If a hospital or health system comes knocking, make sure you've considered these key issues.

ACOs ARE COMING: SHOULD YOU SELL YOUR PRACTICE?

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Unsustainable inefficiencies in our health system have led to a new set of buzz words – accountable care, value-based care, and shared savings, to name just a few. Although the lingo is new, the goal has remained the same for the past 20 years: to find a way to integrate our fragmented health care system.

One of the leading ideas advocated by the Centers for Medicare & Medicaid Services (CMS) is the development of accountable care organizations (ACOs). In brief, an ACO is a local network of providers who agree to manage the full continuum of care for all patients within their network and share any savings and risks involved. (For more background, see "What Family Physicians Need to Know About ACOs," *FPM,* September/October 2011, http://www.aafp.org/fpm/2011/0900/p17.html.) Because of the capital, infrastructure, and risk involved, most early adopters of the ACO model will likely be hospitals or health systems; to be successful, though, they will need a strong base of primary care physicians. As a result, there is currently a flurry of physician practice acquisitions that is eerily similar to the 1990s spree when hospitals purchased practices to support capitation contracts.

The proposed CMS rules for ACOs were released in April 2011 with a resounding thud. They were unwieldy, seemed illogical in some respects, and carried uncertain financial risk, so many hospitals, health systems, and large groups decided then to take a wait-and-see approach before pulling the trigger to develop an ACO under the Medicare program. Although the final, streamlined CMS

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rules for ACOs were released in October (see the summary at right), some hospitals and health systems are still hedging their bets as to whether ACOs are the way to go. Nevertheless, many are taking the first step of acquiring primary care practices. No matter how health care reform plays out, hospitals, health systems, and even health plans see primary care practices as a good investment in referral and feeder bases. But is "selling out" to an organization that intends to become an ACO really in physicians' best interests? This article addresses key questions to ask before you consider trading your private practice for the security of a biweekly paycheck and a life of employment bliss.

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What is the hospital or health system's ACO strategy?

ACOs require a transition from a fee-for-service mind-set to one focused on value-based care and payment.

ACOs require a fundamental shift from a fee-for-service mind-set to a focus on value-based services and outcomes. Operating rooms, scanners, and the like will not be the key revenue drivers in ACOs. Instead, efficiencies and care coordination must become paramount, hospital costs must go down, and the focus must shift from specialty and procedural based services to outpatient and primary care services.

Until that transition happens, newly employed physicians may find that they have to be more productive to maintain the income they had in private practice.

The transition to value-based care and payment will not happen all at once, however, so hospitals and health systems will initially have to balance the opposing demands of fee-for-service and value-based payment. Specifically, high-cost, high-margin services such as cardiac, orthopedics, and imaging must be reprioritized to a population-based strategy. Leadership, fortitude, and a spirit of collaboration are hallmarks of an organization prepared to weather this sea change. Physicians looking to sell to a potential ACO need to ask: What is the organization's strategy for making this transition happen? Is there truly a focus on primary care, efficient care, and care coordination? Are the incentive payments being offered significant enough to aid this transition and motivate the desired change? And what role will primary care physicians play in the anticipated governance of the ACO? If the hospital or health system cannot articulate these ideas sufficiently, then seller beware.

What is the reimbursement model in the short term?

Because value-based payment will not be in full swing for some time, physicians need to understand how they will be paid in the short term.

Newly employed physicians often find that they have to be more productive and generate more revenue just to maintain the same income level that they had in their private practice. (See "Why Did Your Productivity Decrease When We Hired You?" *FPM,* July/August 2011; http://www.aafp.org/fpm/2011/0700/p18.html.) A key reason for this is that overhead costs are often significantly higher in an employed practice because they include shared costs from the health system. The hospital's staffing requirements can also increase overhead. For example, the hospital may require licensed nursing staff rather than medical assistants. In addition, acquired practices are often required to adopt the hospital's electronic health record, which can increase cost and decrease productivity significantly.

If these costs and any associated decreases in productivity are not anticipated in the contract, then the physician's compensation will suffer. These initial contracts could be in place for some time before the organization makes the full transition to an ACO model.

How will the reimbursement model evolve?

All proposed ACO models include fee-for-service payments plus "shared savings" bonuses for achieving quality and cost outcomes. However, there is a caution. If an ACO achieves the cost and quality targets, CMS will pay one

MEDICARE ACCOUNTABLE CARE ORGANIZATION RULES

Although providers can create ACOs in partnership with private payers, Medicare ACOs under the Shared Savings Program are receiving the most attention because of their potential to impact the market nationally and because the Affordable Care Act mandated that they be in place by Jan. 1, 2012. Key points from the final rule for Medicare ACOs are outlined below. (A detailed summary from the American Academy of Family Physicians is available at http://bit.ly/x1Bj62.)

• Providers in a Medicare ACO will continue to receive traditional Medicare fee-for-service payments and be eligible to receive a portion of the ACO's shared savings, if any.

• ACOs can choose from two tracks initially, each requiring a three-year agreement:

1) Track one involves three years of shared savings with no risk.

2) Track two involves three years of shared savings plus shared losses, but it offers higher sharing rates. All ACOs must participate in track two after their initial three-year agreement period expires.

• ACOs must meet a minimum savings rate and meet 33 measures in four domains to qualify for shared savings. In the first year, the ACO must simply report on the measures. In year two, eight measures will continue on the pay-for-reporting basis while 25 measures will be pay for performance. In year three and beyond, 32 measures will be pay for performance and one measure, the health status/functional status module, will be pay for reporting.

• Of the 33 final measures, seven are collected by means of a patient survey, three are calculated from claims, one is calculated from electronic health record (EHR) Incentive Program data, and 22 are collected via the Group Practice Reporting Option web interface.

• Meaningful use of EHRs is one of the quality measures, and it is double weighted to reflect the importance of health IT in redesigning care and providing actionable information at the point of care; however, it is no longer a requirement of participation.

• Small ACOs may be eligible for the Advance Payment Model, which provides up-front payments of $250,000 plus $36 per beneficiary as well as a monthly payment of $8 per beneficiary to help them develop their infrastructure. Small ACOs are defined as those with no hospital partner and less than $50 million in total annual revenue or those with a critical-access hospital or low-volume, rural hospital and less than $80 million in total annual revenue. Application deadlines have passed for the April 2012 start date; however, applications will be accepted from March 1 through March 30 for the July 2012 start date. ACOs must first submit a notice of intent and apply to the Medicare Shared Savings Program. (For more information, see http://www.cms.gov/sharedsavingsprogram/37_Application.asp and http://innovations.cms.gov/initiatives/aco/advance-payment/index.html.)

• The Pioneer ACO Model allows organizations that are already experienced in coordinating care for patients across care settings to take on higher levels of shared savings and risk. Thirty-two organizations have already been selected for this program, which began Jan. 1, 2012. (For more information, see http://innovations.cms.gov/initiatives/aco/pioneer/index.html.)

• The program will use a prospective (rather than retrospective) method to assign beneficiaries to providers quarterly. A minimum of 5,000 beneficiaries is required.

• Entities eligible for forming and participating in ACOs include group practice arrangements, networks of individual practices, physician-hospital partnerships or joint ventures, hospitals, federally qualified health centers, rural health clinics, and critical access hospitals that follow specified billing methods. There is no requirement that an ACO include a hospital.

• ACOs must have processes in place to promote patient engagement and evidence-based medicine, report on quality and cost measures, coordinate care, receive and distribute shared savings, and repay shared losses as needed. In addition, they must maintain an identifiable governing body that includes a beneficiary representative and represents at least 75 percent of ACO participants.

bonus check to the ACO. CMS does not dictate how that bonus check must be allocated, although it does require the ACO to specify on its application how it will distribute any shared savings. CMS clearly expects the funds to be used to further the aim of better care for individuals, better health for populations, and lower growth in Medicare expenditures. That said, a hospital-dominated ACO could be tempted to use the incentive dollars to offset lost revenue due to decreased utilization (decreased bed days, emergency department visits, etc.), instead of distributing the incentive dollars more equitably. So, once again, the importance of understanding the governance model of the

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ACO cannot be overemphasized.

After initial efficiencies are achieved with the shared savings model, the next likely model is bundled or global payments. Global payments are not new. In the last two decades, certain surgical services have been paid with one fee for both the facility and professional components. Moving that concept forward, global payments will include all services provided to a patient for a specified period of time. This includes primary care, specialty care, ancillary services, and so on. While it is impractical to anticipate precisely how all the variables of this model will affect the employed primary care physician, the potential for favoring one stakeholder is real and underscores the need to understand the philosophy and biases of the organization that is interested in purchasing your practice.

Physicians need to understand the philosophy and biases of a potential employer, which could affect their payment in the future.

Are you ready to practice as a "medical home"?

Care coordination and team-based care, key components of the patient-centered medical home (PCMH) model, will be critical to achieving the efficiencies and outcomes required of ACOs. With only a few exceptions, such as Kaiser Permanente, Geisinger, and Group Health Cooperative, the U.S. health care system does not have a great track record for health care delivery as a coordinated team sport. Since most physicians are not part of one of these historically integrated systems, developing this infrastructure will be vital.

Even if you wish to maintain an independent practice, taking steps toward becoming a PCMH is prudent and will help you prepare for any and all possible futures. (For more detail, see the American Academy of Family Physicians' PCMH tools at http://www.aafp.org/pcmh and *FPM*'s PCMH topic collection at http://www.aafp.org/fpm/pcmh.)

Taking steps toward becoming a medical home will help prepare a practice for all possibilities.

Are there alternatives to selling your practice?

Physicians can participate in ACOs without selling their practices if they look for opportunities for strategic partnerships and virtual integration. For example, there may be an independent practice association in your area that could partner with a commercial payer on this endeavor. Or there may be a hospital or health system willing to establish an ACO by contracting with private practices that have taken steps to become medical homes.

Despite the emphasis on ACOs, there is definitely a role for independent practices in the health care system.

Into the unknown

Like it or not, a new chapter in the U.S. health care system is beginning. The unknowns about reimbursement, the frustrations of practice management, and purchase offers from hospitals have many physicians contemplating the sale of their practices. There is no absolute right or wrong decision. However, careful analysis of the key issues discussed above is critical. Physicians should feel neither rushed nor pressured when a hospital makes an acquisition offer. Should you decide not to sell, rest assured there is an important role for independent practices as the health care system moves forward. FPM

Send comments to **fpmedit@aafp.org.**

Editor's note: Look for a related article, "Nine Practice Sales Pitfalls to Avoid," in our next issue.

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