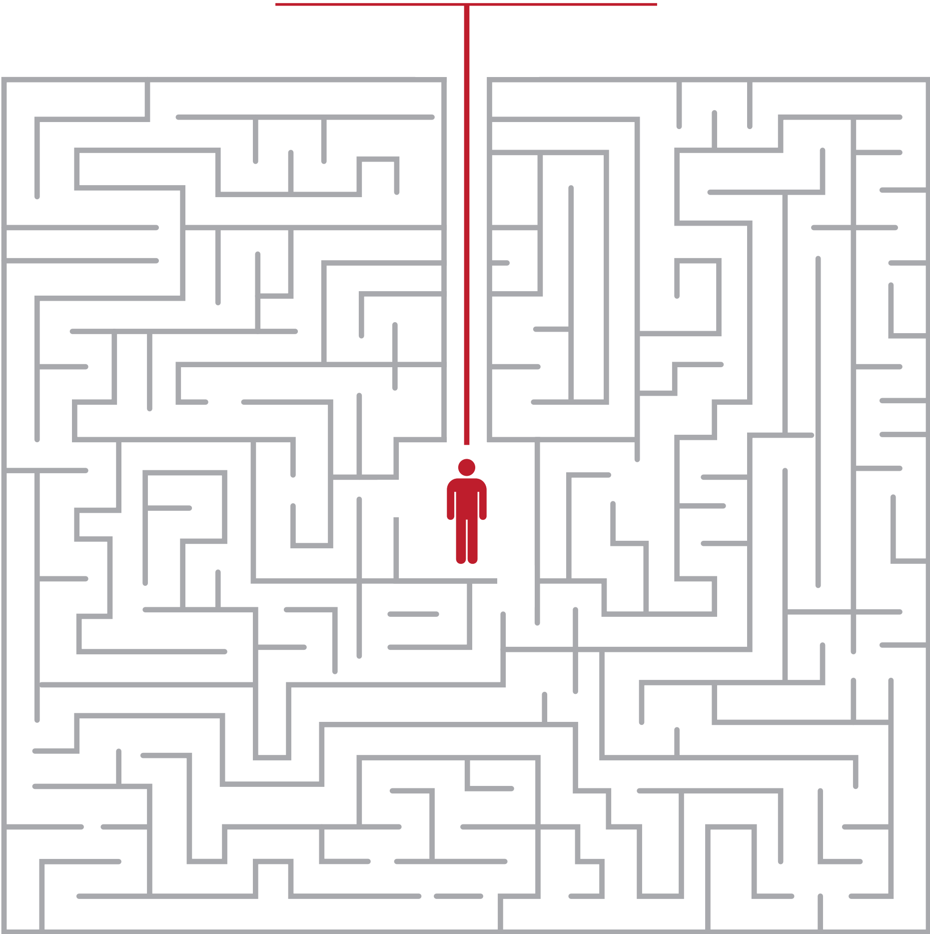
The Health Care Delivery System

A Blueprint for Reform



Center for American Progress and the Institute on Medicine as a Profession

CHAPTER 4

Provider Payment Incentives and Delivery System Reform

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OVERVIEW

Recent analyses by the Congressional Budget Office and others have shown that the long-term federal budget outlook is dominated by spending trends in Medicare and Medicaid. These trends cannot be addressed in the long term without changes in the entire health care delivery system that slow spending increases by promoting more efficient delivery of care and more judicious choices about incorporating new medical technologies into the system.

Health practitioners, such as physicians, and provider organizations, such as hospitals, seek to serve patients in an efficient and high-quality manner. They also respond to financial incentives embedded in the structure of payment rates for their services. Provider payment rates play an important role in how well the health care delivery system is able to supply quality, efficient care.

1 Preparation of this chapter began with Elizabeth Fowler as the co-author responsible for bringing the policy implementation experience to it. She participated fully in the planning of the chapter, drafted some sections, and commented extensively on drafts. But during the process, she rejoined the staff of the Senate Finance Committee, which does not permit its staff to author published papers. I want to acknowledge her valuable contributions to this chapter. My work on this chapter was performed in a private capacity. The views expressed do not reflect those of the Center for Studying Health System Change or its funders.

KEY POLICY RECOMMENDATIONS

- Revamp the Medicare payment system so that relative payments for different services better reflect relative costs of delivering those services, thus eliminating inadvertent incentives that negatively influence practice patterns.
- Promote care coordination through ideas such as having beneficiaries designate a primary care physician practice to serve as their medical home, with the practice receiving a capitation payment designed to cover services not reimbursed under fee-for-service arrangements.
- Bundle payments for acute episodes of care involving a major procedure or inpatient stay; for example, combining facility and home health post-acute services into the payment for inpatient care.

Today, those incentives are sending the wrong signals. Most payment today is fee for service, meaning that each service a doctor provides is paid for separately. Fee-for-service sends an undeniable economic signal that more services are better. The system also underemphasizes to physicians the importance of the cost of services delivered by complementary providers because it does not affect what they receive for their services. Furthermore, high-quality services are not compensated any more than poor-quality ones. In fact, when poor-quality care results in complications that must be treated, total payment can turn out to be higher. Finally, some services involved in managing chronic disease, such as care coordination and patient education, are not paid for by insurers at all.

Inpatient hospital care is a notable exception. Medicare, Medicaid programs, and a growing number of private insurers now pay for inpatient care on a per case, not per procedure, basis, using a classification of diagnosis related groups or DRGs. Yet even these bundled payments apply only to those services delivered in the hospital, not to the services provided by others, such as physicians and post-acute care facilities, involved in a patient's episode of care.

Health insurers aim to ensure that relative payments for different services parallel the relative costs of providing the services, both for fairness and to avoid influencing the pattern of care through unintended incentives. Yet major departures from this goal are evident today. Inpatient admissions for cardiovascular procedures, for example, are widely recognized as the most profitable cases for hospitals. Physicians tend to be paid more—

in relation to costs—for procedures than for evaluation and management services. Minor procedures and services involving expensive equipment are paid particularly generously in relation to costs.

These distortions in payment structures are causing changes in the delivery system. Hospitals have long been aware of which DRGs are most profitable; surgical DRGs, for example, tend to be more profitable than medical DRGs, with those for mental health among the least profitable. But recently some have taken aggressive steps to expand their volume of more profitable cases by selectively developing "service lines" that restructure the organization to attract such cases.[2] The most extreme response is the creation of entire hospitals specializing in heart or orthopedic procedures. Physicians have also recognized that the facility component (equipment, technicians) of services such as imaging—x-rays, MRIs, CT scans—are more lucrative than the professional component (interpretation of the images by a physician). They have invested in free-standing facilities not related to hospitals and expanded their practices through mergers to achieve the scale needed to profitably provide additional facility services, as well as the professional services that must accompany them.

Equally worrisome is the impact of these distortions on segments of the delivery system that cannot do as much to respond to the incentives. Primary care physicians' earnings have been declining after adjustment for inflation, both in absolute terms and relative to other physicians.[3] This trend has precipitated a decline in practitioners training for these specialties. Other specialties in which procedures are not a large part of practice are experiencing the same problems. A recent *Wall Street Journal* article reported that too few physicians are training in neuro-ophthalmology—a subspecialty in which most services are visits—to replace those approaching retirement age.[4] Over the longer term, these inadvertent distortions in our payment system will further exacerbate physician supply problems in important specialties.

As the nation's largest payer of health care services, Medicare can and should do more to reform provider payment incentives. Changes in Medicare's payment structure will likely be adopted by Medicaid programs and private insurers. In physician payment, for example, Medicaid programs and private insurers use the Medicare fee schedule as a baseline; they set payments as a percentage of Medicare rates. Private insurers sometimes negotiate even higher rates for certain large practices to assure adequate

numbers of each specialty in their network. Similarly, Medicare's recently implemented prospective payment system for hospital outpatient care has helped move private insurers from paying on the basis of discounted charges to paying a percentage of the Medicare bundled rate. Private insurers, however, have followed Medicare's lead for hospital inpatient care payments to a lesser extent.[5]

Medicare's leadership in provider payment is an important asset for federal policymakers interested in using this tool to improve the delivery of care. Improving Medicare payment methods has not historically been a partisan issue and represents a way to influence payment broadly without direct federal regulation. The speed and magnitude of the intended impact on the delivery of care will depend on how much other payers follow Medicare's lead. Federal policymakers need to recognize Medicare's leadership role and invite Medicaid program officials, private insurers, and providers of care into discussions aimed at gaining both technical support in developing effective payment tools as well as political support for the reforms.

THE FUTURE OF HEALTH CARE PAYMENTS

A strategy of payment reform has four key components. First, existing payment mechanisms, especially those based on fee for service, should more accurately reflect relative costs of providing different services. As discussed below, these steps can be implemented quickly and do not require extensive experimentation.

A second component involves payment for potentially cost-effective services not currently reimbursed, including services to coordinate care, palliative care counseling, and consultations through e-mail. For services involved in managing chronic disease, a periodic payment to the provider for all of the services they provide to a patient to treat the disease in question (called "capitation"), is often the most attractive way to provide payment because it reduces the need to document numerous services and provides incentives to deliver care efficiently. Capitation rates would vary according to a patient's chronic diseases and their severity. This targeted plan, which would apply only to some patients and services, is different from the broader and cruder approaches to capitation that were used by HMOs in the 1980s and 1990s.

The third component is per-episode payment for acute episodes of care involving a major procedure or hospitalization. Currently much inpatient care payment is based on diagnosis-related groups, and a global fee is the norm for major surgery. Per-episode payment, however, could be far more cost-effective in making care more efficient if a single amount is paid for the services of all of the providers involved in a patient's care, including physician services, outpatient diagnostic services, and pharmaceuticals.

The fourth component is better alignment between payment and outcomes. Providers with better quality should be paid more when they provide better value to patients. This is the notion behind "pay for performance" systems. However, pay for performance will be valuable only if the measures of quality that generate extra payment have strong relationships with important outcomes of care.

POLICY RECOMMENDATIONS

Reversing current perverse payment incentives and implementing new approaches to provider payment will take time. A new administration, working together with Congress, can implement some steps in the short term, within 18 months of taking office. The new administration should also consider a longer-term agenda of changes that might take five years to implement to improve payment incentives in Medicare.

Key Policy Recommendations for Reforming Provider Payment Incentives

SHORT TERM	LONGER TERM
• Revamp the process for updating the relative value scale used in Medicare's physician fee schedule so that relative values more accurately reflect relative costs. • Reduce relative values for services undergoing high rates of growth in volume. • Adopt incentives for additional processes that improve patient care (e.g., electronic health records).	• Bundled payment covering all providers for acute episodes of care and post-acute care. • Capitated payment for the management of chronic disease. The medical home can be seen as a first of such an initiative. • Revise or eliminate Sustainable Growth Rates in conjunction with a major package of payment reforms.

SHORT-TERM REFORM AGENDA

The new administration should make revising payment rates a priority for the Centers for Medicare and Medicaid Services. Congress might want to add its voice by directing CMS to revise payments so as to better reflect relative costs.

A 2007 House bill to reauthorize the State Children's Health Insurance Program contained many initial steps needed to improve the accuracy of relative Medicare physician payment rates. The Children's Health and Medicare Protection Act of 2007, or CHAMP Act, would have modified the Sustainable Growth Rate, the formula used to determine Medicare payments to physicians. The adapted SGR would create separate conversion factors for six service categories:

1. Primary care and preventive services
2. Other evaluation and management, or E & M, services
3. Imaging services and diagnostic tests (other than clinical diagnostic lab tests)
4. Major procedures
5. Anesthesia services
6. Minor procedures and other physician services

The legislation recognized the need for greater emphasis on primary care and preventive services, allowing these services to grow at an annual rate of 2.5 percentage points above gross domestic product. The growth rate for the other five service categories was pegged instead to GDP. Implementation of this new system would have taken place over three years, in order to lower the cost of the SGR changes and to give CMS adequate time to establish service categories.

CHAMP included additional provisions aimed at achieving a more accurate structure of payment rates for physicians. These include bundling services that are typically performed together, adjusting relative values for services that have undergone substantial changes and for efficiency gains for new procedures, and reducing relative values for services with accelerated volume growth. These provisions address many of the shortcomings in the current fee schedule identified by the Medicare Payment Advisory Commission, or MedPAC, and independent analysts, who have pointed out the

need to develop an effective mechanism to reduce the relative payments for services in which providers' productivity increases (faster procedures, lower equipment and supply costs, and higher utilization rates for equipment) have reduced the amount of physician work or practice expense over time.[6] Still, administered pricing systems tend to respond slowly to changes in cost structure. Policymakers therefore might use tools to speed response times, including: market surveillance to identify mispriced services; projecting a learning curve for new services to adjust for expected declines in unit costs over time; and use of rapid growth in volume of a type of service as an indicator of the price having been set too high.

Also in the near term, Medicare could provide incentives for measuring processes that have the potential to improve care, either through rewarding measurement or requiring it as a condition of participation. Indeed, the Medicare Improvement for Patients and Providers Act of 2008, or MIPPA, (P.L. 110-275) will encourage electronic prescribing by offering bonuses for its use, which transition to penalties for not using electronic prescribing beginning in 2011. CMS should explore other opportunities to reward better processes, such as the use of electronic health records.

Ultimately, however, the new administration should prioritize rewarding better outcomes rather than processes of care. For this reason, the new Congress could take steps to transition the current hospital quality reporting program to one in which payments are linked to performance. As outlined in a recent CMS report to Congress, the transition from reporting to performance-based payment will require time to develop measures, determine baselines, and establish benchmarks and thresholds.[7]

Having payment structures more accurately reflect relative costs will help address the cost-increasing incentives of physicians referring patients to their own facilities for services—called "self-referral." Congress has limited physician self-referral, but changing technology and patterns of delivery have made these limits less effective. The Stark physician self-referral laws, passed by Congress in the 1980s, prohibit physicians from referring Medicare patients to an entity in which the provider or a member of his or her immediate family has a financial interest. Exceptions to the existing law, however, have provided ample opportunity for imaging self-referrals. The "in-office ancillary service" exception, "group practice" exception, and nuclear medicine exclusion to the Stark Law have provided many opportunities for physicians to act in a manner contrary to the interests

of Medicare beneficiaries and taxpayers. To curb overuse of imaging services, physicians could be prohibited from referring patients to facilities—including imaging centers—where they own equipment or space that is leased to the provider.

CMS has recently attempted to curb some of these abuses through regulatory changes to the existing Stark Law, but proposed changes were ultimately dropped from final regulations due to provider opposition. MIPPA requires accreditation of providers of the technical component for advanced diagnostic imaging services. Congress could take additional steps to ensure that constraints on physician ownership are reinforced. Yet as longer-term changes move the payment system away from fee for service and toward per-episode payment and use of capitation, restrictions on self-referral will become less important and even counterproductive.

LONGER-TERM AGENDA

Three distinct aspects of a longer-term agenda are important. The first is substantive changes in provider payment methods in Medicare. These include many of the changes outlined above, such as bundled payment for acute episodes of care and capitated payment for management of chronic disease. Some of these changes can be examined through pilots and demonstrations. Too much reliance on demonstrations can be detrimental, however, due to the lengthy delays involved and the fact that providers will not invest as much in time-limited programs.

The second aspect is long-term resolution of the increasingly frequent need to legislate short-term "fixes" to the Sustainable Growth Rate formula. The third aspect, which is discussed briefly in the book's introduction, is potential changes in the governance of the Medicare program.

Reforming provider payment methods

Reforms in payment for management of chronic disease and for acute episodes will require some important changes in Medicare approaches.

The patient-centered medical home, an idea that has gained extensive attention, is really a step toward capitated payments for managing chronic disease. In one model, patients designate a primary care physician prac-

tice to serve as their medical home, and the practice receives a capitation payment designed to cover services not reimbursed under fee-for-service arrangements. Down the road, the entire payment for management of a patient's chronic diseases could be paid by capitation, an approach long used by Medicare to reimburse physicians for management of renal failure. Ultimately, this could be a bundled payment to all of the providers involved in the management of a chronic disease.

Capitated payment for management of chronic disease will require identifying both those beneficiaries with serious enough chronic disease to be involved in this and the physician or medical practice that will be responsible for management and receive the capitated payment. Beneficiaries can designate a physician, in some cases in response to a physician explaining the program to them. Simply using Medicare claims data to assign a beneficiary to a practice is problematic because of too many errors in assigning responsibility.[8] Designating a practice will not limit the beneficiary's choice of provider—they can always designate a different provider to manage their chronic disease. Assignment of beneficiaries to physicians will not be close to 100 percent, but as long as the capitation payments are in addition to fee-for-service payments, less than full compliance would not cause large problems. Indeed, physicians would have strong incentives to have beneficiaries who come into their practice for chronic disease management and designate them as care managers.

Monitoring will be necessary to ensure that the management and coordination services, which are not now reported because they are not eligible for payment, are actually delivered. This issue can be addressed by certifying practices as eligible for these payments and auditing a sample of patient records. Medical home demonstrations can pilot many of the administrative procedures as well as support design issues such as how to assign levels of payments for patients with different chronic diseases and levels of severity. After experience with an additional capitation payment for management of chronic disease, the program could move to payment for all services related to a chronic disease (except perhaps major procedures) on the basis of capitation. Medicare already has experience with this approach for beneficiaries with end-stage renal disease; the program has covered only services related to ESRD through a capitation system, although issues of undertreatment did arise.

Compared with payment for management of chronic disease, bundled payments for acute episodes of care involving a major procedure or inpatient stay has greater need to be approached in stages. A relatively easy step would be to bundle post-acute care (both facility care and home health services) into the payment for inpatient care. The hospital would take on the risk for the costs of care in skilled nursing homes and rehabilitation facilities after patients are discharged. Broadening the per-episode payment to include physician services, outpatient diagnostic services, and outpatient pharmaceuticals would be a more ambitious step. Bundling would sharply reduce the role of fee-for-service payment, but not eliminate it entirely. Diagnostic services and minor procedures would continue to be paid under the fee-for-service model. More accurate relative payments in fee for service would underlie calculation of capitation and per-episode payments.

This would address an undesirable incentive for hospitals to substitute post-discharge care for inpatient care. The step is considered "easy" by some because hospitals are the provider that should receive the bundled payment and take responsibility for payment for post-acute care. Since most of the resources for this broader bundle of services would come from the hospital, the change would not add large amounts of financial risk to the hospital.

Another transitional step would involve reducing DRG payments for re-admissions. Hospitals could be supported in efforts to reduce re-admissions by payments for physicians for activities to ensure better transitions to home and permission for hospitals to share gains from reducing re-admissions with physicians.

A challenge in broadening the bundle further to include physician services is the question of which party should receive the payment and thus be at risk for the costs of the episode of care. Physicians might object to becoming a contractor to hospitals, but the financial risk of bundled care would likely be too large for them to handle alone, since the bulk of the costs of an inpatient episode would be for hospital care. Medicare's demonstration of bundled payment for coronary artery bypass graft surgery during the 1990s included only integrated delivery systems, where physicians are employed by the hospital or where a large physician group has a close relationship with a hospital, so receipt of the payment was not an issue.

In other situations, this challenge could be addressed through a default mechanism that pays each provider involved a fixed percentage of the per-episode amount. For example, if 20 percent of the Medicare payment for

hip replacement episodes goes to the orthopedic surgeon and 65 percent goes to the hospital under today's methods, then the program could pay those percentages of the bundled episode payment to the respective providers. Each provider would have incentives to reduce their own costs and to choose more efficient or higher-quality providers to work with. Providers would develop relationships to work together to reduce overall costs and develop mechanisms to share the rewards equitably. This approach could begin with a carefully chosen set of procedures for which the episode is relatively easy to define and where potential to make care efficient across multiple providers appears to be large.

Role of demonstrations

Many in the policy world approach major changes through initiating demonstrations. But it is important to consider that demonstrations involve substantial delay and are often difficult to learn from. Indeed, many of the major policy changes in Medicare over the years have not involved prior demonstrations. For example, neither inpatient hospital prospective payment nor the physician fee schedule were preceded by federally initiated demonstrations. In many cases, it is better to plunge ahead without the benefit of a demonstration and revise the policy based on the early experience.

CMS has broad authority to conduct demonstrations, but many are conducted under specific authorizations from Congress. The purpose of these authorizations range from emphasizing the priority on certain demonstrations to offering a consolation to members who advocate a policy change but do not obtain sufficient support to enact it. In the payment area, CMS is demonstrating new payment methods for medical groups and is planning one for the patient-centered medical home. But CMS has cancelled a demonstration of payment for disease management services because early results were not encouraging.

Some point to New Jersey's experience with DRGs as a demonstration that led to Medicare's inpatient prospective payment system. New Jersey's pioneering use of DRGs was an asset to Medicare's launching a national policy, but most would not call New Jersey's experience a demonstration. The state launched the experiment on its own as a way to contain hospital costs. Medicare's involvement was granting a waiver to New Jersey that brought Medicare payment under the state's DRG system. In contrast,

when Medicare initiated demonstrations that must cover all providers or beneficiaries in a geographic area—as it did with an alternative payment system for Medicare Advantage plans—the members of Congress from the local areas affected have intervened to block the demonstration. They even intervened in one case in which the demonstration was conducted according to procedures spelled out in a specific congressional authorization. Some of these policy changes have since been implemented despite earlier opposition to the demonstrations.[9]

Demonstrations conducted with volunteer providers tend to skirt opposition, but less is likely to be learned from them. Evaluations of the experience are particularly challenging, and often the results cannot be generalized beyond the uniquely positioned providers that seek to participate in such demonstrations.[10]

The alternative approach is to phase in reforms. Payments for chronic disease management, for example, could be implemented first for chronic conditions that are easiest to define, where differences in severity are easiest to manage, and where important management services, such as care coordination, are not covered under current payment policies. Congress could either give CMS authority to modify the reform on the basis of initial experience or do so through legislation inspired by its program oversight. Giving CMS or a new entity the authority to make modifications would be the more effective way to proceed.

Notwithstanding the above discussion, some payment innovations are large enough departures from current systems that demonstrations are needed. In this case, much more can be learned if Medicare pursues these demonstrations in coordination with other payers. Otherwise, providers have less at stake and less motivation to invest in the infrastructure needed to change the delivery of care.

Sustainable growth rates

The SGR was enacted in 1997 to provide some control over spending on payments to providers in a fee-for-service system. It replaced an earlier formula, the Volume Performance Standards, or VPS, in which spending growth in physician services determined subsequent payment rate changes. When VPS was enacted, with separate mechanisms for surgeons, primary care physicians, and other physicians, the vision behind it was

that organized medicine would respond to these system-wide incentives by developing practice guidelines with the potential to slow the growth of volume of services performed and support Medicare efforts at discouraging unnecessary services. But VPS and its successor, SGR, do not change incentives to individual physicians. For years, VPS and SGR did not garner a great deal of attention because the results were small increases or decreases to payment rate changes otherwise determined by changes in medical practice input prices.

But in 2002, SGR resulted in a 5 percent reduction in payment rates to providers. Each year since then, the SGR formula has called for additional reductions in payment rates and Congress has blocked them. These temporary "fixes" have only postponed reductions and a cumulative reduction of 45 percent over many years is now pending. Although Congress is not happy about the large increases in spending for physician services, it does not want to substantially reduce payment rates because of the risks to access for Medicare beneficiaries. The succession of last-minute "fixes" have resulted in a long-term pattern of minimal payment rate increases, with essentially no increase from 2001 levels. As a result, an increasing number of providers are not accepting new Medicare patients, especially those in primary care practice, who have suffered the largest declines in income.

Addressing the problems with the SGR will require large spending cuts in other parts of Medicare, large tax increases, or acceptance of a larger budget deficit. There are some opportunities for spending cuts, for example in services where the payment rates are widely seen as being too high, such as in Medicare Advantage plans. But Congress is unlikely to be able to close the gap with spending cuts alone, or with tax increases. A major reform of Medicare physician payment does have the potential for long-term reductions in the rate of spending growth, if it leads to greater efficiency in the delivery of care. But the reforms are not developed enough at this point, and their impact is too uncertain for the Congressional Budget Office to confidently estimate large savings in Medicare and federal Medicaid spending. However, Congress may be able to justify increasing the deficit if it at the same time launches a major reform of the program, including revamping the payment mechanism and reforming governance. So, a needed long-term revision of SGR could serve as an important prod to reform the program and serve as a vehicle for the reforms.

DISCUSSION

Adopting these reforms to provider payment incentives will be complicated by the existence of multiple stakeholders on each side. When Medicare's physician fee schedule was enacted by Congress in 1989, there were large winners and losers by physician specialty. But the legislation had the support of the American Medical Association, in part due to the designated role of the AMA in hosting a process to resolve disputes between physician specialties over relative values—the Relative Value Update Committee, which advises the Medicare program. In recent years, decisions on changes in relative values have become more contentious as equipment manufacturers and device companies have played an increasingly greater role in issues that affect the profitability to physicians of services using their products. These additional stakeholders might make reform more difficult than it was in 1989.

Providers will probably find new payment methods threatening because of uncertainty. Although the "average" provider might be unaffected by a change, most providers are not average. Proposals for payments to medical homes are very attractive to primary care specialties because of the potential for payment for services that are not paid for today. The costs of the extra payment are to be offset by reduced need for services by beneficiaries who have better outcomes.

The payment reforms discussed in this chapter do not explicitly involve the patients or beneficiaries. In economics jargon, they are "supply-side" reforms rather than "demand-side" reforms. Medicare spending issues have traditionally been addressed by changing how providers are paid. But private insurance during this decade has placed much more emphasis on the patient side. Although consumer-driven health plans have received the most attention (see chapter 5 on patient activation), the most important changes have been the increasing use of financial incentives for patients enrolled in HMO and PPO products. Some of these approaches have entered Medicare through the Part D prescription drug benefit. Most Part D plans have incorporated their commercial insurance experience with tiered cost sharing, prior authorization, and other cost-containment mechanisms for prescription drugs into their Medicare products. Tiered approaches blend the supply-side approach of making judgments that assign drugs to tiers based on costs and effectiveness with the demand-side approach of allow-

ing consumers to decide on their own whether or not to choose the drugs with lower out-of-pocket payments. Virtually all enrollees who have aged into Medicare in recent years enter the program with experience under private insurance of responding to financial incentives.

Patient and beneficiary-focused elements could be incorporated into some of the payment reforms discussed in this chapter. In addition to rewarding more efficient providers through the payment system, incentives could also be offered to beneficiaries to use them, for example. This might build more political support for reform by giving beneficiaries more of a stake. A safety valve could also potentially be established so that inefficient providers with a loyal following of patients could continue through higher patient payments. Should demand-side tools become a fixture for the long term in private insurance, continuing to oppose their adoption in Medicare will be difficult, especially because most Medicare financing comes from active workers.

ENDNOTES

1 Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (Washington, D.C., November 2007).

2 Robert A. Berenson, Thomas Bodenheimer, and Hoangmai H. Pham, "Specialty-Service Lines: Salvos in the New Medical Arms Race," *Health Affairs*, Web Exclusive (July 25, 2006).

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4 Vanessa Fuhrmans, "Medical Specialties Hit By A Growing Pay Gap," *The Wall Street Journal*, May 5, 2008.

5 HSC site visit interviews do show a slow trend toward adoption of DRG payment by private insurers.

6 Paul B. Ginsburg and Robert A. Berenson, "Revising Medicare's Physician Fee Schedule," *The New England Journal of Medicine* 356 (12) (2007): 1201-1203.

7 Centers for Medicare and Medicaid Services, *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program* (November 21, 2007).

8 Hoangmai H. Pham and others,, "Care Patterns in Medicare and Their Implications for Pay for Performance," *The New England Journal of Medicine* 356 (11) (2007).

9 Payment rules for Medicare Advantage plans authorized under the MMA included elements that were to be tested in demonstrations. These demonstrations were never implemented due to opposition from Members of Congress representing geographic areas chosen for participation.

10 This should not be confused with initiatives in which a permanent program might be limited to volunteer practices, such as medical homes. Ideally, a demonstration should obtain experimental and control groups from a population of those capable of performing what is being tested.

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