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Developing A Viable Alternative To Medicare's Physician Payment Strategy

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ABSTRACT Since 1992 Medicare has reimbursed physicians on a fee-for-service basis that weights physician services according to the effort and expense of providing those services and converts the weights to dollars using a conversion factor. In 1997 Congress replaced an existing spending constraint with the Sustainable Growth Rate (SGR) to reduce reimbursements if overall physician spending exceeded the growth in the economy. Congress, however, has routinely overridden the SGR because of concerns that reduced payments to physicians would limit patients' access to care. Under continued pressure to override scheduled fee reductions or eliminate the SGR altogether, Congress is now considering legislation that would reimburse physicians to improve quality and lower costs—two things that the current system does not do. This article reviews several promising models, including patient-centered medical homes, accountable care organizations, and various payment bundling pilots, that could offer lessons for a larger reform of physician payment. Pilot projects that focus exclusively on alternative ways to reimburse physicians apart from payments to hospitals, such as payments for episodes of care, are also needed. Most promising, Congress is now showing bipartisan, bicameral interest in revising how Medicare reimburses physicians.

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Since 1992 Medicare has reimbursed physicians using a combination of a resource-based relative value scale (RBRVS) and a spending limit currently known as the Sustainable Growth Rate (SGR). These two features were designed to solve two problems associated with physician reimbursement. One problem was that the differences in how much physicians were reimbursed for providing different services didn't make sense: Medicare paid too much for procedure-related services and too little for services associated with primary care, such as the evaluation of patients and the management of patient care. The second problem was the ever-increasing growth of spending on physician services.

There has been growing dissatisfaction by

physicians and Congress with the current physician reimbursement system along with the view that neither the RBRVS nor the SGR has solved the problems they were intended to address. The RBRVS has not effectively increased payments made for primary care relative to procedure-related payments because too many of the updates have favored specialists. However, most of the controversy over physician payment has focused on the SGR and its continued threat to reduce physician payments. The initial SGR would have reduced payments to physicians by annual amounts of 4–5 percent but have now accumulated to a projected reduction of 24.4 percent for 2014.¹ Frustration among physicians remains high because of continuing uncertainty about future fees, even though Medicare has actually reduced fees only once.

The purpose of this article is to review the different paths that physician payment reform has taken relative to the development of bundled payments for other parts of Medicare, the attempt to find mechanisms other than the SGR to slow spending growth on physician services, innovations being tested in various venues and what they suggest for the future of Medicare payments to physicians, and the types of innovations that still need to be tested. Finally, this article reviews the current interest shown by both Republicans and Democrats in the House and the Senate to reform how physicians are reimbursed and what this suggests for the future of physician payment reform.

Differing Medicare Reimbursement Reform Strategies

In contrast to the way physicians are reimbursed, which is still based on a system of paying doctors for each service they perform, reimbursement for hospital services and other parts of Medicare has moved to the use of “bundled payments”—a single payment that covers all of the services provided in a given setting, such as a hospital, during a particular event, such as an admission. The use of bundled payment started in 1983 with the introduction of diagnosis-related group (DRG) payments that cover all hospital-related costs for an inpatient hospital stay. Since the late 1990s bundled payment has also been used to reimburse for visits to outpatient hospital departments; episodes of home care; and, to a lesser degree, nursing home stays.

A system of bundled payments encourages the efficient provision of services because the amount paid for the bundle of services provided is fixed, irrespective of the costs incurred. (Exceptions are made for extreme cost experiences through outlier payment policies.) However, bundled payments produce some of their own undesirable incentives. The most important is that they encourage an increased number of bundled services to be provided, which is one of the reasons Medicare recently introduced a penalty for hospital readmissions stemming from three types of medical conditions that occur within thirty days of discharge. In such cases, short-term readmissions either may reflect a second payment for the same medical problem or may indicate poor quality during the first admission—neither of which warrants a second payment. The current incentive toward the proliferation of bundles is discussed in some detail in a recent Urban Institute issue brief.²

Moving services out of the bundle so that they can be reimbursed in addition to reimbursement for the original bundle, sometimes referred to as

“unbundling,” is another undesirable effect sometimes associated with bundled payment. Unbundling has occurred with Medicare’s global surgery policy, in which some of the services that used to be included as part of the surgeon’s global fee for surgery have been billed separately, along with the global fee for surgery.³

Both bundle proliferation and unbundling could be “cured” through the use of a global or capitated payment that covers all of the services provided to a patient, although these payments raise other concerns—for example, they may provide incentives to providers to skimp on services.

In contrast to Medicare’s use of bundled payment for hospital and other nonphysician services, the program continues to pay physicians for discrete, individual units of service using the RBRVS fee schedule. For example, a physician who provided a flu shot, a pneumonia vaccine, and other tests during an office visit would bill for each service, plus a separate billing for the office visit.

The RBRVS fee schedule establishes relative values based on estimates of the physician work effort required to provide various services to patients combined with an amount reflecting the average expense associated with physician practices and an adjustment for geography. The relative value becomes a dollar value through the use of a metric called a conversion factor, which also reflects any adjustments needed to keep spending at specified growth rates.

Since passage of the Balanced Budget Act in 1997, the growth of payments to physicians has been tied to the growth of the economy, the Sustainable Growth Rate. However, Congress has bypassed the SGR every year since 2004, the one year when physician fees were actually reduced. A downward adjustment in physician fees should have occurred each year since 2004 because spending on physician services increased faster than the growth in the economy. Instead, because of fears that access to physician services would suffer from such a downward adjustment, Congress provided yearly physician fee adjustments that either held fees at the previous year’s level or gave an increase of up to 1 percent. Often Congress acted only days or weeks before the payment reductions were scheduled to go into effect.

Not surprisingly, this game of “kick the can down the road” has become tiresome to both physicians and Congress and has led to repeated calls by clinicians and lawmakers to eliminate the SGR. Some policy analysts have argued that because spending for physician services and the rest of Medicare has been flat in recent years, removing the SGR may not be as consequential

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as previously thought. Other analysts are not as convinced that the slowdown in health care spending is permanent.⁴

The payer community more recently has focused on developing ways to reimburse physicians that encourage value instead of volume, as is the case with the current fee schedule. Under the current fee schedule, a physician earns more money by providing more services and more complex services to patients—thus the volume focus. A fee schedule that reimburses each physician on the basis of approximately 8,000 different codes makes it very difficult to hold physicians responsible or accountable for the health outcomes of their patients or the costs of treating them—both crucial for value.

The use of the SGR complicates the undesirable incentives to increase volume inherent in the RBRVS fee schedule because of the “disconnect” the SGR produces between the behavior of individual physicians and the spending that results from the collective behavior of all physicians. The SGR is driven by the growth in spending on all physician services. Because no one physician or physician practice is big enough to influence the growth in spending on all physician services, nothing the individual physician or practice does will influence what happens to the SGR. For economists who believe in rewarding desirable behavior and penalizing undesirable behavior, the disconnect between a physician’s behavior and the impact on a physician’s reimbursement is another reason to search for an alternative to the SGR to slow spending for physician services.

Despite concerns that the RBRVS-SGR strategy is inconsistent with promoting value-based health care, the RBRVS is likely to remain as an important reimbursement mechanism in the near term because no other reimbursement system for physicians is available to replace it. As a result, a number of analysts have supported refinements to the RBRVS that correct for overvalued procedures and other distortions in the RBRVS calculations.⁵ In addition, section 3134 of

the Affordable Care Act directs the secretary of the Department of Health and Human Services to validate the relative value units in the Medicare fee schedule. Improving the accuracy of the fee schedule and reducing the number and value of “overvalued services” may also encourage physicians to consider some of the alternative payment strategies that are being tested as potential future reimbursement strategies.

Developing Viable Alternatives

Recognition is rising that the use of last-minute changes to temporarily override legislatively driven rate reductions under the SGR should be replaced with a more comprehensive reform of physician payments. This recognition is occurring at a time when the cost of replacing the SGR is much lower than it has been in the past—now just \$138 billion over ten years. Although this is still a substantial amount of revenue, it is much less than the \$300 billion cost of a few years ago.⁶ This “cost” reflects how much more the Congressional Budget Office estimates Medicare would spend on physician services over a ten-year budget period without an SGR restraint in place. (For “scoring” purposes, the Congressional Budget Office does not take into account that the legislated fee reductions have been ignored most of the time.)

Although policy makers and stakeholders struggle to develop the exact specifications for physician payment reform, some consensus seems to be developing that it will take more than just having separate SGRs apply to different groups of physicians, the strategy used in some previous legislation. Examples of this type of legislation can be seen in HR 3162, the Children’s Health and Medicare Protections Act of 2007, and HR 3961, the Medicare Physician Payment Reform Act of 2009, both of which were passed by the House but not by the Senate. The Children’s Health and Medicare Protections Act created six SGRs, while the Medicare Physician Payment Reform Act created two SGRs, each with its own growth rates and conversion factors. Each bill separated out evaluation and management services associated with primary care from other services to allow them to have higher updates.

Now, with a bipartisan physician payment reform bill passed unanimously by the House Energy and Commerce Committee and a bipartisan “legislative framework” recently released by the Senate Finance Committee and the House Ways and Means Committee that contain many common elements, there appears to be growing agreement on some of the elements that a physician payment reform strategy should include.^{7,8}

Both reform proposals would create a brief period of stability for physicians. They provide small updates in physician reimbursement with a higher adjustment available for physicians who participate in an alternative delivery system that can demonstrate improved value. Eventually, lower updates including reductions in payment are provided for those who cannot demonstrate improved value—that is, improved quality at the same or lower cost, or at least improved quality.

The Energy and Commerce Committee bill, HR 2810, repeals the SGR and provides an annual increase of 0.5 percent for the years 2014–18. Beginning in 2019, Medicare payment rate adjustments (positive and negative) would be based on a physician's performance on certain quality measures and clinical performance improvement activities, or on participation in alternative payment delivery models. Which alternative payment models are acceptable is not specified, but the legislation includes a process for developing and implementing such models. The Congressional Budget Office has estimated that HR 2810 would increase direct spending by approximately \$175 billion from 2014 to 2023.⁸

The House Ways and Means Committee and the Senate Finance Committee recently released a “discussion draft” that calls for a repeal of the SGR and replacement of the RBRVS with a more value-oriented payment system.⁹ The proposal in the discussion draft provides for zero updates through 2023 and then annual updates of 2 percent for physicians participating in advance payment models; others would receive 1 percent. Beginning in 2017, updates to fees would be made on a budget-neutral basis, based on the physician's performance in the prior year. This valuation combines three existing programs: the Physician Quality Reporting System, the Value-Based Payment Modifier, and the meaningful-use component of electronic health record adoption. The resulting value-based performance payment would reflect performance on quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records.

Having a joint effort that is bicameral and bipartisan and that has clear similarities to HR 2810 suggests more unity in thinking about how to reform physician payment than has been present since the RBRVS was passed in 1989. As promising as this new effort is, however, there are many issues that remain to be addressed. The most obvious is how to pay the costs of repealing the SGR and replacing it with something else. In addition, more discussion will be needed about the specific performance measures that should be used to determine payment shifts during the budget-neutral period and the specific advance

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payment models that should be included in the higher payment rates available after 2023.⁹

Pilot Projects Could Offer Lessons

Numerous pilot projects and demonstration programs currently under way experiment with different ways to organize or reimburse physicians. Some are relatively new pilot projects funded by the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation, a new center that was created by the Affordable Care Act and provided with \$11 billion over ten years to fund innovative activities. Other pilot projects have been started by private payers, going back to 2006 and 2007. Some of the latter represent initiatives of a single payer. Others have multiple private payers, and a few receive funding from multiple private payers along with Medicare or Medicaid, or both.

Many of the pilot projects are in relatively early stages of evaluation, and some projects are still in the early stages of implementation. Even where results are being reported, legitimate questions have been raised as to whether some of the savings being reported are sustainable and generalizable and how much of the reported savings are associated with one-time subsidies that might not be available in future years.

Despite these questions, the results of these pilot projects could illuminate which alternative payment models offer the best hope for physician payment reform.

PATIENT-CENTERED MEDICAL HOMES Medical home projects focus on providing comprehensive primary care that is patient centric and can better coordinate the care patients receive from all of their various providers. They vary according to whether they include only a single payer or

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multiple payers and how long they have been in existence. Under this model, a fee is generally paid to the physician or to a nurse manager to cover various coordination activities—typically per member per month. Reimbursement remains fee-for-service—thus rewarding volume—with an additional fee paid for coordination.

Patient-centered medical homes have been sponsored both by the government, through its CMS Innovation Center, and by many of the large insurance companies. Some of the private payers initially paid a fee to physicians who added processes of care, such as tools that organize clinical information or the adoption of evidenced-based guidelines, and then included a bonus payment based on improved outcomes, such as observed declines in hospital bed days or emergency department (ED) visits. This makes quality part of the equation, but payment is still basically fee-for-service. Physicians are rarely at financial risk in the medical home models.

Most of the medical home pilots to date have found modest savings at best. The results have generally been reported by the payers piloting them and have not been subject to independent evaluation. UnitedHealthcare, for example, has reported modest savings of around 4 percent over a two-year period for its patient-centered medical homes,¹⁰ while WellPoint reported savings of 3 percent in its first year in New Hampshire. Both payers continue the model of paying physicians on a fee-for-service basis but also make direct payments to physicians to coordinate care as long as certain additional services are provided.

A recently reported independent evaluation of one of the first multipayer patient-centered medical homes indicates some of the challenges medical homes are likely to find. The study covered five small independent practices in Rhode Island beginning in 2006. Like many other patient-centered medical homes, each of the practices received a small per member per month fee to support a nurse care manager. Although the study reported declines in certain ambulatory care-sensitive ED visits, the downward trend

in ED visits and hospital admissions was not statistically significant. There were also no significant improvements in various quality metrics reported. This study supported the notion that patient-centered medical homes that are undertaken outside of integrated care settings produce no more than modest savings.¹¹ Given that the basic financial incentives and structures of the practice remain the same, with an added payment for coordination and integration, this finding is not surprising.

Blue Cross Blue Shield of Michigan is following a somewhat different strategy with its medical home pilots.¹² Although the pilots operate under what is fundamentally a fee-for-service model, physicians receive higher fees for certain evaluation and management codes representing office and preventive care visits. Instead of straight per member per month fees, the higher fees vary according to the number of quality measures adopted and the performance achieved. The higher fees also reflect the outcome results of all patients in the area instead of just those who are Blue Cross Blue Shield of Michigan members and thus has a population focus. Because it has 50 percent of the coverage and 70 percent of the commercial market, Blue Cross Blue Shield of Michigan has more ability to affect the health of the population than a payer who has only a small share of the market.

Blue Cross Blue Shield of Michigan also has taken a different approach than other payers by including some added payment potential for specialists. For 2012 and 2013 the added payment was limited to a specialist's use of evaluation and management codes and was meant to encourage collaboration between specialists and primary care physicians. Starting in 2014, however, specialists will also be able to receive an added payment based on the quality and efficiency of care provided to the population (David Share, senior vice president of value partnerships, Blue Cross Blue Shield of Michigan, personal communication, March 15, 2013). Examples include assessing the clinical appropriateness of rates of joint replacement in the population and not just the cost or outcomes of individual procedures.

Blue Cross Blue Shield of Michigan has reported an upward trend in costs for 2011 and 2012 of less than 2 percent—less than half of their competitors' trend. However, an independent evaluation of its program is under way and will provide more credible results.

In addition to the projects already described, several advanced care pilot projects are also under way and will be subject to evaluations assessing their effects on access, quality, utilization, and expenditures, but it will be at least a couple of years until the evaluations are completed.¹³

The same is true for a Comprehensive Primary Care initiative, which was announced by the CMS Innovation Center in August 2012 and involves public and private payers, self-insured businesses, and primary care practices in seven states.¹⁴

ACCOUNTABLE CARE ORGANIZATIONS Accountable care organizations (ACOs) comprise groups of physicians, other health care professionals, and facilities that agree to work together to provide high-quality, coordinated care to their patients at measureable levels of savings. They generally reimburse physicians on a fee-for-service basis, but to overcome physicians' financial motivation to increase volume, they pay more to physicians who coordinate care and employ information technologies. They may also use other types of financial incentives to change behavior.

The ACO model is authorized in title III, section 3022 of the Affordable Care Act as a Medicare Shared Savings Program. The CMS Innovation Center developed an alternative model, called the Pioneer ACO, for organizations that have already had experience offering high-quality, coordinated care to patients and that meet other requirements, including a willingness to share losses and savings with CMS.¹⁵ As of early 2013 there were about 250 ACOs, including 32 Pioneer ACOs, and another 175 private ACOs.^{16,17}

An ACO needs to meet all of the health care needs of at least 5,000 patients. Unlike health maintenance organizations, there is no enrollment process, and people may be assigned to be part of an ACO after the fact, based on where they receive most of their primary care. And because there is no enrollment process, people in ACOs can seek care from physicians outside the ACO at no extra charge.

ACOs share with the government the savings that can result from better coordination of care as long as the ACO generates a minimum savings of 2 percent, which is calculated according to its own base-year spending, and also provided that the ACO meets thirty-three quality metrics specified in the CMS implementing regulations. ACOs in the Medicare Shared Savings Program are not required to accept "down-side" risk (that is, to be subject to losses) but can receive a higher share of savings if they agree to accept the risk. Pioneer ACOs receive still higher levels of shared savings and risk.

First-year results from the Pioneer ACOs, reported in 2013, indicated uneven performance for these ACOs, all of which were experienced in providing coordinated care.¹⁸ All of them met the quality performance metrics, but only thirteen of the thirty-two produced savings large enough to be shared with CMS. Nine are leaving the program: seven will go to the regular Medicare

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Shared Savings Program, and two will completely cease to function as ACOs.

BUNDLED PAYMENT PILOT PROJECTS The most significant bundled payment projects under way are part of the CMS Innovation Center's Bundled Payment for Care Improvement initiative.¹⁹ This initiative funds four different models of bundling, all of which have the hospital as the focal point of the bundle, including two that include physician services, the postacute provider, related readmissions, and any ancillary services provided during an episode of care. Provider organizations can indicate which conditions they want to bundle and propose a price that provides a discount from what CMS would have paid historically for a similar set of services.

The American Medical Association, working with the various specialty societies, is developing a Condition-Based Payment for Specialty Physicians, a type of bundling payment in which the bundle covers specialty physician costs for treating a given medical condition.²⁰ The conditions can include a single health problem, a combination of diagnosed problems, or a risk factor that predisposes patients to future health problems. Examples of conditions include congestive heart failure, angina, inflammatory bowel disease, epilepsy, and chronic obstructive pulmonary disorder. An "accountable" provider would be designated to negotiate an amount from Medicare that is less than what Medicare would have expected to pay for treating the condition. Payments would be risk-adjusted, and minimum quality metrics would have to be met. Since the American Medical Association's Condition-Based Payment for Specialty Physicians is still in the development stage, it's hard to know how long it will take before it could be piloted or its effects assessed.

What's Missing?

These pilot projects will be helpful in identifying strategies that justify higher payment updates for physicians and thus should be included in alternative payment and delivery systems. What they will not do is provide evidence about the effects of various ways to reimburse physicians when the payments for physicians are not part of a hospital's bundled payment. Alternative reimbursement strategies for specialists using episode payments or other types of bundling strategies are absent from the CMS Innovation Center's repertoire of pilot projects. It may be that the innovations that are being piloted will be sufficient to assess the necessary strategies to improve value, but this seems like an opportunity that could have and should have been exploited.

Perhaps one of the reasons so little is being done to develop episode-based payments for specialists is their lack of interest in trying bundled payment, at least compared to primary care physicians who are very positive about patient-centered medical homes. Specialists' relative lack of interest in alternative payment strategies may reflect satisfaction with the way and the amount they are currently paid—in contrast to primary care physicians, who believe that they have been underpaid and underappreciated.¹⁰ Specialists' attitudes toward alternative forms of reimbursement could change dramatically if their Medicare payments directly reflected their participation in alternative payment and delivery models, such as is being proposed in the Ways and Means and Finance Committees' discussion draft.

Conclusion

The public and private sectors are engaging in innovative reimbursement strategies, with no indication that a saturation point has been reached. Many of the strategies directly increase payments to primary care physicians for coordinating the treatment of chronic care and, in some cases, improving patient care outcomes. ACOs developed by both public and private

payers encourage physicians and hospitals to work together more effectively so that they improve health outcomes at lower costs of care, but ACOs typically continue to pay physicians using fee-for-service reimbursement. The CMS Innovation Center bundling pilots all include hospitals as the focal point of the bundle, which is unfortunate and is likely to only exacerbate the shift in power in favor of hospitals that has already been occurring over the past decade as hospitals merge into larger hospital systems. A few innovative reimbursement strategies directly focusing on specialists are now being tried or are under development. Congress should consider directing the CMS Innovation Center to test other payment strategies directed toward physicians that are outside of the hospital bundled payment.

The most promising development may be the discussion draft, recently released by the House Ways and Means Committee and the Senate Finance Committee, which contains many elements that are similar to a bill that unanimously passed the House Energy and Commerce Committee earlier this summer. These bipartisan, bicameral efforts would move Medicare's reimbursement for physicians away from a system that primarily rewards physicians for volume instead of value—that is, lower costs and improved quality.

Despite these positive steps, many challenges remain. It is unclear which alternative payment models and delivery systems will improve quality while lowering costs and how sustainable any initial savings will prove to be. It is also unclear how generalizable any of the results of these pilots will be when tried on a larger population. The potential for significant self-selection to affect the outcomes seen in voluntary pilot projects is a problem researchers have recognized from the beginning. Finally, the reduced cost of eliminating the SGR, currently estimated at around \$138 billion over ten years, is much less than it has been for most of the past decade but still represents a sizable cost that will have to be paid for with other spending reductions or revenue sources. ■

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