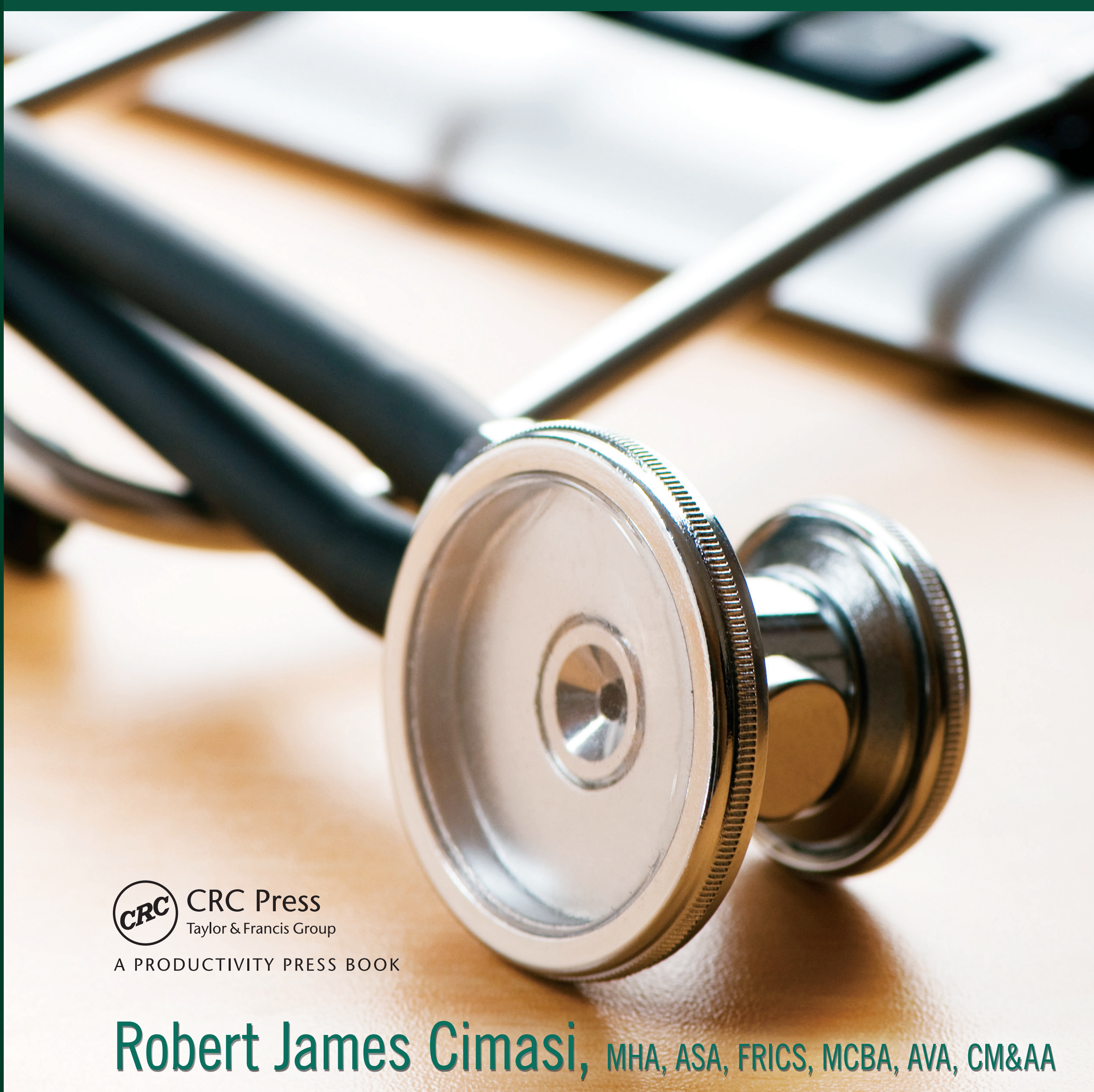
Accountable Care Organizations

Value Metrics and Capital Formation



CRC Press
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A PRODUCTIVITY PRESS BOOK

Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA

Foreword by Peter A. Pavarini, Esq.

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CRC Press
Taylor & Francis Group
6000 Broken Sound Parkway NW, Suite 300
Boca Raton, FL 33487-2742

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Version Date: 20130423

International Standard Book Number-13: 978-1-4665-8184-5 (eBook - PDF)

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To my wife

Laura M. Baumstark, MBA, CAE

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Foreword

On June 28, 2012, the U.S. Supreme Court largely upheld the constitutionality of the Patient Protection and Affordable Care Act of 2010 (ACA) and in so doing removed one of the impediments to a number of reforms that had gained growing support within the healthcare industry. While very few correctly predicted how the Roberts Court would reach its decision, there was as much relief as surprise knowing that the Constitution would not stand in the way of implementing major sections of ACA that were never in dispute. One part of the 2010 law that was rarely the subject of partisan bickering consisted of four pages (out of nearly 2,000) promoting the development of accountable care organizations (ACOs). Despite its brevity, this portion of the legislation has been widely viewed as one facet of reform that could result in a sustainable solution to the nation's healthcare cost conundrum.

Although many authors, including the one writing this foreword, have previously attempted to explain the ACO concept in practical terms, virtually no one thought to thoroughly analyze the financial underpinnings of this model until Bob Cimasi decided to write this book. What an ambitious work it is. Even though most existing ACOs remain gestational or in their earliest years of operation, Cimasi and his associates at Health Capital Consultants have managed to assemble an authoritative body of information on this rapidly evolving subject and to present their findings in an easily understood manner.

Together with many of my colleagues in the American health law bar, I have long respected Bob Cimasi's passion and talent for unraveling complex healthcare equations and objectively assigning value to all or part of a business or relationship. That was difficult enough to do in a traditional fee-for-service environment; it will be much harder as the nation transitions to shared savings, bundled payments, and other new methods of value-based purchasing. With the publication of *Accountable Care Organizations: Value Metrics and Capital Formation,* readers will now have insight on the principles and methods Cimasi and his team of experts carefully use to appraise transactions within a changing healthcare payment and delivery system. This text is much more than a compilation of educational resources on a currently hot topic. Rather, it could become a seminal work relied upon by all stakeholders in a transformed healthcare marketplace. I cannot think of anyone more qualified than Bob Cimasi to take on such a daunting task.

It is always a privilege to be asked to read a manuscript before it becomes publicly available. This time, however, I found reading *Accountable Care Organizations: Value Metrics and Capital Formation* to be like looking through a window on a brave new world. I found myself asking: Is this finally the way Americans will learn how to assure quality, efficiency, and fairness in one of the most important aspects of their daily lives? I hope the readers of this book will be challenged to ask that same question as they seek to understand the ins and outs of ACOs.

Peter A. Pavarini, Esq.
Partner, Squire Sanders (US) LLP

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Preface

> The only thing new in this world is the history that you don't know.
>
> **Harry S. Truman**

This year the consulting firm I started in 1993 will celebrate its twentieth anniversary. Over that period, Health Capital Consultants has developed a diverse clientele, first offering services to solo and small group medical practices, then participating in the consolidation accompanying the managed care boom of the 1990s, and, most recently, directing our focus to the economic and financial challenges of yet another iteration of healthcare reform. As both a healthcare consultant and small business owner (providing employee health benefits), I have witnessed the continuous transformation of the healthcare delivery landscape. In the past three years, however, I have noticed a policy movement that, while similar in many characteristics, may portend, in scope, a heretofore unseen paradigm shift. As I write this preface, the U.S. Supreme Court recently upheld the constitutionality of the Patient Protection and Affordable Care Act (ACA), in two consolidated opinions: *National Federation of Independent Business v. Sebelius* and *Florida v. Department of Health and Human Services.*[1] President Obama has just been reelected to a second term, as the primary driver and namesake for the historic healthcare form known as "Obamacare." These two landmark events will most certainly shape his presidency, as well as dramatically change the course of events in U.S. health policy.

However, regardless of the current level of political relevance, achieving cost and quality is not a new pursuit. For more than 80 years, there has been an effort to improve the cost and quality of healthcare.[2] The year 1946 brought the Hill–Burton Act that offered federal funding to hospitals that didn't discriminate and that covered a reasonable volume of patients. The year 1965 saw the advent of Medicare and Medicaid, the first universal (though limited) coverage for vulnerable populations. Then, in 1999, the Institute of Medicine's seminal work, *To Err is Human: Building a Safer Health System*, boosted public awareness of deficiencies in care for perhaps the first time; a harbinger of change for transparency and disclosure within an industry that had operated behind an opaque veil comprised of patients' often uninformed, and most always, trustful belief in the physicians and healthcare institutions on which they relied.[3]

Today the face of healthcare reform efforts toward a more accountable system of care is symbolized by, and has its foundation in, the ACA and related legislation on both federal and state levels. The Medicare Shared Savings Program (MSSP), which promulgates Accountable Care Organizations (ACO), is set forth on a mere four pages in the ACA.[4] It has created waves throughout the entire industry and public discourse, by seeking to provide the accountability for quality and cost that the healthcare market has sought for decades. The ACA advances the movement toward universal coverage within a framework of existing federal, state, and private insurance models, in contrast to moving to a single payor system. The debate across every sector of healthcare begs the question: Given such high expectations, can ACOs deliver?

The United States attains lower global health ratings and spends nearly 50% more in per capital health expenditures than the next highest nation. At the same time, the percentage of GDP (gross national product) spent on U.S. healthcare is nearing 18%, 5% higher than any other country.[5] As healthcare expenditures continue to rise, the economy has been suffering through the Great Recession.[6] Although technically on the road to recovery, unemployment and the prevalence of uninsured and under-insured citizens have approached an all-time high.

Republicans and Democrats alike have agreed that the cost of healthcare is too high and quality must improve. More importantly, the discussion of quality and costs in healthcare has moved past

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politics and business into the homes of patients, resulting in a consensus that a change, of some sort, is needed, albeit the definition of that change is in volatile dispute. The incentives created by ACOs (a type of value-based purchasing) have the potential to shift the way healthcare is delivered to affect cost and quality issues.

Note that, *accountable care* is not a new concept, with roots in the past failed efforts of both *managed care* and *managed competition*. Despite the deep-seated history of accountable care, the newly proposed models of ACOs represent a renewed, and perhaps enhanced, opportunity to succeed in shifting the way healthcare services are delivered. Accountable care, transparency, and value-based purchasing are already making a foothold in healthcare through federal programs and private payors. The current economic environment of slowed growth, high unemployment, and record federal deficit and debt may be the perfect storm that drives lasting change. Whether ACOs are the ultimate answer, the aims of lower costs and better quality are the change which patients, payors, and the healthcare industry have pursued.

This text is designed to examine what ACOs may potentially offer, how feasible their promise is, and what value they create within the current healthcare environment. To provide a probative understanding of ACOs, requisite for any informed investment decision, we examine the history from which the accountable care concept evolved into the current manifestation of ACOs as conceived within the ACA of 2010. Without this background, a knowledgeable distinction between ACOs and the failed efforts at managed competition, through the managed care plans of the 1990s, cannot be made, dooming ACOs to result in a similar failed outcome.

To make an educated investment decision, the activities of capital and financial feasibility must be based on a thorough understanding of the structure and history of healthcare delivery. Once this foundation is laid, this book, through the looking glass of the *Four Pillars of Healthcare Industry Value* (i.e., regulatory, reimbursement, competition, and technology), addresses the following questions: what are ACOs; under what circumstances and capital structures might they represent a sound investment; what value might they offer; and, are they the cost containment and quality improvement answer for which we have been searching?

Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM & AA
Health Capital Consultants

ENDNOTES

1. *National Federation of Independent Business v. Sebelius,* Certiorari to the United States Court of Appeals for the Eleventh Circuit, S.C. Slip Opinion No. 11-393, June 28, 2011.
2. The committee on the cost of medical care reports. 1932. *The American Journal of Nursing* 32 (12): 1286.
3. *To err is human: Building a safer health system*. 1999. The Institute of Medicine, November.
4. Patient Protection and Affordable Care Act. Public Law 111-148, Section 3032, 124 STAT 395 (March 23, 2010).
5. OECD health data 2011—Frequently requested data. 2011. The Organization for Economic Co-operation and Development, November. Online at: http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (accessed January 1, 2012).
6. Becker, G. S. 2011. The great recession and government failure. *The Wall Street Journal*, September 2. Online at: http://online.wsj.com/article/SB10001424053111904199404576536930606933332.html (accessed April 26, 2012).

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Acknowledgments

Anne P. Sharamitaro, Esq., HCC's executive vice president and general counsel, was central to the development of the book, both in conducting and directing the research and coordinating the efforts of all those who contributed to the project.

Todd A. Zigrang, MBA, MHA, FACHE, ASA, HCC's president, who has excelled for over 18 years in representing HCC throughout numerous healthcare industry client engagements, greatly assisted in the development of the underlying concepts, as well as contributing the benefit of his experience and the specific background issues in this book.

Other HCC colleagues who contributed significantly to this book include Kyle F. Krahl, MBA, vice president; Matthew J. Wagner, MBA, vice president; and John R, Chwarzinski, MSF, MAE, vice president, who assisted greatly with their reviews and comments.

HCC's research and library staff, in particular, Jessica C. Burt, Esq., MHA and senior research associate, as well as members of HCC's consulting and administrative support team were of great help.

Also, many thanks to our professional colleagues and clients who served as reviewers and commentators of the various drafts of this work along the way, including Peter Pavarini, Esq. for his comments and contributing the Foreword; Fred Geilfuss, Esq. of Foley & Lardner, LLP; and David Grauer, Esq. of Squire Sanders, LLP.

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About the Author

Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, is chief executive officer of Health Capital Consultants (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, Missouri, since 1993. Cimasi has more than 25 years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support and expert testimony; and certificate-of-need and other regulatory and policy planning consulting.

Cimasi holds a master's in health administration from the University of Maryland and holds several professional designations: Accredited Senior Appraiser (ASA–American Society of Appraisers), Fellow Royal Intuition of Chartered Surveyors (FRICS–Royal Institute of Chartered Surveyors), Master Certified Business Appraiser (MCBA–Institute of Business Appraisers), Accredited Valuation Analyst (AVA–National Association of Certified Valuators and Analysts), and Certified Merger & Acquisition Advisor (CM&AA–Alliance of Merger & Acquisition Advisors). He has served as an expert witness in numerous court cases and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, including *The Adviser's Guide to Healthcare* (AICPA. 2010) and *Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services in the Era of Reform* (Wiley, 2005), as well as numerous chapters, published articles, research papers and case studies, and is often quoted by healthcare industry press. In 2006, Cimasi was honored with the prestigious Shannon Pratt Award in Business Valuation conferred by the Institute of Business Appraisers. Cimasi serves on the editorial board of *Business Appraisals Practice* of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS) and serves on the editorial board of the RICS *Modus Americas* journal. Cimasi is also the current chair of the American Society of Appraisers Healthcare Special Interest Group (ASA HSIG) subcommittee.

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Introduction

Whereof what's past is prologue, what to come, in yours and my discharge.

William Shakespeare
The Tempest

While the concept of accountable care has existed for some time, it was given new life and renewed vigor by the March 23, 2010 passage of the Patient Protection and Affordable Care Act (ACA), which established the Medicare Shared Savings Program (MSSP) and drove the continued evolution of the Accountable Care Organization (ACO) from its early inceptions, e.g., the Medicare Healthcare Quality Demonstration (2003), the Medicare Physician Group Practice Demonstration (2005), and similar models adapted by provider organizations, such as Kaiser Permanente and Healthcare Partners Medical Group. The promise of lower healthcare costs and higher quality of care has precipitated a national fascination with ACOs throughout every level of healthcare, from government agencies, academic research institutes, and large provider delivery systems to individual physicians. As the nature and structure of both federal and commercial ACOs continue to be defined and distinguished, the question remains: Do ACOs, as a model, provide a sustainable solution to the nation's rising healthcare spending or will these emerging healthcare organizations follow the ascendency and ultimate demise of previous managed care models of the 1990s?

The term *managed care* generally refers to a collaborative effort between health services delivery and benefit design utilizing management and financing to influence cost, quality, or other specific outcomes.[1] Similarly, an ACO is an organized network of providers that coordinates care in order to lower costs and increase quality to achieve financial incentives established through a contract with an associated payor. Just as a square is a rectangle, but a rectangle is not a square, ACOs are a form of managed care, but the two concepts are not interchangeable.

Managed care took off in the 1990s through the advent of the health maintenance organization (HMO), a prepaid health plan model that used designated provider networks to increase efficiency of care for enrolled members. Distinctions between HMOs and ACOs are illustrated below, in Table I.1.

The widespread acceptance of managed care led to a consumer backlash. Providers and insurers were accused of lowering costs in an effort to enrich themselves, resulting in poor quality care and little to no impact on the continual rise in premiums for coverage.[3] Even though some of the managed care initiatives were considered notorious by the end of the decade, the model evolved and still exists in, perhaps, a different form in numerous markets. In line with that historical path, ACOs are now being touted as the means to address a seemingly intractable healthcare budget, quality, and access/coverage issues.

It may be that now, at this present point in time, the U.S. healthcare system has reached a tipping point where either costs will continue to increase until healthcare is unmistakable as a luxury good, available only to those that can afford adequate quality and access or, the triple aim of healthcare reform (i.e., access, cost, and quality) and some stability will be attained through the promotion of evidence-based medicine and value-based purchasing—both key concepts of ACOs. That this essential healthcare debate has polarized political parties and permeated every level of our society is self-evident to anyone who reads a daily paper, watches television, listens to the radio, or follows a blog. The Clinton-era attempt at universal employer healthcare showed that, without public demand and alignment of stakeholder interests, change is not likely to be adopted.[4] As healthcare industry spending nears 18% of the U.S. gross domestic product (GDP) and the prevalence of the uninsured

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TABLE I.1
Differentiating HMOs from ACOs[2]

	HMOs	ACOs
Accountability	Accountable for patients signed up through insurer	Accountable for patients based on payment method (e.g., Medicare or a specific commercial insurer)
Providers	Providers offer specified services for predetermined payment (premiums)	Providers integrate and coordinate care to meet evidence-based targets set by CMS or insurer
Risk	Some plans bear risk, but not a requirement	Risk based on reimbursement for outcomes and value-based payments
Reimburstment	Reimbursement primarily based on financial performance	Reimbursement based on quality and cost measures

and under-insured patients reaches an all-time high, the calls for change are resounding. ACOs are one of the current methods of implementing value-based purchasing toward the goal of meeting these demands.

Especially within the commercial market, ACOs are revitalizing coordinated care and episode-of-care payment ideals to further their success. There has been a growing acknowledgment that traditional fee-for-service reimbursement models are leading providers down the wrong path, toward volume incentives, instead of value incentives.[5] The variety of financial incentives utilized by ACOs covers many of the episode-of-care payment models that have been associated with the transition to a focus on the value of care provided, including pay-for-performance, bundled payments, population payments, and any other model that rewards care coordination and efficiency.[6]

ACOs are often compared to the mythical unicorn, i.e., “everyone has heard of one, but no one has ever seen one.”[7] At the time of publication of this book, over 200 ACOs have come into being across federal and commercial markets and, unlike unicorns, their existence and performance can now be observed and evaluated.[8] Yet, despite growing health policy support of the accountable care concept, tangible evidence of ACO feasibility and sustainability related to their monetary or nonmonetary success is lacking. Practitioners, providers, and policy makers outside already clinically integrated health systems (e.g., Kaiser Permanente) are especially weary of investing the time and capital required in chasing what may prove to be yet another unicorn. Even as ACOs continue to evolve and spread, the question remains as to whether ACOs can avoid the fate of the 1990s HMO model.

In developing an understanding of the forces and stakeholders that drive healthcare markets, it is useful to examine the Four Pillars of Healthcare Industry Value, i.e., regulation, reimbursement, competition, and technology. A visual depiction of the Four Pillars is set forth below, in Figure I.1.

These four elements shape the value metric of healthcare delivery and serve as a framework for analyzing the viability, efficiency, efficacy, and productivity of healthcare enterprises. A comparison of the potential value of ACOs to their necessary capital requirements and financial feasibility is requisite to understanding the likelihood of success for this emerging model.

It is not the intent of this book to declare whether the ACO model will ultimately prevail. Rather, in Chapter 1 through Chapter 5, we seek to lay out the historical background and evolution of the ACO model as the basis for the development of the value metrics and capital formation analyses that are foundational to accessing the current efficacy and capacity for change, which may result from pursuing the development of an ACO, both to their potential for nonmonetary as well as monetary value. The discussion of nonmonetary value is focused on a review of aspects of population health within the context of such objectives as improved quality outcomes and access to care.

In Chapter 6 and Chapter 7, this book addresses the value metrics of ACOs, including the requirements for capital formation, financial feasibility, and economic returns.

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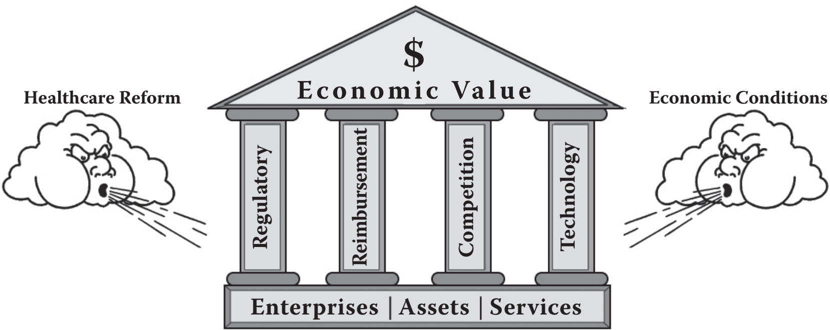

FIGURE I.1 The four pillars of healthcare industry value.

It has long been held that all financial value is the expectation of future economic benefit.[9] Accordingly, part of any investment analysis involves a forecast of the most probable future economic outcomes. In developing these forecasts, a concise and clear understanding of historical market conditions that represent the setting from which those outcomes spring is required. Otherwise providers, patients, and policy makers may fall victim to the failures of history, as "those who cannot remember the past are condemned to repeat it."[10] Therefrom arises the concern surrounding the development of ACOs repeating the failures of the past. To discourage this counterproductive outcome, there must be a discussion of the foundation and roots of managed competition from the earliest efforts of care integration to the current attempt at accountable care.

In Chapter 8, this book examines the positive externalities of the ACO model, including results for third parties outside the basic construct of the ACO contracts shared savings payments.

Finally, in Chapter 9, this book presents a brief discussion of (1) the potential role of consults in assisting providers in the consideration, development, implementation, and operation of an ACO; (2) the various modalities and specific types of consulting engagements typically utilized in such endeavors; and (3) the respective benefits, drawbacks, and opportunities to be derived from each.

Also included are some concluding remarks, a brief epilogue, a review of significant literature, and a compendium of bibliographic sources.

In applying the lessons from the past to today's rapidly evolving healthcare environment, this work seeks to present the requisite analytical exercise to facilitate decisions as to whether ACOs are feasible and have the potential to overcome decades of failed efforts at managed competition. These decisions and their outcomes may well impact the entire healthcare industry, now one-fifth of the U.S. economy, and growing.

ENDNOTES

1. Marcinko, D. (ed.) 2006. Managed care. In *Dictionary of health insurance and managed care,* p. 174. New York: Springer Publication.
2. Aon Hewitt. 2011. Integrated health care delivery/ACO's: What does it all mean to employers? Paper presented at the National Accountable Care Organization Congress, November 1, p.13.
3. Kaiser Family Foundation. 2006. The public, managed care, and consumer protections. *Kaiser Public Opinion Spotlight*, January, p. 1.
4. Bok, D. 2003. Leadership in the great health care debate of 1993–1994. In *Public discourse in America: Conversation and community in the twenty-first century*, p. 97. Philadelphia,: University of Pennsylvania Press.
5. Institute of Medicine. 2006. *Rewarding provider performance: Aligning incentives in Medicare.* Washington, DC: National Academies Press, p. 4.
6. Davis, K. 2007. Paying for care episodes and care coordination. *The New England Journal of Medicine* 356 (11): 1166.

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7. Morrison, I. 2011. *Leading change in health care: Building a viable system for today and tomorrow*. (Concept attributed to Mark Smith, president and CEO of the California Healthcare Foundation). Chicago: Health Forum, Inc., p. 184.
8. Muhlestein, D., et al. 2012. *Growth and dispersion of accountable care organizations: June 2012 update*. Salt Lake City: Leavitt Partners, p. 2.
9. Pratt, S. P., Reilly, R. F., and Schweihs, R. P. 2001. *Valuing a business: The analysis and appraisal of closely held companies*, 4th ed. New York: McGraw Hill, p. 40.
10. Santayana, G. 1998. *Life of reason: The phases of human progress*. New York: Prometheus Books, p. 82. (Republication of 1905 text)

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1 Background and the Path to ACOs

INTRODUCTION

Driven by the current healthcare environment and the passage of healthcare reform legislation, healthcare professionals and policy makers have been considering new ways to increase efficiency and quality, while decreasing the cost of providing healthcare services, including the creation of accountable care organizations (ACOs). ACOs are healthcare organizations in which a set of providers, usually physicians and hospitals, are held accountable under a contract with payor(s) for the cost and quality of care delivered to a specific local population.[1] There is no set model for ACOs, nor is their success completely assured. Ideally, ACOs will help shift the current healthcare payment system from its present emphasis on achieving revenue solely by generating high volumes of procedure-driven services to a system emphasizing quality and efficiency of care leading to lower overall costs.[2]

Key Term	Definition	Citation
Accountable Care Organization (ACO)	A healthcare organization where a set of otherwise independent providers, usually physicians and hospitals, willingly integrate to become responsible for the cost, quality, and overall care delivered to a specified patient population.	*Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?* By Kelly Devers and Robert Berenson, Urban Institute, (October 2009) p. 1.

HISTORY OF ACCOUNTABLE CARE

While the term ACO has recently captured the imagination of the healthcare industry, the Patient Protection and Affordable Care Act (ACA) was not the first iteration of the accountable care concept. ACOs are merely the latest version in a dialog that has been evolving for generations as to how to manage the rising cost of healthcare in a manner that addresses both *cost* and *quality*. Specifically, the concept of *accountable care* has existed in the U.S. healthcare industry for decades—long before the emergence of ACOs, beginning with the very origins of managed care.

Key Concept	Definition	Citation
Accountable Care	A strategy for managing the rising cost of healthcare in a manner that addresses both *cost* and *quality*	*Health Capital Consultants*

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History of Managed Care

Managed care plans were designed to integrate the financing and provisions of health services through a Managed Care Organization (MCO) in an effort to contain costs. MCOs attempt to hold providers accountable for providing care to a population through clinical practice standardization, selective contracting, low-cost settings, reduced discretionary hospital admissions, and effective use of staff.[3]

Factoid 1.1

Five major recommendations of the 1932 Committee on the Costs of Medical Care: (1) organize medical service by groups of physicians, nurses, pharmacists, etc., centered around a hospital; (2) make all basic public health services available to the entire public; (3) implement group payment, such as insurance or taxation, for costs of medical care; (4) state focus on coordination of care and creation of agencies that further such actions; and (5) make professional medical education stricter with emphasis on prevention and expansion of primary care physicians. (Source: I. S. Falk, the Committee on the Costs of Medical Care, and the Drive for National Health Insurance. By Milton I. Roemer, *American Journal of Public Health*, vol. 75, no. 8 (1985), p. 842.)

The discourse related to accountable care began as early as 1932 with the Committee on the Costs of Medical Care (CCMC), which issued a report in 1932 that marked the culmination of a five-year survey and an intensive study of the organization and cost of medical services. The report is not unanimous, and a wide divergence of viewpoints exists between the main body of the committee representing institutions, social interests, public health, social sciences and the public, and a minority group effectively representing the American Medical Association.[4] Seventeen of the 25 physicians on the committee, and 35 of the committee's total membership of 48, signed the majority report. Eight of the nine who approved the minority report were physicians.[5] The committee was established under the auspices and with the financial backing to the extent of almost $1 million of several of the great educational and eleemosynary (charitable) institutions of the United States, including the Rockefeller and the Carnegie Foundations and the Julius Rosenwald and Milbank Memorial Funds.[6]

Although the members never reached complete agreement, they issued five major recommendations for the healthcare community:

1. Organize medical service by groups of physicians, nurses, pharmacists, etc. centered around a hospital
2. Make all basic public health services available to the entire public
3. Implement group payment, such as insurance or taxation, for costs of medical care
4. State focus on coordination of care and creation of agencies to further such actions
5. Make professional medical education stricter with emphasis on prevention and expansion of primary care physicians.[7]

The committee's members supported an increased governmental and organizational presence and control over medical care.[8] A two-volume set was produced, presenting some of the committee's theories and efforts during meetings. The first of the volumes, *The Cost of Medical Care*, reported the data collected during the committee's research, and the second volume, *Medical Care for the American People,* expressed the committee's recommendations.[9]

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Factoid 1.2

The term "accountable care organizations" was first coined in 2006 during an exchange between Elliott Fisher, a physician and professor of medicine at Dartmouth Medical School and arguably the creator of the ACO idea, and Glenn Hackbarth, the chairman of the Medicare Payment Advisory Commission (MedPAC). (Source: Creating Accountable Care Organizations: The Extended Hospital Medical Staff. By Elliott S. Fisher, et al., *Health Affairs*, vol. 26, no. 1 (2007), p. 56, note 7.

The committee's report was based on a majority consensus rather than requiring unanimous agreement. While the minority and majority factions agreed on the overall direction of healthcare and both emphasized the importance of community evaluation in order to appropriately care for a population, they differed on focus areas.[10] Specifically, the majority highlighted "cooperative planning" whereas the minority "stress[ed] individualism in medical practice."[11]

The committee minority also produced a report emphasizing the maintenance of a "personal relationship between physician and patient, and the free choice of physician by the patient," and provided suggestions to aid in such efforts without commercialization or increased monitoring and regulation.[12] The minority report suggested that the government should emphasize public health and public service efforts comparable to those associated with the army and navy, the provision of medical services to indigent individuals should be viewed as a community issue, and the costs associated with providing care to low-income populations should be distributed throughout the community. Writers at the time suggested that, while the committee majority would not likely disagree with the minority report, they would have prioritized these issues differently.[13]

The committee majority recommended that large, organized groups of providers oversee and deliver all medical care. The report also provided suggestions for organizational structure standards to ensure protection of the physician–patient relationship. Unlike the minority report, the majority report was centered on the increased role of organizational regulation and maintenance. The committee majority proposed the establishment of comprehensive community medical centers with hospitals. Branches and medical stations were to be included in the comprehensive centers to allow for a delivery and payment of services within the proposed organizational structure.[14]

Of note is the theme of accountability expressed in both the majority and minority opinions, with numerous aspects of each report foreshadowing elements of the modern concept of ACOs. Historians monitoring the progress of the CCMC's recommendations have noted that four of the five major recommendations have been essentially fulfilled in the modern healthcare marketplace; only the fourth recommendation to achieve better coordination of care is left to accomplish.[15] Notwithstanding the extraordinary changes in the healthcare industry as it developed since 1932, the common aspirations to reduce waste, decrease cost, and provide quality care set forth in the report of the Committee on the Costs of Medical Care are still significant today.

Prior to the establishment of Blue Cross and Blue Shield, insurance was not purchased as a set of benefits. Instead, individuals could purchase accident or casualty insurance, which would replace income in the case of an illness or accident, but did not offer coverage for medical services. The first insurance company, which provided casualty insurance for rail and steamboat accidents, started in 1847. By the end of the 1800s, 47 companies existed and offered insurance for nearly every type of accident.[16] This type of coverage protecting against catastrophic risk remained prevalent until the 1930s, when "The Blues," as they were commonly referred to, entered the insurance market.[17]

The Blue Cross Blue Shield Association (BCBSA) started as two separate entities, with Blue Cross covering hospital services and Blue Shield providing coverage for physician services.[18] The Blue Cross Organization was created first in 1929 as a nonprofit, prepaid hospital plan for Dallas-area

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teachers developed by Justin Ford Kimball, a vice president of the University Hospital at Baylor University.[19] The plan initially covered 1,500 teachers who paid $6 per year for 21 days of hospital care at the University Hospital.[20] At that time, the Great Depression resulted in a growing number of patients who could not afford to pay their bills, and prepaid plans similar to the Baylor Plan quickly began to develop at hospitals across the country.[21] These plans providing hospital coverage were called Blue Cross and gained formal recognition in 1934 when the American Hospital Association and the American College of Surgeons expressed their approval of hospital group plans.[22]

Blue Shield developed in response to the public's desire to have prepaid coverage for physician services, comparable to what Blue Cross offered for hospital services. Beginning in 1933, Dr. Sidney Garfield offered prepaid physician services to 5,000 aqueduct workers in California, each of whom paid a nickel per day.[23] Admiring this success, Henry J. Kaiser adopted Dr. Garfield's approach in the late 1930s to provide his employees with physician services. The Kaiser Foundation Health Plan prospered and thrives today as the Kaiser Permanente plan.[24]

Since their formation, Blue Cross and Blue Shield have remained strong forces in the insurance market, but they did experience some issues in development. In the 1960s and 1970s, the government began challenging Blue Cross and Blue Shield plans across the country to use their market power to hold down hospital and medical costs, while their for-profit competitors challenged their tax-exempt status (which was later partially revoked by the Tax Reform Act of 1986).[25] The plans also were hampered by a dual structure and a lack of a clear, coherent viewpoint.[26] In response to these challenges, Blue Cross and Blue Shield merged into one organization—BCBSA—in 1977 that allowed the new organization to become a "*more efficient and effective network*."[27] BCBSA currently provides insurance to more than 100 million individuals.[28] The companies with BCBSA offer many forms of insurance plans, including managed care and one of the first commercial ACO contracts.

Blue Cross and Blue Shield were two of the earliest widespread versions of managed care. The prepaid, group practice plan models associated with Blue Cross and Blue Shield continued to expand in the 1930s and 1940s and several new plans were formed, including Kaiser Permanente in Los Angeles, Group Health Association in Washington, D.C., Group Health Cooperative of Puget Sound in Seattle, and the Health Insurance Plan (HIP) of Greater New York. These plans were the precursors to today's health maintenance organization (HMO).[29]

In his 1904 address, *The Doctor's Duty to the State*, John Roberts, the then president of the American Academy of Medicine, noted the unethical pitfalls that may ensnare the medical profession:

> The professional coward and the commercial coward have aided efficiently, if perchance unwittingly, the present degradation of the body politic and the body medical. Moral cowardice is a characteristic of both corporations and individuals in this twentieth century, and is the result of the worship of the "Almighty Dollar," which has usurped the place of "Self-Respect" in men's minds.[30]

The moral dangers associated with the seductive *nostrums of ill-gotten financial incentives,* were perceived and condemned by many patients during the managed care boom in the 1990s.

Key Term	**Definition**	**Citation**
Health Maintenance Organization (HMO)	An organization providing an agreed-upon set of basic and supplemental health maintenance and treatment services that are reimbursed through a predetermined fixed, period prepayment made by each person or family unit that is voluntarily enrolled.	Glossary of Terms Commonly Used in Health Care. *AcademyHealth,* 2004 Edition.

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HMOs are a prepaid health plan model that use provider networks with a system of *primary care gatekeepers* and capitated provider reimbursement incentivizing decreases in utilization and increases in the efficiency of care for HMO members. When issues of cost containments and coverage for the uninsured became topics of political contention, Congress passed the Health Maintenance Organization Act of 1973, which funded the development and spread of HMOs. The HMO Act originally promised some of the same major fundamental objectives of accountable care, i.e., lower costs and higher quality outcomes for patients. Although the federal government did not meet its stated goals of increasing the number of HMO plans from 30 in 1970 to 1,700 by 1976 and covering 90% of the population by 1980, managed care plans flourished throughout the 1970s and 1980s, maintaining prominence into the 1990s. There were over 600 HMOs in operation by 1996 with almost 65 million enrollees—almost one fourth of the U.S. population at the time.[31]

The significant shift to HMOs was not without controversy. The American Medical Association (AMA) staunchly opposed any form of nonphysician control over the medical profession, including the types of prepaid health plans that grew out of the managed care movement.[32] Along with the AMA's misgivings, individual providers resisted dramatic changes to reimbursement models. To promote provider acceptance, the HMO Act allowed for the formation of independent physician associations (IPAs), which were less restrictive and allowed physicians to maintain a level of control with less loss of autonomy than traditional group practices of similar size. Many providers, in choosing the IPA model as a less restrictive form of integration, were acting as resistors, which led to the failure to fully achieve desired goals of the HMO Act.[33] Public fear regarding the loss of their chosen physician providers' control over their patient care ultimately led to a backlash against the cost containment models of many managed care plans, HMOs in particular.

During the 1990s, a significant consumer backlash followed the rapid and widespread incursion of managed care plans, as both providers and patients turned against the model. The capitation form of payment in many plans, originally hailed as a means for reducing health costs, instead caused physicians and hospitals to underprovide services for fear of surpassing their spending thresholds. Patients accused HMO gatekeeper providers and insurers of being more focused on managing the cost of care for their own financial benefit, rather than the interests of their patients.[34] By 1997, 52% of U.S. citizens were in favor of the government stepping in to regulate managed care companies, even if it resulted in increased cost. Further, 54% believed the continued use of managed care plans would harm the quality of medical care.[35]

The public discontent with managed care plans was heavily publicized, adding fuel to the eventual consumer backlash, despite surveys indicating overall satisfaction with the level of medical care received from HMO providers.[36] Since the 1990s, HMOs have continued to be utilized as a means of controlling costs; however, reports suggest that restrictions on provider preferences have been relaxed.[37] The boom in HMO enrollment in the late 1990s, its subsequent decline, and its ultimate staying power, is illustrated in Figure 1.1.

The resistance to change that has affected the implementation of new provider reimbursement models is not a novel phenomenon. Prominent philosopher John Dewey has suggested that this type of resistance has happened in different industries throughout history, notably in the scientific community during the sixteenth century:

> Take, as an outstanding example, the difficulties experienced in getting a hearing for the Copernican astronomy a few centuries ago. Traditional and customary beliefs, which were sanctioned and maintained by powerful institutions, regarded the new scientific ideas as a menace. Nevertheless, the method which yielded propositions verifiable in terms of actual observations and experimental evidence maintained themselves, widened their range, and gained continually in influence.[39]

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