VIEWPOINT

Can Small Physician Practices Survive?
Sharing Services as a Path to Viability

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In a health care environment moving toward accountable care organizations (ACOs) and population health management, what is the role of small physician practices? Can they compete? Does it matter if they cannot?

The number of small practices has been declining for decades. Between 1983 and 2014, the percentage of physicians in practices of 10 or fewer declined from 80% to 61% and those in solo practice, from 44% to 19%.[1] In 2015, 34% of physicians were in practices of 100 or more.[2] This trend has likely been accelerated by recent policy changes, such as quality and outcomes reporting, health information technology (IT) requirements, and the scale requirements needed to participate in ACOs and other value-based purchasing programs. Physicians in large practices or employed by hospitals also are often relieved from the business side of medicine and secure higher payment rates that large organizations can negotiate with health insurers, and such consolidation may lead to increased profits.[3]

It is possible that this is a positive development. An often unstated assumption of delivery system reform efforts is that larger organizations can reduce care fragmentation, scale ancillary services, and improve chronic disease management through better collaboration across specialties. Large medical groups and hospitals have the capital to invest in skilled quality improvement leaders, nurse care managers, population health management programs, and sophisticated electronic health records and data analytics teams. Small practices, by contrast, generally do not care for enough patients to support such investments.

However it is not clear that large medical groups or hospital-employed physicians provide better care than small practices. Data comparing practices by ownership are limited, but a recent review of hospital employment of physicians concluded that "vertical integration generates higher prices, higher spending, and ambiguous changes in quality."[4] Even less data are available on performance by practice size. For example, 1 study found that practices with 1 to 2 physicians (n = 570 practices) had a risk-adjusted preventable hospital admission rate 33% lower (4.31 vs 6.47 per 100 beneficiaries per year) than practices with 10 to 19 physicians (n = 53 practices), and that practices with 3 to 9 physicians (n = 422 practices), had a 27% lower (4.73 VS 6.47 per 100 beneficiaries per year) admission rate than larger practices.[5] Another study analyzed practices with 5 to 750 physicians and found that smaller practices (each additional full-time equivalent physician is associated with $22.60 increase in annual per capita costs) had fewer preventable hospital admissions and lower costs of care for patients with diabetes.[6] The optimal practice size is not known and likely depends on the specialty being studied and the question being asked: Optimal for improving quality? Lower costs? Negotiating prices? Promoting physician well-being?

New policies aimed at improving care may drive physicians into large groups or hospital employment. It is complex and expensive for small practices to participate in federal and commercial ACO programs and medical home initiatives. The Medicare Access and CHIP Reauthorization Act (MACRA) may be particularly burdensome for small practices. Indeed, recognizing that small practices are likely to be penalized under the law, the Centers for Medicare & Medicaid Services (CMS) has exempted practices that treat fewer than 200 unique Medicare patients or those with less than $90 000 in annual Medicare revenue from reporting requirements and has made $100 million available in technical support for those participating.[7]

How can small practices survive in the current environment? Some small practices are experimenting with ways to pool resources across groups, while maintaining their independence and intimacy. These practices are forming "pods," or networks of practices, that contract with "shared service providers" to pool and manage resources. These linkages take several forms—those organized by local hospitals, independent practice associations, payers, or private companies—and may allow small practices to compete in value-based contracts and a policy atmosphere favoring consolidation (**Table**).

In an effort sponsored by the New York City Population Health Improvement Program (PHIP), the United Hospital Fund conducted a series of surveys, interviews, and focus groups with clinicians in small practices (generally with fewer than 5 physicians).[8] Fifty-six practices were surveyed, followed by 5 focus groups with a total 83 participants, among whom three-fourths were physicians and the remainder were nurses, nurse practitioners, and practice managers. Clinicians in small practices identified several priorities for services with which they need assistance, including care management support, data analytics teams, quality reporting infrastructure, and electronic health record maintenance and optimization. A variety of organizations have begun offering these services, enabling small practices to gain access to shared personnel like care managers, pharmacists, social workers, and behavioral health specialists in ways that make sense for a given pod. Behavioral health specialists, for instance, can be shared through telemedicine, from a centralized site, or by being embedded in multiple practices. These shared service organizations often provide data analytics support, which is consistently identified as a top priority by small practices.

Over the past decade some hospital systems have developed service sharing infrastructures that support both hospital-employed and independent practices. In the Adirondack Medical Home Demonstration, for example, a local hospital, Champlain Valley Physicians' Hospital (CVPH) in upstate New York, offers a range of shared services to a group of primary care practices, enabling

Table. Variations of Shared Service Provider Arrangements With Examples

Type	Example	Scope	Focus	Financing
Hospital sponsored	Adirondacks Medical Home Demonstration	82 PCPs in 25 practices with 50 000 attributed patients	Chronic disease care management (including medication management, social services, and care transitions) Behavioral health support and patient education Data analytics and quality improvement	Directly financed by practices that receive PMPM payments as part of a regional multipayer medical home initiative Currently transitioning to a mix of PMPM payments and VBP incentive payments
Independent practice association (IPA)	Greater Rochester Independent Practice Association	350 PCPs in 162 practices; 60% in small practices of 1 to 4 clinicians	Data analytics for risk management Quality improvement support Care management, home nursing visits, pharmacists, and diabetes educators	Some care management fees from self-insured employers Revenue from quality incentive and ACO contracts Administrative fees in some commercial contracts
Payer-sponsored	Acuitas Health	194 Clinicians in 32 practices serving 160 000 patients	Assistance with registries and coding Population health analytics Shared care managers, behavioral health specialists, and patient educators Quality improvement staff and collaboratives	PMPM fee for contracted services, which can be purchased a la carte or full menu Practices receive PMPM payments via some payer contracts and CMMI's CPC+ program
Private companies	Aledade	1200 Physicians in 200 practices serving 240 000 patients	Data analytics assistance Care management support Quality improvement services	Practices participating in MSSP Practices pay small PMPM fee for each attributed Medicare beneficiary Startup funding from venture capital

Abbreviations: ACO, accountable care organizations; CMMI, Center for Medicare and Medicaid Innovation; CPC, Comprehensive Primary Care Plus; MSSP, Medicare Shared Saving Program; PCP, primary care physician; PMPM, per member per month; VBP, value-based purchasing.

them to achieve recognition as medical homes and participate in value-based contracts, such as the Medicare Shared Saving Program (MSSP). The services are paid for by participating practices, which, as part of a multiplayer initiative, receive incentive payments for achieving medical home recognition. The hospital hosts and manages the services, employs shared staff, and provides office space and financial and human resources support (Table).[8]

Traditionally, most independent practice associations (IPAs) have been networks of small practices organized for the purpose of negotiating fee-for-service contracts with health insurers. But they can also act as a platform for sharing resources. The Greater Rochester IPA (GRIPA) includes 350 primary care physicians in 162 practices. GRIPA offers its members data analytics services to stratify and manage patients, as well as care management support, pharmacists, visiting home nurses, and diabetes educators.[8] Most shared services are centrally deployed, but shared care managers are assigned to (or embedded in) specific practices.

Payer-sponsored arrangements are also emerging. Acuitas Health, for example, is a partnership between a nonprofit health plan and a large multispecialty group that offers a range of services to small practices, including billing and coding assistance, practice transformation consulting, and patient aggregation, to allow practices to achieve the scale needed for value-based contracts. Acuitas currently provides services to 194 clinicians in 32 independent practices caring for 160 000 patients.[8]

In addition, some private companies have recently created shared service infrastructures to allow small, independent practices to participate in alternative payment models, such as MSSP ACOs. Companies like Aledade and Collaborative Health Systems work with small practices and IPAs to participate in ACOs, offering low-cost shared resources, in return for a portion of downstream savings. Aledade partners with more than 200 practices serving 240 000 patients across 15 states.[8]

Service sharing arrangements offer a mechanism through which small practices can meet the broader goals of delivery system reform. But many questions remain: Are shared services as effective as those grounded in a large unified medical group? How should services be financed? Will there be an acceptable return-on-investment? Is one type of arrangement preferable to others? Nevertheless, in a health care environment shifting rapidly toward physician employment and practice consolidation—without clear evidence of benefit—shared service organizations may offer small practices a path to sustainability, and offer patients and physicians the flexibility to engage in an endangered form of medicine should they choose.

ARTICLE INFORMATION

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