

The PHIP Small Practice Project

Interim Qualitative Report

June 2018



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Staff Contributors

NYC Department of Health and Mental Hygiene: Oxiris Barbot, MD; Sonia Angell, MD; Sarah Shih; Patrick Germain; Sachin Jain, MD; Angelica Bocour; Alison Frazzini; Jennifer Karr; Alvin Lin; Stephanie Lizza; Wende Mwanyika; Matthew Silverstein; and Jameson King.

United Hospital Fund staff contributors: Gregory Burke; Chad Shearer; Kristina Ramos-Callan; and Suzanne C. Brundage.

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Introduction

The health care delivery system and the payment system that supports it are both changing quite rapidly. Two forces—the emergence of the medical home model, and the adoption of new value-based payment (VBP) methods—are challenging providers to change the way they work. These changes are particularly challenging for small primary care practices, whose operations, work flow, and business model are grounded in a visit-based, fee-for-service (FFS) payment system.

Over the past year, the New York City Population Health Improvement Program (NYC PHIP) has been measuring the magnitude of this challenge for small practices in New York City. In semi-structured interviews, providers from small practices identified a range of services they need but cannot afford on their own. The project went on to evaluate the potential ways in which those services and their costs could be organized and shared across several small practices.

This document is an interim qualitative report from the NYC PHIP describing the challenges that small practices face in acquiring the new capacities required to become medical homes or to participate in VBP systems.

The final report of this effort is available at <https://uhfnyc.org/publications/881276>. It analyzes the financial and organizational issues involved in sharing services, and lays out a framework for small practices and their potential partners to use in considering whether to participate in such ventures.

Background: The Changing Primary Care Landscape for Small Practices

Small primary care practices are a critical part of New York’s health care delivery system, and they face particular challenges in the broader changing environment. Based on studies by the New York State Department of Health (NYS DOH) and the New York City Department of Health and Mental Hygiene (NYC DOHMH), practices with four or fewer providers make up roughly 40 percent of all primary care providers in both New York City and New York State. In New York City, small practices play another important role—they provide accessible, culturally competent care to specific underserved communities. Ensuring the sustainability of these unique resources matters greatly to the health and health care of New York’s diverse population, including many immigrants and longtime New Yorkers alike.

The medical home model and VBP systems present major challenges for all primary care practices, but they particularly threaten the viability of small practices’ traditional operating model, which is based on billable visits. In its 2016 *Strategy*¹, the NYC PHIP identified the challenges facing New York City’s small primary care practices as a high-priority issue, one requiring a specific focus and action. In theory, a share-services model could help small practices become medical homes, help them more effectively serve populations for which they are responsible, and eventually help the participate in VBP systems that connect more of their income to performance on measures of quality and cost-effectiveness.

A brief overview of the medical home and VBP follows. Both models demand that primary care practices acquire and master a new set of new skills and capacities; there is considerable overlap in the two sets of skills.

High-Performing Primary Care: The Medical Home: Essentially all visions of health reform cite the need for higher-performing primary care as their foundation. Primary care serves as the health system’s “front door.” Reform advocates believe that, if primary care practices can expand access to high-quality team-based care, and serve as a locus for managing the health of the populations they serve, then the entire health care system will perform better.

Universally, these visions for reform suggest some variation on the theme of a medical home² model. The various models are quite similar, including a consistent roster of new or expanded capabilities that primary care practices must have in order to improve their performance: improved access and continuity; care management for high-risk patients; improved comprehensiveness and coordination of care; ongoing quality improvement; patient engagement; and a focus on planned care and actions to improve population health.

These are not entirely new ideas. Current medical home models all borrow heavily from Wagner’s Chronic Care Model³ and from the work of Coleman and Naylor on managing care transitions.⁴ They also take advantage of the expanding capabilities of electronic medical records and emerging regional and statewide health information exchanges. Recent technological advances, such as the availability of clinical and claims-based data, offer primary care providers new ways to understand their patients as a population. With this broader perspective, they can analyze their population’s overall health care utilization, identify gaps in recommended care and

opportunities for quality improvement, and reduce potentially avoidable use of hospitals and emergency departments.

Changing primary care practices' operations to implement these new models requires substantial re-engineering and can disrupt their work flow. Primary care practices across New York are being offered "practice transformation" help to achieve those changes. Currently, four practice transformation programs are underway in New York State, each slightly different and each funded under a different federal, state, or local payer initiative.⁵ In each program, expert consultants offer practices technical assistance and support in designing and implementing new capacities.

Practice transformation also requires new infrastructure for primary care practices: data analytics, quality improvement programs, and systems for managing the care of specific high-risk patients. These often represent new skills for primary care providers—and new costs not recognized or covered by prevailing FFS payment systems.

What Small Practices Need

1. New systems and staff enabling them:
 - to manage their patient panels as a population, particularly their highest-risk patients
 - to measure, improve and report on their performance against a series of quality measures
 - to use sophisticated data analytics, to track performance target interventions
2. Expert consulting and assistance to help them to re-engineer their practice and workflow
3. Enough patients covered by a given payer's VBP program¹ to generate statistically reliable results

The medical home also requires scale. Practices need enough providers to be able to invest in, organize, and deploy the series of new capacities designed to support these new capacities.

Many medical home capacities are simply unaffordable for small, freestanding, independent practices. While the adoption of the medical home model has expanded across New York over the last ten years, small practices lack the infrastructure needed to operate as medical homes, and the have seen the lowest rates of adoption among all primary care providers in the state.⁶

The Shift Toward Value-Based Payment: A second major challenge facing primary care practices is the movement by essentially all payers—Medicare, Medicaid, and private payers—away from volume-incenting FFS payment methods and toward VBP methods. While there are many types of VBP, in general a VBP arrangement is simply a contract between a given payer and an individual or specific set of providers where providers receive financial

incentives to improve quality and reduce unnecessary utilization. This fundamentally changes the way payers interact with providers.

Under VBP, providers agree to assume responsibility for the care and costs of care of a defined population, a specific cohort of a given payer's members. In return, payers agree to reward improved provider performance. Many VBP arrangements are based on shared savings/shared risk, under which providers are rewarded based on their performance in terms of quality, cost, and member satisfaction in caring for a payer's members. This gives providers the opportunity to share in any savings they generate against a predetermined benchmark.

Because of the overlap in types of skills needed, becoming a medical home can help position small practices to participate in the VBP contracts being used by an increasing number of payers. However, VBP requires additional skills and costs, including robust quality improvement efforts and the ability to measure and report on performance against quality and cost benchmarks. A provider must also serve enough of a given payer's members to qualify for a VBP contract, often determined by their ability to generate statistically valid results. This is a bar that few small practices can clear on their own. To achieve the required scale, small practices would need to partner with other small practices or participate in larger organizations' VBP contracts. (Both options are discussed in this interim report and in the accompanying final report.)

Medical Home and VBP in a Broader Context: Recent initiatives by Medicare and Medicaid have greatly increased the momentum toward medical homes and VBP. In early 2019, the Medicare and CHIP Reauthorization Act (MACRA) will change the way physicians are paid under Medicare, replacing Medicare's traditional FFS payment system with the Merit-based Incentive Payment System (MIPS), which gives physicians incentives to improve the quality and cost-effectiveness of care. A variety of other delivery system and payment innovations are adding to this momentum: the spread of accountable care organizations (ACOs), paying primary care physicians for care management, transitional care payments, and a variety of new payment methods for models similar to the medical home now being tested by the Centers for Medicare and Medicaid's Innovation Center, to name a few. Taken together, these steps provide a clear message that these new primary care delivery models and value-based payment are the future.

In New York State, the Medicaid Delivery System Reform Incentive Payment program (DSRIP) has amplified this message. Under DSRIP, providers across the state have organized into 25 Performing Provider Systems (PPSs), charged with the stated goal of reducing avoidable hospital and emergency department use by 25 percent over five years.

The DSRIP program is providing PPSs with over \$7 billion in investment capital to help build new capacities, funds that PPSs are using: to help their participating primary care practices gain medical home recognition by March of 2018; to integrate behavioral health into primary care; and to help primary care practices function more like integrated delivery systems. In parallel, the state is reinforcing that message through its Value-Based Payment Roadmap⁷ that proposes to change the way providers are paid, moving—like Medicare's MIPS program—from a predominantly FFS-based system to one that rewards providers for improving the quality and cost-effectiveness of the care they provide.

Beyond Medicare and Medicaid, many commercial payers are adopting and implementing a variety of VBP methods. It is increasingly clear that, if small practices are to succeed in this new environment, they will need to find ways to adapt their practices to respond to these new demands and payment approaches.

Understanding What Small Practices Need

Methodology

To gauge the viability of the shared-services model, and to identify an initial roster of services that practices expected to need, NYC PHIP conducted a series of surveys and interviews with

providers in small primary care practices. Several organizations helped with this effort: the New York State chapters of the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics and the county chapters of the NY State Medical Society. An initial web-based survey was followed by five borough-specific focus groups (each attended by 15–20 providers) with representatives of small practices in New York City. Those focus groups were designed to probe two questions:

- What services and capacities do you need—but cannot afford—in this changing environment?
- Which of those could you envision sharing with other independent practices?

Specific needs identified by representatives of small practices included five different types of services, systems and staff needs, which are summarized in Table 1, below, and discussed in more detail in Appendix 1.

Table 1. Capacities Identified by Small Practices as Needs That Could Be Shared

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, below)
	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	
	Claims data analytics (for analysis, reporting, to guide QI actions)
	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 and 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

Sharpening the Focus

The small practices identified a wide range of support services they felt they needed. Those five broad groupings, however, fall into two different categories.

The first two groupings—health information technologies (HIT), including EMR acquisition and optimization and ongoing support; and practice management support, including help with coding, billing and general administrative support—are not new, and are they are not driven by

HIT: A Related but Different Issue

Health information technologies are required for all practices wishing to serve as medical homes or participate in VBP contracts. Practices must have a functional electronic medical record (EMR) system in order to support many of the medical home's requirements, including empanelment; the ability to use registries to identify and stratify the populations they serve into low, moderate, and high-risk patients (the latter groups being the focus for care management); and to support their quality improvement programs.

Practices also need functional EMR systems connected to regional health information exchanges in order to coordinate and manage transitions of care; they need secure messaging capacities to request and track consultations, receive consultant reports and operate patient portals; and they need to be able to use EMRs to analyze and report on quality measures, to manage and reconcile medications, and for many other functions.

Finally, EMR systems are essential for practices to operate in VBP contracts, which require regular measurement and reporting of their performance on quality, utilization, and cost. These reports serve as the basis for VBP contracts' incentive payments. Small practices, however, have historically lagged behind larger practices in this area, as evidenced by their historically low participation in Medicare's PQRS reporting system.¹ Increasing the acquisition and "meaningful use" of EMRs and regional data exchanges have been the focus of a series of major federal and state initiatives, with funding for providers who meet specific targets.

HIT has a high capital cost and a range of ongoing operating costs (software updates and service) for small practices; it has a variety of funding streams, tied to specific deliverables; and it involves contracts between practices and third parties, vendors of EMRs, and other HIT-related services, to provide, update and troubleshoot operational problems. While a potential provider of shared services may choose to include a variety of core HIT supports in its offering, most of those interviewed for this project did not. For that reason, HIT contracting, management, and support it is not discussed in this report as a core element of a shared services arrangement.

recent changes in the environment. These are services that have become commodified and are already offered to small practices by a variety of vendors. These services do not necessarily require a new shared-services platform.

The remaining three groupings are more clearly new skills, capacities that small practices will need in order to achieve recognition as medical homes or to participate in VBP systems.

- **Data Analytics:** Practices are expected to be able to manage their patient panels as populations, which requires new skills, including the ability to stratify their patient panels into risk groups, and to understand how to use clinical and claims data analytics to assess and improve their performance.
- **Quality Improvement:** Under VBP contracts, a practice must be able to measure, report on and improve its performance on specific measures of quality.
- **Shared Professional Staff:** Finally, practices are being asked to expand their skill-sets—and teams—by adding professionals with specific training: care managers, behavioral health specialists, pharmacists, health educators/coaches, and social workers.

In this project, we have focused sharply on these last three skill sets. These are not capacities that small independent practices have traditionally set up, and support for them has not been widely commodified, making them particularly relevant to a shared-services platform.

Shared-Services Arrangements in New York State

In early 2017, we identified several organizations that are currently offering shared or contracted services to primary care practices. We conducted semi-structured interviews with leaders from 10 of those organizations, using a common interview guide (see Appendix 2).

An issue that arose immediately was whether a shared-services arrangement is financially viable. One key driver of that financial viability is whether the shared-services entity is freestanding, or attached to another organization.

A new freestanding operation requires a new administrative infrastructure (management, finance, human resources, HIT) to support it, but an existing organization can theoretically develop and offer the shared services to small practices on the margin, using its existing administrative infrastructure. The economics of the two models are resoundingly in favor of having the shared services function as a part of a larger host organization, one that has demonstrated capabilities in the key operational areas and the ability to absorb the costs of the required administrative infrastructure. In our review, we focus on models in which those services are hosted and supported by an existing organization.

Organizational Types

In the interviews we identified four different hosted organizational types: those sponsored by hospitals or health systems; those sponsored by physician groups or independent practice associations; those sponsored by payers; and entrepreneurs.

Sponsored by Hospitals or Health Systems

The hospitals and health systems we interviewed have both employed and affiliated primary care practices. These practices are important to the parent organization, since they generate referrals to its inpatient facilities and to affiliated specialists; they are the main driver of patient attribution in the organization's VBP contracts; and their performance in managing their patient panels is central to the organization's success in those VBP contracts. Over the past decade, a growing number of hospitals and systems have built shared-services organizations to support their employed physicians or faculty. In some cases, they also offer those services to their affiliated small, independent practices.

These arrangements resemble hospital-led PPSs under the DSRIP program. For such PPSs, patient attribution is largely based on the patients served by their partner primary care practices, and their performance and funding are also largely a function of their partner practices' performance in managing the care of their Medicaid patient populations.

Perhaps the best-developed example of a shared-services arrangement is the Adirondack Medical Home Demonstration. In this example, a local hospital (Champlain Valley Physicians' Hospital) hosts a management services organization (MSO) that offers a range of shared services and staff to a "pod" of primary care physicians in its region, enabling them to achieve and maintain medical home status and to participate in VBP contracts. Those services are offered to primary care practices participating in the region's seven-year-old multipayer medical home program, under which practices that have achieved NCQA recognition as PCMHs receive added payments, a portion of which they use to support the shared services.

Other hospitals and systems across the region, such as Northwell and Montefiore, have well-established programs extending a range of shared services to help their affiliated practices become medical homes or join in hospital-sponsored independent practice associations (IPAs)—which in turn are participating in Medicare's ACO program and VBP contracts with

other payers. Similarly, hospital-led PPSs such as Maimonides are creating central service organizations that can offer shared services to their employed and affiliated practices, using DSRIP funding to help cover the start-up costs of those ventures.

Sponsored by Physicians or IPAs

Physician groups that have formed IPAs generally comprise a range of different specialties and practices of different sizes and capabilities. Historically, IPAs' primary role has been in negotiating FFS payer contracts for its members. Over the past decade, however, some IPAs have evolved to take on wider roles, to better serve their members and help them operate more effectively in a changing environment. Many physician-led IPAs have helped their members achieve medical home status, participate in Medicare ACOs, and join VBP arrangements. Some physician-led organizations are also participating in the state's DSRIP program, as partners or as Performing Provider Systems.

Some IPAs in New York State have developed a substantial infrastructure, and offer a range of services either to some or all practices in the IPA. CHS Beacon, the Chinese American Independent Practice Association, and the Greater Rochester IPA have all built on their IPA framework and contracting ability, with a robust population health management infrastructure, enabling them to participate in Medicare's ACO program and to accept other performance-based payment contracts with private payers.

Sponsored by Payers

Payers are interested in having high-performing primary care networks to serve their members and their families. Though many of their members statewide are served by larger, capable groups, they recognize that many of their New York City members are served by small primary care practices. The number of members in any given practice may not be large, but in aggregate small practices provide primary care to a substantial proportion of their members, ranging from 25 to 40 percent. Crafting ways to help their small practices survive, succeed, and improve their performance is viewed by many payers as a strategic priority.

One payer, United Healthcare, has a subsidiary (Optum) that offers a range of MSO services to two large multi-specialty groups in the New York City metropolitan area. Another payer (Capital District Physicians' Health Plan, CDPHP in the Capital Region) is building shared/contracted service capabilities by partnering with high-performing physician groups to develop, expand, and offer a range of services to small practices in their networks. Other payers, such as EmblemHealth and Empire Blue Cross, have other initiatives under way to help small practices that are serving their members.

Sponsored by Entrepreneurs

With the initiation of Medicare's ACO program in 2010, several organizations across the country saw an opportunity to use their core expertise to help organize and partner with high-performing physician groups, to help privately practicing physicians and groups to participate in Medicare's ACOs program. Typically, these host organizations invest in the creation of a shared services infrastructure, and offer it to their participating physicians at a comparatively low cost, in return for a portion of whatever shared savings the group can generate.

Perhaps the best-known example is Collaborative Health Systems (CHS), a division of Universal American that works with group practices and IPAs across the country to cosponsor Medicare ACOs. CHS currently participates in 28 Medicare ACOs across the country, including four in New York. CHS offers its partner groups a range of the support services (notably, claims data analytics, quality improvement, and care management) they need to participate in the Medicare Shared Savings Program (MSSP) and other risk-based contracts.

Another entrepreneur, Aledade, was formed in 2013 with the expressed purpose of enabling small practices to participate in risk-based contracts. Like CHS, Aledade has identified high-performing small primary care practices (networks that they select and recruit) in regions across the country and organized them into virtual groups. These groups can participate in the Medicare ACO program and have the potential to expand to accountable care contracts with private payers. Aledade provides a range of data analytics, care management expertise, and quality improvement services to these networks of small primary care practices, aggregating and organizing them to be able to participate in the MSSP and other VBP contracts.

Characteristics of Shared-Services Programs

Once we understood the four different categories of service providers, it was important to look at the characteristics of each service provider and assess the similarities and differences across each organizational model. Exhibit 2 looks at several characteristics, including the number of practices involved, services provided, how those services are paid for, and other involvements (e.g., participation in the MSSP or other accountable care contracts).

As is noted in Exhibit 2 and discussed in more detail in Appendix 3, there is considerable variation among the four service provider categories in various characteristics:

- Their maturity/stage of development;
- The range of services they provide, and the way those services are provided;
- The practices to whom they offer these services, and the patient populations targeted;
- How the noted shared services are organized and governed;
- Their involvement in Medicare's ACO program, and/or the state's DSRIP program
- How they were capitalized/financed;
- How the shared services program's operating expenses are paid for; and
- Whether the shared service provider also helps aggregate practices for VBP.

Maturity/Stage of Development

Among those interviewed, there was a substantial variation in how long the organization had been providing shared services. Some are comparatively longstanding organizational investments in a care-managing infrastructure, but the proliferation of shared service programs was

stimulated by two recent events: the inception of the Medicare ACO program in 2012, and the initiation of New York's DSRIP program in 2015.

Among the hospital- and system-sponsored programs, some early adopters (like Montefiore) have been providing these services in support of their IPA and managed care contracting for nearly 20 years; others (like Northwell) are more recent, influenced by the system's rapid growth, pursuit of risk-based contracts and by the recent expansion in its employed physician base. Others, like Maimonides Central Services Organization, stimulated and funded by the DSRIP program, are early in their implementation.

Physician- and IPA-sponsored models show a similar range. A few, like the Greater Rochester IPA (GRIPA) and Beacon, have been in existence for 15 to 20 years, with a history of providing services to their members; others, like the Chinese Community Accountable Care Organization, were formed in 2012 specifically to enable their physicians to participate in Medicare's ACO program. Others, like Advocate Community Partners, were formed more recently still to enable the physician and IPA partners to participate in the state's DSRIP program.

The entrepreneur-sponsored models were developed in response to the initiation of Medicare's ACO program in 2012, but they have expanded their focus to include additional VBP contracts with other payers. The payer-sponsored models like Acuitas are the most recent; in many ways they are a niche product developed to help small practices respond to the recent and rapid spread of VBP contracts.

Table 2. Organizations Providing Services to Small Primary Care Practices

	Hospital/System	IPA	Payer	Entrepreneur
Also Participating in	Medicare ACO, other VBP, DSRIP	Medicare ACO, other VBP, DSRIP		Medicare ACO, other VBP
Number of Physicians Served	Large full-time staffs, IPAs with a mix of salaried and independent physicians.	Large IPAs, over 1000 physicians, with roughly 1/3 primary care. Proportion of small independent primary care practices varied.	Example: a large, high-performing multi-specialty group (>100 providers) partnering with a payer, starting to contract w/small practices	Two models: One partners with organized groups, another aggregates independent practices, with an average of 15-20 small practices per region
Who Receives Shared Services?	Members of full-time staff, IPA or pod, with priority to practices participating in VBP	Varies; all IPA practices, or mainly practices participating in VBP, MSSP contracts	Practices contracting for services	Only to "partner" practices
What Patients Receive These Services?	Variable: Incentives to focus shared services on patients in VBP, MSSP contracts; some provide services for to all patients			
Services Provided				
VBP Support				
Claims data analytics (for analysis, reporting; to guide QI action)	Yes			
Practice/data aggregation to ensure adequate patient population for VBP	Yes	Varies	Optional; not part of core offering	Yes
Document/report quality, utilization measures/outcomes	Yes			
QI Staff and Services				
Aggregating quality measures, utilization and outcomes; sharing dashboards and reports with participating practices	Yes			
Shared staff working w/practices to support quality improvement	Yes			
Shared QI, learning collaboratives, sharing best practices	Yes	Varies	Optional	Yes
Shared Professional Staff Who Interact with Patients				
Care management	Yes			
Nutritionists/diabetes educators	Varies, if provided, generally by referral			
Behavioral health professionals	Yes	Varies, if provided, generally by referral	Optional	Under consideration
Care Coordination	Varies: some provide assistance w care transitions, others view this as a core practice function			
Patient engagement & outreach	Varies, if provided, generally by referral			
How Shared Staff Are Deployed				
Combination of centralized and embedded (larger practice sites)				
QI staff	Centralized, some deployed to practices	Centralized	Centralized, some deployed to practices	Centralized
BH staff	Generally offered as referral, centralized, but some deployed to practices			
Pharmacists	Varies; if provided, is provided on-call, centralized			
Capitalization and Startup	Hospital/system funds, DSRIP	IPA, member fees, borrowing, DSRIP	Partners' equity contributions	Sponsoring organization, other investors
How Operating Costs Are Paid For	Mix of hospital/system/PPS support; admin fees from payers on contracts, or PMPM payments from practices	Mix of admin fees from payers; payments from participating practices; grants	Contracted services supported by payments from practices	Small PMPM, plus gain-sharing
Practice Involvement in Governance	Varies, generally via committee structure		No	Specific areas, like quality improvement

What Services Are Provided, and How?

There was general agreement among those interviewed that small practices in fact needed the services identified to achieve medical home status and to participate meaningfully in VBP contracts. However, there was variation among the host organizations in terms of the services they currently provide.

One common element across all the shared service providers—identified as among their highest priorities—was the provision of clinical and claims data analytics support. It was viewed as fundamental to population health management and care management for the highest-risk patients, to targeting and supporting quality improvement efforts, and—critical, in VBP—to being able to report on their performance on specified quality and utilization measures. In essentially all cases, this service is organized and produced as a centralized service, with regular reports and analyses provided to the participating practices. In several cases, this is coupled with practice-specific site visits, with staff providing advice and consultation on how to interpret the information and how to best to use it to improve performance.

The host organizations also provide support services aimed at measuring, improving, and reporting on quality measures. These efforts rely heavily on the data analytics infrastructure, focusing on improving performance in areas specified in their VBP contracts.

All the host organizations provide practice-specific (and generally provider-specific) reports on performance; most provide comparative reports, showing a practice's performance against its peers or a benchmark; and a few offer quality improvement staff who can work with a practice (sometimes involving multiple practices in learning collaboratives) to disseminate and increase adoption of proven best practices.

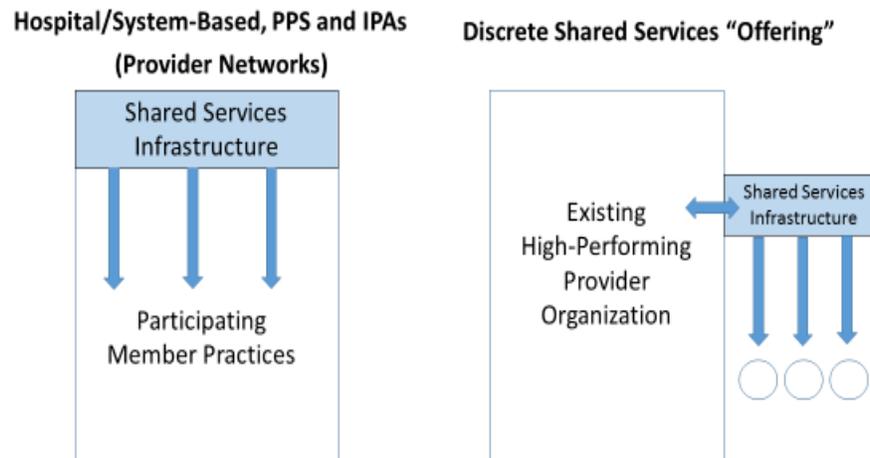
A third common element was care management. All interviewed noted this as a high-value shared service. The type of personnel employed, however, varied; some of the host organizations use nurse care managers, where others use different types and levels of personnel. Similar variation was also seen in how the host organization provided the service: some choose to embed care managers in the practices (in some cases, sharing a care manager across two or more practices); others use centralized care managers (often designating specific care managers or teams to serve to specific practices, to build relationships, trust, and continuity); others use a combination of embedded and centralized approaches.

There was less consistency in whether a host organization includes other shared personnel—such as PharmDs, behavioral health specialists and social workers. Some of the organizations interviewed deploy behavioral health specialists in a way similar to care managers (a mix of embedded, shared, and centralized personnel, in one case augmented by telemedicine). These personnel are not always included in the package; and when they are, they are often provided on referral, or as a centralized resource available on-call.

To Which Practices Are the Services Provided?

In general, host organizations have built their shared services as part of the organization's infrastructure, primarily focused on serving their member physicians and practices. Only one (Acuitas) was designed to serve outside practices.

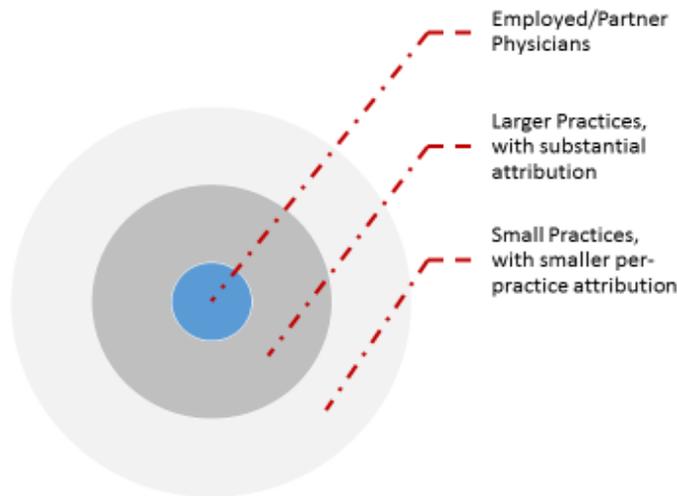
Figure 1. Organizational Models for Offering Shared or Contracted Services



The target practices for shared services varied as well. Hospitals and systems tend to focus their shared services on their employed physicians and faculty practices, and on larger practices within their current IPAs. Some hospitals and systems pursuing risk-based contracts have built infrastructure to support those contracts, and they often extend this infrastructure to participating primary care practices. They do so because primary care is an important source of patient attribution in most VBP contracts; and because the performance of primary care practices in caring for their attributed patients is critical to meeting their VBP targets.

However, as is depicted in Figure 2, not all primary care providers are of equal importance to hospitals and systems. Given their limited resources, such systems are likely to prioritize practices with whom they have shared finances, offering services first to their employed physicians, and next to those participating in their VBP contracts or generating substantial volumes of admissions and referrals into their system. Smaller independent practices, particularly those that do not generate many referrals, represent a third orbit unlikely to be prioritized for receiving shared services.

Figure 2. Priorities in Providing Shared Services: Hospitals, Health Systems, and PPSs



PPSs have similar incentives in providing support to their participating practices. Under the state’s DSRIP program, a PPS’s patient attribution is largely driven by Medicaid enrollees’ relationships with a primary care provider; and its performance scores and funding will be in large part driven by the performance of the primary care practices in its network.

Hospital/system-led PPSs are likely to establish priorities among the practices they support with their shared services, based on their historical relationship to the lead hospital and the volume of attributed patients.

IPAs are somewhat differently situated. Historically, IPAs tend to have large and diverse memberships, and their role has focused on negotiating with payers around FFS payment rates for their members. Like hospitals/systems, IPAs focus their shared service offerings internally, on their larger practices. Some IPAs (those with single-signatory contracting, binding all members to a given payer contract) offered their shared services to all their member practices.

Other IPAs, those offering a “messenger” model for contracting (in which practices can opt-in to contracts) offer some services to many of their practices, but tend to focus personnel-intensive services on practices participating in their VBP/risk-based contracts and on patients attributed to those practices.

IPAs face a particular challenge when approaching VBP contracting: they represent a diverse group of providers and practices, some of whom are performing better than others. They need to decide whether to contract for entire IPA membership, or to support the creation of smaller subsets of practices capable of succeeding under VBP.

The payer-supported models are a comparatively new phenomenon. Conceptually, these are perhaps the cleanest model: they were designed *specifically* to provide shared services to small, independent primary care practices. In Acuitas, CDPHP is partnering with a high-performing physician organization (CapitalCare, a large group practice), building on its existing infrastructure to create an MSO that can offer shared services to small, independent practices. Other payers have developed different approaches. EmblemHealth is partnering with a high-

performing IPA (HealthCare Provider IPA) to build the capacity of its affiliated small practices; and Empire Blue Cross is helping small practices in its networks to organize virtual groups and is offering them sophisticated data analytics and other support to help them participate in VBP.

Like the hospital/systems and PPSs, the payer-sponsored programs have an incentive to prioritize the delivery of shared services, focusing first on the small practices that in aggregate serve appreciable numbers of members in the payer's network. However, some models—in which the payer is partnering with an existing, high-performing provider group for shared services—have the potential to share the services more broadly and regardless of payer. Once a practice contracts for those services, they can use those services for essentially any of their patients, which in theory would enable those practices to participate in VBP contracts with other payers, as well. One concern, however, is whether other payers would be comfortable having their claims data analyzed by an organization sponsored by another, competing plan.

The entrepreneur-sponsored category is somewhat different from the others. The two organizations noted select and recruit practices with whom they want to partner. These entrepreneurs provide shared services and other support only to those groups they have selected and with whom they are working in risk-based contracts.

The entrepreneurs have a strong incentive—shared economics with their partner practices under Medicare ACO and other VBP contracts—to focus on improving the performance of their physician groups in the care of their attributed patient populations. They support their partner practices in generating clinical (EMR-based) data analytics and transitional care management for all of their patients to enable quality improvement; but they can only provide claims-based data analytics on patients who are part of their risk-based contracts, and they tend to focus the more resource-intensive services and on patients covered by those contracts.

How Are They Financed?

All the organizations interviewed noted the substantial investment required to start up and deploy their shared-services infrastructure. While exact figures are not available, two spoke of an initial investment in the range of \$ 2 million. The source for that initial financing varied across the organizational types. Hospitals and systems reported using institutional resources, but some hospitals leading PPSs also used DSRIP funding to build their care managing infrastructure. IPAs tended to use a combination of borrowing, investments by their physician members, and grants. One of the payer-sponsored models reported capitalizing its joint venture using funds from payers and in-kind investments by their provider group partner (e.g., transferring staff and systems to the joint venture).

The two entrepreneur-sponsored models both funded their start-up costs through investments by their parent companies, but the source of those funds differed somewhat. Collaborative Health Systems received its start-up funding from its parent insurance company, Universal American; Aledade used private investments (venture capital).

How Are the Shared Services Organized and Governed?

In the Adirondack Medical Home Demonstration, the shared services provided to practices participating in the pod are paid for directly by the participating practices, which allocate a

portion of the funds they are receiving under the region's multipayer medical home project. The pod is organized as a separate MSO, hosted by the hospital, and governed by a board made up of representatives of the participating physician practices.

Other hospitals and health systems are organizing shared services as part of their network management infrastructure, or as a central services organization managed by the hospital housing services that they offer to practices in their IPAs or participating in their VBP/managed care contracts.

The IPAs interviewed also reported organizing their shared services as an integral part of the organization's administrative infrastructure, managed by the IPA and overseen by physician-led committees.

The payer-sponsored models are joint ventures between a payer and a provider organization (a group or IPA) that organizes and hosts the services. These programs are managed and governed by the sponsoring entities, offering their shared service products to interested practices as contracted services, for a fee.

Finally, the entrepreneur-sponsored models are partnerships between the sponsoring organization and the participating physicians, which provide a range of support services to the participating practices. As in IPAs, these services are overseen by committees that include most of the participating practices.

How Are the Ongoing Costs of Shared Services Covered?

Host organizations reported a range of different ways in which they covered the operating costs of the shared services. In one hospital-sponsored example (the Adirondacks pod), the services are supported by the participating primary care physicians themselves. The foundation for the Adirondack Medical Home Demonstration was an agreement by essentially all of the region's payers, to provide primary care practices recognized as medical homes with a monthly care management payment of \$7.00 per member per month (PMPM). The practices decided to allocate roughly half of that care management payment (\$3.00 PMPM) to pay the shared-services host (Champlain Valley Physicians Hospital) to support those shared services.

Other hospital systems reported supporting their shared-services infrastructure as part of their overall administrative costs, with the operating costs covered by the hospital or by fees taken off the top of their managed care and VBP contracts. IPAs reported a variety of methods to cover shared services, including administrative fees paid to them by payers, small contributions by the participating physicians, grants, and other sources.

One of the payer-sponsored shared service programs (CDPHP) plans to charge participating practices a PMPM fee for the services they use. The entrepreneur-sponsored programs have a different financial model. Participating practices receive the shared-services infrastructure free or for a nominal fee; and in return, the practices agree to share with the sponsor a portion of the savings they generate under the MSSP and other VBP contracts.

Do the Shared-Service Providers Also Aggregate Small Practices for VBP?

Aggregating small practices to entering into VBP contracts is a fundamentally different undertaking than the provision of shared services to them. Conceptually, aggregation serves two different purposes:

- grouping practices to achieve threshold volumes necessary to participate in a VBP contract; and
- aggregating practices to negotiate VBP contracts and payment rates.

In addition to aggregating patient panels across independent practices, this may also require the host to take on a broader set of responsibilities—crafting VBP contracts with payers, generating reports on practices’ performance on cost and quality, and distributing any incentive payments among the participating practices.

The host organizations we interviewed were less consistent in their efforts to group small practices and aggregate their payer-specific performance data for the purpose of participating in a VBP contract. Hospital systems use existing structures (such as hospital-sponsored IPAs) for contracting, and they include participating physician practices in those contracts. However, hospital- and system-based IPAs tend to be large, diverse, and complex organizations, in which small practices fear they would be lost or undervalued.

Similarly, many IPAs (like GRIPA) serve as a contracting vehicle for their entire membership, negotiating and managing VBP contracts that generally include their entire membership. As noted above, crafting VBP contracts for subsets of their provider network (smaller aggregations of practices) may not be easy in such models. Other IPAs (notably those using a “messenger” model⁸ of contracting) were open to allowing subsets of their participating providers to choose VBP contracts.

At least at the outset, the payer-sponsored models appear to be focusing on building capacity in practices with whom they have contracts of a certain scale, providing those small practices with needed shared services, rather than serving as vehicles for organizing those practices for broader contracting. One of the payers, Empire, is helping small practices organize themselves into virtual groups so that they are better positioned to negotiate and operate under VBP contracts—with Empire and with other payers.

Emerging Themes and Issues

In our discussions with primary care providers and payers, some key themes emerged as issues to monitor and resolve when moving toward sharing services. A number of those issues are described below, from the different perspectives of the primary care practice and the host organization.

The Practice Perspective

During our focus groups with small practices and in our interviews with shared service providers a series of issues and concerns were noted, things that small practices need to consider as they think about entering into such arrangements.

What Do You Mean, “Share”?

Providers in small practices value their independence; they are not, by their nature, joiners. Entering into shared-services arrangements is not a natural act for them. This is particularly true for arrangements that involve sharing sensitive information or income.

Who Is Providing the Shared Services?

The first concern voiced by small practices was the identity and capacity of the proposed host organization, noting two major issues:

Competence: The provider must have a track record and competence in organizing and delivering specific services: data analytics, care management, quality improvement, and results reporting.

Trust: The organization hosting the shared services must be one that practices feel they can trust with their sensitive information, with their toughest patients, and (under VBP) with their money.

In general, physicians in small independent primary care practices tend to be wary of relationships with hospitals and health systems, preferring to work with physician-led organizations, like IPAs. Hospitals and health systems, however, often have more resources than physician-led organizations.

How Are the Shared Services Governed?

Practices want to have control, or at least a meaningful voice in the selection of the services they are offered, in the way those services are organized and delivered, and in how they are priced.

How Are the Shared Services Managed and Provided?

Practices are concerned about the quality, availability, and reliability of the services being provided and with their ability to integrate and work effectively with new shared professionals as part of their teams. For some services—like health education, and perhaps behavioral health and medication management—practices appear to be comfortable with a refer-and-follow model; in others, notably care management for their highest-risk patients, they said that they

would be substantially more comfortable if they knew the staff involved and trusted their judgment.

What Are the Costs of These Services, and Are They Affordable?

Small practices tend to be low-margin operations. The practices with whom we spoke were very concerned with the added costs of the shared services, in the absence of any predictable, incremental support from payers for these theoretically value-added services.

Who Will Be in the Group for Value-Based Contracts?

Shared-services providers could act as practice aggregators, organizing practices into virtual groups large enough that a given payer's members could produce statistically valid results on performance measures. Most VBP contracts require such scale, and grouping small practices together could enable them to participate in such contracts.

This prospect raised a concern among small practices long used to their independence: since VBP contracts would measure the performance of the group in aggregate, the measurement and payments to a given practice's performance would be averaged with the other practices with which it is grouped. So in selecting its practice partners, a practice needs to pay close attention to the performance of its potential partners on measures of quality, utilization, and cost—as well as the performance of affiliated specialists.

The Host / Shared-Services Provider Perspective

The shared-services providers interviewed are a diverse group, with different histories, varying relationships with the small practices, and growing capacities to provide shared services. Like small practices, potential hosts had concerns and questions about shared-services arrangements.

Is This Venture Central to the Host's Core Strategy?

Each type of potential host organization has an interest in improving the performance of the small practices it works with. In the case of the hospital/system-sponsored model, helping small practices has three benefits: it is likely to increase their loyalty to the hospital or system; having a primary care network that works increases the value of their core offering as a delivery system; and, to the extent that small practices have appreciable attributed members, it could position them better to succeed in VBP.

The same benefits are largely true of the physician/IPA-sponsored and entrepreneur-sponsored models. The payer-sponsored models have an analogous interest: improving the performance of their primary care network increases the value of their insurance products in a competitive market.

The strategic importance of helping small practices become medical homes and participate in VBP contracts is likely to depend, however, on the practices' importance to the sponsor's core business; on the priority the host organization places on small practices, compared to employed physicians and larger, more capable practices; and on the economics of that support—whether and how the services are paid for.

Is There Requisite Experience and Expertise in the Key Shared Services?

Not all hospital/systems, group practices or IPAs have a robust infrastructure in place to provide their core physician constituencies with the services they need to function as medical homes and/or succeed in VBP contracts. Those with proven expertise in data analytics, quality improvement (particularly in a small private practice setting), care management, population health management, VBP are best-positioned to offer these capacities as shared services.

Are the Existing Competencies Scalable?

Host organizations need to consider whether their existing services are sufficiently deep and robust to scale up, and organized in a way that would enable them to package and offer these services in a predictable, high-quality manner to other, often un-affiliated practices.

Organizations considering hosting shared services will also need to consider the economics of extending their services to independent practices, and the costs involved in scaling up their infrastructure to serve small practices. Certain services, like data analytics and related quality improvement reports, require a substantial initial investment, but once implemented, can be produced and delivered at a relatively low marginal cost. Conversely, personnel-intensive services, like care management or staff working on-site in quality improvement, may require a lower initial investment but have higher ongoing operating costs.

Startup Costs and Returns on Investment

Organizations currently hosting shared services all noted the initial investment required to establish these new services, citing estimated investments of \$2 million or more. Organizations considering building those capacities need to consider the investment required to build sufficient capacity, and the likelihood (and timeframes) of achieving breakeven or some return on that initial investment.

This calculus depends on several factors, including:

- Whether the investment is being made to serve their core business and constituency—or to serve unaffiliated practices. The latter case could be considered freestanding business venture, in which return on investment is more important.
- How the return on investment is envisioned and configured. The entrepreneurs, for example, use a model that involves little or no investment by the practices in providing those services, in return for their sharing in the shared savings generated by its partner practices.

Operating Costs and Revenues

The shared-services package could have substantial operating costs. It is important for a potential host to understand what the shared service package would cost, at various sizes and scales, from startup through full-scale operation. A related issue is whether and how to charge practices for these services.

In hospitals, health systems, PPS groups, and IPAs, there is a convergence of economic interests: a higher-performing primary care system can help ensure that the sponsor succeeds in accountable care and other VBP arrangements. In these cases, the host organization may charge a small fee to the participating practices and choose to absorb some of the remaining costs, offsetting them with whatever administrative fees and shared savings they are able to negotiate as part of the VBP contract. Similarly, entrepreneur-sponsored arrangements generally include a gain-sharing component, once the practices can generate shareable savings.

In the payer-sponsored models, the costs of offering the shared services may be subsidized, but it appears that the participating practices will be charged for the services they use.

Administrative Overhead

The host organization can handle the administrative overhead (space costs, human resources, HIT, finance, management) required to operate the shared service in various ways: allocating the full cost of that overhead to the shared-services venture, partially subsidizing those services, or providing them at no cost.

Pricing

The pricing of the shared-services package will be critical, since it will determine whether the host will be able to break even on the services it offers. The price of the package must be affordable for small practices, as cost is one of the key characteristics that they consider in determining whether to participate in such a program. Some of the hospitals, health systems, and IPA-sponsored models offer the shared services free or at a low cost to their participating practices, using other methods—like administrative fees from payers—to offset their costs.

Conclusion

As we found in our interviews, there are several ways to host shared services for small, independent primary care practices—options that hold promise as ways for practices to acquire the capabilities they need to perform as medical homes and participate in VBP.

Hospitals and health systems are structurally similar to IPAs. All are developing a new infrastructure that can help them succeed in VBP contracts, and deploying those services to their core physician base—and, in some cases, offering them more widely. The potential exists to extend those services in an affordable manner to the small practices in their networks as well. The questions that remain are:

- Will those two organization types make providing services to their small practices a priority?
- Which of the two organizational models would small, independent practices would be most comfortable with, and willing to trust for those services?
- Which of the two organizational models is likely to have the resources and capacity to do so?

A third broad option is the entrepreneur-sponsored model, in which a capable and well-resourced organization partners with specific group of high-performing practices, to better position them to participate in accountable care and other VBP contracts. However, this approach is a more limited option for providing services to independent, community-based primary care practices, since those partnerships employ a business model that is based on partnering with a specific and limited set of provider-partners.

The fourth approach is the payer-sponsored model, in which payers organize and offer a menu of available services (directly, or in partnership with an existing provider) which small primary care practices can purchase, under a contract.

As providers in small practices consider the alternatives available to them, they will need to consider which of these models best suits their needs, and build on existing relationships. In the final analysis, the choice of a shared service provider—one with whom they can partner in improving the care of the patients they serve—will be about trust.

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 for which there are currently few if any sources of off-setting payments. Primary care practices will need a source of incremental income to pay for these services, and the hosts of these services need a reliable source of payment to support them in providing these services. Without a reliable payment system that recognizes these needs and pays adequately for them, these models are unlikely to succeed.

A related report, *Running the Numbers: How Small Practices Can Evaluate the Opportunities and Costs of Sharing Services*, describes and analyze some of the financial and organizational issues involved, laying out a framework for small practices and their potential partners to use in considering whether and how to develop or participate in such ventures.

Appendix I. Shared Services—Small Practices Detail (from Listening Sessions, Summer 2016)

Specific needs identified by representatives of small practices included five different types of services summarized in Table 1 of this report: health information technologies, administrative services and support, data analytics, quality improvement, and shared staff who interact with patients.

Health Information Technologies

Over the past decade, Electronic Health Records (EHRs) have become an expected, core competency for primary care physicians. EHRs are essential for participation in a variety of medical home programs, and they are foundational to primary care physicians' ability to operate as medical homes, and essential to participate in most Value-Based Payment (VBP) arrangements. As noted by the NYS DOH¹, however, adoption of electronic health records by small practices is estimated to be roughly 40 percent.

Providers in the listening sessions identified four broad areas in which they needed assistance:

- **Acquisition and optimization / use of EMRs:** Despite ongoing programs like ONC's Meaningful Use and Regional Extension Center initiatives, many small practices currently lack functional EHRs, systems that support their practices with a solid and flexible tool to use in caring for patients, reporting and billing. For many, the challenges have been in finding the necessary investment capital for an EHR, and in managing the changes and disruption of their workflows involved in their installation and use.
- **Electronic health record maintenance and technical assistance:** Similarly, small practices do not have reliable access to expert staff to help them maintain and update their systems, troubleshoot problems and train the providers and support staff on their use.
- **Registry setup and management:** Increasingly, primary care practices are expected to be able to cohort patient populations according to disease or functional status, or risk for hospitalization and ED use, and to use registries to support care management programs, track referrals, and identify patient population with gaps in care.
- **Regional Health Information Organization (RHIO) connection and use:** Finally, the providers noted that they need better ways to be alerted, real-time, about their patients who have been admitted or discharged from a hospital or ED, so that they can respond in a timely way to their needs for transition management.

¹ New York State response: CMMI RFI on State Innovation Model Concepts, 10/28/2016, page 3

Administrative Services and Support

Small practices are small businesses, which brings both advantages and disadvantages. Independence and flexibility—highly valued attributes of small practices - are balanced by a lack of resources, scale and expertise. Providers in the listening sessions identified three areas in which they are disadvantaged, relative to larger physician groups and hospital-employed physicians:

- **Reducing operating costs:** Help in managing their operating costs (purchased supplies and services), potentially by participating in group purchasing of business supplies, employee benefits or other services, or in co-op arrangements through which a group of practices pre-negotiates discounted rates for consultants or other services, which are available to participants on an as-needed basis.
- **Identifying and effectively pursuing revenue opportunities:** Consultation and advice on improving coding and billing, improving revenue cycles and collections, effectively pursuing strategies for practices to document patient attribution, appropriately calculate patient risk scores, and identify and pursue new revenue opportunities under Medicare (e.g. using and documenting appropriately for care management codes), and other payers.
- **Training and managing their personnel:** Small practices have small staffs, each performing a range of different functions. Small practices find training opportunities are difficult to arrange, and would appreciate training and workforce development programs that can help keep their staffs' skills up-to-date in any of a variety of areas, ranging from office/business management to clinical and patient / population health management. An additional need identified was a pool of reliable, well-trained personnel who could be available to fill-in for and/or replace office staff when they are out of the office or on leave.

Data Analytics Needed to Participate in Value-Based Payment

Small practices face particular challenges in participating in many Value-Based Payment (VBP) models, under which payers reward providers who meet or exceed performance benchmarks for a given patient population, in such areas as screening and prevention, chronic disease management (e.g. hypertension or diabetes control) utilization and costs. VBP programs, which are increasing in popularity with payers, require scale (enough patients covered by a given payer to generate reliable results) and a specific set of data analytic and reporting capabilities:

- **Aggregating data from multiple practices to ensure adequate patient population for VBP:** Most VBP programs are payer-specific, and require a large enough population of patients / plan members to generate statistically valid results. Such programs work well for larger physician groups, but tend to be out of reach for small practices, which tend to serve several different payers, and thus do not have sufficient volume with any single payer to produce reliable results.

- **Documenting/reporting quality and utilization measures/outcomes:** Payers sponsoring VBP programs expect that a participating practice has the capacity to generate reports that document its performance, against a series of benchmarks of quality, patient satisfaction and utilization / costs. This is an area in which small practices have not historically performed well².
- **Clinical and claims data analytics:** Most small practices lack the capacity to analyze clinical (EHR) and claims data, to track and manage the care of the populations for whom they are responsible, particularly their high-risk patients; to identify and close gaps in care, and to track their performance against quality measures. This is an important capacity under VBP.

Quality Improvement Staff and Services

A robust quality improvement program—one that identifies specific areas of under-performance, assesses the gap-to-goal against a benchmark and focuses QI efforts on specific targets—is a requirement under most medical home models. It is even more important under VBP, where the ability to meet or exceed specific performance benchmarks is an important driver of incentive payments³.

Most small practices lack the resources and scale to support the staff and systems required for a strong, data-based QI program, and they also lack the volume of patients and a comparator group with whom to collaborate on QI efforts. In this area, small practices noted three needs:

- **Shared QI staff:** They need expert staff to lead and guide quality improvement efforts
- **Shared QI analytics and partners/collaborating practices:** They would benefit from being able to analyze and share their QI data and performance improvement efforts with other similar practices, including learning collaboratives through which they can share experiences/best practices with similar practices.
- **Achieving statistical significance and scale:** Finally, they need to be able to aggregate and report to payers sponsoring VBP programs on their performance against quality benchmarks—the aggregate performance measures and outcomes across enough participating practices to achieve statistical validity - so that they can participate in payer-specific VBP programs.

² Only about half of physicians in private practice—and few small practices - submit data for Medicare's PQRS incentive program, due to the administrative burden for small practices (Berenson)

³ in Medicare's MIPS program, for example, quality measures drive for 50% of the first year's incentive payments

Shared Professional Staff Who Interact with Patients

Finally, the small practice representatives identified clinical and support staff types needed by their patients, whom they lack the volume and scale to be able to employ themselves. Personnel they identified in this category, the patient-facing functions, included:

- Nutritionists/diabetes educators
- Behavioral health professionals
- Staff to assist with care coordination, tracking and managing referrals and care transitions
- Care managers, to help manage the care of their most complex patients, with multiple chronic diseases,
- Staff to assist with patient engagement and outreach

Appendix 2. Small Practice/Shared-Services Interview Guide and Survey Instrument

Service Provider Background

- 1) What kind of organization are you?
- 2) How many physicians or practices does your organization include/serve?

Building an Infrastructure for Population Health Management and VBP

- 3) Do you offer shared/contracted services to your members, esp. small/medium-sized practices?
 - a. If yes, what kind of services do you currently provide? (see attached chart for prompts)
- 4) Why did your organization develop this infrastructure / these services?
 - a. Position organization / members for accountable care / VBP
 - b. Specific services requested/needed by practices
 - c. How did you decide which specific services to offer?

Target Market

- 5) To whom do you offer these shared services?
 - a. All practices your organization serves
 - b. Subsets of the practices your organization serves
 - i. Are there specific criteria for participation?
 - ii. Is it mainly focused on small practices, or anyone else?
 - c. Outside practices not currently included in / served by your organization
 - i. How do you determine which practices to recruit/offer services to?
- 6) How are the shared services offered to practices?
 - a. As a package
 - b. On an a la carte basis, practices can opt to use specific services, for example
 - i. Care management staff
 - ii. Patient education/Nutritionists
 - iii. Behavioral health professionals
- 7) Who actually uses the shared services?
- 8) Roughly how many practices do you currently provide shared services to?
 - a. Among the practices using shared services, what is the range of practice size?
 - b. How many individual providers?
 - c. How many patients are served by these practices?
- 9) Do practices use the services to cover all of their patients, or just specific patient panel(s)?
 - a. Are services focused on managing high risk / chronically ill patients
 - b. Only those covered by payers offering medical home payments, or VBP arrangements?

Helping Small Practices Participate in VBP

- 10) Do you also help aggregate and support physicians in small practices for VBP contracting?
 - a. What does that support entail?
- 11) Do you help practices aggregate/group, so they can participate/succeed in VBP contracts
 - a. Helping aggregate PCPs into groups so they can structure and negotiate VBP contracts
 - b. Aggregating practices' patients and performance data, so they can achieve the scale required to participate in payers VBP contracts
 - c. Helping practices improve their performance in quality, through data analytics and targeting, in-office QI staff support and learning collaboratives
 - d. Supporting data reporting and allocation of performance incentives received
- 12) How are these contracting groups organized?

- a. All practices participating in a given payer's VBP contracts
- b. Subsets, practices who have agreed to partner with each other, for VBP contracting?

13) What services do you provide to support small practices in performance-based/VBP contracts?

- 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

Organization, Management, and Governance

14) How do you organize/offer the shared services that you provide?

- a. Offered directly by your organization
- b. Offered via an affiliated/owned management services organization (MSO)
- c. Offered via pre-negotiated arrangements with outside vendors

15) How many personnel are employed in your shared services program (by service type)?

16) For whom do the individual shared service staff (care managers, educators) actually work?

- a. Who employs them?
- b. How and by whom are individual service professionals managed?
- c. Does management vary by type of service?

17) To whom is the shared services program accountable?

- a. Do practices participate in the governance of the shared services?

Economics

18) What was the initial investment required to mount your shared service capacity?

- a. How was that initial investment funded?

19) How much do these services cost you to operate and manage?

- a. Direct costs of the shared personnel and services
- b. Full cost, incl. allocated overhead and supervision (management, finance, HR)

20) How are practices charged for their use of shared services? Does your organization

- a. Absorb/cover the full costs for all your members, or
- b. Charge practices for the shared services they use (full cost, or direct costs)?

21) If costs of shared services are passed along to the practices, 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?
- c. Do payers pay a (negotiated) admin fee to the host organization (IPA/ACO, /system) for this infrastructure?
- d. Practices do not pay, but agree to meet specific performance standards (e.g. CAIPA)?

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

- a. If 20a or b, do practices receive reimbursement to cover these costs?
 - i. Are the payments enough to cover all the costs?
 - ii. What is the average margin or loss?
- b. If 20c or d, are the negotiated payments from payers or other sources of funding sufficient?
 - i. Are the payments enough to cover all the costs
 - ii. What is the average margin or loss?

Sustainability

23) Is the shared service offering sustainable for small practices, based on current practice economics?

- a. Why, or why not?

- i. If not, how much additional payment to PCPs might be needed to break even?
 - ii. What other revenue sources at your organization might cover the gap in costs?
 - b. Do you think there will be future funding (from payers, other revenues) to cover these charges?
- 24) **Is the shared service offering sustainable for small practices, based on their projected ROI from participation in VBP contracts?**
 - a. Why, or why not?
- 25) **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)

Expansion plans

- 26) **Do you plan to expand your service offering, provide more services than you do currently?**
 - a. What's on your list?
- 27) **Do you plan to expand to more practices?**
 - a. What type of practices would you offer these services to?

On Reflection...

- 28) **How important do you think the availability of affordable shared services is to small practices?**
 - a. If important, why?
 - b. If unimportant, why not?
- 29) **What were the hardest things to address when setting up a shared service capacity?**
- 30) **What are the hardest things to address when operating a shared service capacity?**
- 31) **What did we forget to ask, that's actually quite important?**

Appendix 3. Profiles of Host Organizations Providing Shared Services

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 subsidiaries⁴.

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;

⁴ 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.

support for quality improvement, measurement and reporting; and shared professional staff and services, including care 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 dietitians, 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.

Endnotes

¹ NYC Population Health Improvement Program. August 2016. *A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City*. <http://uhfnyc.org/publications/881151>

² The term “medical home” is used here and throughout this paper in its generic sense, covering a range of recognized and fundamentally similar primary care practice models, such as National Committee for Quality Assurance’s Patient-Centered Medical Home; New York State’s Advanced Primary Care program; the CMS Innovation Center’s Transforming Clinical Practice Initiative and its Comprehensive Primary Care Plus program; and a variety of payer-sponsored models.

³ Bodenheimer T, EH Wagner, and K Grumbach. 2002. Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2. *JAMA* 288(15): 1909–14.

⁴ Coleman EA, et al. 2006. The Care Transitions Intervention: Results of a Randomized Controlled Trial. *Archives of Internal Medicine* 166(17): 1822–8. Naylor MD, et al. 2011. The Importance of Transitional Care in Achieving Health Reform. *Health Affairs* 30(4): 746-54.

⁵ New York State’s Delivery System Reform Incentive Payment program (DSRIP) and Patient-Centered Medical Home; New State Innovation Models and Advanced Primary Care, CMMI’s Transforming Clinical Practice Initiative and Comprehensive Primary Care Plus program, and a wide range of payer-supported models.

⁶ Burke G and S Brundage. 2016. *Performance of New York’s Accountable Care Organizations in Year 2 of the Medicare Shared Savings Program*. United Hospital Fund. <https://uhfnyc.org/publications/881114>. Burke G. 2015. *Recent Trends and Future Directions for the Medical Home Model in New York*. United Hospital Fund. <https://uhfnyc.org/publications/881069>

⁷ New York State Department of Health. June 2015. *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*. Retrieved from New York State Department of Health: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

⁸ “Messenger model” refers to a contract negotiation process wherein a third party, such as an IPA, conveys a fee schedule to its member providers, who then have the option to individually accept or reject the contract terms—i.e., a provider can be an IPA member, but not a contract participant.

