Exploring Community Care Cooperative: An All-FQHC ACO Participating in Massachusetts' Medicaid ACO Program

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Overview of Community Care Cooperative

• In 2016, **15 Community Health Centers** (all FQHCs) formed a new MassHealth Accountable Care Organization (ACO) called **Community Care Cooperative (C3)** (www.C3aco.org)

• An ACO is a group of health care providers that work together and are “accountable” for both the **Total Cost of Care** provided to their patients and for the **Quality** of the care provided

• An ACO provides high-quality, coordinated care to a defined population in a way that is different from historic fee-for-service

• **C3 is a Primary Care ACO** which means patients can access the full MassHealth PCC Network. Patients may see any specialist or hospital that accepts MassHealth at any time with no new paperwork rules
C3’s Statewide Footprint

[Map of Massachusetts with locations marked by numbers and associated health care organizations]
Membership Criteria

- Must be a Federally Qualified Health Center (FQHC)
- Must be Patient Centered Medical Home (PCMH) accredited
- Must be in Good Standing with MassHealth, CMS, and HRSA
- Last audited financial statements support that the organization is a Going Concern and thereby, the entity has neither the intention nor the need to liquidate or materially curtail the scale of its operations in the upcoming 12 months
- Must be willing to create needed EHR and other currently required clinical data exchanges and at their own expense and have these capabilities tested in and production for date of entry
- Agrees to adhere to C3’s shared principles of collaboration and cooperation
- Agrees to adhere to all regulatory requirements
- Clinicians must use ONC certified EHR’s
- Agrees to pay one-time membership fee
Why a Health-Center Based ACO?

American Journal of Public Health June 2016 article: **Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings**

- Compared health care use and spending of Medicaid enrollees seen at FQHCs versus non–health center settings
- **Methods.** Using fee-for-service Medicaid claims from 13 states in 2009, we compared patients receiving the majority of their primary care in federally qualified health centers with propensity score–matched comparison groups receiving primary care in other settings.
- **Results.** Patients had lower use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care and 25% fewer admissions and 27% lower spending on inpatient care. Total spending was 24% lower for health center patients.
- **Conclusions.** Our analysis of 2009 Medicaid claims, which includes the largest sample of states and more recent data than do previous multistate claims studies, demonstrates that the health center program has provided a cost-efficient setting for primary care for Medicaid enrollees.
What Makes C3 Unique?

Most Massachusetts ACOs are hospitals or health systems

VS

C3 is the only health-center based ACO and one of only three non-system based ACOs in Massachusetts

We have the ability to transform the health of those we serve in a way that large health systems are simply unable to do.
How Did We Bring Health Centers Together?

• At the time we were putting the Company together, the market dynamics in the state were very similar to what we see nationally:
  o Hospitals/hospital systems were aggressively acquiring primary care, through acquisitions or through ACO affiliations
  o All of our health centers were assuming they had to join a hospital system to participate in the MassHealth ACO Program
  o Therefore, when health centers learned there was a different viable option, we quickly gained momentum and participation
Why is this Critically Important?

• Interestingly, health centers take more risk in C3 than they do in hospital system ACOs
  o We believe this is critical to provide a burning platform for health centers to develop the capabilities needed to both succeed in VBPs and also to remain competitive as new competitors enter the Medicaid market
  o Systems tend to protect health centers from risk in exchange for health centers abdicating real influence in governance or how infrastructure dollars are invested
Why Do FQHCs Like C3?

- Best chance at financial success
- Best strategy to preserve health center autonomy
- We learned a lot from NY’s 1115 waiver

**Typical Model**
- DSRIP
  - $ comes from State to ACOs
- ACO
  - ACO passes funds to hospital
- Hospital system
  - Hospital system decides how to spend money
- Health Center
  - Health center gets what is left

**C3 Model**
- DSRIP
- ACO
- FQHC
- FQHC
- FQHC

Typical Model

C3 Model
Why We Chose a Primary Care/Model B ACO

• As an independent FQHC-based ACO, our organization wants to be the decision maker about how we are organized and operated
• Offers members the greatest choice of doctors and hospitals through full PCCC network
• Performance risk and not insurance risk
• Obtains unit pricing from MassHealth
• No quibbling over “who gets what” with regards to DSRIP and/or administrative dollars with an MCO
• No “core business” conflicts over roles, responsibilities and priorities
Why We Think Our Strategy Can Work

- As a health center-based ACO, we do not face the core existential issue that a traditional system ACO must overcome to achieve cost savings targets
- This allows us to leverage a whole new approach to managing the cost and quality of vulnerable populations
- Our care model is designed to de-medicalize an approach to health, wellness and happiness
  - Moving from “health care” to “health” for vulnerable populations
  - Meaningful whole person care: highly integrated physical & behavioral health
  - More engagement of community partners
  - More focus on alleviating social impediments to health, wellness & happiness
- We have already created “a coalition of the willing” locally and nationally of organizations that want to support our efforts
  - We have also received numerous inquiries from throughout the country
Internal Financial Architecture (IFA) Scope & Guiding Principles

• Our IFA methodologies included:
  o Risk Unit budget setting
  o Internal funds flow
    – Surpluses
    – Deficits
  o Performance management systems, including remediation
  o How quality impacts financial performance

• The principles behind these methodologies include key elements such as:
  o Ensuring risk unit actuarial stability
  o Aspects of socialization of risk to support ACO-wide goals
  o Rightsizing the amount of ‘skin-in-the-game’
Risk Tiers & Care Management Delegation

• We offer three choices for how much risk a health center assumes:
  o High: high financial exposure, high care management delegation
  o Medium: medium financial exposure, medium care management delegation
  o Low: minimal financial exposure, no care management delegation
• We work to ensure that health center choices match their capabilities based on fiscal position, experience with risk contracts, and ability to recruit, manage and retain the staff required to perform the work
• All Health Centers, regardless of delegation level are held accountable for adhering to the Model of Care and will be measured against the same KPIs
• The board must approve a health center’s risk tier election
• The board has the right to revoke a risk tier election
• High delegation sites are overseen by an ACO Delegation Manager
Solving our Capital Need Requirements

• A major barrier to entry to two-sided ACO risk for health centers is access to needed capital
  o A fundamental problem with addressing rising health care costs is that the industry sectors who are responsible for the majority of cost growth are also the ones with all of the capital (hospitals; pharma)
  o Efficient industry sectors therefore, have not amassed capital (FQHCs)
  o Therefore, if the state and/or federal government want to support efficient sectors in leading in health reform efforts, they need to figure out how to support these organizations in solving capital their capital needs
• As a non-profit, start-up, FQHC-ACO, we had to solve this issue
Solving Capital Needs

• Although we had interest from the private capital market, the end of every conversation was being asked to put up health center balance sheets as collateral
• Therefore, we had to figure out how to solve this problem in a different way
• Through a competitive RFR process, we found a company to contract with who could assist us with operating needs and capital needs
• When coupled with the Primary Care ACO design, and external reinsurance polices, we were able to put in place a solid capital plan that satisfied all Massachusetts regulatory agencies and met MassHealth contract requirements
What can MassHealth do to support our success?

• In many ways, this is completely new role for MassHealth
  o As our Third Party Administrator (TPA), we are their customer
    – For us to succeed, they need to be extremely effective in this role, including ensuring that:
      » Systems are operating correctly
      » Issue resolution TAT reflects level of operational impact
      » Data is of the highest integrity
      » A customer-focused approach is acculturated
Systems & Data Flows: How We Create the Data Assets

**FQHCs / EMRs**
- Brockton
- Charles River
- Cape Cod
- Franklin County
- Dimock
- East Boston
- Fenway
- Hilltown
- Holyoke
- Lynn
- North End
- North Shore
- Upland's
- EMK
- Family

**HOSPITALS**
- Baystate Franklin
- Baystate Med Center
- Beverly (Lahey)
- BIDMC
- Boston Med Center
- Cape Cod Health Care
- CHA
- Children's
- Cooley Dickinson
- Good Samaritan
- Holyoke Hospital
- Holyoke Med Center
- Partners
- Signature Brockton
- St. Elizabeths
- UMass
- St Vincent's
- Metrowest

**PAYERS**
- MassHealth
- Eligibility, Medical Claims, Rx Claims, BH Claims

**LABS**
- Quest Diagnostics
- LabCorp
- Quest VPN?
- LabCorp VPN?

**OTHER DATA**
- Beacon
- Dartmouth
- Healthify

**EDW**
- Analytics Engine

**EVOLENT**
- Identifi Practice
- Identifi Care
- Identifi Analytics
- RAF
How We Use Data to Help Us Provide the Right Care at the Right Time

- Patient screens
- EHR
- SDoH data
- Claims
- ADT & Auth alerts

“The Main Brain”
Data Warehouse with a Rules-based engine

- Risk of Big Events
- Complex Care
- Risk of Readmissions
- Transitions of Care
- Care & Social Needs
- Care Coordination
- Gaps in Quality & Care
- Performance Analytics
  - Cost & Quality performance information
- Population Health & Risk Adjustment
The Model of Care

Our Model of Care:

- Builds on existing capabilities and strengths at our health centers
- Integrates new programs at the provider level (health center or hospital)
- Improves quality of care for patients
- Brings targeted and tailored care to the entire population