Community Care Cooperative’s Journey from Start-Up to Industry Leader

A Modern Robinhood Tale
Christina Severin

President and CEO of Community Care Cooperative
Overview of ACOs
What is an ACO?

- An ACO is a provider-led entity (e.g., a group of providers or a health system), that includes PCPs.
- ACOs are expected to build explicit coordinated care teams with providers across the care continuum.
- ACOs are expected to deliver a coordinated and improved member experience.
- ACOs are rewarded financially for achieving costs and quality measures.
- ACOs are financially penalized for overspending budgets and/or not meeting quality goals.
Arguably, although the term “ACO” might be relatively new, the concept is not.

The Staff Model HMOs of the 1980s-1990s were essentially ACOs, however, a major difference from Staff Model HMOs and today’s ACOs is the ability to incorporate quality measurement in program design.

In Massachusetts, Commercial insurance companies have been doing ACO contracting with providers since 2009.

Through the Affordable Care Act, CMS started a Medicare ACO program in 2011 which is still in place today.
The Origins of the MassHealth ACO Program

- MassHealth (MA Medicaid program) is unsustainable
  - Grown to 40% of the Commonwealth’s budget (over $15 billion per year)
  - Serves 1.9 million MA residents
  - No major structural changes in the last 20 years

- CMS authorized a $1.8 billion investment over 5 years
  - Expansive “restructuring” initiative
  - Funding will support the move to ACOs
Overview of Community Care Cooperative
Our Story

Early 2016
Nine health center leaders created Community Care Cooperative to play a leading role in a redesigned Medicaid program, facing stiff opposition.

Late 2016
MA launched its value-based redesign of Medicaid in December 2016 with a one-year Accountable Care Organization Pilot program.

2019
We grew to 17 health centers serving 125,000 Medicaid members in the largest ACO in Massachusetts.

2021
We expect to go-live with a second risk contract and expand our transformation of health center-based care with a fundamental change in payment methodology.
Current Vision, Mission and Strategy

- **Vision**
  - Transforming the health of underserved communities

- **Mission**
  - To leverage the collective strengths of federally qualified health centers to improve the health and wellness of the people we serve

- **Strategy**
  - We unite federally qualified health centers at scale to advance primary care, improve financial performance, and advance racial justice.

- **Core values**
  - Social Justice
  - Integrity
  - Learning
  - Respect
  - Optimism
  - Results
Our Statewide Footprint
Great Health is Our Primary Purpose
At a Glance: History of Health Centers

1965
Demonstration in Massachusetts and Mississippi

1975
Health Centers were authorized on a permanent basis under section 330 of the US Public Health Service Act

2017
27 million patients received care at 1,373 health centers in every state in the U.S.
Health Centers Provide Care to 1 in 12 People in the US, including:

- 1 in 3 people living in poverty
- 1 in 5 people in rural areas
- 1 in 6 Medicaid beneficiaries
- 1 in 8 people of a racial/ethnic minority
- 1 in 9 children

Source: NACHC Community Health Center Chartbook, January 2019
Health Centers Provide *Better* Care for Patients Than Other Forms of Primary Care

- Health Centers Achieve Higher Rates of Hypertension and Diabetes Control than the National Average, Despite Serving Higher Need Population

![Bar chart showing comparison between National and Health Center percentages for hypertension and diabetes control.]

- Health centers provide more accessible and satisfying care
  - 96% of low-income patients satisfied with FQHC hours vs. 37% nationally
  - 98% of low-income patients satisfied with FQHC care vs. 87% nationally

Source: NACHC Community Health Center Chartbook, January 2019
Health Centers Provide More *Economic Value* Than Other Forms of Primary Care

Health centers deliver **24% lower** total health care spending than non-health center based care...

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Health Center (n = 144,075), Estimate (95% CI)</th>
<th>Health Center (n = 144,075), Estimate (95% CI)</th>
<th>Difference, a % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits, no.</td>
<td>8.2 (8.2, 8.3)</td>
<td>7.6 (7.6, 7.7)</td>
<td>-7 [-8, -7]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>1845 (1815, 1876)</td>
<td>1430 (1418, 1442)</td>
<td>-23 [-24, -21]</td>
</tr>
<tr>
<td>Other outpatient care b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits, no.</td>
<td>15.7 (15.5, 15.9)</td>
<td>12.2 (12.0, 12.4)</td>
<td>-22 [-24, -21]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>2948 (2900, 2996)</td>
<td>1964 (1938, 2000)</td>
<td>-33 [-35, -32]</td>
</tr>
<tr>
<td>Prescription drug spending, $</td>
<td>2704 (2664, 2744)</td>
<td>2324 (2296, 2352)</td>
<td>-14 [-16, -12]</td>
</tr>
<tr>
<td>Emergency department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits, no.</td>
<td>1.3 (1.3, 1.4)</td>
<td>1.2 (1.2, 1.2)</td>
<td>-11 [-13, -10]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>244 (240, 247)</td>
<td>216 (213, 219)</td>
<td>-11 [-13, -10]</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions, no.</td>
<td>0.25 (0.25, 0.26)</td>
<td>0.19 (0.19, 0.20)</td>
<td>-25 [-27, -22]</td>
</tr>
<tr>
<td>Length of stay, c, d</td>
<td>1.1 (1.1, 1.2)</td>
<td>0.8 (0.8, 0.9)</td>
<td>-26 [-29, -23]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>2047 (1987, 2114)</td>
<td>1496 (1446, 1548)</td>
<td>-27 [-30, -24]</td>
</tr>
<tr>
<td>Total spending, $</td>
<td>9889 (9784, 9996)</td>
<td>7518 (7448, 7597)</td>
<td>-24 [-25, -23]</td>
</tr>
</tbody>
</table>

Source: Nocon et al, Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings, Am J Public Health 2016
Why is this Critically Important?

- Interestingly, health centers take more risk with us than they do in hospital system ACOs
  - We believe this is critical to provide a platform for health centers to develop the capabilities needed to both succeed in VBPs and to remain competitive as new competitors enter the market
  - Systems tend to protect health centers from risk in exchange for health centers demanding real influence in governance or how infrastructure dollars are invested
  - Systems may also drive primary care providers, like health centers, to “performance measures” that do not advance authentic ACO goals, but support hospital goals
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 PCC 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.
Finance & Funds Flow
Health Centers Take Meaningful Risk Together

Our internal risk model achieves 3 goals:

1. Meaningful incentives for health centers
2. Responsible and actuarially valid risk sharing
3. Ensuring we can manage, and repay if needed, the risk we take
Internal Risk Model: Scope & Guiding Principles

- Our internal risk model achieves three goals
  - Meaningful incentives for health centers
  - Tailored, responsible and actuarially valid risk sharing
  - Resilient risk sharing model in which health centers, C3, and excess loss insurance account for one-third each of shared losses in a worst case scenario
- This model is summarized in a transparent written policy approved by the Board called the Internal Financial Architecture (IFA)
  - Describes risk tiers and how surplus and deficits are accounted for at the health center and C3 level
  - Includes an important role for quality in surplus and deficit situations
  - Provides pooling and risk transfer to mitigate impact of high cost claimants
- In summary, the IFA allows health centers 3 choices of up/down risk so they can pick a level of risk that matches their expertise and financial position
Our Financial Model with MassHealth

“Budgeted reconciliation” total cost of care (TCOC) model
- FFS claims continue to get billed and paid
- At the end of the year, all of the FFS claims are added up and debited against the TCOC budget
  - If budgeted dollars are left after debiting all FFS claims, the ACO keeps some of the money
  - If budgeted dollars are overspent after debiting all FFS claims, the ACO gives back some of the money
- Then the State uses our quality performance to determine final performance
Solving our Capital Need Requirements

- A major barrier to entry to two-sided ACO risk for health centers is access to needed capital
  - 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)
  - As a result, efficient industry sectors have not amassed capital (FQHCs)
  - Therefore, if the government payers and/or private payers want to support efficient sectors in leading health reform efforts, they need to figure out how to support these organizations in solving capital needs/requirements
- As a non-profit, start-up, FQHC-ACO, we had to solve this issue
How We Use a Portfolio Strategy for Risk Distribution

Illustration

- Max Exposure: 14.3
- Excess loss insurance: -4.9
- FQHC share of risk: -5.5
- Misc other risk sharing: -1.1
- Remaining ACO risk: 2.7
To take on TCOC two-sided risk, an ACO must have a strategy to harvest multiple data streams into a harmonized enterprise data warehouse (EDW).

The EDW becomes the engine of virtually all aspects of the operating model, including:

- Rules-based approach to workflow automation
- Universe for performance analysis, actuarial, financial reporting, KPIs
- Research database
Systems & Data Flows: How We Leverage Data Assets

[Diagram showing data flows between various entities such as FQHCs/EMRs, Hospitals, Payors, and Labs.]
Structured Care Management

- Manage chronic patients with a comprehensive, longitudinal record across all points of services and clinical IT systems
- Reach out to patients via phone or SMS message and capture responses
- Intuitive workflows to capture notes about interactions and share with the care team
- Task yourself or others with follow-up actions on a patient
- Build and assign cohorts based on engagement level, risk, chronic conditions, or care gaps
Risk Adjustment

- Use automated EHR interfaces to perform thousands of chart audits in minutes.
- Identify opportunities to more accurately document patient risk, increase reimbursements, and improve patient care.
- Deep-mining of unstructured data powers enhanced risk algorithms – HCC, CDPS, and Johns Hopkins ACG.
- Real-time risk profiling and full progress note availability.
Patient Empanelment & Management

- Unified patient registry presents patient complexity across 85 condition categories
- Track patient risk and find documentation gaps leading to under-represented acuity
- High cost and high risk prioritization
- Dozens of decision support rules and alerts highlight quality gaps
- Integration with scheduling data for highly relevant pre-visit planning reports
- Customize and share your lists with other members of the care team
Quality Measure Management

- CMS ACO
- CMS QPP (MIPS)
- State and Regional P4P
- NCQA HEDIS
- NCQA PCMH
- CQM
- NQF
- UDS
- and more coming every month...
The Cost and Utilization Analysis functions of Arcadia Analytics allow you to see patterns and trends for your emergency care population through interactive geographical maps, graphical data visuals, and side-by-side comparisons of data. Measure sets that may be included within your implementation include:

- Medical Expense Management Dashboard
- Utilization Analysis
- ED Detail
- ED Frequent Flyer Report
Bindery

Bindery is a novel publishing user interface and distribution platform for complex ACO contract analytics and provider scorecards for the enterprise.

- Email “push” of pixel-perfect PDF printouts of complex scorecards, PHI redacted, with secure links to interactive patient-level content.
- Scorecards are built from a library of “cards” that cover topics like cost grouping & continuance, membership trends, demographics, and more.
- Rich configuration capabilities mean analytics can be custom-tailored for your organization.
Send appointment reminders, visit requests, and other patient engagement nudges to thousands of patients with one click.

Supports text messaging (SMS) or natural text-to-speech phone calls.

Dynamic text populates a message with up to 12 dynamic parameters.

Capture patient responses, including any opt-out requests.

Role-based access puts the feature in the hands of those that need it, and nobody else.

Fully customized outreach templates can be shared independently with different users.
Success and Growth
Growth

- Health Centers: 18 FQHCs
- Membership: 159,000 Members

Year:
- 2018
- 2019
- 2020
- 2021
Early Success in Shared Savings

- In 2018, our first full year of operation as an ACO, we saved $12.4M for the Commonwealth of Massachusetts; on a $533.6M total cost of care budget, our actual claims were $521.3M, 2.3% lower than expected.
- Because of this efficiency, we earned an $8.1M shared savings payment, and by earning a 100% quality score from the state Medicaid program, it also received $1.3M. We were able to share $5M with its health center members, numbering 15 at the time.
- We achieved this efficiency through supporting advanced and holistic primary care at their health centers, as well as providing training, IT, quality, and practice improvement programs and strengthening relationships with patients and their communities.
COVID Response and Telehealth

- In partnership with the MA League of Community Health Centers, we created the FQHC Telehealth Consortium, comprised of 35 of the 37 FQHCs throughout the Commonwealth
- To date we have raised over $11M to launch robust telehealth services, purchase equipment and internet access for patients, conduct FQHC/community needs assessments, and expand expertise for technology, capacity, and workforce planning
Awards

The Boston Globe

CHRISTINA SEVERIN
President and CEO of Community Care Cooperative
#1 Women-Led Business in Massachusetts, 2019

- We have been named one of the Top 100 Women Led Businesses in MA for the past four years in a row
- In 2019, we ranked #1 on this list, which is awarded by the Boston Globe and Commonwealth Institute
We launched our Flexible Services program in April 2020 to provide food insecurity, housing instability, and homelessness support for eligible C3 members across the state.

Partnered with 14 social service organizations (SSO) statewide to engage members – this program is available to all health centers.

Members are assigned to a nutrition or housing specialist at the SSO.

The SSO provides intensive case management for nutrition and housing issues, as well as goods and services to meet member’s unique needs.

Services and goods provided:

- Home delivered, medically tailored meals
- Grocery store gift cards
- Kitchen items
- Nutrition education

- Housing search and transition support
- Housing stabilization through goods/services
- Home modifications to support mobility challenges or environmental concerns
Social Determinants of Health: Flexible Services

5,300 Members served since program launched April 2020 through partnerships with 19 SSOs

Target population: Members with complex physical & BH needs and high ED utilization

Program activity:
- 5,000 nutrition referrals
- 1,350 housing referrals

Spending to date: $5.6 M
- 76% nutrition, 24% housing
- 38% on services, 62% on goods provided directly to members
Preliminary Program Outcomes

- Improvements in Food Insecurity & Food Stability
- Improvements in Housing Instability
- Reduction in average Total Cost of Care
  - Members who successfully completed the nutrition program had a greater reduction in TCOC: $11,309 decrease vs $345 decrease (p=0.013)
  - Comparison Group: Eligible TOC and CM members
- Lower ED Utilization: Only 8% of FS members had 4+ ED visits during the time period vs 31% in comparison group
Current Strategic Focus: Getting Off of FFS

- **Primary Care Capitation**
  - For the last several years, we have had a policy agenda of getting off of the Fee-for-Service chassis and into prospective, enhanced primary care capitation.
  - This policy agenda includes pulling up all vestiges of the FFS system:
    - A non-encounter-based cap build up
    - Non-claims-based risk adjustment
    - Non-claims-based quality measures
  - We call this, Integrated Primary Care and we have developed our own standards and outcomes for IPC.
The Integrated Primary Care Model

- Engaged Leadership
- Quality Improvement
- Patient Centered Access
- Behavioral Health Integration
- Substance Use Treatment
- Social Determinants of Health
- Trauma Informed Care
Current Strategic Focus: Expand Risk Contracting

- We are expanding our risk contracting in order to:
  - Serve more patients served under a transformative primary care capitation model
  - Bring the best value-based care economics possible to FQHCs, measuring performance in a transparent and fair framework

- Focus today is BCBS AQC and Medicare Direct Contracting
  - We expect to go live 1/1/2022 with small group AQC
  - We have completed negotiations with a current DC Entity to join their group for 1/1/2022
  - We expect to add additional risk contracts once this work is complete
Current Strategic Focus: Shared Services

- We are working on offering Shared Services to health centers to support/improve their business operations
  - Epic EHR implementation
    - Currently working with a large group of health centers, both C3 and non-C3, who are interested in going direct to Epic (hosted)
  - Pharmacy services
    - Increasing health center control over the clinical and financial benefits of health center prescribing
  - Insurance Captive
    - Saving FQHC employers the cost of carrier profit margins, and aligning both employee health and employee health care cost concerns for the long-term
  - Coding services
    - Supporting more accurate coding in value-based contracts
In Closing

- The ACO movement is still new and the data on results is mixed
  - However, there is consistent data that provider-led (not hospital) ACOs are achieving significant savings

- Independent primary care in MA and nationally, is becoming an endangered species
  - If we let independent primary care become extinct, it will be another dark point in any hope to control health care cost and quality
    - Hospitals and health insurance companies will be the only voices in the health care ecosystem

- Health care cost and quality are inversely related
  - If you care about controlling costs and improving quality, please find ways to support local primary care
Thank You

Questions?

@C3aco
Community Care Cooperative
www.communitycarecooperative.org