

Realigning Incentives In Fee-For-Service Medicare

A proposal to reform Medicare payment while retaining the fee-for-service system.

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PROLOGUE: Notwithstanding its maiden promise to keep government's hands off the health care delivery system, Medicare began efforts to restrain runaway spending long before the managed care boom of the 1990s. With 85 percent of beneficiaries still receiving fee-for-service care, those efforts are destined to continue well into the future. Neither Medicare nor private insurance has yet solved the age-old contradiction between patients' and providers' demand for more and payers' need for restraint. The chimerical notion that all of these imperatives could somehow be aligned in a common scheme still floats beyond reach.

Physicians have always viewed third-party payment as a deal with the devil: necessary and inevitable, perhaps, but essentially alien and threatening. The average doctor's office is a daily battleground between the conflicting imperatives of treatment and thrift. Payers' efforts to solve the conflict unilaterally—administered pricing in Medicare and discounting and capitation by employers and insurers—have not done the trick. Efforts to simplify the basic equation by integrating hospital and physician services ended up calling into question just how decisions should be made.

The logic of looking for answers where the problem arises—in the doctor's office—is inarguable, and that is what the following reform proposal does. It recognizes the increased importance of provider organizations, including medical groups, as the physician's workplace and provides incentives for aligning the interest of Medicare, the provider organization, and the physicians providing the medical care. Stanley Wallack and Christopher Tompkins began their work on volume performance standards for medical groups more than a decade ago. In the aftermath of a broad retreat from insurer-driven strategies for managing cost and care, their ideas are even more relevant now, as evidenced by the legislation requiring the Centers for Medicare and Medicaid Services to demonstrate the model.

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ABSTRACT: This paper proposes Medicare payment reform built on the fee-for-service system, with incentive payments to eligible provider organizations determined by their rate of increase in cost per patient compared to the overall growth rate in the community. By planning and monitoring how care patterns are altered to achieve greater efficiency, policy-makers can align the incentives of Medicare and the provider organization better than using either fee-for-service or capitation alone. This reform, unlike capitation, maintains Medicare's historical role as insurer and focuses providers on managing care.

THE CURRENT MEDICARE PROGRAM is at a crossroads. Efforts over many years to revamp the fee-for-service (FFS) payment system have led to low, administered payment rates that can give providers incentives to deliver individual services or episodes of care efficiently. However, the program gives little incentive for physicians to manage their patients' total care, which in many cases also calls upon support from larger, often integrated service organizations. Particularly absent are incentives to help patients navigate among many providers or to develop system-level infrastructure and care processes that help to match patients with appropriate levels of care and to move patients along a continuum of services. Such techniques are possible, or even expected, in managed care organizations (MCOs). However, Medicare enrollment in private health plans has always been small, concentrated in a few market areas, and is likely facing decline overall.

This paper proposes a blended payment system that includes FFS coupled with potential bonus payments to provider organizations for improving aggregate efficiency (based on spending per patient) over time. The proposed payment system emphasizes the organizations that employ or coordinate physicians as the focal point for managing patient care and ensuring the appropriateness of services. The objectives of this payment reform are to modernize and transform Medicare but to not do away with its traditional responsibilities as insurer and prudent purchaser. This includes reducing spending over time while preserving access to providers that are appropriate for the elderly, chronically ill, and disabled.¹

Toward these ends, it is important to align the goals, incentives, and strategies of the insurer (Medicare), provider organizations, and individual practitioners. Such alignment does not happen under either traditional FFS or capitation, in which incentives frequently work at cross purposes and result in win-lose outcomes (that is, winning at the other's expense).² A realignment of incentives and processes could create a win-win scenario in which sicker people have access to appropriate services and the improved efficiency is mutually beneficial for the providers and payer.

The 2001 Institute of Medicine (IOM) report discussing the "quality chasm" noted the absence of real progress toward restructuring the health care system to address both cost and quality.³ Although the requisite alignment appears to occur in a few MCOs as a result of their integrated structures or blended payment systems, it is doubtful that systemwide reform can occur without the largest payer,

Medicare, undertaking major payment reforms as well.⁴

The proposed payment reform is aimed at the 85 percent of Medicare beneficiaries who remain under FFS. Their physicians would continue to be paid based on FFS, encouraging efficient delivery of individual units of service. However, their respective provider organizations would be eligible for additional bonus payments, based on a portion of savings their individual providers and system-level changes generated over time by lowering Medicare payments per patient served. In other words, utilization is measured on average for Medicare patients, at the level of the physician organization.

Since the total expenditure rate for a population is algebraically equivalent to total expenditures per physician times the ratio of physicians per population, payments per physician is just another way of expressing payments per person for a community. Yet measuring and appropriately rewarding utilization patterns at the organizational level has the advantage of adding incentives at the practice level, where infrastructure supports and clinical protocols are needed to assure appropriate and coordinated services.

The approach described here would give provider organizations new incentives to improve the efficiency of total patient care without requiring beneficiaries to enroll into private health plans. Under the current Medicare+Choice (M+C) program, Medicare faces adverse risk selection at the health plan level because continued plan participation is contingent upon payments that are adequate to cover costs.⁵ In addition, under the proposed reform Medicare would not have to forgo the data necessary to monitor utilization patterns for quality, efficiency, and research into future program improvements. By aligning the individual physicians and their organizational environments with a blended payment system that rewards both levels, the multiple goals of a payment system—efficiency, appropriateness, and coordination of care—can be addressed comprehensively.

Background And Context

The vast majority of Medicare beneficiaries today (and for the foreseeable future) receive services in the FFS sector, where the government is able to administer very low prices for services, but there is little incentive for the organizations where physicians work to manage the volume and intensity of services. The federal legislation that established Medicare's physician fee schedule and national Medicare Volume Performance Standards (MVPS) also required the development of alternatives to the MVPS that would permit physician groups to opt out of blanket penalties that could result if aggregate national expenditures exceeded projected amounts.⁶ This requirement reflected the difference between the MVPS as a budget tool versus a needed incentive structure for providers to reduce Medicare spending over time. The MVPS was viewed as a failure on both counts and was replaced with a more aggressive budget tool (the sustainable growth rate).⁷

The payment system proposed here was designed in response to federal legisla-

tion to establish a workable and effective incentive structure for physician groups. The objective was to make new incentives applicable to all beneficiaries seen by a provider organization, allowing the organization to implement strategies more often associated with managed care (for example, hospital admission avoidance and clinical preventive services).

During the development process in the early 1990s, many provider organizations declared to the Centers for Medicare and Medicaid Services (CMS, then HCFA) their interest in demonstrating the feasibility of this approach. They believed that this approach would make their service systems respond to capitation payments and Medicare FFS in a more consistent and improved manner. The continued interest of Congress and these provider organizations led to a legislatively mandated demonstration project, as part of the Benefit Improvement and Protection Act (BIPA) of 2000. The CMS has published a request for applications from group practices to participate in a three-year demonstration.⁸ Having a small demonstration in place will assist the CMS in learning how to handle the logistics of the approach. However, the lack of widespread participation in M+C suggests the need for considering this type of model as a policy alternative for broader Medicare reform.

Allocation Of Risk

Payers have implemented various payment systems designed to transfer financial risk to health care delivery systems and physicians in hopes of inducing lower costs for services. Physician groups can assume the risk directly, if payers engage in direct contracting, or collectively, if a health care organization receives the risk on behalf of a physician group. The unit of payment, generally speaking, defines the extent to which financial risks are retained by the payer or transmitted to the entity representing providers.

Exhibit 1 presents a matrix that relates the unit of payment and the accompany-

**EXHIBIT 1
Unit Of Payment And Financial Risk In Medicare**

Unit of payment	Trigger for payment	Selection risk	Utilization risk
Fee-for-service (for example, office visit)	Delivery of service	Almost none; sicker patients lead to greater volume or more intense service mix, or both	Providers try to have their cost (intensity per unit) below other providers' costs
Case rate (for example, treatment for prostate cancer)	Onset of treatment for diagnosed or qualified patient	Average severity within the definition of a qualified case	Providers must control the volume and intensity of each case
Capitation (for example, per member month)	Enrollment or assignment to panel	Areawide incidence rates, plus average severity, for all types of conditions	Providers must control the volume and intensity of each member

SOURCE: Authors' conceptual analysis.

ing financial risks. An FFS payment system with administered prices can establish incentives to efficiently produce an individual unit of service, such as an office visit. Moreover, under the Medicare physician fee schedule, for example, physicians are essentially protected against selection risk because the volume and intensity of services, and corresponding revenues, will vary strongly in accordance with the degree of morbidity.

Case rates are payments to providers to handle the service needs of patients meeting relevant criteria that define the specific kind of case. Specialty groups often receive case rate payments from MCOs upon the referral to them.⁹ Providers are given incentives to manage the volume and intensity of a bundled set of services, or services a patient may need over a period of time. The provider's responsibilities, and the payment, are triggered by the onset of a case that meets the specified criteria. Therefore, the risk borne by the provider organization is related not to the incidence rate in the population for the defined cases but to the cost of services per identified case.

The movement from case rates to capitation, however, makes the entity at risk responsible for the community's incidence rates of disease, injury, and disability, which are added to the utilization risk for all cases that develop. By adding responsibility for the probability or incidence rate of new cases under capitation, the risk-assuming organization is encouraged to focus on attracting healthier and lower-risk patients, to have patient panels that reflect the population in the community, many of whom use a minimal amount of services. If the entity fails to attract this healthy population (that is, fails to act like a discerning insurer), it will suffer financially. In principle, ideal risk adjusters in a capitation formula would eliminate incidence risk and allow the financial performance of providers and health plans to be determined by their efficiency in the provision of care.

Separating The Insurance And Provider Roles

Insurers are very concerned with the risk selection or underwriting effects of their policies. In contrast, provider delivery systems are established to care for the ill and may not have a culture or mission that allows them to transform easily into an insurer that seeks to enroll the healthy. More importantly, we need to ask whether we want providers to undergo such a transformation.

If Medicare can change its FFS payment system to one that incorporates care management and quality through its payment policies and contracting, it need not relinquish its role and responsibilities as insurer. These include spreading incidence risk over the whole population, assuring that benefits are administered equitably across the whole covered population, and making use of integrated and comprehensive information systems to ensure quality of care and to improve system performance as necessary. The movement by private-sector MCOs away from global capitation for physicians and to other incentive arrangements reflects the same need to balance cost containment and quality in payment systems.¹⁰

Basis For Provider Risk Under Reform

Payment systems ranging from FFS to capitation vary in ways that affect financial risk and incentives, including along the two major dimensions of retrospective versus prospective determination of the payment level, and reference to community-based versus provider-specific experiences. Under FFS, payments are determined retrospectively based on the provision of services by each respective provider. Although capitation rates typically are based on cost experiences for the population, they are paid prospectively as fixed revenues each month, with resulting incentives for the capitated organizations to lower their own costs and realize savings. Capitation is based on the utilization occurring in the larger community and, therefore, incorporates the overall utilization rates for all local providers.

The incentive payments added to FFS under the proposed reform can be viewed from the perspective of this two-dimensional framework. The retrospective component of the proposed formula continues the use of FFS (that is, prevailing Medicare payment policies) for all services. The prospective component incorporates the difference between communitywide and each specific provider organization's average annual increase in the intensity and volume of services per patient seen.

Generally, blended payment systems to date have modified only the terms of payments to capitated MCOs.¹¹ In the blended system proposed here, FFS payments encourage efficiency for individual units of service, while bonus payments to organizations give incentives for providing the appropriate services and needed coordination of care. Thus, the blending is done in terms of mixing retrospective and prospective elements, based on a combination of provider-specific and communitywide experiences.

This provider-specific payment approach is analogous to the hospital payment system of the early 1980s (enacted under the Tax Equity and Fiscal Responsibility Act, or TEFRA, of 1982), in which yearly allowed increases were based on historical costs for each provider, with a sharing of losses and gains. The cost reductions under the TEFRA system were found to be slightly smaller than the prospective payment system (PPS) based on diagnosis-related groups (DRGs) but did not have windfalls to particular hospitals resulting from lower costs that were not associated with efficiency.¹² Under the PPS, the Medicare program does not pay for the excessive profits to some hospitals resulting from the redistribution of funds, because other hospitals suffer offsetting losses.

Provider Performance And Medicare Savings

In the proposed payment system, spending per patient for each provider organization, and for the community as a whole, is measured as reimbursements per unique patient seen (RPUPS).¹³ This includes all Medicare payments to all providers for patients seen at least once during the year by the respective entities. During any given year, if physicians improve their efficiency by making efficient substitutions and enhancements, the mean reimbursements are reduced.

In the proposed model, the community average rate of increase is applied to each provider's base-year measure of RPUPS to yield a provider-specific target from which savings can be estimated, and subsequently bonuses determined. In each performance year, the actual spending per patient would be compared with the target level for that year, yielding the estimate of Medicare savings per patient. Total savings are estimated by multiplying the savings per patient times the number of unique Medicare patients seen by the provider organization that year.

For example, consider two organizations operating in communities that experience a 6 percent growth rate in Medicare payments per beneficiary. The beneficiaries seen by each organization had on average \$6,000 in Medicare costs during the base year. One of the organizations mirrored the community with a 6 percent growth rate, resulting in \$6,360 per Medicare patient seen the following year. The target expenditure rate for that organization also would have been \$6,360 because of the matching communitywide growth rate; hence, the provider generated no Medicare savings. If the second organization held the growth rate to 1 percent, resulting in \$6,060 per patient, there would be a savings to Medicare of \$300 per beneficiary (\$6,360–\$6,060). If the provider had seen, for example, 20,000 Medicare patients during the year, the total Medicare savings would be \$6,000,000 (20,000 × \$300).

To help ensure validity, the target would be adjusted according to any observed changes in an organization's mix of patients. This could be accomplished by categorizing patients each year according to a classification system such as Adjusted Clinical Groups (ACGs).¹⁴ The ACG distribution of beneficiaries seen in the performance year could be used to reweight the base-year RPUPS. When this adjusted RPUPS is trended forward according to the communitywide growth, it represents a target that approximates the case-mix served in the performance year.

Since Medicare would be contracting directly with provider organizations and would continue to generate FFS claims, a uniform data set would continue to exist for all providers and services—a tremendous logistical advantage over the attempts to integrate data across disparate M+C plans in order to calculate relative risks. This would allow adoption of systems that include all ambulatory diagnoses and procedures, rather than inpatient services only. The observable changes in case-mix will continue to hold constant many provider-level factors and better isolate beneficiary-level factors, which should bolster the reliability of the target.

Some provider organizations with relatively high RPUPS could be less efficient than others or serve sicker patients, or both. If we were certain that such an organization was simply inefficient, there might be an equity concern. However, bonuses and penalties under this modified FFS system, in any case, are more equitable than national service-specific budget targets are (such as MVPS for physician services). Under the MVPS or other “blanket” budget tools, providers making the greatest efforts to reduce services will forgo the most revenues yet still will suffer along with all other providers when a service-specific budget is exceeded. Under

this proposed reform, each participating provider's bonus depends only on its own behavior.

Incentives Through Shared Savings

Medicare would retain a portion of the savings and would share a portion with the provider organization via lump-sum payments. There are several factors involved in setting the bonus payment for the provider, and the accompanying incentives. A prerequisite is that there are positive savings to Medicare in that year and cumulatively since the base period; there are no extra payments to a provider organization if there are no savings, on average, for that group of patients.

The proposed system, in its original form, offered two parameters to determine the proportion of savings shared with the provider, as illustrated in the following formula: Bonus payment = Medicare savings \times patient capture ratio \times sharing rate. The first, called the patient capture ratio (PCR), is the proportion of total savings that approximates revenues forgone by the organization in generating the savings. The second, called the sharing rate, is a policy parameter that balances incentives to the provider organization against savings retained by Medicare. In response to subsequent legislative requirements to include quality measures, the CMS added a third provision to make a portion of the bonuses contingent on meeting selected claims-based process-of-care standards.

In the FFS system, patients are at liberty to see more than one provider organization; accordingly, it is important to have rules for allocating the savings across organizations. The sharing of positive savings can be gauged by the PCR, which is defined as the proportion of all Medicare payments that were made to that specific provider organization. The beneficiaries seen by a participating organization also may have received services from other providers in the community. The PCR is the proportion of Medicare payments to the participating organization out of total Medicare payments for those beneficiaries. By extension, the PCR reflects the portion of the forgone revenues that the provider might have been expected to receive under ordinary FFS. Thus, for example, if a provider had a PCR of one-third, then at most one-third of the savings would be shared with the provider. Having the PCR in the savings formula limits shared savings commensurate with forgone revenues to the provider and prevents Medicare from double-counting savings across providers with overlapping patient populations (which is the norm). An added advantage to this approach is that it is not necessary to uniquely assign beneficiaries to provider organizations; rather, providers can count on having the new payment system apply to their entire Medicare patient base.

Providers other than physicians, such as hospitals, could be affiliated with a participating physician group as long as the physicians are willing to take responsibility for the quality and efficiency of those services. In calculating the utilization measure (RPUPS), the hospital payments would be included already; however, payments to affiliated hospitals would be added to the group's PCR,

reflecting the explicit cooperation in patient care and the combined forgone revenues for the affiliated organizations.

Policymakers could further decide what proportion of savings to share with the providers. The possible values for the sharing rate range from zero, which reduces the model to merely FFS, to one, which allows the PCR alone to gauge the savings shared with the provider. Higher values increase the incentives for efficiency but reduce Medicare's share of the savings. It cannot be known with any certainty how effective such a system could be in controlling utilization rates and producing savings; however, broad implementation could induce savings from a large proportion of the physicians and beneficiaries involved in Medicare.

For substantial incentives to exist, it is not necessary to restore all lost revenues for providers, for two reasons. First, the provider's own costs are lower when services are not provided. Second, managing utilization can include engaging patients through continuity of care and proactive management so that they do not seek avoidable services that would have been delivered under FFS by different provider entities.

Administrative Issues For Medicare

There has to be a limit to the number of new entities operating under their own performance standards, because of both the technical criteria for participation by each entity and reasonable limits to using administrative resources. Most or all physicians might be affiliated with one (and only one) of these larger health care delivery groupings; their individual provider numbers would be pooled under the respective umbrella organizations. The development work included empirical analyses that easily identified group practices by their corporate tax identification numbers. For qualifying single organizations, this identifier could uniquely identify all employed physicians, and the unique Medicare beneficiaries seen by them. Similarly, independent practice associations (IPAs), preferred provider organizations (PPOs), and other groupings could pool these identifiers under a single new unique identifier. Computer algorithms for calculating savings and potential bonus payments have already been developed and tested.

For example, the government could decide that about 1,000 provider organizations may operate under their own performance standards. If these organizations were geographically dispersed and were fairly large, seeing an average of 20,000 or more beneficiaries per year, then half of the approximately forty million Medicare beneficiaries could be involved in relatively short order.

Another important feature of the reform is delivering data reports to the participating provider organizations. These would exhibit the utilization patterns for Medicare patients seen, including aggregate summaries of services delivered. Again, this function is consistent with today's practice of MCOs and insurers working with providers to improve utilization patterns. The feedback can be designed to allow monitoring of improvements against target opportunities and to

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assess progress toward objectives identified in organizations’ action plans for improving total care for subgroups of patients. A standard format can be established for defining actions to be taken and for monitoring their effectiveness.

Transition To Medicare Policy

Certain features of this model make rapid and sizable expansion much easier than capitated enrollment programs do. Beneficiaries need not opt out of Medicare and into separate insurance plans. Medicare continues to apply its payment policies as implemented under FFS. There are no new data collection requirements, nor is there any need to merge incompatible data systems from diverse health plans.

The application of these reforms to the Medicare program would involve at least two major provider groupings operating under their own performance standards in accordance with the payment model described above: (1) vertically integrated organizations, and (2) “virtually” integrated organizations consisting of providers connected by contract and common agreements.¹⁵ There are some criteria necessary for a provider organization to operate as a distinct entity with performance tracking. First, there would need to be enough Medicare patients served to have stable costs per patient from year to year; technical analyses suggest a minimum of about 10,000 unique patients in a year.¹⁶ The level of patients seen under this model to achieve stable costs is considerably lower than is necessary under an insurance model or in the current capitation system, which has to account for the variation in population incidence rates and in the care patterns across providers.

In addition, the physician network would need to include a solid base of primary care practitioners, to exert some oversight of the full spectrum of patients’ needs. Third, an important aspect of this reform is to move away from a mindset or practice of proprietary, “black box” managed care. Organizations would be expected to outline their plans for improving patient care, which could be subjected to ongoing monitoring or, in some cases, even formal evaluation. Similarly, participating organizations would need to disclose their internal arrangements so that affiliated providers are treated equitably in the distribution of bonus payments.

Many provider organizations consulted during the development phase determined that they were better off to remain under FFS than to take capitation payments under M+C. The proposed system should prove more attractive to many organizations because it emphasizes managing the use and intensity of services and dampens the risk of adverse selection.¹⁷

Furthermore, large provider organizations see large segments of the Medicare population and account for large portions of total Medicare spending each year.

For example, analysis of Medicare data in the early 1990s showed that about 3 percent of medical practices accounted for more than one-third of Medicare's payments for physician services.¹⁸ While most of these are large single- and multi-specialty groups, the vast majority of other physicians have contracts with one or more MCOs.

IPAs are formed for similar functions to serve various private and public populations. State and local medical societies also might serve as loci for area physicians to pool their experiences and coordinate total patient care. Implementation of the reform might begin mainly with large multispecialty groups where physicians work full time within a single corporation (as in the group practice demonstration being started by the CMS) and with various provider-based organizations that have experience contracting as one entity for managing the health care of a population. This Medicare reform program can grow quickly to incorporate a large number of providers and the Medicare beneficiaries they serve, thereby having a profound effect in bringing care management to the Medicare FFS population relatively quickly.

Final Thoughts

The entire Medicare program needs updating and an alignment between the interests of payer, provider organizations, individual physicians, and beneficiaries. For the system to provide the appropriate care yet become more sensitive to costs, all involved parties' interests need to be better aligned. In such a system, financial risks associated with global patient management would be aligned with practice management activities. In other words, provider organizations and individual physicians would have an interest in managing their own patients' total care, even though, as provider organizations and not insurers, the formal scope of their responsibility would be limited to their own practices.

Financial performance under this model depends more on improving efficiencies than on favorable selection patterns. Thus, while the incentives to reduce costs are not as strong under this FFS reform as under capitation, the savings to Medicare are more "real" and could be substantial with broad implementation.

Under the proposed payment system, policymakers can instill new incentives to all physicians while continuing to monitor utilization as necessary. The proposed reform could be rolled out nationally to include large numbers of Medicare-qualified provider organizations, with some physician group practices participating as individual entities and others grouped in voluntary alliances. Since payments are established for identified cases and are not strongly driven by risk selection, serving expensive, chronically ill patients is not discouraged.

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NOTES

1. Any broad Medicare payment reform should try to achieve at least two related objectives: mainstreaming Medicare beneficiaries into the types of products available for employed populations, and achieving efficient, appropriate and coordinated care. Managed FFS, preferred provider organizations (PPOs), and point-of-service (POS) plans have been widely adopted by the private sector, in addition to and even in place of, health maintenance organizations (HMOs). This means that Medicare's objective of having beneficiaries served in "mainstream" situations can include a wider range of options, including managed, open-network environments. The prevalence in the market of a variety of managed care choices reflects the fact that more efficient use of hospitals and other high-cost technologies is not contingent on their being provided by a highly integrated, tightly managed, or closed-panel environment. Contractual models between payers and providers with performance incentives are very common today.
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6. *Omnibus Budget Reconciliation Act (OBRA) of 1990*, P.L. 101-239.
7. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, Vol. 2 (Washington: MedPAC, March 1998), 95-97. The major problem with the MVPS was that it set targets for spending growth that were not sustainable. The targets were based on average volume growth, which had dropped from 8 percent in 1992 to 3 percent in 1996. This drop, coupled with legislated reductions in the targets that were intended to slow the rate of spending growth, led to targets that were too low. Congress recognized this problem and, as part of the Balanced Budget Act of 1997, replaced the MVPS with the sustainable growth rate system.
8. *Federal Register* (27 September 2002): 61116-61129.
9. Robinson, "Theory and Practice."
10. J.C. Robinson and L.P. Casalino, "Vertically Integrated and Organizational Networks in Health Care," *Health Affairs* (Spring 1996): 7-22.
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12. J. Feder, J. Hadley, and S. Zuckerman, "How Did Medicare's Prospective Payment System Affect Hospitals?" *New England Journal of Medicine* 317, no. 14 (1987): 867-873.
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16. G. Pope et al., *Technical Summary and Review of Demonstration Design for Group-Specific Volume Performance Standards*, Report to HCFA (Waltham, Mass.: Health Economics Research, 1997).
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