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THE BEST ANTIDOTE TO PROVIDER MARKET POWER IS TO CHANGE THE HEALTHCARE PAYMENT SYSTEM

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There is growing national concern that consolidations of healthcare providers are leading to higher prices for healthcare services. The June 2014 issue of the policy magazine *Health Affairs* includes four separate papers that propose a range of policy options to try and address this issue[1].

Unfortunately, those hoping for answers will not find the *Health Affairs* papers very satisfying. Not only is there little agreement among the authors about what to do, most of them do not express much enthusiasm about either the feasibility or benefits of the options they do identify.

False Premises Lead to Wrong Conclusions

The reason why most policy prescriptions about prices and market power are so unsatisfying is that the underlying analyses are based on three fundamentally false premises.

False Premise #1: Consolidation of Providers is Necessary and Desirable (In Fact, It's Not). The first premise is that consolidation of hospitals and physician practices is both necessary and desirable to improve the quality and efficiency of healthcare. This is taken as article of faith by most of the authors of the papers in *Health Affairs*; only one of the papers provides a reference to support this premise, and that is an opinion piece focused on the difficulty of implementing new payment models with solo and small physician practices.[2]

You don't see many references to support the necessity or desirability of consolidation because there is little evidence to cite. What few studies exist indicate that consolidation is neither necessary nor sufficient for either better care coordination or greater efficiency of care delivery.[3] In contrast, as noted by one of the papers in *Health Affairs*, there is evidence that competition can lead to lower prices and higher quality.[4] A Commonwealth Fund report that is commonly cited to support the need for greater integration in healthcare states that there is no single way in which providers should be organized to improve care delivery, and it explicitly cites networks of independent providers as well as large groups and integrated systems as a feasible approach.[5]

In fact, there are many examples around the country of small physician practices and small hospitals providing high quality, efficient care while remaining independent.[6] There are also many examples of large "integrated" systems that are simply charging the high prices everyone is concerned about rather than significantly improving care coordination or quality. Many of the healthcare providers that are currently consolidating in order to form a "clinically integrated network" have no clear plan for how they will improve care for patients or lower healthcare costs and they may well decide it is easier simply to raise prices after consolidation is complete.

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Obviously, if consolidation is not necessary to achieve the better healthcare everyone is seeking, then there is an entirely new set of solutions available to combat higher prices driven by provider market power, namely, revoking or revising policies that encourage or require providers to consolidate. Instead of promoting consolidation based on a fallacious premise and then trying to figure out how to control the resulting market power, it would make more sense to find ways to make the desired improvements in care delivery without consolidation.

False Premise #2: The Payment System Isn't the Problem (In Fact, It Is). The second premise is generally unstated, but equally important; the premise is that consolidations and pricing strategies have nothing to do with the way healthcare providers are paid. In fact, the exact opposite is true – a major cause of both consolidations and demands for higher prices is the way we pay for healthcare today, and many so-called "payment reforms" are actually making the problem worse, not better. Only one of the papers in the *Health Affairs* collection discusses paying healthcare providers differently, and even that only addresses part of the problem with the way providers are paid.[7] We need radically different payment systems for both physicians and hospitals in order to get better quality care at lower cost. If a payment system can only be implemented by large provider organizations, the solution is to redesign the payment system, not to try and control the prices charged by a consolidated organization.

False Premise #3: Price and Utilization Are Independent (In Fact, They're Not). The third premise is that price and utilization are independent of each other, and that purchasers and payers can pursue policies aimed at controlling price without concern about utilization, and vice versa. Yet what should matter to purchasers is how much they *spend on healthcare in total* not how much they *pay for individual services.* In some cases, the prices of individual services may need to increase in order to support lower utilization and lower overall spending. Conversely, demanding lower prices may simply result in higher utilization and higher overall spending, or it may force providers to consolidate in order to resist what they see as unreasonable pricing demands.

We Don't Pay Hospitals For What We Really Want Them To Do

Hospital prices seem to be the major source of concern today, but few people recognize that the way we currently pay hospitals is completely at odds with what we most want them to do, namely, be there when we need them. When we're injured, we want a hospital close by that is ready to treat the injury quickly and effectively. When we have the symptoms of a heart attack, we want a hospital close by that is ready to quickly and accurately determine if we're having a heart attack and if so, to treat it quickly. If a disaster strikes our community, we want a hospital close by that can respond rapidly and treat all of those who are injured.

But we don't pay hospitals to be there when we need them. We only pay them when they actually do something for us. If you're not injured, the hospital doesn't get paid for having the emergency room staffed and ready for you. If you don't have a heart attack, the hospital doesn't get paid for having a cardiac catheterization lab organized to ensure you have a low door-to-balloon time. If your community doesn't have a disaster, a terrorist attack, a flu epidemic, or any similar unfortunate event, the hospital doesn't get paid for the capacity it has created and the preparations it has made to deal with such events.

We treat hospitals as though they were manufacturing plants or grocery stores, paying them only when we want to buy a particular service. But obviously, we have higher expectations for hospitals than for manufacturing plants and grocery stores. If the grocery store is closed, we will wait until the next day to

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buy what we need, and if we find a better product at a lower price from a manufacturer on the internet than at the local store, we will wait for it to be shipped to us. But if we're badly injured in a car accident, having a heart attack, or can't breathe due to an asthma attack, we want the hospital to be ready to give us high quality care right away, even if it's in the middle of the night.

In effect, a hospital is a combination of an insurance plan and a service provider. The hospital maintains a certain amount of standby capacity as a form of insurance for the community so it can respond to needs when they arise, and then it adds additional capacity in response to both actual patient needs and discretionary choices that physicians and patients make. However, Medicare, Medicaid, and commercial health plans pay only for the service provider component, not the "insurance" (standby services) component. As a result, the hospital has to treat enough patients in order to generate the revenues needed to cover its standby capacity, and that can lead to overutilization.

Current Payment Systems Richly Reward Overutilization

In fact, because hospitals are paid the same amount for each procedure, regardless of how many procedures they deliver, and because the payment rates for a procedure are generally based on the *average* cost of all procedures, not the *marginal* cost of additional procedures, every additional patient can be highly profitable for the hospital. Once the hospital has treated the minimum number of patients needed to cover the fixed costs of its standby capacity, the revenue for each additional patient only has to cover variable costs (i.e., the things the hospital has to pay for only when it has a patient) and then the rest is pure profit. The more patients the hospital treats, the more money it makes.

Price Discounts and Narrow Networks Exacerbate the Problem

Purchasers and health plans encourage overutilization and consolidation by demanding large discounts on hospital prices without regard to whether they're adequate to cover the hospital's costs. If a hospital is delivering care as efficiently as possible but is being pressured by a payer to accept payments that are below the average cost of delivering care, then the hospital's only choices are to (1) find ways to increase the number of services it delivers, (2) raise prices to other purchasers and payers, or (3) consolidate with other hospitals in order to resist the demand for discounts. Regardless, the end result of demanding discounts on fee for service payments may not be lower overall spending for any payer.

"Narrow networks" promise to send the hospital more patients in return for discounts, but that simply reinforces the idea that volume is more important than value. Moreover, narrow networks are short-term strategies – if a payer gets a discount by shifting business to a subset of providers this year, what will it do next year? Will it force patients to switch doctors and hospitals every year in order to get a discount from the members of the new narrow network? And if there is only one hospital in town, how can one "narrow" the network or send the hospital more volume?

Cost-Shifting and Cross-Subsidization Makes the Problem Worse

Not only do we expect hospitals to be there when we need them, we expect hospitals to care for people whether they can pay or not and to care for patients on Medicaid even if the Medicaid payment is less than what it costs to deliver care. As a result, hospitals have to charge the paying patients more in order to cover the losses they incur on the under-paying and non-paying patients. All else being equal, a hospital

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with a higher proportion of charitable care will have to charge more to the paying patients to cover its costs. If a paying patient goes to a different hospital that can charge a lower price because it's not cross-subsidizing other services, the first hospital will then be forced to charge the remaining patients even more or to reduce the charitable care it provides. Either way, the outcome from the community's perspective is not desirable.

The Price of Hospital Care Will Likely Be Higher If Patients Are Healthier

A corollary of all of this is that if we are successful in keeping patients healthier so they don't need as much hospital care, the price of hospital care for the remaining patients may have to increase.

Let's assume that your local hospital is operating as efficiently as it possibly can in dealing with the number of patients who are coming to it today, and assume further than it has been able to maintain a small positive operating margin while charging prices for services that are at or below the average of other similar hospitals. It's covering the cost of the ER with the payments it's receiving for the patients who come to the ER; it's covering the cost of the cath lab with the payments it's receiving for patients who receive angiograms and stents for both heart attacks and stable angina; it's covering the cost of the nursing units with the payments it's receiving for the patients who are being admitted for chronic disease exacerbations and elective surgeries as well as those who are injured in accidents.

Now, what will happen if improvements are made in primary care access so patients who don't really need emergency room care get help from their PCP rather than coming to the ER? What will happen if primary care physicians and cardiologists help low-risk patients prevent and manage stable angina with medications rather than invasive procedures so there are fewer elective procedures in the cardiac cath lab? What will happen if primary care physicians and specialists help patients with chronic diseases manage their conditions and avoid exacerbations so they don't need to be hospitalized as often?

Two things will happen. First, under current payment systems, the hospital will lose 100% of the revenues it was receiving for those avoidable ER visits, cardiac procedures, and admissions for chronic disease exacerbations. Second, the hospital's costs will go down, because it will spend less on medications, stents, and other out-of-pocket costs, and it may be able to reduce staffing on those units somewhat. But its costs probably won't go down as much as its revenues will, because it will still need to keep the ER, the cath lab, and the nursing units equipped and staffed adequately to provide care for the patients who are still hospitalized and for potential emergency admissions.

So if the hospital were operating efficiently and generating a small positive margin at reasonable prices before, it will likely now be losing money. The reason is that the hospital's average cost per patient for the patients who are still coming to the hospital is now higher than it was before, because the hospital now has to spread its fixed costs – the cost of the ER, the cath lab, the nursing units, the burn unit, etc. – across a smaller number of patients. But the payments to the hospital were based on the previous average cost, and that was lower than it is now because there were more patients receiving care with the same fixed costs. With enough time, the hospital may be able to restructure its facilities and operations to lower its fixed costs, but that won't happen immediately and it may not be enough to return the hospital to positive margins. In the meantime, we don't want the hospital to understaff simply as a way of balancing the budget.

What can the hospital do to stay afloat with fewer admissions if there aren't enough places to reduce costs? The logical and appropriate action is to raise its prices on the services that it's still providing. It's

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appropriate to charge a higher price because the cost per service is now higher than it was before. Even with higher prices, though, the *total* amount a health plan or employer will be spending on hospital care can still be lower than it was before (or lower than it would have been otherwise, after accounting for growth in the population and its needs), because the hospital's costs will decrease with fewer patients, and prices need only increase enough to cover the new, lower cost.

It's Not Just Hospitals – Physicians Face Similar Problems With Payment

Physicians face many of the same kinds of problems with current payment systems that hospitals face. What we really want a primary care physician to do is to keep people healthy, but a PCP isn't paid at all if a patient doesn't need office visits or if a problem can be handled over the phone. We'd like specialists to take the time to help patients decide whether they need a risky, invasive procedure, but if fewer patients choose to have the procedure, the specialists may not have enough revenues to cover their practice expenses, even though the patients may be better off. And if you think it's only the hospital that needs to be available 24/7, imagine how the hospital will treat anyone during the night or on a weekend if there isn't a physician available during those same times. However, physicians aren't paid by Medicare or health plans to be available in case patients need them in the hospital, only hospitals pay them for that.

If doctors do a better job of keeping patients well, they may need to be paid more for the patients who do get sick in order to continue covering the fixed costs of maintaining their practice – paying the rent, paying for the EHR, paying for the office staff, etc. However, even with higher payment for individual services, overall spending will still be lower if the physicians are ordering fewer tests or doing fewer procedures in hospitals.

Some Price Increases Are Appropriate, Some Are Not

So if a hospital or a physician practice is raising its prices, it *might* be because it's using its market power to demand higher prices and subsidize inefficiency. However, it *might* also be that it needs higher prices to offset lower utilization. But if health plans won't willingly pay higher prices per case to the hospital or physicians that reduce utilization, the only choice those providers may face is to consolidate with other providers so they have the market power necessary to demand higher prices, and if that happens, prices may end up increasing far more than they would have otherwise.

It may well be the case that costs could be reduced further if the providers consolidated with other providers, particularly if there are multiple hospitals in the community that provide similar services. But fewer hospitals will also mean fewer choices for consumers, less competition among hospitals, and less incentive to be efficient about the delivery of services. Policies that encourage providers to reduce total healthcare spending while maintaining competition among providers would clearly be preferable to alternatives which achieve one but not the other.

It's likely that all of these scenarios are occurring today across the country. *Some* providers may be raising prices to offset lower utilization, while keeping total spending lower than it would have been otherwise. *Some* providers may be consolidating in order to deliver necessary services at lower cost. And *some* providers are likely charging higher prices simply because they are big enough to do so, not because they need to, and others are consolidating not to reduce costs or utilization, but simply to demand higher prices. None of the papers in *Health Affairs* acknowledges that these different scenarios exist, much less proposes solutions that differentiate among the different causes. If better payment systems are created that enable

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providers to improve care, reduce costs, and work together without consolidating, antitrust enforcement or price controls will only be needed in situations where providers raise prices inappropriately.

Maryland is the only place that has acknowledged these issues and is trying to address them. Several years ago, the state began implementing a series of reforms designed to encourage hospitals to reduce preventable admissions, preventable complications, preventable readmissions, etc. Because the state regulates both hospital prices and overall hospital spending, it realized that the prices of individual admissions would need to increase as the number of admissions decreased, even though total spending was lower than it would have been otherwise. However, since the federal waiver that allowed Maryland to set hospital prices for Medicare patients was contingent on the prices for individual hospital services in Maryland being lower than standard Medicare DRG payment rates, the state realized that it would soon reach the point where hospital *prices* for Medicare beneficiaries might be higher than standard Medicare rates, even though Medicare was *spending less in total* on hospital care for those beneficiaries. A new agreement that Maryland and CMS announced in January, 2014 will be based on whether Medicare *spending* is lower than in other states, not whether *hospital prices* are lower.[8]

Current Payment Reform Proposals Make the Problem Worse, Not Better

Although there is growing recognition that changes in payment systems are needed, most of the payment reforms being discussed or implemented by Medicare and commercial payers don't really solve the problems with the current payment system and may actually make some aspects of the problem worse.

Most Episode Payments Are Still Based on Procedures. For example, most of the episode payments and bundled payments being implemented by Medicare and commercial payers are triggered by a particular procedure in the hospital. The episode payment creates an incentive for the hospital to reduce readmissions and post-acute care costs, but the episode payment still disappears completely if the patient doesn't need to be hospitalized or if the hospital uses a different procedure to treat the patient. If the hospital can generate higher margins through the episode payment than under the current payment system (e.g., by retaining some of the savings from reducing spending on skilled nursing care after discharge), the hospital may have an even greater incentive to do more of the procedures, potentially increasing total spending.

"Shared Savings" Doesn't Change the Basic Payment System. The "shared savings" payment systems being implemented by Medicare and commercial payers are simply a form of pay for performance added on top of fee for service. If a hospital and physicians can avoid the need to admit a patient to the hospital, both the hospital and the physicians will lose 100% of the revenue they would have been paid for that patient but their costs will not go down that much. A year later, the hospital and/or physicians may receive a shared savings bonus payment, but the arbitrary formula that determines that payment will likely result in too little, too late to cover the costs the hospital and physician already needed to incur.

Shared Savings Programs Force Hospitals to Acquire Primary Care Practices. A little recognized problem with shared savings programs is that they attribute all savings to primary care physicians regardless of who is responsible for generating the savings. If a hospital successfully reduces readmissions, avoidable procedures, or infections and complications, none of the resulting savings will be returned to the hospital unless the primary care physicians for those patients are employed by the hospital. So hospitals are forced to hire primary care physicians, not to promote "clinical integration," but merely to protect their own revenues.

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Designing and Implementing True Payment Reforms

What's needed are true payment reforms – *accountable payment systems* that give physicians and hospitals the flexibility to redesign care, reward them for keeping patients healthy, pay them adequately for treating the patients who do need care, and give them accountability for ensuring that costs are lower and quality is higher. Several different approaches to accountable payment systems could be used:

Condition-Based Payment. Under condition-based payment, doctors and hospitals would be paid based on the types of health problems the patient has, not based on the specific procedures or treatments used to treat them. If the doctors and hospitals can address the patient's health problems using fewer tests or procedures, or if the necessary procedures can be delivered in lower cost settings, the price the providers charge can be set a lower level than what is being spent today while allowing the physicians and hospitals to maintain positive margins. Appropriate use criteria can be used to avoid undertreatment of patients in a condition-based payment system. For example, the American College of Cardiology's SMARTCare project is designed to enable physicians and hospitals to provide the most appropriate care for patients with stable angina at a lower cost than today but also at a payment level that maintains the financial viability of high-quality cardiac care programs.[9]

Partial Capitation. A partial capitation payment to a hospital could be structured by paying a fixed amount to the hospital based on the population of the community or based on the number of individuals insured by a particular payer in order to maintain an appropriate level of standby capacity for essential services, and then the hospital would be paid a second amount for each patient treated. The payment for each treatment could be based on the hospital's marginal cost of services, rather than the average costs.[10] A partial capitation payment to a physician practice could be structured by paying a fixed amount per patient for the physician practice's services, for tests and other physician's services, and for a portion of the costs of hospitalizations for those patient; the payer would then make an additional payment to cover the remaining portion of hospital costs for patients who need to be admitted.[11]

Risk-Adjusted Global Payment. Under a risk-adjusted global payment, a physician group, physician IPA, physician-hospital organization, or health system would have an overall budget for delivering healthcare services to a population of patients. The budget would be increased if the health needs of the patients increased. For example, the Alternative Quality Contract developed by Massachusetts Blue Cross Blue Shield provides this kind of flexible, accountable payment.[12]

Better Care Without Consolidation

All of these payment systems would support the ability of physicians and hospitals to deliver better care at lower cost. Although in most cases, solo/small physician practices and independent hospitals would not be able to manage these types of payments on their own, there is no need for them to merge or consolidate to do so. Physicians can work together through an Independent Practice Association and physicians and hospitals can work together through a Physician-Hospital Organization to manage accountable payment systems. As noted earlier, there are many examples around the country of physicians and hospitals remaining independent but working together to manage bundled and global payments.

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What About Prices?

While better payment systems are a *necessary* element of a true solution to controlling healthcare costs, payment reform isn't *sufficient*. A provider can still charge too high a price, no matter what the payment system is, if there is not a sufficient incentive both to keep costs low and to charge prices that are as close to those low costs as possible. So we need payment systems that reward providers for keeping patients healthy rather than giving them more expensive treatments, but we also need ways to ensure they keep patients healthy at the *lowest possible cost*.

The current systems of administered pricing used by Medicare and the negotiations over discounts used by commercial health plans have not worked well under the current payment system, and many of their weaknesses will not be solved merely by changing the payment system.

However, changes to payment systems *can* resolve many of the challenges to giving patients greater responsibility for choosing their healthcare providers based on cost and quality. For example, the problem with current "transparency" initiatives is that prices today are assigned to over 7,000 CPT codes and over 700 DRGs, and patients don't know which of those services they're going to receive, much less how to compare the prices and quality across providers. In contrast, the accountable payment models described above would define prices based on a patient's health problems rather than the procedures they receive, so patients can choose the physicians and hospitals that offer the best combination of price and outcomes for the specific health problems those patients are facing.

Moreover, instead of forcing patients to pay copays, co-insurance, and high deductibles for individual services, which can discourage people from getting lower cost care in a timely fashion, the patient's health insurance could pay the lowest amount that quality providers charge for a complete package of care, and if the patient wishes to use a higher-cost provider, they can do so simply by paying the difference themselves. In the few situations in which this approach to payment and benefit design has been implemented, consumers choose lower cost, high-quality providers, and the higher-cost providers reduce their prices.

Right-Sizing Healthcare Delivery for Choice and Competition

Of course, consumer choice can only control prices if there are choices of providers available. If one designs a payment system that does not require physicians and hospitals to consolidate into large systems, and if one removes unnecessary regulatory requirements that increase costs for smaller providers or prevent them from participating in better payment models, then it will be more likely that patients will have multiple providers to choose from. Instead of forcing patients into "narrow networks," patients can decide themselves which provider is best for them based on cost and quality, and providers can compete for patients based on both cost and quality.

Purchaser-Provider Collaboration to Find Win-Win-Win Solutions

Redesigning payment and delivery systems to support higher quality, lower-cost care cannot happen overnight. Hospitals and physician practices have made major investments in facilities, equipment, training, and staff based on the types of care the current payment system supports and the volume of services needed for financial viability, and it will take time to right-size those services and reduce the associated costs. Physicians and hospitals will need to collaborate to determine what the right amount of care is for a patient population and how much it will cost to deliver that care.

Purchasers will need to support the implementation of new payment systems and patient benefit designs, but those payment systems and benefit designs have to be structured in ways that support the better care

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that providers want to deliver. Consequently, payment reforms have to be designed in *collaboration* with providers, not *imposed* on them by payers. Moreover, payment reforms and benefit design changes must be phased in on a timetable that is feasible for payers, providers, and patients.

Success will be far more likely if payment systems, delivery systems, and benefit structures are designed to be "win-win" rather than "win-lose." In many cases, all of the stakeholders can "win" – i.e., patients can get better quality care, purchasers can spend less, and providers can be more financially viable – but only if they work together in a collaborative way to find the "win-win-win" approach. Instead of purchasers and providers treating each other as the enemy, and focusing on ways to beat the other in a war over prices, they need to recognize that each can help the other win. Purchasers will win if their employees and members stay healthy and receive quality care at an affordable cost, and physicians and hospitals will win if they are paid a reasonable amount for the delivery of efficient, appropriate, high-quality care that patients need to be as healthy as possible.

Fortunately, a growing number of communities have neutral conveners ready to help find win-win-win solutions. Regional Health Improvement Collaboratives – non-profit multi-stakeholder organizations focused on improving healthcare quality and reducing costs – can facilitate discussions between purchasers and providers and provide the objective data analysis both sides can trust in designing truly higher-value healthcare delivery and the payment systems needed to support it.[13] Purchasers and providers need to recognize the value of this kind of service and use it to move to better payment and delivery systems as quickly as possible.

ENDNOTES

[1] Ginsburg PB, Pawlson LG. Seeking lower prices where providers are consolidated: an examination of market and policy strategies. Sage WM. Getting the product right: how competition policy can improve health care markets. Vladeck BC. Paradigm lost: provider concentration and the failure of market theory. Gaynor M. Competition policy in health care markets: navigating the enforcement and policy maze. Health Aff (Millwood). 2014; 33(6)

[2] Ginsburg and Pawlson say "the integration of hospitals, physicians, and others across care settings has the ***potential*** to improve clinical quality and increase efficiency" (emphasis added). Vladeck says "at least some of the factors driving increased concentration are ***believed*** to improve care and population health" (emphasis added). Sage says "the ***potential*** payoff is greater efficiency through integration and consolidation" (emphasis added).

[3] See for example, Burns LR, Muller RW. Hospital-physician collaboration: landscape of economic integration and impact on clinical integration. Milbank Quarterly. 2008; 86(3), and Bazzoli GJ, Dynan L, Burns LR, Yap C. Two decades of organizational change in health care: what have we learned? Med Care Res Rev. 2004 Sep; 61(3): 247-331.

[4] Gaynor, *op cit*.

[5] Shih A *et al*. Organizing the U.S. Health Care Delivery System for High Performance. Commonwealth Fund. August 2008.

[6] Examples of IPAs composed of primarily or exclusively small physician practices that are managing risk-based contracts include North Texas Specialty Physicians in Fort Worth, Texas (www.ntsp.com), the Mount Auburn Cambridge Independent Practice Association in Boston, Massachusetts (www.macipa.com), the Hill Physicians Group in Northern California (www.hillphysicians.com), and Northwest Physicians Network in Tacoma, Washington (www.npnwa.net).

[7] Although the Ginsburg and Pawlson paper begins by saying that "moving the healthcare delivery system away from volume-based fee-for service payment is critical," none of the eight strategies it lists to "promote greater competition on price and quality" involve changes in the method by which providers are paid. Only the Sage paper explicitly addresses the need for payment reform by proposing to pay based on "competitive products" that are broader than the narrowly-defined procedures used in fee-for-service payment today.

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[8] See “CMS and Maryland Announce Joint Initiative to Modernize Maryland’s Health Care System to Improve Care and Lower Costs” http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-10.html.

[9] A description of the SMARTCare project is available at http://www.chqpr.org/downloads/SMARTCare_Overview-of-Payment-and-Care-Changes.pdf. The CMS Innovation Center awarded the SMARTCare project a $15.9 million Innovation Award on May 22, 2014. http://innovation.cms.gov/initiatives/Participant/Health-Care-Innovation-Awards-Round-Two/American-College-Of-Cardiology-Foundation.html

[10] For a discussion of this form of partial capitation, see Newhouse JP. Risk adjustment: where are we now? Inquiry 35: 122-131.

[11] See *Using Partial Capitation as an Alternative to Shared Savings to Support Accountable Care Organizations in Medicare* http://www.chqpr.org/downloads/PartialCapitationPaymentforACO.pdf.

[12] More information on the Alternative Quality Contract is available at http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf.

[13] More information on Regional Health Improvement Collaboratives is available from the Network for Regional Healthcare Improvement (NRHI) at http://www.nrhi.org.

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