ACOs Offer Realistic Hope of Economic Fix for Health Care

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Health care, just like any other business or industry, must function with limited resources. Physicians and other providers of medical services appropriate the financial resources of the patient populations they serve. It is in the financial interests of each provider to extract as much of that resource as possible.

Yet, if too much resource is extracted, the economy that produces those financial resources may be damaged and become less productive, or even collapse.

The fraction of Gross Domestic Product devoted to medical care in the U.S. in 2009 was 17.4 percent. The Netherlands, the next highest country within the Organization for Economic Cooperation and Development (OECD), spent 12 percent of its GDP compared to the OECD average of 9.5 percent.

The U.S. spent $7,960 on health per capita in 2009, 2½ times more than the OECD average of $3,223 (adjusted for purchasing power parity).[1] On top of the higher spending, we don't appear to receive good value for all that expense.

The U.S. ranks better than average on only three of 12 major OECD population health status measures.[2] The U.S. wastes about 6 percent of GDP (a third of total spending[3]) through profligacy of the country's health care system and that puts us at substantial economic disadvantage. This level of drain on the economy may be unsustainable; our medical care community may have already surpassed the carrying capacity of the economy.[4]

One way to avoid this would be through privatization,[2] but that's highly unlikely. If the resources that were once held in common becomes the sole property of a single individual or business entity, the disparity between individual marginal gain and communal loss disappears. It now makes economic sense for the owner not to over-utilize the resource and risk collapse.

However, it is difficult to see how the U.S. medical care system could be truly privatized—either in whole or as multiple regional/local monopolies. Leaving aside the legal and political impossibilities of such an idea, how could the totality of the economic resources of, say, a referral region be "owned" at all?

A second way to avoid collapse is through governmental regulation.

For example, the National Oceanographic and Atmospheric Administration is responsible for implementing a Fishery Conservation and Management Act that mandates the use of annual catch limits to end overfishing in U.S. coastal waters.[5] However, attempts to manage health care through regulation in the U.S. have been ineffective, even in the Medicare segment of the population over which governmental control can be most easily exerted. "Catch limits" have not proven successful in medicine.

The final way to avoid upheaval is the idea for which Elinor Ostrom, PhD, was awarded the 2009 Nobel Prize for economics. Ostrom observed that, under favorable circumstances, groups of resource extractors, be they farmers or fishermen, can self-organize and self-regulate very effectively, more effectively, in fact, than could be achieved by the imposition of government regulation.[6]

She empirically determined a number of "design principles" that support this sort of self-regulatory activity to preserve the integrity of resources:

1. **Clearly defined boundaries**

- Effective exclusion of external unentitled parties from becoming extractors
- Separation of the common-pool resource from the larger social or ecological system

2. **Rules adapted to local social and environmental conditions**

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- Rules regarding the appropriation of common-pool resources
- Rules ensuring that the distribution of costs (to individual extractors) is reasonably proportional to the distribution of benefits of resource appropriation

3 Collective-choice arrangements that allow most resource appropriators to participate in the rule-making process

4 Effective monitoring by individuals who are part of, or accountable to, the group of appropriators

- Of the appropriators themselves and their levels of resource extraction
- Of the resource's well-being

5. A scale of graduated sanctions for resource appropriators who violate community rules

6. Mechanisms of conflict resolution that are relatively easily and inexpensively applied

7. Self-determination of the community recognized by higher-level authorities

8. In the case of larger common-pool resources, organization in the form of multiple layers of nested enterprises, with small local common pool resources managed at the base level

It is not necessary to meet all of these conditions to have successfully

functioning self-regulation, but the more conditions met, the higher the likelihood of success.

If neither privatization nor regulation is effective in protecting the economy from over-appropriation by medicine, is self-regulation possible? The answer, unfortunately, is rarely. The conditions conducive to self-regulation are not normally achievable in medicine.

One notable exception is the experience of Grand Junction, CO.[7,8] In 2006, the annual cost per Medicare beneficiary was $5,900, compared to the national average of $8,310—while scoring very well on quality metrics. Ways in which Grand Junction's circumstances promote self-regulation are:

Clearly defined boundaries

- As defined by the Dartmouth Atlas, Grand Junction is a hospital service area (HSA) that is also the center of a referral region having four other HSAs with very small populations. It is surrounded by mountains and deserts, making travel to other referral regions arduous. These physical barriers create clear functional boundaries for the population and that population's resources. In essence, the common-pool resources are separated from the larger health care system.
- The same physical barriers prevent part-time/out-rider physicians from intruding into the Grand Junction medical community. A home-grown non profit HMO was created by a local IPA and about 85 percent of physicians belong. The HMO at one time had a near-monopoly on payer contracts and still has about 40 percent of the market. If you are not a member of the HMO it is hard to make a good living practicing medicine in Grand Junction. Thus, there is reasonably effective exclusion of unentitled providers from the ability to extract resources.

Rules applicable to local conditions

- The HMO has set up an extensive system designed to promote high-value care for the entire population. Their rules include: provider payments leveled across payers to prevent cherry-picking patients of generous payers or avoiding patients of meager payers such as Medicaid, paying primary care physicians for hospital visits, even when they are not the managing physician, etc.

Participation in the rule-making process

- The HMO members developed and periodically modify the rules.

Effective monitoring of providers and resource

- Provider members of the HMO are elected to a peer review committee that tracks expenses against expectations/budget and monitors the clinical and financial performance of each of its members.

Graduated sanctions

- The utilization management committee may apply sanctions ranging from requiring a physician to appear before the committee to discuss unfavorable findings (which, while educational, may also be experienced as public shaming), through intermediate steps of warnings and financial penalties, all the way to expulsion from the HMO. Data on individual physician cost and quality are made available internally. Primary care physicians use that information to steer referrals away from low-value specialists.

Economical conflict resolution

- Provider committees resolve conflicts.

Recognition by higher-level authorities

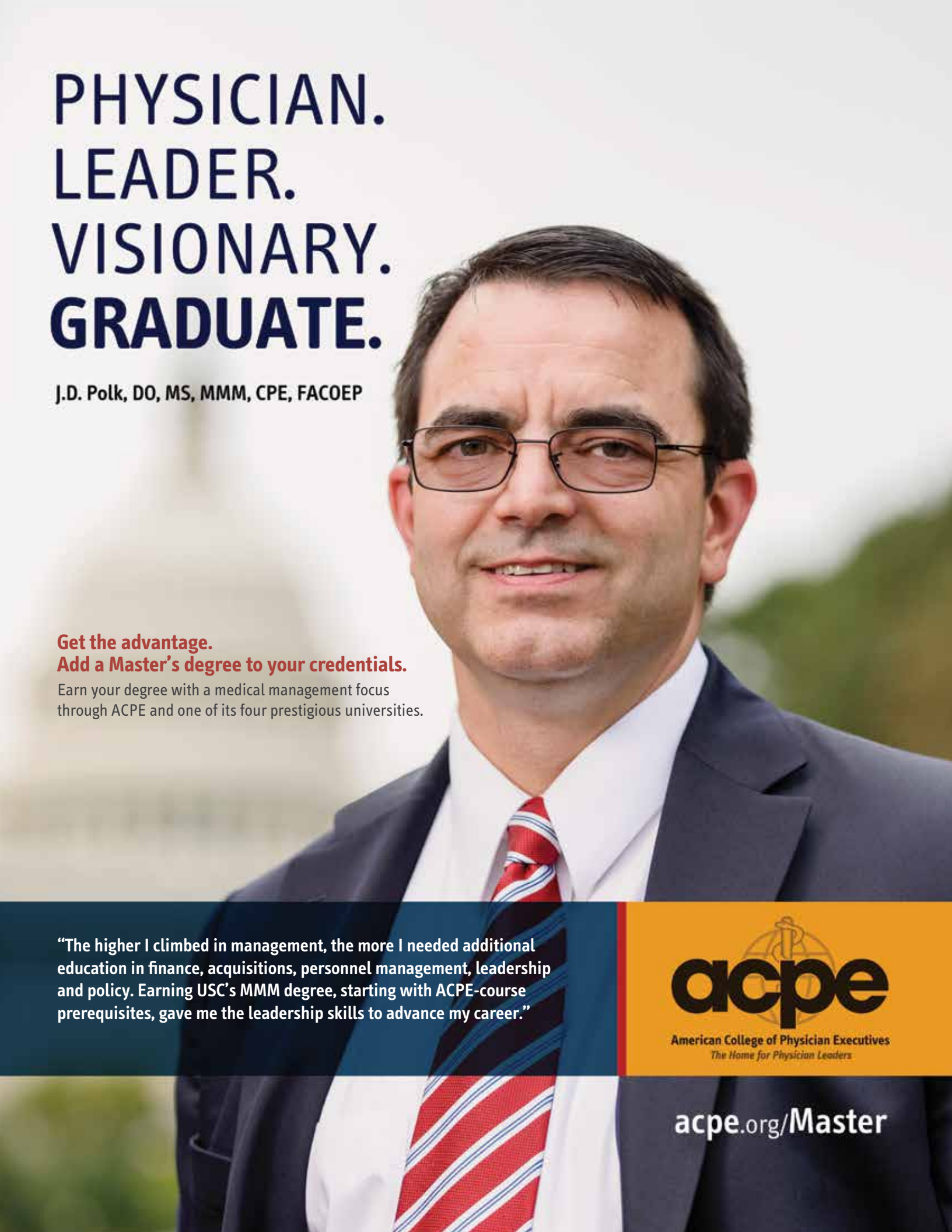
- Whenever you create a near monopoly, as has the local HMO, you invite scrutiny from the Federal Trade Commission. Such was the case in Grand Junction. In the mid 1990s The FTC challenged the legality of the local HMO–IPA arrangement. The FTC initially alleged that it was driving up the cost of medical care in the county. However in 1998 the FTC acknowledged the positive outcomes and issued an anti-trust exemption.

Given the will, resources, and FTC cooperation,[9] most of the conditions for medical self-regulation could be created in many locations. The non reproducible element of Grand Junction's success is clearly defined boundaries. In most locations, the ability to define a distinct served population is made impossible by service area boundaries that are quite fuzzy rather than clearly discernable. Thus the sense of community and social cohesiveness observed in Grand Junction are much less likely to be achieved, particularly in communities substantially larger than the 150,000 population in the Grand Junction area.

Nor is the effective exclusion of unentitled extractors (non participating physicians and other providers), achievable in most locales. Anyone with a license can come to town and set up shop with confidence that they will be able to be a provider with Medicare and the dominant preferred provider organizations (PPOs).

Accountable care organizations (ACOs) solve the issue of boundaries definition, albeit better in a commercial setting than in Medicare.

In an ACO, the served population is clear: Each person is either covered by the ACO or not. In the commercial venue membership is defined without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having to discern where the patient has actually been receiving care as is the case with the Centers for Medicare and Medicaid Services' model.

In the commercial situation, the population definition is entirely prospective, analogous to being a life covered by a particular health plan or under the aegis of a particular PPO. The fact that patients may occasionally leave an ACO does not interfere with the ability to manage the resource any more than the fact that fish can swim out of a fishery is problematic for fishery management. Nor does the population being geographically interspersed with others interfere with resource management: a clear functional boundary is just as good as a clear spatial one.

In an ACO, external extractors can be excluded as well. In a commercial setting, the same substantial benefit coverage differentials that provide PPO steerage are applicable and effective. In the CMS model, ACO physicians should still have enough influence over referrals to limit "leakage" of resources outside the organization except to preferred outside vendors (sub-specialty services not available in the ACO).

Although medical care is far more difficult to manage than some businesses, the ability of the ACO to define boundaries for the population and its resources, as well as the medical providers entitled to use those resources, enables participants to successfully manage a common-pool budgetary resource.

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