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HOSPITAL EMPLOYMENT OR PHYSICIAN-LED ACO?

New Data Sheds Light on the Answer

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NEW DATA SHEDS LIGHT ON THE ANSWER

Primary care physicians around the country are facing the largest decision of their lives: Do I stay independent and maybe form an accountable care organization with other independent physicians, or do I become an employee of a hospital or health system?

As accountable care is taking hold, new data may alter historic thinking on this "bet-the-practice" question.

Tired of being overworked, undersatisfied, and overwhelmed with growing regulatory requirements, many primary care physicians have sought the security and strength of hospital employment. They say the pressures to invest in technology, billing, coding, and continued reimbursement pressures are just too great.

Yet, the majority of these physicians miss their days of self-employed autonomy, are on average less productive, and worry that the clocks on their compensation guarantees are ticking down.

Most of the moves by your colleagues, and perhaps you, to hospital employment have been defensive. It was just no longer feasible to stay afloat in the current fee-for-service system. You cannot work any harder, faster, or cheaper. You can no longer spend satisfactory time with your patients.

On the other hand, some of you may have joined a hospital or health system to be proactive and gain a solid platform to prepare for the new value-based payment era.

You may have envisioned being integrated with a critical mass of like-minded physicians and facilities, aided by advanced population management tools and a strong balance sheet, and all linked together on the hospital's health information technology platform. You read that primary care should be in a leadership position and financially incentivized in any accountable care organization – including a hospital's. Independent physicians could theoretically form ACOs, too, but lack the up-front capital, know-how, and any spare intellectual bandwidth to do so.

So, from a strategic perspective, becoming employed with other physicians by a health system seemed the way to go.

The pace has quickened of health care's movement away from fee for service or "pay for volume" to payment for better outcomes at lower overall costs, or "pay for value." The factors that applied to the decision to become employed in the fee-for-service era may be yielding to those in the accountable care era sooner than anticipated.

Independent physician-led ACOs appear to be adapting better than hospitals to this change. Although much better prepared fiscally, hospitals are conflicted, or at least hesitant, to make this switch, because much of the savings comes from avoidable admissions and readmissions. On the other hand, emerging data and experience are showing that physician-led ACOs can be very successful.

There are some very integrated and successful hospital-led ACOs or other value-delivery hospital/physician models. In fact, I believe that if the hospital is willing to right-size and truly commit to value, it can be the most successful model.

However, many physicians signed volume-only physician work relative value unit (wRVU) compensation formulas in their hospital employment agreements, with no incentive payments for value. They have not been involved as partners, much less leaders, in any ACO planning. Even though the fee-for-service days are waning and strains are showing for many hospitals that are not adapting, for many employed physicians, the pace of preparedness for the accountable care era has been disappointing.

New data show that while most of the early ACOs in the Medicare Shared Savings Program were hospital led, there are now more physician-led ACOs than any other. At the same time, early results of some modest primary care–only ACOs have been exciting. The rural primary care physician ACO previously reported on in this column, Rio Grande Valley Health Alliance in McAllen, Tex., is preliminarily looking at 90th-percentile quality results and more than $500,000 in (unofficial) savings per physician in their first year under the Medicare Shared Savings Program.

In fact, in a May 14, 2014, article in JAMA, its authors stated: "Even though most adult primary care physicians may not realize it, they each can be seen as a chief executive officer (CEO) in charge of approximately $10 million in annual revenue" (JAMA 2014;311:1855-6). They noted that primary care receives only 5% of that spending, but can control much of the average of $5,000 in annual spending of their 2,000 or so patients. The independent physician-led Palm Beach ACO is cited as an example, with $22 million in savings their first year. The authors recommend physician-led ACOs as the best way to leverage that "CEO" power.

These new success lessons are being learned and need to be shared. Primary care physicians need to understand that the risk of change is now much less than the risk of maintaining the status quo. You need transparency regarding the realities of all your choices, including hospital employment and physician ACOs.

As readers of this column know, I heartily endorse the trend recognized in the JAMA article: "[A]n increasing number of primary care physicians see physician-led ACOs as a powerful opportunity to retain their autonomy and make a positive difference for their patient – as well as their practices' bottom lines."

*This article appears courtesy of **Internal Medicine News**. Bo Bobbitt is the author of Internal Medicine News "ACO Insider" column.*

Bo has many years of experience assisting physicians form integrated delivery systems. He has spoken and written nationally to primary care physicians on the strategies and practicalities of forming or joining ACOs. This article is meant to be educational and does not constitute legal advice. For additional information, please contact

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