# The PHIP Small Practice Project

# Final Report

June 2018

## Acknowledgments

This project was a collaborative effort under the NYC Population Health Improvement Program (NYC PHIP), made possible by funding from the New York State Department of Health. Many individuals made contributions to this report. The NYC PHIP staff is extremely grateful to the providers from small practices, whose interest, comments and suggestions were the foundation for this work; to the leaders of organizations currently offering shared services to small practices, for their assistance and insights; and to an exceptional group of advisors from practices, specialty societies, health plans and other organizations, who provided expert feedback and advice, as we conducted this work.

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United Hospital Fund

*Improving Health Care for Every New Yorker*

June 2018

Dear Partner,

While the winds of change and uncertainty continue to gust across the health policy and delivery system landscape, it is comforting that the United Hospital Fund partnership with the New York City Population Health Improvement Program (PHIP) remains a calming force dedicated to improving the health of our communities. The report that follows is evidence that multi-stakeholder collaboration can result in strong models and recommendations for how public health and the health care system can work together to prevent premature deaths—and ultimately transform our city's health delivery system.

UHF's unique focus as part of the broader PHIP has been on improving New York City's primary care system. Prepared with the Primary Care Improvement Project and many other partners at the New York City Department of Health and Mental Hygiene, this latest report builds on an initial strategic plan that identified five major primary care issues facing the city and recommended a series of actions to address them. Since that seminal report we've focused on one of those issues: the challenges confronting the city's small, independent primary care practices.

Small practices are a critical part of New York City's health care system. Representing over 40 percent of the city's primary care workforce, they provide accessible, culturally competent care to residents of the City's poorest and most diverse communities. Small practices are not, however, well positioned to adapt to changes under way in the health system—notably the adoption of the medical home model and participation in value-based payment (VBP) systems. These are innovations that require scale and capacities beyond the reach of many small practices.

The report that follows answers important questions about what skills small practices need in order to succeed in the new environment, and how small practices might work together to share the services necessary to develop those skills. It also breaks new ground by presenting a financial model for the cost of shared services and probing the legal and regulatory issues raised by such arrangements.

Strengthening primary care is essential for improving the health of our communities and preventing premature deaths. Health equity cannot be achieved by a single individual, organization, or institution: we do our best work together. As you read this report, please consider the importance of small practices to health care delivery and population health in New York City, and how you and your organization can support collaborations that help these practices effectively adapt to this quickly changing environment.

Sincerely,

Anthony Shih, MD, MPH
President
United Hospital Fund

NYC Health

June 2018

Dear Partner,

All people deserve access to high quality and affordable healthcare. We New Yorkers are lucky to live in a city with as many opportunities as it has, including both world-class institutions and community-based providers with deep knowledge and connection to their neighborhoods.

In many of our city's neighborhoods, the primary source of healthcare is independent primary care practices. As the health care environment changes, and as the financial pressures for those providers increase, their ongoing ability to meet the needs of their communities is at risk. I am excited to share with you the attached report, developed by the United Hospital Fund (UHF) in partnership with the New York City Health Department as part of the New York City Population Health Improvement Program (PHIP), which outlines one potential solution to this challenge: shared services arrangements that would enable small primary care practices to successfully adjust to the new reality of value-based payment.

This report was developed with input from local health care stakeholders as well as experts who have developed successful shared-services arrangements in other regions of the state. It outlines a financial and operational model for small practices to share the cost of services and capacities that they need in order to thrive in the new realities of healthcare delivery and financing. We hope it will be a valuable tool for healthcare providers, payers, and other stakeholder organizations seeking to develop and host such arrangements. Supporting small practices in making this transition will be essential for maintaining and improving access to high quality health care for all people in New York City.

Health equity cannot be achieved by a single individual, organization, or institution: we do our best work together. As you browse the attached report, please consider what you and potential collaborators can do to strengthen our primary care system and help improve health outcomes for all New Yorkers.

As always, thank you for your partnership as we work toward a healthier New York City.

Sincerely,

Oxiris Barbot, MD
First Deputy Commissioner
NYC Department of Health and Mental Hygiene
Chair, NYC Population Health Improvement
Program Steering Committee

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# Executive Summary

Primary care practices in New York are under increasing pressure from payers and regulators to move toward a medical home model and to participate in value-based payment (VBP) contracts. The changes required—new staff, skills, and capacities—increase operating costs in a way that is particularly onerous for small primary care practices. These practices are critical points of access for residents of some of New York City's poorest neighborhoods, offering accessible, culturally competent care to the city's diverse population.

The New York City Population Health Improvement Program (NYC PHIP) has been working with small practices across New York City and with a group of expert advisors to define and test the viability of a shared-services model—an approach for small practices to share those needed services and their costs.

The study verified that there was a potential demand for such arrangements, and that at least some organizations were willing and able to serve as "host" organizations providing shared and contracted services to small independent primary care practices. Practices participating in the study identified about 20 capacities as high-priority and potentially shareable with other practices.

An analysis of the legal, regulatory, and economic issues suggested that shared-services arrangements are not likely to raise legal or regulatory concerns. VBP arrangements bring up specific legal and regulatory concerns, but there are comparatively clear pathways to follow.

The study developed a financial model to estimate the costs involved in sharing services, based on a set of services that practices feel they need, and which a host organization might provide. The model estimates the staffing patterns and unit costs based on the staffing and costs of a number of such arrangements currently in operation across New York State; and it applies those estimates to a cohort of 20 small practices. This model distinguishes between those capabilities necessary to achieve medical home status, and those required to participate in VBP arrangements.

This report is intended to serve as a framework for practices considering joining a shared-services organization, and for larger "host" organizations considering initiating such an effort. It includes a distilled checklist of shared services that a host organization might develop to address high-priority needs, which can be tailored to the existing capabilities of participating practices.

When using this model, small practices and their potential shared-services hosts will need to assess their actual competencies in the key areas and identify gaps in capacity. They can then decide on which services to include in the shared-services bundle, and on the staffing patterns that are best for their situation.

Shared-service arrangements of the type described in this report have the potential to add substantial value to small practices, improving their ability to manage the health of the populations they serve. They also add costs. Ultimately, the feasibility of shared-service efforts will rely on changes in the way primary care is paid for, using methods that recognize the value of shared-service arrangements, and support the initial investments and ongoing costs involved.

# Introduction

As health care reform progresses, primary care practices are facing two major challenges: they are being encouraged—by New York State and by payers—to implement a medical home[1] model; and they need to adapt to new payment models, using the principles and techniques of value-based payment (VBP).

The medical home model has been shown[2] to be effective in improving the quality of care and reducing the costs of care, particularly for patients with multiple chronic diseases, by reducing avoidable hospitalizations and emergency department visits, among other improvements. It requires a practice to improve patient access and care continuity, provide comprehensive and coordinated care, including care management for high-risk patients, improve quality and patient engagement, and focus on planned care and actions to improve population health. The most prevalent of the medical home models is the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH).

At the same time, state and federal policymakers and health care payers have been testing new VBP arrangements[3] that reward providers for health, quality and cost outcomes. Instead of simple fee-for-service payment, these new arrangements pay providers using performance incentives, shared savings, bundled payments, and risk-sharing arrangements. VBP contracts give providers financial incentives to improve performance on specific quality measures, and to reduce utilization and cost for insurance plan members covered by a VBP contract (aka attributed patients).

These two forces—the need to expand primary care capacities to provide care as a medical home, and the drive toward VBP—are a challenge for all primary care providers. The magnitude of the challenge, however, is quite different for primary care practices of different sizes and organizational relationships.

Large integrated health systems (e.g., hospitals) and group practices have the advantage of resources and scale. Leveraging these resources, larger providers have become early adopters of the medical home model and are actively participating in new payment arrangements. However, small independent practices (those with four or fewer providers) have limited resources. Few have received formal recognition as medical homes, and even fewer are participating in VBP arrangements.

## Small Practices

Small primary care practices are an important part of New York City's health care delivery system. In the City (and the state as a whole), small practices represent 40 percent of primary care providers, but make up a disproportionately smaller share of those achieving medical home recognition.[4] [5] Small practices serve the residents of some of the City's poorest neighborhoods, and

[1] The term "medical home" is used in this paper to refer to any of the prevailing models of a transformed primary care practice, including the National Committee for Quality Assurance's Patient-Centered Medical Home (PCMH), New York State's Advanced Primary Care (APC) and recently-adopted model (developed in partnership with NCQA),the "New York State PCMH", and two models sponsored by the Centers for Medicare and Medicaid Services (CMS), Transforming Clinical Practice Initiative (TCPI), and Comprehensive Primary Care+ (CPC+).
[2] Yalda Jabbarpour, MD, Emilia DeMarchis, MD, Andrew Bazemore, MD, MPH, Paul Grundy, MD, MPH, The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization: A Systematic Review of Research Published in 2016, Patient-Centered Primary Care Collaborative, July 2017. https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_08-1-17%20FINAL.pdf
[3] A value-based payment arrangement is a contract between a health plan and a specific set of providers, under which the providers accept responsibility for managing the quality and costs of health care for a defined cohort of their patients who are covered by that payer, and attributed to their physicians. The two most common approaches to VBP are *shared savings* (in which providers share in any savings they can generate, against an expenditure benchmark) and *shared risk* (in which they also are at risk for expenditures above the benchmark).
[4] Special analysis conducted by NYSDOH Office of Quality and Patient Safety (OQPS), October 2016.
[5] Patient-Centered Medical Homes in New York, 2017 Update, http://uhfnyc.org/publications/881250

offer accessible, culturally competent care to diverse populations. These practices are at risk in an environment quickly shifting to the medical home model and VBP arrangements.

Achieving recognition as a medical home is a challenge for many practices. It may require substantial changes to a primary care practice's traditional visit-based model for delivering care, and it requires new skills and often new staff. With their more limited resources, small practices have difficulty putting in place the capacities needed to serve as medical homes. Incorporating and paying for new staff, training existing staff, and expanding patient service capacities all increase operating costs. These added costs can threaten small practices' financial viability. Though the evidence suggests medical home models can improve quality and reduce the cost of health care, few payers have provided meaningful or consistent payment to support its adoption.

Small practices are also at a disadvantage in VBP contracting. Payers will generally only accept a practice into a VBP arrangement if it serves enough of the health plan's members to generate results (on cost and quality metrics) that the payer considers statistically valid.[6] VBP contracts also require the capacity to regularly report to payers on quality measures, and respond to planprovided information on health care utilization and cost. Putting these new skills and capacities in place requires a series of cumulative, sequential, and stepped investments.

- First, practices need to invest in health information technologies, such as an electronic medical record (EMR) that can help practices track and assess a patient population and proactively recall patients for follow-up or assessment. EMRs also allow practices to participate in regional/statewide health information exchanges, so they can receive alerts regarding patients' ED visits, or hospital admissions, discharges, or transfers.
- Next, practices undergo "transformation" into a medical home, which entails major workflow changes including how appointments are scheduled, systematizing patient management and follow-up, and connecting patients to appropriate community supports. This step requires training existing staff to take on new roles, learning to work as a care team, and may also require investments in new personnel. Practice transformation also affects practice operations and cash-flow. Ideally, this step results in the practice receiving recognition as a medical home.
- VBP contracting requires a third set of investments. Under VBP, practices need to augment data and analytic capacity to use and report from EMR and insurance claim systems, and to negotiate and manage the VBP contracting process. These capacities often entail new staff or contracts with outside experts, additional costs for small practices participating in VBP contracts.

At each step, a practice increases its capacity to provide high-quality care to patients. To accomplish this evolution, small practices require access to investment capital, the ability to absorb increased operating costs, and to withstand the disruption to practice operations and cash flow.

[6] See Appendix 6 for sample interview summaries, drawn from the the interim report of this project.

## Role of Shared Services

One possible response to the small practice dilemma involves the development of shared services across several practices, enabling practices to share the cost of needed capacities and staff. This concept has been noted in the literature[7] as a potentially promising approach, but it has not been fully developed or quantified.

The NYC PHIP sought to test the appeal and feasibility of a shared-service model, working with providers in small practices across New York City and consulting with a group of expert advisors.[8]

- The first phase of this project explored the idea of shared services with providers working in small practices, identifying the services and capacities they felt they needed in this changing environment but could not afford on their own. In a parallel set of interviews, organizations providing shared services ("hosts") were asked to describe the types of services provided to affiliated practices, and the issues encountered in doing so.
- The second phase engaged a legal expert to review the legal and regulatory issues around shared-service and VBP arrangements, and a financial consultant to help create a model for estimating the costs of shared services from both the host and practice perspective.

The remainder of this report describes the type of services small practices need, potential organizational structures for establishing shared services, and the costs of acquiring/providing those services.

[7] Abrams L Schor, and S Schoenbaum. June 2010. How Physician Practices Could Share Personnel and Resources to Support Medical Homes, *Health Affairs* 29:6.
[8] See Appendix 3 for a listing of advisors.

# PHIP Shared-Services Initiative

## What Do Small Practices Need?

In the summer and fall of 2016, the NYC PHIP partnered with the three primary care specialty societies (the American College of Physicians, American Academy of Pediatrics, and the American Academy of Family Physicians) and the Medical Society of the State of New York to conduct a survey and five listening sessions (one in each borough).[9] These efforts probed small practices' needs and potential interest in the shared-services model. Major findings included:

- There are specific skills and capacities that small practices felt they needed, in order to operate as medical homes and participate in VBP contracts, but could not afford on their own.
- The practices would be willing to consider sharing services with other small practices, if the services were affordable and were provided by a trusted organization with a track record of competence.

Participating practices identified about 20 capacities as high-priority and potentially shareable with other practices. They fell into five broad areas, as shown in Figure 1.

**Figure 1. High-Priority and Potentially Shareable Services**

| |
|---|
| **I. Health Information Technologies** |
| Electronic Medical Record acquisition and optimization/use |
| Electronic Medical Record maintenance and technical assistance |
| Registry setup and management (see care management) |
| Regional Health Information Organization (RHIO) connection/use |
| **II. Business/Administrative Services** |
| Group purchasing of business supplies or other services |
| Consultation/assistance in pursuing revenue opportunities |
| Workforce development/staff training/practice management support |
| **III. Data Analytics and VBP Support** |
| Clinical and claims data analytics (to guide QI actions, and for reporting) |
| Data aggregation to ensure adequate patient population for VBP |
| Document/report quality, utilization measures/outcomes |
| Negotiation of VBP contracts with payers |
| **IV. Quality Improvement Staff and Services** |
| Shared staff to support quality improvement |
| Shared QI, learning collaboratives, sharing best practices |
| Aggregating quality measures, outcomes across participating practices |
| **V. Shared Professional Staff Who Interact with Patients** |
| Nutritionists/diabetes educators |
| Behavioral health professionals |
| Care coordination |
| Care management |
| Patient engagement and outreach |

[9] The *PHIP Small Primary Care Practice Project Interim Qualitative Report* is available at https://uhfnyc.org/publications/881276

## Shared Services: Examples and Models

Large group practices have the scale required to organize and deliver many of these services to their members. Groups manage physician compensation arrangements and set group-wide quality improvement and performance goals and expectations, all under a governance structure managed by the physicians themselves. Similarly, primary care physicians employed by hospitals and systems often receive shared services through their organization's core infrastructure, or through a separate management services organization (MSO).

In both group practices and hospital employment arrangements, the operating costs of the new services are often borne by the group or system, offset by a share of the income generated by the participating physicians. The challenge facing small independent practices is how best to acquire these capabilities while retaining independence and control over their own operations. Niche providers offer some specific services—e.g., health information technology (HIT) consulting or practice management—but few organizations offer the full range of services.

In theory, a group of small independent primary care practices could work together to create and fund a new organization to provide these services in-house. However, the required management infrastructure (e.g., finance, human resources, health information technology), start-up costs, and ongoing expenses of a new, freestanding organization can be prohibitive. A more viable way to acquire those services would be to contract or partner with an existing organization—an independent practice association (IPA), a large medical group, a hospital, or a health system—that could act as a "host" for a range of shared services.

To better understand the prevalence and scope of such shared-service arrangements in New York, we interviewed 15 organizations currently offering shared services to their affiliated primary care practices.[10] We noted four basic organizational models for providing shared services to small practices:

- Some hospitals, health systems, accountable care organizations (ACOs), and Performing Provider Systems (PPSs, created under the Medicaid Delivery System Reform Incentive Payment program, or DSRIP) have expressed interest in developing services to support their affiliated small practices.
- Many small primary care practices belong to IPAs that provide a vehicle for contracting with health plans. Some of those IPAs already have or are developing the capacity to offer additional services to their members.
- A few health plans are partnering with group practices or IPAs to create management services organizations (MSOs) that can offer a range of services to small practices.
- A few entrepreneurs are partnering with small practices, providing them with a range of needed services to help them participate in ACOs and in other VBP contracts with payers.

The shared-services providers we interviewed generally offered similar core services – quality improvement, care management, data analytics and behavioral health support – to their affiliated small practices.[11] Many also offered other shared professional staff, including diabetes educators. Understanding these current examples provided a strong foundation upon which the second phase of the small practice project was built.

[10] See Appendix 4 for a listing of the organizations interviewed as part of this project.

[11] The *PHIP Small Primary Care Practice Project Interim Qualitative Report* is available at https://uhfnyc.org/publications/881276

# Legal and Regulatory Issues of a Shared-Services Program

The NYC PHIP engaged a legal and regulatory expert (David Oakley from Manatt, Phelps and Philips) to analyze existing laws and regulations applicable to providers and hosts potentially interested in shared services. Current host organizations interviewed mainly engage in two broad categories of activity: sharing services and facilitating value-based payments. Those categories are defined as follows:

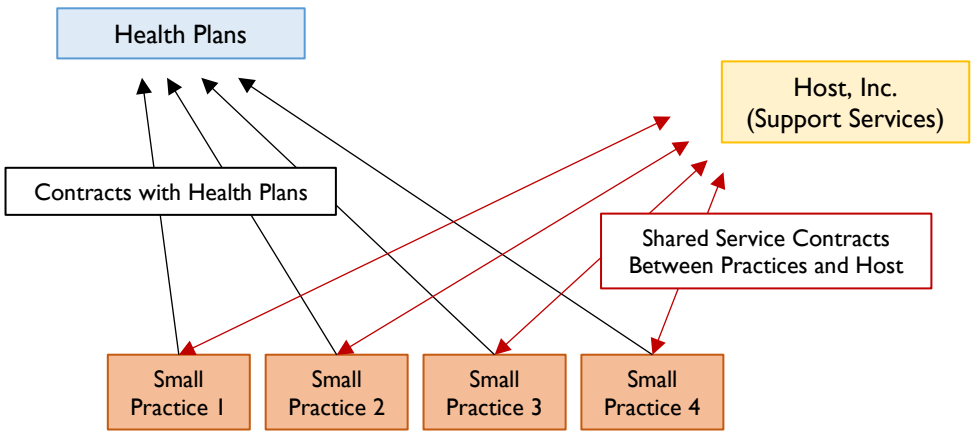
- Shared-services arrangement: a business relationship between a group of practices and a host the practices engage for organization and delivery of specific services.
- VBP arrangement: a contractual relationship between a group of practices and a payer, covering a cohort of that payer's members, who are cared for in those practices.

Shared services are governed under a well-established and well-understood legal structure that are relatively easy for a host organization to navigate. The role of host organizations in VBP arrangements, however, raises a series of questions depending on how providers are contracting with a payer.

## Establishing Shared-Services Arrangements

If a host organization provides shared services to a cohort of small practices, it is effectively acting in the role of a management services organization (MSO), an organization that provides services to another organization under contract. To receive shared services from the host, each practice in the cohort would sign an independent contract with the host governing the terms under which agreed upon services would be provided, as illustrated in Figure 2. This organizational design is already common and well-established in the health care field, and it raises no significant or unusual legal or regulatory issues.

**Figure 2. Potential Organizational Model for Shared Services**



## Establishing Value-Based Payment Arrangements

Practices participating in shared-services arrangements may also want their host organization to facilitate and manage VBP contracting. While assistance with VBP contracting is not necessarily required as part of a core shared-services bundle, and a shared-services host may not have experience or expertise in this area, having the shared-service host help organize the practices' VBP contracting could be a logical additional role for the host.

To fully support the negotiation and management of VBP contracts, a host would need to have the capability to aggregate the patient panels of participating practices to negotiate VBP contracts as a group, and would need to be granted the authority to do so by the practices. The host would also need the technical capability to perform sophisticated data analytics using clinical and claims data and to combine and report practice-specific quality and utilization data. A host would also need the financial expertise and contractual authority to receive and distribute incentive payments to individual practices based on the aggregate performance of their group.

In New York State, contracts between providers and payers are governed by laws and regulations specifying that only two types of organizations—both licensed by New York State—can enter into VBP contracts with payers: clinical providers themselves, or their authorized intermediaries (such as hospitals, health systems, organized group practices, IPAs, and ACOs).

Practices seeking to participate in a VBP arrangement facilitated by a host can select from two main models—intermediation by an Independent Practice Association (IPA), or direct practice-to-payer contracting.

## Independent Practice Associations

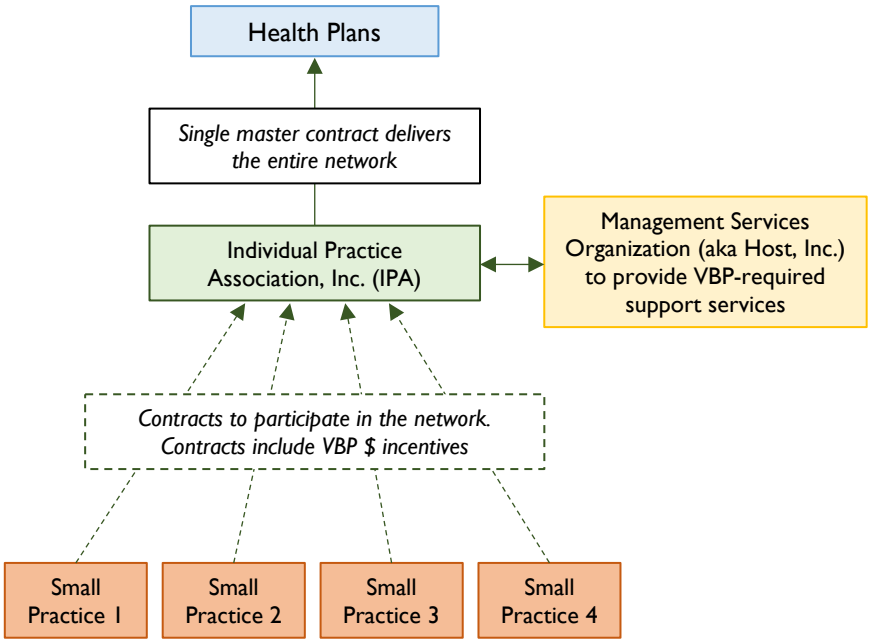
Most provider groups use an IPA structure to contract with payers, with the IPA serving as an intermediary entity between the health plan and the physicians, as illustrated in Figure 3.

IPAs are legal entities through which independent physician practices (and possibly other providers) act collectively as though they were an actual, integrated group. There are extensive variations across IPAs and their service offerings: some IPAs are just a vehicle for negotiating fee-for-service payment rates, while others supply extensive services and facilitate significant interactions and cooperation among the various practices.

Where an IPA provides VBP contracting services for its members, the IPA will commonly provide shared services to the providers participating in these contracts as a part of that relationship, often through an affiliated MSO. Should a cohort of practices working with a shared-services host decide to enter into a VBP arrangement by means of an IPA, the host organization could fill that MSO role under contract with the providers' IPA.

In pursuing the IPA approach, small practices have two basic options: (1) they can work together with a host to establish their own IPA or (2) they can work with an existing IPA, medical group, hospital, or health system that has VBP contracts, potentially organizing themselves as a subset of providers with their own separate contracts.[12] This approach is depicted in Figure 3.

**Figure 3. IPA Role in VBP Contracting**




## Direct Practice-to-Payer Contracting

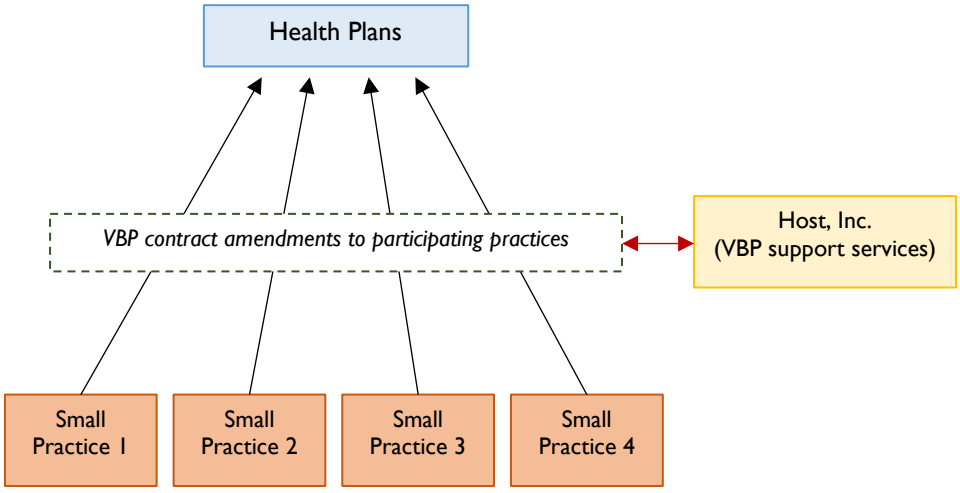
However, practices are not required to use an IPA structure to arrange VBP contracts. Some health plans prefer to contract directly with the participating physicians, with no intermediary entity involved.

Should a cohort of practices wish to enter into a VBP arrangement with a payer without the use of an IPA intermediary, they could do so by entering into parallel VBP contract amendments that would be added to their existing health plan participation agreements, which effectively convert the agreements from a fee-for-service to a VBP structure. Such contract amendments would describe the terms of a VBP arrangement (e.g., shared savings or shared risk), the attribution methods, how cost and quality benchmarks are established, whether the contract measures and rewards the performance of individual practice, or the virtual group, etc.

[12] Most IPAs serve comparatively large numbers of providers, ranging from a few hundred to thousands, including both primary care and specialty physicians. Not all IPAs may be willing or able to craft separate shared-services and VBP arrangements for a subset of their members, such as discrete groups of small primary care practices.

Where the practices elect to enter into direct (and parallel) contracts with payers, the shared-services host can provide the participating practices (the virtual group) with core shared services, as well as augmented capacities required to support VBP contracting, without being a party to the practices' agreements with their payers. Such an arrangement is depicted in Figure 4.

**Figure 4. Parallel VBP Contract Amendments**



# Modeling the Economics of a Shared-Services Program

To model the economics of a shared-services program, the NYC PHIP engaged financial consultants (Peter Epp and Aparna Mekala from the accounting firm CohnReznick). The consultants helped design a financial model under which an existing organization could host a shared-services program providing the set of services that small practices need. Their methodology involved three sequential steps:

**Key services matrix**: A complete set of services to be included in a shared-services offering, responding to the needs articulated by small practices.

**Cost drivers**: A set of assumptions for estimating the required staffing levels and costs of providing the key services to a cohort of small practices.

**Cost estimation**: A financial model estimating the initial and ongoing costs of such a program, from two perspectives: (1) the overall startup and ongoing costs, from the perspective of the host; and (2) the costs of that full range of services, from the perspective of the participating practice, stated as a per-member, per-month (PMPM) expense.

## Key Services

In early 2017, four shared-services host organizations (all of which were already involved in accountable care or VBP arrangements)[13] were re-interviewed to obtain a better understanding of the types of services provided, how these services were delivered (e.g., directly by the host or through a contract with an outside organization), and the types of practices hosts were working with.

In most cases, the services provided by these host organizations aligned well with the needs identified by the small practices (see Figure 1, on page 5). These host organizations provided most of the services directly, but in some cases (notably health information services, practice management consulting, and data analytics), those services were acquired and delivered through a contract with an outside organization with specific expertise.

## Cost Drivers

To generate the assumptions required to create a financial model, it was vital to understand the detailed staffing levels and other costs associated with the key services. Three of the host organizations whose shared-services programs focused primarily on supporting small primary care practices (Acuitas, Aledade and the Northern Adirondacks Pod), provided detailed information on their staffing ratios (e.g., number of care managers per provider), salaries, and other costs.

This information was used to generate a set of assumptions about personnel costs and additional costs related to start-up investments and use of contracted services. In August 2017, an expert advisory group reviewed the cost assumptions in an initial presentation of the financial model and suggested a number of refinements and adjustments to better reflect New York City's salary levels and incorporate more realistic estimates of the costs of program management, host overhead, certain HIT-related services, and claims data analytics vendor contracts. The resulting staffing and additional cost assumptions used for the financial model are presented in Figure 5.

[13] The following profiles summarize interviews with four organizations providing shared services, covering the four organizational sponsorship types identified during Phase 1: a hospital system (Champlain Valley Physicians Hospital, which hosts the Northern Adirondack Pod); an IPA (Greater Rochester IPA); a payer-sponsored program (CDPHP's Acuitas program, organized as a joint venture with CapitalCare Physicians Group); and an entrepreneur (Aledade). Profiles of these organizations' shared-services programs are presented in Appendix 6.

## Figure 5. Cost Assumptions Used in Financial Modeling

| Shared Services | Description, Staffing Ratios | Estimated Cost / Salary (Annual cost or FTE salary unless otherwise noted) |
|---|---|---|
| ***I. EMR and RHIO Assumptions*** | | |
| EMR tune-up, registries, care gaps, etc. | Contracts with EMR vendor: One-time cost (per practice) | $20,000 per practice |
| RHIO connections | Connect to RHIO: One-time cost paid to EMR vendor (per practice) | $5,500 per practice |
| Ongoing RHIO subscription | EHR RHIO module (per physician) | $300 per physician |
| ***II. VBP Claims Data Analytics Contractor*** | | |
| One-time start-up (per payer contract, Year 2) | 3 | $50,000 per contract |
| Ongoing cost | $1.50 per VBP member/month | $18 per VBP member/month |
| ***III. Practice Management Ongoing Support*** | | |
| Practice management consultant salary | 1:10 practices | $75,000 |
| ***IV. Medical Home and VBP Data Analytics Staff*** | | |
| Data analyst (MBA) | 1:20 practices | $100,000 |
| Clinical analyst | 1:20 providers | $100,000 |
| ***V. Quality Improvement Staff*** | | |
| Staff working with practices on QI | 1:20 providers | $100,000 |
| ***VI. Shared Professional Staff*** | | |
| Care manager | 1:4 providers | $90,000 |
| Behavioral health—LMSW / LCSW | 1:10 providers | $90,000 |
| Pharmacy—RPh / PharmD | 1:20 practices | $150,000 |
| Health Education—CDE | 1:10 practices | $50,000 |
| ***VII. Overhead / Central Services*** | | |
| Finance | * | $1,500 |
| Legal | * | $1,500 |
| Human resources | * | $1,000 |
| HIT | * | $3,000 |
| Office space | * | $10,545 |
| VBP contract management | Negotiate, manage, and report for VBP contracts | $200,000 |
| ***VIII. Management Staff*** | | |
| Director | 1:6 Account managers | $150,000 |
| Manager / Account managers | 1:5 Practices | $100,000 |
| ***XI. Start-Up Costs—Planning and Project Management*** | | |
| Project Manager | 1 | $100,000 |
| Analyst | 1:20 practices | $70,000 |
| Coordinator | 1:20 practices | $50,000 |

*Costs estimated are per FTE, based on other NYC nonprofits.

A final step in developing assumptions for the financial model was the specification of a "client" for the shared services, a group of small practices to be served. For this exercise, a shared-services host would serve a small practice cohort of 20 practices with the broad characteristics depicted below.

| | |
|---|---|
| Number of practices | 20 |
| Average number of providers per practice[14] | 2.0 |
| Total providers | 40 |
| Patient panel per provider | 1,500 |
| Total patient population | 60,000 |

| | | |
|---|---|---|
| EMRs | All practices have EMRs, but not being optimally used | |
| Practice transformation technical assistance | Grant-funded[15] | |
| **Payer/Line of Business** | **% of patients** | **# of patients** |
| Medicare | 25% | 15,000 |
| Medicaid | 25% | 15,000 |
| Commercial | 50% | 30,500 |
| Case mix | Average | |

The sizing of the cohort of practices was based in part on the need for enough patients to participate in VBP contracting. The basic assumption was that participating practices would need to serve an aggregate panel (60,000 patients) large enough negotiate VBP contracts with a number of different payers—i.e. that the participating practices would serve enough of a given payer's members to generate statistically reliable results on cost and quality. A cohort with a smaller aggregate panel might be too small into enter into contracts with some of its major payers.

## Cost Estimation

Using the assumptions noted above, the financial model distributes costs across three distinct phases to reflect a reasonable timeframe for start-up, capacity development, VBP contracting and ongoing administration.

In Year 0, the host and participating practices would develop and execute a project plan for implementing the shared-services program, and would make a series of one-time, start-up investments to prepare for practice transformation, including: upgrading health information technology; creating usable registries to identify, stratify, and track patients; developing systems to identify and close gaps in recommended care, and to support referral management and care transitions; and connecting practices to Regional Health Information Organizations (RHIOs) and State Health Information Network of New York (SHIN-NY).

[14] The average size of small (1-4 providers) primary care practices in NYC is 1.7 physicians/practice.
Source: NYSDOH analysis—Special Study of Small Practices in NYS, August 2016.

[15] Grant-funded practice transformation technical assistance is available under three statewide initiatives: SIM/APC, DSRIP/PCMH, and TCPI.

In Year 1, the participating practices would need to put core medical home capacities in place. The host would help practices acquire (generally grant-funded) practice transformation consulting, and provide staff to support the practices as they implement the new capabilities needed to perform as a medical home. While complete practice transformation to the medical home model is difficult to achieve in a year, the model assumes that by Year 2 participating practices would have achieved sufficient competence in population health management to position them to enter into VBP contracts.

In Year 2, the shared-service host organization would need to take on two additional responsibilities related to VBP contracting:

- The host organization would need to negotiate VBP contracts with payers, and help participating practices manage services under those contracts. To do so, the host would likely need to generate regular performance reports for practices; provide quality and utilization reports to payers; and—if shared savings are generated—distribute those savings to the participating providers.
- The host would need to analyze information derived from claims data, which is generally provided by payers to small practices and their individual physicians as part of a VBP contract. If the host lacks the in-house capability to do so, it could contract with an outside data analytics vendor to provide this service. Such arrangements often entail two costs: a one-time investment to set up the data analytics system to accommodate each payer's VBP contract, and an ongoing PMPM charge by the vendor to cover the costs of running analyses and reports.

The model assumes that starting in Year 2, the practices would enter into VBP contracts with three of their largest payers, together covering roughly 20,000 patients (i.e., one-third of their overall patient panel). This is intended as a rough but realistic starting point for small practices as they begin to shift from fee-for-service to VBP payment systems.

Figure 6 presents a summary of the host organization costs for the first three years of creating and operating a shared-services program for a model cohort of 20 small practices. Detailed costs inclusive of assumptions are also presented in Appendix 1.

**Figure 6. Shared-Services Program Costs, Host Organization Perspective**

| Cost Category | Start-Up (Year 0) | Year 1 | Year 2 |
|---|---|---|---|
| I) Health Information Technologies | $510,000 | $12,000 | $12,000 |
| II) Practice Management Support | | $150,000 | $150,000 |
| III) Data Analytics | | | |
| Dedicated Host Staff | | $100,000 | $300,000 |
| Contracted Service - VBP | | | $528,000 |
| IV) Quality Improvement Staff | | $200,000 | $200,000 |
| V) Shared Professional Staff* | | $1,510,000 | $1,510,000 |
| VI) Host Expense / Overhead | | | |
| Program Management Staff | $220,000 | $550,000 | $550,000 |
| Administrative Overhead | | $508,818 | $508,818 |
| VBP Contract Manager | | | $200,000 |
| Benefits (30% of salary total) | $66,000 | $753,000 | $813,000 |
| Total Operating Cost / Year | $796,000 | $3,783,818 | $4,771,818 |

* Shared Professional Staff: 10 Care Managers, 4 Behavioral Health , 1 PharmD, 2 Health Educators

The financial impact of a shared-services program from the perspective of a practice is reflected in Figure 7, stated in costs per practice, per year, and costs per member, or active patient on their panel, per year.

**Figure 7. Shared-Services Program Costs, Small Practice Perspective**

| | Year 1 | Year 2 (including VBP) |
|---|---|---|
| Per Practice (2 PCPs), Per Year | $189,191 | $238,591 |
| Per-Member, Per-Month | $5.26 | $6.63 |

## What Will It Really Cost? "It Depends…"

This report presents a rough financial model depicting the costs of the services that small practices had identified in our surveys and focus groups as their highest needs, estimating those costs at three levels: per-enterprise, per-practice, and per-member, per-month. This model, however, is a starting point rather than an endpoint. The model assumes a "maximum cost" scenario—in other words, the cohort would start from essentially zero capability in each of the five service areas, and need to develop or acquire every single key service. As applied to a real cohort, many of these costs would be lower, or would be zero, as a cohort of small practices would not need to acquire every service listed.

To be useful, this model must be tailored to reflect local circumstances and the practices' current capacities and priorities. The actual cost of a shared-services program serving a specific cohort of practices will depend on several factors, including the composition and nature of the practice cohort, the case mix and disease burden of the patient populations they serve, and the motivation and capacity of the shared-services host. Each of these three issues requires consideration.

**Baseline Capabilities of the Practices.** The model currently assumes that participating practices have a limited baseline of staffing capacity and capability, and that the practices, as a group, would need and avail themselves of the full range of shared services. As many practices have already adopted health information systems and connected to regional health information organizations, those services may not require a lot of support. However, access to some services and staff may be nonexistent. Depending on the capabilities of the involved practices, the cost of shared services and support may be substantially different, often less than projected in the model.

**Nature of the Population Being Served.** The number of high-risk or high-healthcare-need patients will contribute to the cost of shared services. The model assumes participating practices serve a population with an "average" burden of disease and case mix. However, certain services are likely to be particularly sensitive to severity and number of patients. Practices serving an older or sicker population—or a population with more social factors (e.g., housing or food insecurity) affecting their health—are likely to require more support than those serving younger, healthier populations. Providing medical home-related services to such a population may also yield a greater return on investment, in the way of reduced costs.

**Host Administrative Costs.** The assumptions may also overstate the administrative and overhead costs that a host will incur in organizing and managing a shared-service program, and the extent to which these costs will be passed along to the participating practices.

Our basic assumption was that the shared service would be provided by an existing organization, capable of providing the new shared-services "on the margin", so the venture would not need to bear the full costs of supporting a new, freestanding organization. In this model, the host organization employs the

shared staff, sets up contracts with vendors for services on behalf of the participating practices, and bears some costs for program administration and overhead (e.g., for office space and human resources).

Host organizations will incur real overhead and administrative costs in developing and managing a shared-services program. The model's original estimates of those costs were based on the experience of two programs (the Adirondacks Pod and Acuitas) already providing such services—but those two organizations' overhead costs might not be representative. Both organizations had other reasons for investing in the success of their small practice constituents, and were therefore prepared to offer their host services at a discount.

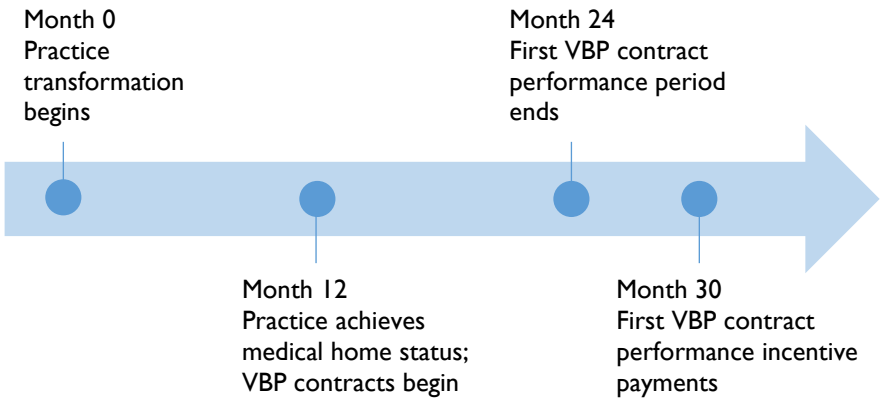
To make our overhead cost estimates more generalizable, we adjusted the overhead costs using benchmarks from other organizations in New York City. Depending on the nature of the host and its interest in assuring the survival and success of the involved practices, the host may choose to offer those services at a lower cost.

Finally, we assumed that the host would likely have some experience in negotiating and managing payer contracts, and therefore would be able to work effectively with practices and payers on VBP contracts as well. We assumed that the host would require additional staff to manage the practices' new VBP contracts, and that the practices would need to compensate the host for that additional service in Year 2. If practices partner with a host organization that already has sufficient experience and staff, the VBP contracting staff costs included in the Year 2 operating costs may be lower than projected.

### Timing and Cash Flow

VBP arrangements can offer primary care practices an opportunity to generate additional revenue to help offset the cost of building the capacities necessary to enter into those arrangements. If practices improve their patient panels' health outcomes and reduce potentially preventable utilization and costs, they can share in the resulting savings. However, there is a substantial lag time from when the practice sets up these new capacities until the time when the practice's payers will calculate and pay shared savings out to the practice (Figure 8).

**Figure 8. Timeline for Practice Transformation and VBP**




Under shared savings and shared risk VBP arrangements, provider incentive payments are generally calculated after the end of a "performance year", and then an additional a six-month period is needed for late claims to be adjudicated. This lag time means that a primary care practice participating in a shared-services arrangement would need to absorb substantial costs over a period of 30 months: one year to

achieve medical home competence, another year beginning to perform under a VBP contract, plus an additional 6 months before receiving a VBP contract incentive payment.

For the example two-physician practice serving 3,000 patients, the cost of a comprehensive shared-services program would total more than $500,000 over a period of 30 months from the time of first investment before the practice might be able to receive any incentive payments from any VBP contracts ($190,000 for Year 1, $240,000 for Year 2, plus $120,000 for 6 months of Year 3).

To make a venture of this sort more financially feasible, the involved small practices will likely need to consider phasing shared services in incrementally, and/or pursuing other sources of income.

### Consideration #1: Tailor and Phase-In Services

As noted above, not all practices are likely to need all of the services included in the model. Practices and hosts interested in pursuing a VBP arrangement will need to review the participating practices' current competencies in the areas included in the shared-services model, tailoring them to the practices' specific needs.

Practices and their host organization may also decide to begin with a smaller, more affordable mix of services or staffing levels that address their highest near-term priorities, and then add other services over time. Interviews with organizations currently providing services to small practices suggested that a reasonable starter set might include EMR tune-ups, quality improvement services, care management, patient education, and data analytics support—all providing practices with substantial value in the near-term as they pursue recognition as medical homes and move into VBP contracting.

### Consideration #2: Pursue New, Offsetting Income

In addition to traditional fee-for-service revenue, the additional capacities acquired may enable the participating practices to access new revenue sources. Many payers offer practices "pay-for-performance" incentive payments for achieving and demonstrating better performance on specific quality indicators.

Medicare now recognizes and pays for new billing codes for annual wellness visits, transitional care management, and care management for patients with multiple chronic and behavioral health conditions. These revenue sources could also soften the financial impact of adding new services.

Perhaps most important, Medicaid and some other payers provide incentive payments to practices that have achieved recognition as a patient-centered medical home or its equivalent. In prior years, Medicaid has offered practices that achieved NCQA recognition as PCMHs an incentive payment of as much as $7.50 PMPM for each Medicaid patient the practice serves. In the cohort of small practices used in the financial model, Medicaid's medical home incentive payment would apply to roughly 15,000 patients, potentially generating over $1.3 million per year. However, New York State Medicaid is currently reconsidering both the criteria for its medical home incentive payments and the applicable amounts, which could substantially reduce its impact as a source of offsetting revenue.

Under its State Innovation Models (SIM) initiative, the New York State Department of Health is striving to broaden the base of payers offering such incentive payments to practices operating as medical homes. Expanded, multi-payer incentive payments for medical homes could provide practices recognized as medical homes with a major source of revenue, which could help offset the added costs of the shared-services program they need, in order to achieve that recognition.

# Evaluating Whether Primary Care Practices and Hosts Are Ready for Shared-Service Arrangements

Small practices and potential host organizations need to ask several questions before entering into a shared-services arrangement.

## The Small Practice Perspective

For providers in small practices, participation in a shared-services program (particularly one that involves VBP) is a new type of venture. It raises a threshold question: whether they are willing to give up some autonomy and independence to partner with other practices and a host organization. If the answer to that question is "Yes," then several additional questions follow:

Services Included:

- What services are really needed, and would a shared-services arrangement provide them?
- What are the costs of these services, and are they affordable?

Practice Partners:

- Will small practices want to share services and VBP contracts with other practices?
- Which other practices would make good partners?
- With whom will the practice be grouped in value-based contracts?

Host Organization:

- Are there host organizations able and willing to offer shared services?
- Who has (or could build) the infrastructure required to provide services of high quality?
- How will the shared services be managed and provided?
- How will the shared services be governed, and how much say will practices have?

## The Host Perspective

Several types of organizations could offer shared services to their affiliated small practices: IPAs, organized group practices, hospitals, health systems, or vendors of MSO services. The threshold question for any organization thinking of assuming a shared-services host role is, "Are these practices central to our core strategy?" If the answer to that question is "Yes", then several additional questions follow:

- Do we currently have the requisite experience and expertise in the key shared services?
- Can our existing competencies scale up?
- Are the start-up costs manageable, and what type of return on investment will be needed?
- Are the cash flow and ongoing operating costs and revenues manageable?
- Should the full cost of overhead be passed on to the shared-services venture, or are there reasons to discount or subsidize it?
- How should the shared-services package be priced?

# The Need for Investment—and Payment System Reform

However appealing the concept of shared services, those purchased services represent new costs to the primary care practices, and to the organizations that host and deploy them—costs that can only be recouped from payers after much complication and a long delay.

The shared-services model requires two different types of financing:

- capitalization of the startup of such ventures, a one-time investment; and
- payment change to support the ongoing operating costs of the shared services they need.

Neither of these is currently in place, in any systematic or broad-based way.

There are some potential sources of investment capital to help cover the start-up costs required to establish a shared-services program, including investment by hospitals and health systems, private sector investments or social impact bonds. One timely and particularly appealing source of investment capital would be to allocate unspent funds from the New York's State Innovation Models (SIM) grant or DSRIP program — both of which stress the importance of a "transformed" primary care system — to help support some shared-service pilot projects in New York City and elsewhere in the state.

However, shared-services programs also require the second form of financing: augmented payments to compensate the involved practices (or host organizations) for their increased operating expenses. Primary care practices will need a source of incremental income to pay for these services and their added costs, and the hosts offering these services need a reliable source of payment to support them. The State, in its role as regulator and as payer, is in the position to help put in place reliable payment systems that recognize these unique needs and pay adequately for them.

Shared services could be part of a solution to the survivability of the small independent primary care practices on whom many of the City's and state's most vulnerable populations and communities rely for their care. Without investment capital and a reliable payment system that recognizes the unique needs of small practices and pays adequately for them, however, such shared-services models are unlikely to succeed.

# Conclusion, and Next Steps

The purpose of this project was to quantify and evaluate an appealing concept: the idea that small practices—which are at a distinct disadvantage in terms of becoming medical homes and participating in VBP—could better position themselves by banding together and partnering with a host organization to share services and the cost of those services.

The financial model presented in this report used a comprehensive approach in calculating the costs of a shared-services arrangement. The model relied on the perspectives of the small practices, themselves, to identify the range of services and competencies required; used estimates of staffing patterns and unit costs based on examples from similar arrangements across the state; and applied those estimates to an assumed practice cohort of 20 small practices, calculating the start-up and incremental costs that would result, from the perspectives of the host organization and the involved practices.

This model provides a framework for practices and potential hosts to use when thinking about initiating such an effort. It may be most useful as a checklist of required competencies for practices and potential hosts to use in developing a plan that is tailored to their baseline capabilities, identified capacity gaps and high-priority needs. They can then decide what services to include in the shared-services bundle, and what staffing patterns are best for their situation.

One immediate next step would be to test the viability of the concept with primary care providers and host organizations across New York City and New York State. Creating and funding a series of pilot projects could test the proposition, that together, small practices and host organizations can develop high-quality and affordable shared services that effectively transform practices and ready them for VBP arrangements. Identifying different regions or different types of practices to demonstrate the value of the proposed model could provide further insights as to the viability of the shared-services idea.

# Appendices

## Appendix 1. Assumptions and Cost Estimates of a Shared Service Program

| Shared Service "Host" Serving 20 Practices, 40 Providers, 60,000 Patients | | | | | | |
|---|---|---|---|---|---|---|
| | | Units/FTEs | Cost/Unit | Start-up (Year-0) | Year-1 | Year-2 |
| I. | **Health Information Technologies** | | | | | |
| | EMR tune-up, registries, etc. | | | $400,000 | | |
| | RHIO connections (1-Time) | | | $110,000 | | |
| | Ongoing RHIO subscription | | | | $12,000 | $12,000 |
| II. | **Data Analytics** | | | | | |
| | Dedicated Staff | | | | | |
| | Data Analyst (MBA) | 1 | $100,000 | | $100,000 | $100,000 |
| | Clinical Analysts | 2 | $100,000 | | | $200,000 |
| | VBP Contracted Services | | | | | |
| | Contract Setup | 3 Contracts | $50,000 | | | $150,000 |
| | Contract Cost/year-2 | 33% of Patients | $150/mm | | | $378,000 |
| III. | **Practice Mgmt Support** | | | | | |
| | Staff consultants | 2 | $75,000 | | $150,000 | $150,000 |
| IV. | **Quality Improvement Staff** | | | | | |
| | | | | | | |
| | Staff Working w Practices on QI | 2 | $100,000 | | $200,000 | $200,000 |
| V. | **Shared Professional Staff** | | | | | |
| | Care Managers | 10 | $90,000 | | $900,000 | $900,000 |
| | Behavioral Health - LMSW/LCSW | 4 | $90,000 | | $360,000 | $360,000 |
| | Pharmacy - RPh / PharmD | 1 | $150,000 | | $150,000 | $150,000 |
| | Health Education – CDEs | 2 | $50,000 | | $100,000 | $100,000 |
| VI. | **Host Central Services** | | | | | |
| | Start Up - Planning and PM | | | | | |
| | Project Manager | 1 | $100,000 | $100,000 | | |
| | Analyst | 1 | $70,000 | $70,000 | | |
| | Coordinator | 1 | $50,000 | $50,000 | | |
| | Operational Management | | | | | |
| | Director | 1 | $150,000 | | $150,000 | $150,000 |
| | Manager / Acct Manager | 4 | $100,000 | | $400,000 | $400,000 |
| | VBP Contract Manager | | | | | $200,000 |
| | Overhead/Support Services | | | | | |
| | Finance | | | | $43,500 | $43,500 |
| | Legal | | | | $43,500 | $43,500 |
| | HR | | | | $29,000 | $29,000 |
| | HIT | | | | $87,000 | $87,000 |
| | Space | | | | $305,818 | $305,818 |
| | Fringe (30% of salary total) | 30% | | $66,000 | $753,000 | $813,000 |
| **Total Operating Cost/Year** | | | | **$796,000** | **$3,783,818** | **$4,771,818** |

## Appendix 2. Description of Shared-Services Personnel and Functions

1. Staff practice management consultants
    a. Provide literature and recommendations to guide risk stratification
    b. Educate on healthcare landscape, value-based payment, etc.
    c. Provide workflow recommendations and best practices
    d. Educate on healthcare programs (e.g. MIPS, Meaningful Use, etc.)
2. Data analysts (MBA)
    a. Manage data warehouse
    b. Create predictive modeling, with guidance from clinical leadership and staff consultants
    c. Create reporting infrastructure for clinical analyst and QI team to use
3. Clinical analysts
    a. Create Gaps-in-Care lists
    b. Create registries and educate staff on protocols relating to registries
    c. Build clinical reports to stratify patients
    d. Create provider dashboards
4. Care Managers — Certified MA
    a. Develop and manage care plans
    b. Manage transitions of care
    c. Maintain regular contact with care management patients to ensure care plan goals and objectives are being met
    d. Hold care conferences with all providers
    e. Link patients to social service, community supports, etc.
5. Behavioral health — LCSW
    a. Provide behavioral health services, including one-on-one and group counseling
    b. Provide collaborative care services, including co-management of patients with Care Manager
    c. Screen and diagnose for behavioral health conditions, refer to resources, psychiatry, outside services and follow
    d. Manage behavioral health registry
6. Pharmacist (PharmD)
    a. Conduct Medication Therapy Management
    b. Perform consultations with patients discharged from the hospital for medication reconciliation
7. Quality improvement staff
    a. Develop and manage Quality Improvement projects
    b. Manage quality data, including chart audits, etc.
    c. Manage delivery of quality dashboards & educate providers and staff about applicable quality measures
    d. Conduct LEAN/operational excellence activities
8. Health educators (CDEs)
    a. Lead self-management education on individual and group basis (e.g. DSMP/ NDPP/ CDSMP)
    b. Coordinate with care manager and other practice staff to provide support to patients with education-related care plan goals
9. Staff already in the practice
    a. Manage referrals
    b. Conduct outreach to provide warm hand offs to care management
    c. Conduct outreach for gaps in care
    d. Manage relationships with community resource

## Appendix 3. NYC PHIP Small Practice Project: Advisors and Participants

| Name | Title | Organization |
|---|---|---|
| Brian Morrissey | President, Practice Support Services, LLC | Acuitas/CDPHP |
| Diego Ponieman, MD | Chief Medical Officer | Advocate Community Partners |
| Lidia Virgil | Executive Vice President, Healthcare Innovation | Advocate Community Partners |
| Mary Ellen Connington | Chief Operations Officer | Advocate Community Providers |
| Kimberly Lynch | SVP, Adoption & Practice Success | Aledade, Inc. |
| Elie Ward | Executive Director, New York State Chapter | American Academy of Pediatrics |
| Linda A. Lambert | Executive Director | American College of Physicians, NY Chapter |
| Lisa H. Noel | Manager, Practice Support Services | American College of Physicians, NY Chapter |
| Jonathan Goldstein | Executive Director | Beacon Health Partners |
| Irene Kaufmann | Executive Director | Bronx Partnership for Healthy Communities |
| Peter J. Kelly MBA | Director and Head of Value Based Programs | CareMount Medical P.C. |
| Bing Lu, MD, PhD, MBA | Primary Care Physician & CEO, CAIPA | CAIPA |
| Louis Snitkoff, MD | Chief Medical Officer | Capital Care |
| Kathleen Mattice | Chief Clinical Officer | CapitalCare |
| Winsley Tam | Chief Operating Officer | CCACO |
| Henry Chen, MD | Chief Executive Officer | CCACO |
| Dana Zhu | Chief Operating Officer | CCACO |
| Thomas Mahoney, MD | Chief Medical Officer | Common Ground Health |
| Melinda Abrams, MS | Vice President, Delivery System Reform | The Commonwealth Fund |
| Karen Ashline | Director, Northern Adirondack Medical Home Program; Operations Director Adirondack ACO LLC | Champlain Valley Physicians Hospital (CVPH) |
| Bob Cafone | Director, ACO | EmblemHealth |
| Carl Lund | Vice President, Hospital Contracting and Value Based Arrangements | EmblemHealth |
| Cindy Goff | Vice President, Policy | EmblemHealth |
| Robert La Penna | Network Director, Payment Innovations | Empire Blue Cross Blue Shield |
| Lisa Dulsky Watkins | Director, Multi-State Collaborative | Milbank Memorial Fund |
| Cleo Dixon | Assistant Vice President, Network | HealthFirst |
| Susan Beane, MD | Vice President and Medical Director | HealthFirst |
| Donna Seminara, MD | Primary Care Physician | Island Internists; ACP NY Chapter |
| Jenny Tsang Quinn, MD | Chief, Clinical Programs/Network Development | Community Care of Brooklyn Central Services Organization (CSO) |
| Karen Nelson | Chief Medical Officer | Maimonides Medical Center |
| Robert W. Morrow, MD | Primary Care Physician, New York Treasurer | New York State Academy of Family Physicians |
| Vito Grasso | Executive Vice President | New York State Academy of Family Physicians |
| Valerie Grey | Executive Director | NY eHealth Collaborative |
| Donna Shelley | Associate Professor | NYU School of Medicine |

| Name | Title | Organization |
|---|---|---|
| Dave Chokshi | Chief Population Health Officer | One City Health |
| Grace Wong | Chief Network Officer | One City Health |
| Anna Flattau, MD | Chief Clinical Officer | One City Health |
| Deborah Johnson Ingram | Program Director | Primary Care Development Corporation |
| Louise Cohen | Chief Executive Officer | Primary Care Development Corporation |
| Mark H. Belfer, D.O. | Chief Medical Officer | Greater Rochester Independent Practice Association |
| Joseph S. Vasile, MD, MBA | President/CEO | Greater Rochester Independent Practice Association |
| Salvatore Volpe, MD | Chief Medical Officer | Staten Island PPS |
| Linda Efferen, MD | Medical Director | Suffolk Care Collaborative |
| Hope Plavin | Director, Medicaid Policy | United HealthCare |
| Lawrence Casalino, MD | Professor of Healthcare Policy and Research | Weill Cornell Medical College |

## Appendix 4. Organizations Interviewed as Part of This Project

| Organization | Type | Phase 1 | Phase 2 |
|---|---|---|---|
| Adirondacks Northern POD | Hospital-based | X | X |
| CHS Beacon Physician Partners | IPA | X | X |
| Greater Rochester IPA | IPA | X | X |
| Acuitas | Payer-Medical Group Joint Venture | X | X |
| Aledade | Entrepreneur/MSO | X | X |
| Community Care of Brooklyn Central Services | Hospital/PPS | X | |
| St. Barnabas Health System | Hospital/PPS | X | |
| OneCity Health | Hospital/PPS | X | |
| Northwell Health System | Hospital/System | X | |
| Eastern Chinese Affiliated Physicians (ECAP) | IPA | X | |
| Chinese Community ACO (CCACO) | IPA | X | |
| CareMount Medical Group | Medical Group | X | |
| CapitalCare | Medical Group | X | |
| Allied Physicians Group | Medical Group | X | |
| Advocate Community Partners | PPS | X | |

# Appendix 5. Phase 2 Interview Tool

**Building an Infrastructure for Population Health Management and VBP Target Market**

1) Roughly how many practices do you currently provide shared services to?

2) How many individual providers?

3) Average number of providers per practice?

4) Among the practices using shared services, what is the range of practice size?

5) How many patients served by these practices?

6) Average patient panel size per physician?

7) What are characteristics of populations served?

8) Are there significant variations among the practices in panel size, due to patient acuity/complexity?

9) Estimate of case payer mix: Medicare, Medicaid, Commercials? (% of panel)

10) How many managed care or health insurance plans do your practices serve?

**Infrastructure**

We have identified below some functional domains of shared service provision in support of small practices, which we have assessed as being "core" and "optional', either for primary care practices to function as medical homes, for them to participate in VBP, or both. Do the categorizations in the tale below make sense to you? What would you change or add?

**Service Provision**

11) Do you "make" (provide, directly) or "buy" specific services noted in the table below?

12) Are the shared services a la carte or as a package? e.g.

a. Care management staff

b. Patient education/Nutritionists

c. Behavioral health professionals

13) Do you offer shared services to all practices/providers in the network or only a subset?

a. If a subset what % of your overall provider network/patient #?

14) Do practices use the services to cover all of their patients, or just specific patient panel(s)?

a. Only those covered by payers offering medical home payments, or VBP arrangements?

b. Focused on severity of illness, multi complex conditions? On patients experiencing care transitions?

c. Is "Care Coordination" part of your service package, or is it something practices are expected to provide, baseline?

### Potential Shared-Service Package

| | PCMH (Y/N) | | VBP (Y/N) | |
|---|---|---|---|---|
| **Description** | **Core** | **Optional** | **Core** | **Optional** |
| **Health Information Technologies** | | | | |
| Registry setup and management (support care management services) | X | | | |
| Regional Health Information Organization (RHIO) connectivity and access | | X | X | |
| **Technical/ Administrative Services** | | | | |
| Managing costs: group purchasing of business or other services | | X | | |
| Enhancing revenues: consultation/assistance in pursuing revenue opportunities for VBP | | X | | |
| Workforce development/staff training for VBP | | | X | |
| Practice transformation consulting, ongoing support | | X | | |
| **PCMH/VBP Support** | | | | |
| Clinical/EMR Data Analytics | X | | X | |
| Claims data analytics (for analysis, reporting; to guide QI action (e.g., gaps in care, variation) | | | X | |
| Practice and data aggregation to ensure adequate patient population for VBP | | | X | |
| Documenting/reporting quality and utilization measures/outcomes | | | X | |
| Contracting services for VBP (e.g. performance analyst/business intelligence) | | | X | |
| **Quality Improvement Staff and Services** | | | | |
| Shared staff to support quality improvement | | X | X | |
| Shared QI, learning collaborative, sharing best practices | | X | X | |
| Aggregating quality measures and outcomes, across participating and payers | | | X | |
| **Shared Professional Staff Who Interact with Patients** | | | | |
| Nutritionist/diabetes educators | | X | | |
| Behavioral health professionals | | X | X | |
| Care coordination | X | | X | |
| Care management | X | | X | |
| Patient engagement and outreach | | X | | |

### Helping Small Practices Participate in VBP

15) What are the staffing ratios (FTEs per some metric) for shared services staff you provide to support small practices?

16) Is FTE basis per provider, per practice, per panel size, or other? E.g.,

a. Shared professional staff to support care (e.g., care managers, behavioral health, etc.)

b. Data analytics (incl. claims data?) and feedback of quality/cost experience to practices

c. Quality reporting, supported by quality improvement staff and programs

### Economics: Costs

17) What was the initial investment required to mount your shared service capacity? What was the investment used for in the start-up period?

18) How much do these services cost you to operate and manage? (PMPM)?

a. Direct costs of the shared personnel and services

b. Full cost, incl. allocated overhead and supervision (management, finance, HR)

**Economics: Payment/Reimbursement for New Infrastructures**

19) Are the costs of shared services passed along to the practices, and if so, how is that done?

a. Do practices pay an "average" fee

i. How is that payment structured? (per-practice, per-provider, per-member fees)

ii. Is payment by practices risk-adjusted for the nature of the provider's panel?

b. Do practices pay "a la carte" for only those services they use?

i. How is that payment structured?

20) Are payers are paying the practices enough to cover the direct costs of these shared services?

a. What proportion of the payers are paying to support the augmented services?

b. What are the average PMPM payments received by practices compared to your costs?

c. Are those payments enough to cover all the costs?

d. What is the average margin or loss?

**Economics: Sustainability**

21) Do payers pay a (negotiated) admin fee to the "host" organization (IPA/ACO, /system) for this infrastructure?

a. If so, are practices not expected to pay, but agree to meet specific performance standards (e.g. ACO/IPA model?)

b. Are those payments enough to cover all the costs?

c. What is the average margin or loss?

22) Are the shared services designed to be self-perpetuating or time-limited (e.g., dependent on renewal of payer contract, practice agreements, grant/ACO arrangement)

23) Does your model require additional payment to PCPs to break even?

a. For how long do you anticipate needing the additional payment

24) How does your organization cover the gap in costs? What are potential revenue sources to cover these charges in the future?

## Appendix 6. Profiles of Host Organizations Providing Shared Services

The following profiles summarize interviews with four organizations providing shared services. These organizations cover the four organizational sponsorship types identified during Phase 1: a hospital system (Champlain Valley Physicians Hospital, which hosts the Northern Adirondack Pod); an IPA (Greater Rochester IPA); a payer-sponsored program (CDPHP's Acuitas program, organized as a joint venture with CapitalCare Physicians Group); and an entrepreneur (Aledade).

These profiles also appear in the appendices of the PHIP Small Practice Project Interim Qualitative Report.

### Northern Adirondacks POD

*Contact Interviewed*

Karen Ashline

*Organization Overview*

The Northern Adirondacks POD (the POD) is a hospital-sponsored central services organization, built on a pre-existing management services organization sponsored and hosted by the Champlain Valley Physicians' Hospital (CVPH). CVPH is the employer of record for all POD staff, provides the POD with needed office space, Human Resources functions, IT and support to manage finances, with all expenses covered by a portion of the PMPM that each provider practice/organization receives on a monthly or semi-annual basis.

*History*

The POD was created in 2010, as part of the multipayer Adirondacks Medical Home Demonstration (AMHD), to provide shared services to small practices in CVPH's service area, who were participating in that project. Originally, the AMHD included 8 private payers (including Medicaid), who agreed to pay an incentive of $7.00 pmpm for members attributed to primary care practices which achieved NCQA recognition as Level 2 or 3 PCMHs. In 2011 CMS joined the project, including the AMHD in CMS's Multi-Payer Advanced Primary Care (MAPCP) program.

*Key Design Features Noted*

Payer support adequate to support POD's (and practices') start-up and increased operating costs; physician governance and trust of the POD's host, and physician engagement.

*Practices Served*

82 primary care providers in 25 primary care sites, 50,000 attributed patients.

*Services Provided*

The POD employs 25 staff, 13 RN care managers, 2 Transitional Care LPN's, a Pharm D, data analysts, nutrition educators and community resource specialists, and quality improvement staff. Additionally, there is a dedicated administrative staff to support the care management team.

*How Shared Services Are Organized and Provided*

The POD is organized as a discrete department with physician oversight and a dedicated management team. CVPH continues to function as the host—managing the personnel and the financial requirements to provide supports across the practices.

We have three areas of support—Transitional Care, Chronic Disease Management (embedded care) and Pediatric Team based care. RN Care Managers are fully embedded in the primary care practices, with roughly 3 of those personnel shared across 2 or more practices. All other staff are centralized, and available to participating practices on an as-needed basis.

Clinical and claims analytics are not provided by the POD, but are available through a parallel organization.

*Financing and Payment for Services*

CVPH funded the initial capitalization / start-up costs of the POD (estimated investment: ($300,000), to create the shared services entity.

The involved payers began to pay practices the agreed-to $7.00 pmpm at the start of the AMHD project, in advance of the involved practices achieving NCQA recognition (having a practice achieve PCMH recognition by the end of year-1 was a criterion for continued payer support). This gave the participating providers the funds to invest in the POD.

Participating primary care practices contribute $3.00 pmpm (out of the $7 pmpm they receive from payers) to support the operating costs of the POD. That contribution represents a total of $1.7 mil per year, roughly 80% of the POD's annual operating costs. (Note: Participating practices also contribute $0.50 pmpm to support the clinical and claims data analytics function.)

## Greater Rochester IPA (GRIPA)

*Contacts Interviewed*

Joseph Vasile, MD, MBA, President and CEO
Mark H. Belfer, DO, FAAFP, Medical Director

*Organization Overview*

Greater Rochester IPA (GRIPA) is a for-profit independent physicians association, but part of a larger system, Rochester Regional Health System (RRHS). RRHS and the Rochester Regional Physician Organization are each 50% owners of GRIPA.

*Practices Served*

Greater Rochester IPA includes 1340 physicians. It includes 350 primary care providers in 162 primary care practices, 60% of which (100) are small practices, with between 1 and 4 physicians. GRIPA's provider base includes physicians in private practice and those employed by RRHS, and a mix of large and smaller groups. GRIPA includes comparatively few small practices (defined as 4 or fewer providers) due to a regional trend toward total employment.

All providers in GRIPA are covered by performance based, value-based contracts, but not all patients are part of such a contract. The proportion of a given practice that is covered by a VBP contract is a function of its payer mix; some practices have more of their panels covered by payers (many of the region's commercial payers, and its Medicare ACO) with whom GRIPA has an accountable care contract.

*Services Provided*

GRIPA provides several supports for its member practices Value based Payment (VBP) contracts with payers. Its HIT services are focused less on EMR support, and more on data analytics, to help practices to stratify and manage their patient populations; its claims data analytics support primary care practices pursuing medical homes and participating in VBP contracts. Quality improvement support is delivered to all practices through its provider relations teams.

Shared professional supports are organized under GRIPA's care management unit, which also includes some health system care managers. Care management provides member practices with augmented capacities like home visits, pharmacy, nutritionists, diabetes educators, etc. Care management does not cost patients or practices anything; it is a service provided by GRIPA to facilitate patient engagement.

*How Shared Services are Organized and Provided*

Most of the shared services GRIPA provides to its member practices - the provider relations teams (including quality improvement staff) and care managers—are centrally organized and deployed. However, GRIPA's care managers and other shared staff each have specific panels of practices for which they are responsible, in order to build knowledge of, and relationships with the practices they serve. GRIPA's care management team has approximately 15 people including pharmacists, nurses, social workers and support staff. GRIPA is in the process of integrating its care management staff with the RRHS system's care managers.

In some cases, a care manager will be embedded in a larger practice, and/or shared (e.g. half-day, once a week) across two or more smaller practices. The care managers engage with their practices' patients and communicate regularly with the practice. GRIPA's care management team includes social workers, but does not (yet) have employed, dedicated behavioral health professionals. Social workers fill some of that need, but most behavioral health needs are referred out to network members. GRIPA's care management is available for all patients, but focuses primarily of patients attributed to its physicians as part of its performance-based contracts.

*Management and Governance*

The shared services provided are managed by GRIPA's clinical and administrative teams, in partnership with a clinical integration committee composed of physicians, which reviews quality metrics and develops allocation formulations for shared savings, based on performance.

*Financing and Payment for Services*

GRIPA did not provide firm figures regarding their investments to date in creating their care management infrastructure, but noted that creating this infrastructure was developed over a period of 20 or more years, at a cost of few million dollars. Revenue streams to support GRIPA's infrastructure include conducting care management for self-insured employers, operating a revenue

recovery and risk adjustment subsidiary company, and shared risk contracts with its two major payers, Excellus and MVP. The practices aren't exposed to additional incremental costs; these services are part of their GRIPA membership.

## Acuitas Health

*Contact Interviewed*

Brian Morrissey
President, Practice Support Services LLC
Executive Vice President, Partner Solutions, CDPHP

*Organization Overview*

Acuitas Health, LLC, a joint venture between a not-for profit health plan (the Capital District Physicians' Health Plan, CDPHP) and a large and successful multi-specialty group practice (CapitalCare Medical Group), was organized to provide shared/contracted services to primary care practices in the Capital region of New York State.

Described as a population health services company that empowers physicians to make the transition to a value-based care delivery system, Acuitas is a subsidiary of Practice Support Services LLC (PSS), an umbrella organization owned by CDPHP, to provide a range of shared/contracted services through Acuitas, and additional services through other subsidiaries[16].

CDPHP chose to partner with CapitalCare on this venture because of its historical performance on measures of quality and cost, and its existing, potentially expandable infrastructure of systems and staff required to support high-performing primary care, and to participate in VBP. Improving aggregate quality is a prime focus, but not the only focus for VBP; Acuitas is focused on improving financial performance, as well. For practices, and for CDPHP, reducing ED visits and admissions is also part of the formula for success; practices need to better manage referrals, and to direct referrals and revenue in-network.

*Practices Served*

Acuitas is presently starting operations, and marketing its services to primary care practices. Currently, it provides services to CapitalCare, a group that includes 79 physicians and 115 advanced practice nurses in 32 independent practices serving over 160,000 patients.

*What Services Are Provided*

Acuitas offers primary care practices a range of services, including assistance with health information technology, clinical and claims analytics, value-based payment arrangements; support for quality improvement, measurement and reporting; and shared professional staff and services, including care

[16] In addition to Acuitas, Practice Support Services LLC offers a range of collateral (and optional) services for small practices, including practice transformation consulting; practice management and billing/coding assistance (provided through another subsidiary). They also plan on providing assistance to small practices wishing to enter into VBP contracts with CDPHP, including help in aggregating their patient volumes in order to achieve the scale required by most payers for such contracts.

managers, health educators, pharmacists and behavioral health professionals. Practices are offered a menu of available services, from which they can select, and for which they pay on an a la carte basis.

*How Services Are Provided*

Acuitas initially will have 28 experienced staff in place (7 FTE care managers, 3 social workers, 3 dieticians, 2 pharmacists, 4 quality analysts, 9 administrative and technical roles), many of whom transferred to Acuitas from CapitalCare as its contribution to Acuitas' start-up. Acuitas is currently building/expanding its staff; once fully operational, its staff complement and mix will be determined by demand from the small practice market.

Acuitas provides shared/contracted services to practices in two ways: services like data analytics are centralized, with related on-site support and consultations are tailored to a practice's needs. Shared/contracted service professionals are salaried by Acuitas, but are dedicated to (and in many cases, embedded in) a specific practice (or to a cohort of practices, if they are responsible for more than one practice), so a practice has a reliable and known source of services, and those staff can function as a member of the primary care practice's team.

Shared professional staff provided under the Acuitas arrangements are available to serve all patients in a participating practice and not limited to serving specific populations (e.g. those covered by a given VBP contract), since most providers with whom they have spoken "want to practice medicine one way."

*Financing and Payment for Services*

Acuitas was initially capitalized in two ways: both CDPHP and CapitalCare made available equity investments to help cover its start-up costs; and both are in the process of transferring to Acuitas many of the initial staff (part of CapitalCare's in-kind contribution to Acuitas' start-up). While Acuitas may bring in additional investors and stakeholders in the future, initially Acuitas is co-owned by two organizations, CDPHP and CapitalCare.

Currently, CapitalCare pays Acuitas for the services it has contracted to receive, using a PMPM fee, similar to the arrangement designed for outside practices. Acuitas offers practices the option of purchasing services a la carte, or purchasing its full menu of services (which includes embedded shared professional staff, quality improvement consulting and assistance, population health analytics tools, and practice redesign training) for a fee of roughly $8 pm/pm.

At the practice level, practices that already have value-based contracts (like CPC+) may find particular value in purchasing shared/contracted services from Acuitas. While CDPHP is the major payer in the region, it is not the region's only payer; and having the required capacities in place is expected to make it easier for a practice to pursue and succeed under VBP contracts with other payers.

## Aledade

*Contact Interviewed*

Kim Lynch

*Organization Overview*

Aledade is a venture-capital-backed startup that helps small practices take on risk and manage business processes. The services as designed enable small practices to engage in risk-based contracts and value-based payment arrangements with CMS and other payers.

Their "value-based care network" operates ACOs in 15 states; 14 of the ACOs are in the Medicare Shared Savings Program. The network includes over 200 physician practices and covers over 240,000 patients.

*Practices Served*

Aledade targets practices based on their patient mix, focused primarily on practices with significant proportion of Medicare beneficiaries. Aledade also considers whether the practice may be a good fit for the Medicare Shared Services Program. Targeted practices—presumed to have basic HIT infrastructure, such as electronic medical record systems, in place—must be willing to adopt new cloud-based data collection and health informatics tools.

Before entering into a partnership with a practice, both Aledade and the potential partner do a two-way assessment to determine interest in a partnership and its sustainability. Risk is analyzed and adjusted based on preliminary data that Aledade pulls on practices from claims and Medicare data feeds, plus analysis of the practice's Medicare Quality Resource and Use Reports.

*Services Provided*

Aledade's service model includes "automating what can be automated." This helps practices accurately report and submit claims on their work with patients; analyze across patient data to create registries and pull records based on key health indicators; and collect quality measures for documentation and reporting. Aledade also helps practices organize hospital discharge notifications to improve efficiency in follow-up scheduling. To a lesser degree, they also help practices shape their requests for services from other vendors.

Taking a closer look, quality reporting managed by the electronic health record optimization team, gives practices routine data hygiene checks. In addition, Aledade's practice transformation specialist use a set curriculum to support practices on quality improvement tasks like chart reviews, data checks, and reporting.

Aledade's teams also help practices map and capture quality measures to enhance their reporting with improved data capture and reduced effort by the practice staff. Aledade may also occasionally offer assistance with group purchasing on an item specific basis, depending on what the practices ask for.

*How Shared Services Are Organized and Provided*

Aledade creates ACOs with the practices where the practice can opt-in on contracts, depending on fit. Service "vends" don't overlap between members of the ACO, and practices have single signing

authority. The ACOs have practice transformation staff, an executive director, and a medical director.

Services are provided through both local and centralized shared supports and telemedicine systems. Centralized services are used for social work, some behavioral health tasks, clinical pharmacy services such as medication management, and consults. Care management and care coordination is provided locally by practice-based care managers. Practice support professionals are staffed three ways: direct hires by the practice, indirect hires through a centralized staffing agency, and indirect hires by Aledade that are placed in the practice.

Patient load helps determine staffing level recommendations: e.g. how many Medicare beneficiaries or commercial payer covered lives do you need to support a full-time employee for care management, wellness visits, and transitional health visits?

Some of the services are used for the whole patient panel, such as event notifications. Other services are prioritized by risk and need for referral and care management. Some of this analysis can be done by the practice using just their claims data leaving the practice. The data is not uniform across all payers and Medicare, which is frustrating for Aledade and the practices themselves, as they cannot get a comprehensive view of the practice.

*Financing and Payment for Services*

To finance shared services, practices pay an initial commitment fee (based on the size of the patient panel) and an ongoing commitment of $1 pmpm. Aledade collects a share of savings generated by the application of VBP contracts and risk arrangements, as well as practice efficiencies developed through use of Aledade's services and tools.


P H I P
Population Health Improvement Program
NYC Health
United Hospital Fund