California HealthCare Foundation

Accountable Care Organizations: Avoiding Pitfalls of the Past

December 2010

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Prepared for

California HealthCare Foundation

December 2010

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About the Foundation

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As reform moves ahead, providers hope to avoid the problems of earlier integration efforts.

Déjà Vu All over Again?

Hospitals, physician groups, and other provider organizations across the country are gearing up for the latest Big Idea in health care: accountable care organizations.

ACOs represent the centerpiece of delivery reform in the Patient Protection and Affordable Care Act of 2010 and are being touted by proponents as a solution to today's expensive and fragmented care system. By combining essential elements of local care in a coordinated and incentivized virtual "community," backers say ACOs can constrain unnecessary utilization, boost efficiency, increase quality, and reduce cost.

The claims have a familiar ring. Through the early-to-mid 1990s, similar assertions were made as waves of consolidation swept through the health care industry. Nationwide, hospitals and physicians scrambled to align in the face of changing market conditions and the looming prospect of federal reforms.

Yet more than a decade later, the bold promises of that earlier era remain largely unfulfilled. While there's no doubt that the consolidation of the 1990s produced success stories, the harsh reality is that many—if not most—of the unions arranged during that period fell well short of expectations.

Given policymakers' decision to propose the ACO as the next step in the evolution of integrated care delivery, critical questions arise: What went wrong last time around? And what lessons can be learned from those experiences to improve the odds of success today?

The California HealthCare Foundation set out to find answers to these admittedly broad questions by interviewing a variety of individuals, mainly Californians, who were directly or indirectly involved in the consolidation efforts of the 1980s and 90s.The answers were wide-ranging: As several observers noted, where you stand depends on where you sit.

Nonetheless, a picture emerges of organizations that—with some notable exceptions—pushed aggressively into consolidation without a true understanding of financial risk; without aligning financial and strategic incentives; without the infrastructure necessary to

support integrated delivery; without effective joint governance; and, perhaps most importantly, without a coherent vision or consensus about what the ultimate objectives of consolidation really were.

And while many of those interviewed acknowledged that major problems often accompanied hospital-to-hospital combinations, it was the range of difficulties associated with physician-to-hospital unions that drew the most post-mortem analysis.

"A lot of hospitals thought they needed to integrate physician practices in the worst possible way, and they succeeded beyond their wildest dreams. And I mean that literally," said Brian Wong, M.D., a family physician and chief executive officer of The Bedside Trust, a Seattle-based health care consulting company. Wong also is former chief medical officer of the Providence Clinic Network in Seattle and a former partner at Arthur Andersen. He additionally served on the board of the Providence Health System during the early 1990s, a period during which the system was acquiring physician practices.

"There was this idea that we'd better buy practices now, because if we don't, there won't be any left," he said. "But not a lot of thought was given to whether it made sense operationally, organizationally, structurally, or strategically. People just amassed the pieces and it quickly became a very, very expensive undertaking. And then, just as fast as hospitals wanted to buy practices in the early '90s, by the late '90s, they were saying, 'How do we unwind these? How do we sell them?'"

Several industry veterans, including Wong, suggested that at the core of numerous physician-hospital fiascos were cultural and organizational differences that may have doomed the ventures from the start. What that may portend for the future development of ACOs (which will rely heavily on hospital-physician care coordination) remains to be seen. Yet some already question whether the lessons of health care's recent past are being, or will be, heeded.

"I haven't seen a lot of evidence of truly shared governance and leadership, of a shared clinical mission, of a commitment to invest in the coordination of care systems, and of a commitment on the part of the hospital to act like a cost center, as opposed to a profit center," said Robert Margolis, M.D., chairman and chief executive officer of Healthcare Partners Medical Group, based in Torrance, California. "So we'll see."

"Heads in Beds"

The vertical and horizontal health care integration that reached its climax in the 1990s was, in fact, set in motion years before. As managed care and capitated payments began to replace traditional fee-for-service indemnity insurance in the early 1980s, providers began to aggregate to meet payer requirements for comprehensive services.

In California, corporate practice of medicine requirements barred virtually all health care organizations except county hospitals from directly employing physicians. As a result, strategies evolved to work around the restriction and to allow for the amalgamation of doctors. Independent practice associations (IPAs) were created to take on risk by contracting directly with managed care companies for fixed, capitated rates. These organizations would then align with hospitals. Physicians also began to assemble beneath the umbrella of hospital-sponsored, multidisciplinary, tax-exempt foundations, which frequently created their own HMOs.

Momentum toward consolidation further accelerated as the Clinton health care reform initiative took shape in the mid-1990s. Components of the Clinton plan—accountable health plans, health purchasing cooperatives, integrated delivery

systems—all suggested a future in which the provision of care would be divvied up among only the largest players. Aligning in front of these anticipated but ultimately doomed reforms thus became an important catalyst for many provider combinations.

For some, network formation was merely a response to market realities. According to Margolis, the CEO of Torrance-based Healthcare Partners Medical Group, much of the consolidation was defensive in nature. By banding together, hospitals and physicians hoped to generate enough volume to counter the growing pricing clout of managed care firms, which had undergone their own period of consolidation and become larger and more powerful.

"To put it bluntly, hospitals were hiring or buying up practices to keep 'heads in beds,'" Margolis said.

That view was echoed by William Gurtner, retired vice president for clinical services for the University of California system and a former Blue Cross of California executive.

"The hospitals were looking to consolidate and solidify a physician population to feed their institutions, and the physicians were looking for a secure revenue source," Gurtner said. "But I think, in retrospect, neither party was all that interested in actually affecting the way health care was delivered. They were simply trying to control their marketplace."

As a former managed care executive, Gurtner acknowledged that restoring a balance of power was not an unreasonable goal for providers, given the muscle commercial carriers had at that point. "I was doing the payer negotiations for Blue Cross at the time and there isn't any question that I had huge leverage. I basically could set a price and say, 'There it is; take it or leave it.'"

Gurtner recalled one telling episode involving the medical staff at a major Southern California teaching hospital, which had not been included in the Blue Cross provider panel. The hospital's faculty was furious.

"I met with several hundred of them in an open session and they were extremely angry," Gurtner said. "They wanted to know how we could possibly produce a product without them in the mix. And I told them the reason they didn't have a contract was because we didn't need them. We had every service we wanted within a few miles of their location, and our patient population wasn't screaming for access to their institution. I essentially told them, 'I don't need to contract with you, but if you want one, here's the price.'"

Vision Test

Thomas Priselac, chief executive officer of Cedars-Sinai Medical Center in Los Angeles and former chair of both the American Hospital Association and California Hospital Association, agreed that market pressure was a major factor behind many of the unions that occurred in California and nationwide in the 1990s. But he is quick to point out that the results of integration were a complex mix of both successes and failures, essentially "no different than many other kinds of strategic changes undertaken in any industry."

From Priselac's vantage point, the most important ingredient in a successful integration—be it hospital-to-hospital or hospital-to-physician—was and remains "a shared vision about the provision of care and a consensus about what the right thing to do is and the best way to go about doing it."

Those organizations that did not succeed, he said, were unable, unwilling, or simply uninterested in achieving that kind of strategic clarity and commitment. Instead, many viewed consolidation as merely a financial gambit, said Priselac; their motivation was to increase market share, to gain the

upper hand in managed care negotiations or, in some instances, to move a step closer toward a much-anticipated liquidity event that would personally enrich those involved.

"You have to be financially responsible, but the question is, to what end?," Priselac said. "Organizations that integrated effectively and remain in business today saw their objective as being responsible providers of care and stewards of resources in the areas they served. In places where the concept failed, it failed because people looked at the financial aspect as an end in itself, and not a means to an end."

The absence of shared vision and commitment unleashed a range of forces that collectively conspired to unravel many mergers, acquisitions, and alignments, observers said.

"There were always relatively few people who had a vision and were trying to drive it, and fewer still who wanted go in that direction," asserted Bruce Spivey, M.D., an ophthalmologist and veteran hospital executive who served as chief executive officer of both California Healthcare System and California Pacific Medical Center, as well as for systems in Chicago and New York.

"Instead, most were nervous or scared or worried about losing prestige to others, or else they were busy trying to figure out how to gain prestige for themselves," he said. "So if you boil it all down, the problems, in my view, were primarily due to egos."

Ross Stromberg, a director with PricewaterhouseCoopers and long-time health care attorney in California, said one difficulty that repeatedly undermined the vision of integrated delivery was the "consensus philosophy" that predominated in many nonprofit organizations.

"This is not necessarily a criticism, but it's kind of the idea: 'Let's not make waves, let's not upset anybody,' or sometimes, 'Let's defer to the person who screams the loudest.' Unfortunately, that individual or department or organization was often the weakest link, so by accommodating them, you're automatically compromising what you're trying to achieve."

The Hazards of Capitation

Beyond a lack of vision, observers said one of the biggest problems of physician-to-hospital consolidations of the 1990s was the ineffective management of risk, or specifically, the inability to be consistently profitable in a capitated environment.

J. Kendall Anderson, president and chief executive officer of the John Muir Health system, based in Walnut Creek, California, noted that in the 1980s—when HMO panels remained relatively restricted and utilization management was robust—physicians groups were able to more effectively accommodate lump-sum capitated reimbursements. But as both consumers and employers began to rebel against the constraints imposed by managed care, HMO panels morphed into broader PPOs and utilization management began to fade. The result, Anderson said, was that organizations were providing an ever larger number of services for the same amount of money.

The problems were compounded as hospitals began to assemble their own physician foundations through the acquisition of small or solo practices that had traditionally worked on a fee-for-service basis, according to one executive associated with a large, nonprofit health system.

"You had individuals coming from a fee-for-service culture and mind-set, and all of a sudden, the payment is capitated and everything changes," he said. "But you don't just flip that switch overnight. People still had the practice patterns from the fee-for-service world. And they had no incentive to change."

In some cases, the newly formed IPAs and foundations would continue to pay physicians on a fee-for-service basis, even though the managed care contracts they'd agreed to were capitated. This, predictably, was a recipe for disaster, said Robert Montgomery, a retired regional executive for Sutter Health in the San Francisco Bay Area and also a former executive with Alta Bates Medical Center in Berkeley.

Along the same lines, hospitals found it difficult, if not impossible, to control patient admissions, nor could they influence length of stay, according to John Muir's Anderson. Indeed, there was frequently no alignment between physician and hospital interests with respect to inpatient utilization. In a capitated payment environment, this could prove extremely costly, particularly if the patient was referred to an out-of-network specialist or out-of-network academic medical center for complex and expensive care.

"People just didn't understand from an actuarial standpoint what kind of financial risk they were taking on when they started an HMO or accepted capitated contracts," Montgomery said. "In addition, most of the hospital/physician/HMO initiatives were undercapitalized, and therefore couldn't respond effectively to new products like PPOs, nor could they build a big enough network to appeal to major employers."

De-incentivized

The lack of knowledge about managing insurance risk created a precarious financial footing for many hospital-physician unions. That foundation was further destabilized by the absence of physician incentives as a condition of alignment. In many cases, the result was a precipitous decline in physician productivity.

"What often happened was that the physicians were willing to sell, but only if they received a pretty good income guarantee for a certain number of years," said the executive associated with a large, nonprofit California system. "And once they got that income guarantee, they had no productivity incentive. So in many cases, you saw declining productivity in those practices, because the hospital had assumed all the risk."

Brian Wong of The Bedside Trust said hospitals that created physician foundations sometimes found themselves in the worst of all possible worlds: Practices would be acquired (and frequently subsidized), yet the physician's patients would continue to use another hospital—either because they were accustomed to doing so or because the physician wasn't contractually obligated to refer to the acquiring hospital.

"It kind of defeated the whole purpose of putting a network together, at least from the hospital's standpoint," Wong said.

Discontinuity also was reflected in a lack of standardization among physician contracts, Wong added. "They'd start off with a specific salary structure and performance expectations, but when they'd approach a doctor about acquiring their practice, there was always a wrinkle," he said. "The physicians would say, 'Well, we do it this way' or 'we don't do it that way' or 'we already have an electronic medical record' or 'we have a building you need to buy.' So you had this dynamic that didn't lend itself well to building a system. Instead, you ended up with an aggregation of pieces. And the pieces never really meshed together."

Putting It Together to Take It Apart

Linda D'Agati, now chief operating officer for Humboldt-Del Norte Independent Practice Association in Eureka, knows all too well the disconnects that plagued many physician-hospital affiliations in the 1990s. From 1998 until 2002,

D'Agati was involved in integration efforts at St. Joseph Health System - Humboldt County, part of the Sisters of St. Joseph of Orange. The system owns two hospital facilities in Eureka and Fortuna. D'Agati served as the system's director of clinical operations in Humboldt County.

"Basically, I spent the first two years working to integrate clinics into the health system, and the last two years selling them back, because it was clear the strategy was not beneficial, either for the hospital or the community," she said.

According to D'Agati, the problems at St. Joseph began with strategy: Acquisitions of primary care and specialty practices were intended to increase referrals to the hospitals. But because Humboldt County is largely rural, isolated, and underserved, most area patients were already coming to the St. Joseph hospitals, she said. This basic oversight apparently was lost in the tumult that accompanied frequent changes in executive leadership. The local system, the St. Joseph Health System-Humboldt County, had four CEOs in the four years D'Agati was there.

Although D'Agati initially was hired to sort out chronic billing problems involving what ultimately would total nine practices, she soon was trouble-shooting other aspects of the affiliations. One major difficulty, she said, was the manner in which the acquisitions had been structured. Unlike affiliations elsewhere in California, an umbrella clinical foundation was not established at St. Joseph until after the first eight clinics had been acquired. Instead, the system purchased the assets of each practice while simultaneously contracting with the physicians, an approach which essentially made the physician groups departments of the hospital.

This construct created unanticipated problems that steadily eroded the financial health of both the hospitals and practices. Among these were rigid restrictions on how physicians were paid. Because contract terms could only be altered every 12 months, it became impossible to make monthly compensation adjustments that would reflect changes in patient volume or practice overhead. In addition, physician compensation could no longer include any ancillary service revenue, such as X-ray or lab. The loss of this revenue stream was sorely felt by physicians who had previously reaped the benefits of their office's ancillary services.

Further, since the practices were now de facto hospital departments, they suddenly were compelled to adhere to Joint Commission standards. That meant developing consistent policies and procedures, meeting clinical and operational standards; essentially, developing the entire survey infrastructure for each practice. This process proved time-consuming and costly, D'Agati said.

Another unanticipated expense involved staffing. In an outpatient setting, medical assistants could be used to provide immunization and phlebotomy services. But under hospital licensure, those tasks had to be performed by a nurse. "Well, nurses cost more than twice what a medical assistant does, so that was a big added expense to the practice, and ultimately to the hospital," D'Agati noted.

Even seemingly minor issues like material resupply became problematic, since the groups were now required to buy through a central purchasing office. Time and physical distance often made it difficult for physicians to get what they needed in a timely fashion.

"Basically, there was zero infrastructure in place to accommodate these practices and keep them running smoothly," D'Agati said.

Unintended consequences also cropped up on the revenue side. Planners had anticipated generating additional collections under Medicare and Medi-Cal rules, since services were now being provided in a facility-based setting, as opposed to an office-

based location. However, no one apparently thought through what this might mean from a patient satisfaction standpoint: Individuals who'd been seeing the same physician for years suddenly faced an added $75 facility fee, and many were furious, D'Agati said. The facility fee eventually was separated from the standard visit fee, but billing nonetheless remained complicated, due to the need to submit both professional and facility claims for every Medicare and Medi-Cal office visit.

And even after a unifying foundation structure was created, albeit belatedly, most physicians showed little interest in working together to coordinate care or improve efficiencies, according to D'Agati. With overhead increasing and revenues falling, physicians continued to see their incomes decline. This fact, D'Agati said, as much as any other, set in motion the unwinding of the acquired practices. The system's then-CEO worked as quickly and efficiently as possible to divest the practices.

"The system lost well over $10 million by the time all was said and done," D'Agati noted. "It had a tremendous financial impact on the hospitals and, indirectly, on the community."

The clinics that were failing financially when they were acquired ultimately were closed, she said. Others were taken back by the physicians. But not all of the departing doctors reacquired their patient records from the hospital. This led to tremendous confusion among patients and ongoing copying expense for the hospitals, she added.

What, then, were the lessons learned? "Know why you're doing it," D'Agati said. "Articulate it. Model it. Try to look at every detail without rose-colored glasses. Really make sure the expectations on both sides are in alignment before you leap in. And if you're experiencing leadership turnover, it's really not the best time to be making major strategic changes."

Hospital Mergers—Whose Ox Gets Gored?

Although different issues emerged, the core problems surrounding hospital-to-hospital mergers were not unlike the impediments that upended many physician-to-hospital consolidations. As with physician combinations, one of the most common problems was a lack of shared vision between entities, according to Spivey, former system and hospital administrator.

"Tensions resulted because there wasn't a lot of trust, and that meant that the affiliations were less secure and complete than they could have been or should have been," he said. "There were a lot of reserve powers that were left to each hospital board."

Determining how to consolidate service lines when duplication existed in a particular market often became an enormous sticking point, despite the fact that rationalization had been widely touted as one of the primary benefits of hospital-to-hospital integration.

"Real opportunities exist to lower cost and probably improve quality when you've got facilities in close proximity," said one executive who declined to be identified.

"But a lot of systems just didn't have the will to see it through." The executive asserted that the problem in most cases was "massive resistance from physicians. You have separate medical staffs entrenched in the way things were being done, and they didn't want to change or be inconvenienced."

Indeed, the executive said the consensus in the Bay Area was that the short-lived, star-crossed merger of the University of California-San Francisco and Stanford medical centers unraveled in 1999 mainly because administrators realized that overcoming widespread physician resistance to service consolidation would be impossible.

"When you have two premier academic centers, you've got a lot of egos and a lot of turf to defend. They just realized they couldn't do it and pulled the plug."

William Gurtner, who served as vice president of clinical services at UCSF and was principal negotiator for the medical center during the merger talks, said two central lessons emerged from the aborted union: One was that it was too easy for the parties to bail out of their agreement. "When things got really tough, the simplest thing to do was to walk away." The second mistake was the failure to integrate the faculty on the front end of the transaction.

"There was an assumption that if you consolidate the hospitals, the faculty would resolve itself," said Gurtner. "But that was not the case. The faculty never came along."

Wong of The Bedside Trust said many systems that combined in the 1990s still grapple with service rationalization, although the conundrum increasingly is being resolved through attrition rather than attention. He walked through the kind of scenario that frequently played out in the 1990s: "As an administrator, you could look at it and say, 'If a community can only support 4,000 deliveries per year, and we already have a hospital doing 4,000 deliveries a year, why do we need two other hospitals doing deliveries?'"

"So on paper, it would look like a slam dunk to close those two ob/gyn departments. But the reality would be that some doctors preferred those hospitals and would resist changing their practice patterns, and they'd say, 'If you want to buy us, then we're going to stay at our hospital.' At that point, it became a question of who would blink first. And usually, it was the hospital."

Anderson, president and CEO of John Muir Health, agreed that consolidation of services has always been a major challenge. Closing or combining service lines can create physician dissatisfaction and result in additional costs, he said, particularly when doctors are asked to take call at distant facilities. But Anderson also pointed out that in some instances, eliminating capacity at an institution can create patient safety risks by reducing the number and types of specialists needed to respond to cases arriving through the emergency room.

"I'm sure planners would say that they were disappointed there wasn't more consolidation of services (through the mergers of the 1990s)," he said. "But I can tell you one of the things we found out was that if you have a large number of emergency room visits, you need to have the full range of physician specialties available to meet those patient needs. Otherwise, it can pretty quickly become a patient safety and quality issue."

Culture Wars

Ongoing conflict and mistrust between physician groups and hospitals — a problem repeatedly identified in both hospital-to-hospital and hospital-to-physician consolidations — reflects the fundamental cultural differences between the respective parties, according to Wong.

"Physicians have a very strong heritage of being rugged individualists, of functioning autonomously," he said. "They're really socialized that way from medical school on — to be independent, to be the captain of the ship. So with that as a backdrop, I think the failure was really underestimating how powerful this force was and how difficult it would be to achieve standardization. Because if you fail to address and resolve the "every-man-for-himself" ethos, what difference does it make what type of structure, contract, or formula you have?"

Spivey, an ophthalmologist and former CEO of California Pacific Medical Center, concurred that physicians are inherently independent and frequently

don't want anything to do with hospitals. He said the mistrust stems in part from the way physicians traditionally have been treated by some hospital executives.

"I think there was a common attitude among non-physician CEOs that physicians didn't have a lot of sense and needed to be controlled," he said. "As a result, the physicians were not viewed as capable or equal partners. So the doctors ended up feeling either manipulated or like junior partners that were left out of the real decisionmaking process."

Stromberg agreed that this paternalistic, often condescending attitude—coupled with administrators' frequent lack of knowledge about what it takes to operate a physician practice—led to the downfall of many hospital-physician combinations. "Someone once said, when it came to hospitals running medical practices, the typical hospital administrator had trouble running a three-car funeral. The fact is, many of them simply didn't know what they were doing," he said.

Creating new awareness and clarity about the role each party plays in the provision of care is the key to helping physicians and hospitals function more effectively going forward, according to Wong.

"People understand their jobs, but they often don't know a lot about their roles," he said. "And by roles I mean how they interact with their peers and where they fit in along the overall continuum of care. By paying more attention to roles, instead of jobs, we can develop greater trust, cooperation and mutual respect, and achieve the goals that we all agree are essential—namely, higher-quality and lower-cost care."

Spivey agreed that successful integration comes down to fostering mutual trust, mutual respect, and fairness among providers and administrators. "It's a matter of creating a very clear decisionmaking structure, of creating shared leadership wherein both physicians and hospitals are part of the decisionmaking. The hospital can't be advantaged over the physicians any more than the physicians are advantaged over the hospital."

For his part, Priselac of Cedars Sinai said he senses a different attitude among his peers this time around regarding consolidation—at least in Southern California. "I do get the feeling that people are trying to approach this in more of a partnership way," he said. "I think everyone recognizes that each component is highly dependent on the other, and for one to approach the future with the attitude that the only way to succeed is at the expense of the another—I think that is a fundamentally flawed strategy."

ACOs—The Right Road?

Assuming that the central integration lessons of the 1990s are understood, or at least acknowledged, the question then becomes whether the accountable care organization is the most effective model for moving the system toward true integrated delivery. On that point, opinions vary.

Because the Centers for Medicare and Medicaid Services has yet to flesh out, through detailed rules, the broad ACO framework sketched in the Patient Protection Act, much uncertainty continues to surround the model. The regulations are expected to be published in early 2011.

An ACO is generally defined as a provider-controlled entity that takes responsibility for meeting the health care needs of a defined population while pursuing the goals of improved health, improved patient experience, and reduced per capita costs.[1] Starting in 2012, Medicare will contract with ACOs and create financial incentives for providers to meet quality and efficiency targets. The financial incentives would be a share of savings if the per capita fee-for-service expenditures are below benchmark amounts.

1. National Committee for Quality Assurance, www.ncqa.org.

Thus, the ACO, at least in its earliest iterations, will not necessarily mean a return to capitated payments.

Proponents of the ACO model, including its architects, the Dartmouth Institute for Health Policy and Clinical Practice, believe the approach can incentivize primary care physicians, specialists, and hospitals to proactively manage and coordinate patient care, reduce unnecessary services, and improve outcomes.[2]

Margolis of Healthcare Partners Medical Group said he believes the ACO model is viable and pointed out that his organization is a participant in one of five national ACO demonstration projects launched earlier this year by Dartmouth and the Brookings Institution. Nonetheless, Margolis believes that until and unless the costs of chronic disease are addressed and true comprehensive care capabilities are developed, ACOs will not come close to spurring a fundamental transformation in care delivery.

"The real cost of health care is in chronic disease," Margolis said. "And affecting that requires intense coordination—disease management, critical care teams, pharmacy management, investment in prevention, home care, preventing ER usage and unnecessary admissions and readmissions, and then post-hospital care to reduce recidivism.

"All of that takes time, money, and commitment," he said. "It's a lot of work to get from a fee-for-service mentality to a fully integrated, coordinated system. So I'm rather skeptical that most of these hospital systems that are hiring up docs like crazy right now in anticipation of ACOs are really going to become the next Kaiser [Permanente] or the next Sharp [HealthCare] system."

Anderson of John Muir agreed that the ACO concept may be a move in the right direction. But he thinks it will do little, at least initially, to address excess utilization.

"From what we can tell, ACOs will improve continuity of care and quality of care," he said. "But we also have to look at whether the procedure is appropriate and should have been done in the first place, because as long as we're in a fee-for-service environment, incentives will exist to perform a procedure whether it's the best solution or not."

It is generally presumed that if full capitation eventually supersedes fee-for-service in the ACO model, pay-for-performance and quality benchmarks would keep providers from withholding care and would also constrain unnecessary utilization. What remains to be seen is whether the difficulties physicians and hospitals experienced in the earlier era of capitation would again be prevalent. Several observers believe that capitation would not be as problematic this time around.

"I think you're dealing with a much more sophisticated physician-hospital community across the country regarding managed care and financial risk," said Montgomery, former executive for Sutter Health and with Alta Bates in the San Francisco Bay Area.

"Everybody has experimented with things, they've gotten their fingers burned, they've learned a lot," he said. "So I think the government is going to have to be a lot more sophisticated this time in dealing with the medical and hospital communities. I don't know if they're fully aware of that or not. But the good news is that because the knowledge base is greater, it gives the government more latitude to write regulations that are really going to work.

"I don't think the country will be well-served by hundreds and hundreds of small, undercapitalized ACOs," he added. "There remains an important, continuing role for large HMOs and insurance companies with effective managed care provider networks. So my wish is that the government writes strong, tight rules to create vehicles that are similar

2. "Health Policy Brief: Accountable Care Organizations," *Health Affairs,* July 27, 2010.

to those that are already working effectively in our environment."

For his part, Stromberg, a director with PricewaterhouseCoopers and a long-time health care attorney, pointed out that sophisticated new technologies make it far easier today to adjust pure capitation in ways that take into account case severity and other factors. The technologies allow providers and carriers to essentially tweak group risk profiles and rates, or "true up" the capitation model in the face of unanticipated severity and resulting expenses among an assigned patient population.

Stromberg said another factor that augers well for ACOs is that incentive-based physician compensation mechanisms are much more prevalent today than was the case in the 1990s. That means physicians are more accustomed to a performance-driven pay environment, and are less likely go on "cruise control."

Priselac of Cedars Sinai agreed that ACOs are a potentially effective mechanism for moving health care toward more organized and efficient delivery, but echoed others in stating that it will all depend on how the rules are written.

He added that ACOs must avoid a critical mistake that was frequently made in the 1990s: the pricing of managed care services "on the margin" by physicians and hospitals. "They were very aggressive in their pricing when the people who were covered by managed care represented a relatively small proportion of the patients they were seeing," he said. "But over time, as the managed care population increased, they found themselves in the very difficult position of trying to get the payments they needed to cover the true cost of providing care. They got financially strangled."

Rosalio J. Lopez, M.D., chief medical officer with Presbyterian Intercommunity Hospital in Whittier, said he believes that ACOs' viability will hinge on whether the difficult lessons of the 1990s are heeded. The mergers that succeeded "got the recipe right" in balancing the four key elements of effective, integrated managed care: cost, access, quality, and choice.

"The patients were happy, the employers were happy, the health plans were happy, the doctors were happy and, in some instances, even the hospitals were happy," he said. "But I think what happened was that

Lessons Learned: Key Elements of Successful Provider Integration

- A shared strategic vision that identifies the longer-term goals of the ACO within the context of community health needs, provider capabilities, and state and federal health policy.
- An organizational structure that supports the ACO's strategy through shared hospital-physician leadership; transparent decisionmaking; and clarity surrounding participants' roles.
- Alignment of provider financial incentives consistent with the ACO's strategic goals and addressing the issues of cost, access, quality, and choice.
- Appropriate clinical and organizational infrastructure, including coordination of medical care, financial systems, and information technologies.
- Sufficient capital and clinical/financial management capabilities to support the assumption of risk, and a plan to transition from lower-risk payment models, such as shared savings, to higher-risk models, such as partial or complete capitation.
- Trusting, respectful relationships among ACO participants, and clear channels of communication.

most delivery networks around the country were not able to balance those four legs of the stool."

ACOs can only work, then, if those components are in harmony and the respective stakeholders remain supportive, engaged, and focused on the patient to create centric delivery systems," he said.

Robert Margolis, M.D., of Healthcare Partners in Torrance, remains upbeat about the prospect of positive change in health care, despite his misgivings about the ACO model and doubts about whether people will learn from the mistakes of the past. But time is of the essence, he stressed.

"You can't put 30 million people into a leaky boat and expect it to float better," he said. "So let's figure it out before everyone climbs aboard."

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