

ing chronic illness, and a robust health information technology infrastructure.

Finally, critical to the success of an ACO is the strength of its administration and non-physician staff. Physicians alone cannot make ACOs work; there must also be investments in intellectual capital to ensure that an organization's systems are highly-functioning. Developing the capabilities and infrastructure needed for high performance can be challenging, but it will be necessary if ACOs are to meaningfully take clinical and fiscal responsibility for large populations of patients.

increased administration required

SIZE: ECONOMIES AND DISECONOMIES OF SCALE

The size of ACOs in California is most frequently measured in terms of HMO enrollment, a metric that is applicable to IPAs as well as to integrated medical groups, but that does not measure services provided to PPO, Medicare fee-for-service, and other non-prepaid patients. ACOs range in size, as can be seen in Table Three; some are very large, but the vast majority of entities (223, or 78%) serve fewer than 50,000 prepaid patients.

The largest ACOs benefit from modest economies of scale when investing in patient registries, electronic medical records and supporting clinical programs.

However, they may also suffer from diseconomies of scale that can afflict large practices, in terms of loss of culture and sense of ownership by individual physicians.

On top of this, the empirical evidence does not support the claim that larger medical groups have meaningfully better chronic care programs or clinical performance as measured in the state's pay for performance program.^{viii,ix,x} Small ACOs have persisted, despite the absence of scale economies. Some small ACOs