COMMUNITY
CARE COOPERATIVE

Community Care Cooperative: Harnessing the Power of FQHCs to Drive ACO Success

Overview of Community Care Cooperative

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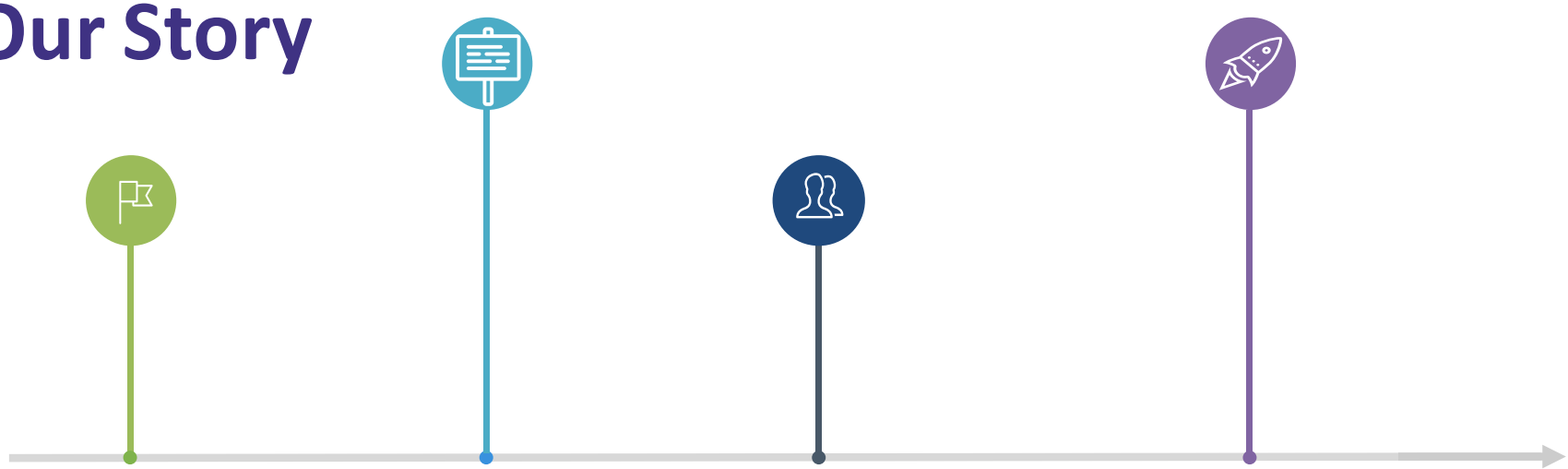
Our Story



Early 2016

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

2018

We launched our MassHealth ACO with 15 health centers and 110,000 members following a one-year ACO Pilot

2019

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

2022

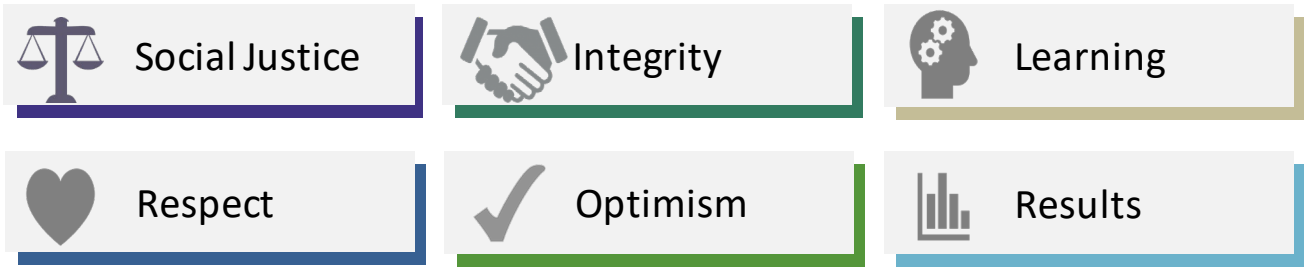
We are 18 FQHCs serving 170,000 members in 3 risk contracts; our BCBS and Medicare DC contracts have a primary care capitation

We have launched pharmacy and IT (Epic) services subsidiaries

We will welcome several new FQHCs in 2023
We are exploring out-of-state work

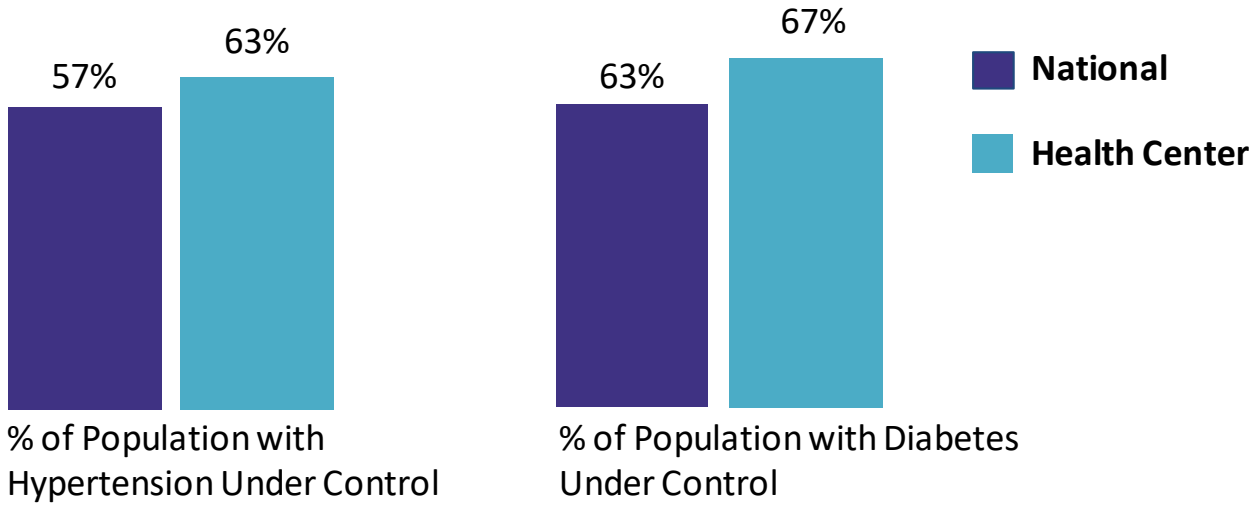
Current Vision, Mission and Strategy

- 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



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



- 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

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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 2—Use and Expense for Health Center Patients Compared With Matched Non–Health Center Patients: United States, 2009

Variable	Non-Health Center (n = 144 075), Estimate (95% CI)	Health Center (n = 144 075), Estimate (95% CI)	Difference,[a] % (95% CI)
Primary care			
Visits, no.	8.2 (8.2, 8.3)	7.6 (7.6, 7.7)	−7 (−8, −7)
Spending, $	1845 (1815, 1876)	1430 (1418, 1442)	−23 (−24, −21)
Other outpatient care[b]			
Visits, no.	15.7 (15.5, 15.9)	12.2 (12.0, 12.4)	−22 (−24, −21)
Spending, $	2948 (2900, 2996)	1964 (1930, 2000)	−33 (−35, −32)
Prescription drug spending, $	2704 (2664, 2744)	2324 (2296, 2352)	−14 (−16, −12)
Emergency department			
Visits, no.	1.3 (1.3, 1.4)	1.2 (1.2, 1.2)	−11 (−13, −10)
Spending, $	244 (240, 247)	216 (213, 219)	−11 (−13, −10)
Inpatient			
Admissions, no.	0.25 (0.25, 0.26)	0.19 (0.19, 0.20)	−25 (−27, −22)
Length of stay,[c] d	1.1 (1.1, 1.2)	0.8 (0.8, 0.9)	−26 (−29, −23)
Spending, $	2047 (1987, 2114)	1496 (1446, 1548)	−27 (−30, −24)
Total spending, $	9889 (9784, 9996)	7518 (7440, 7597)	−24 (−25, −23)

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

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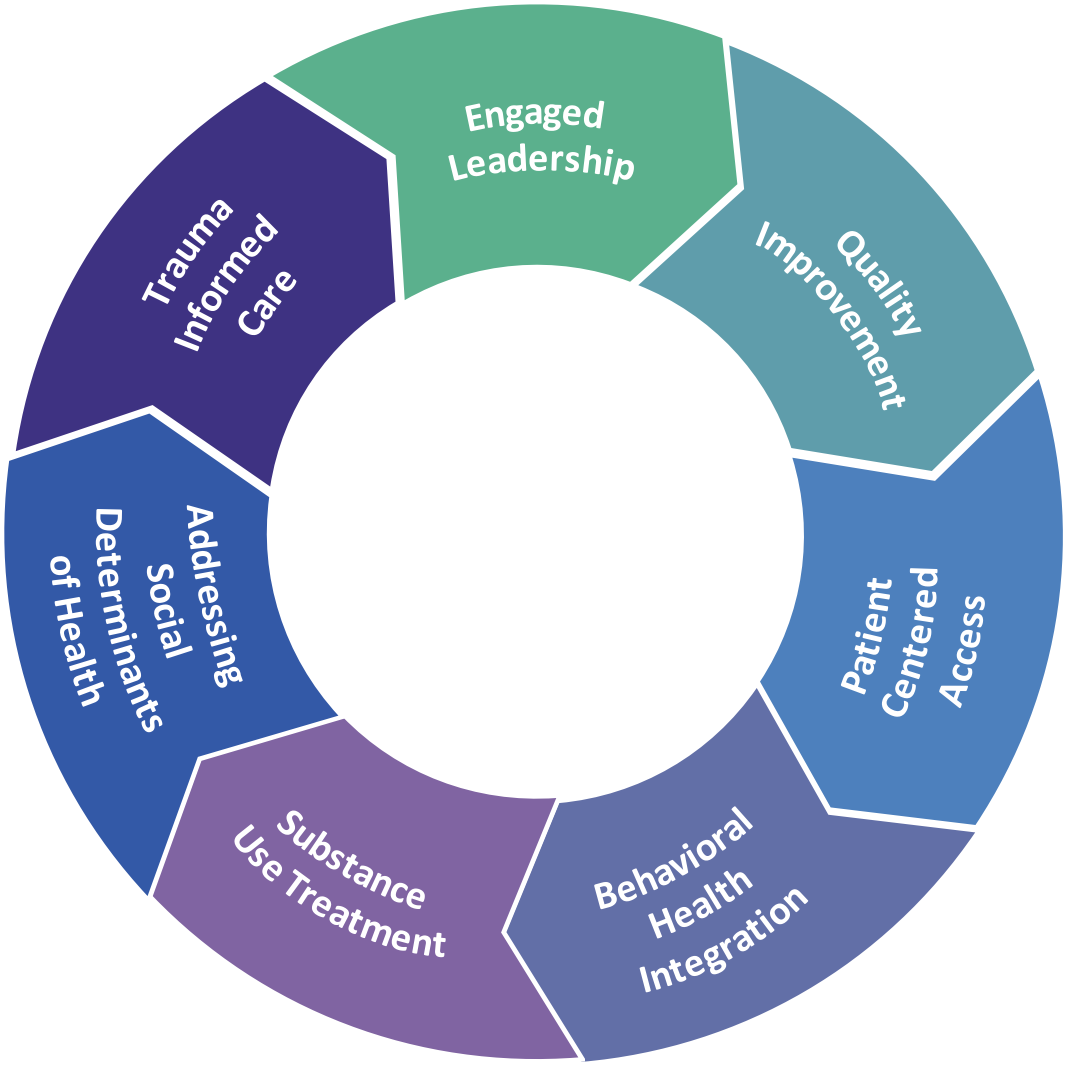
Primary Care Capitation: The Integrated Primary Care Model



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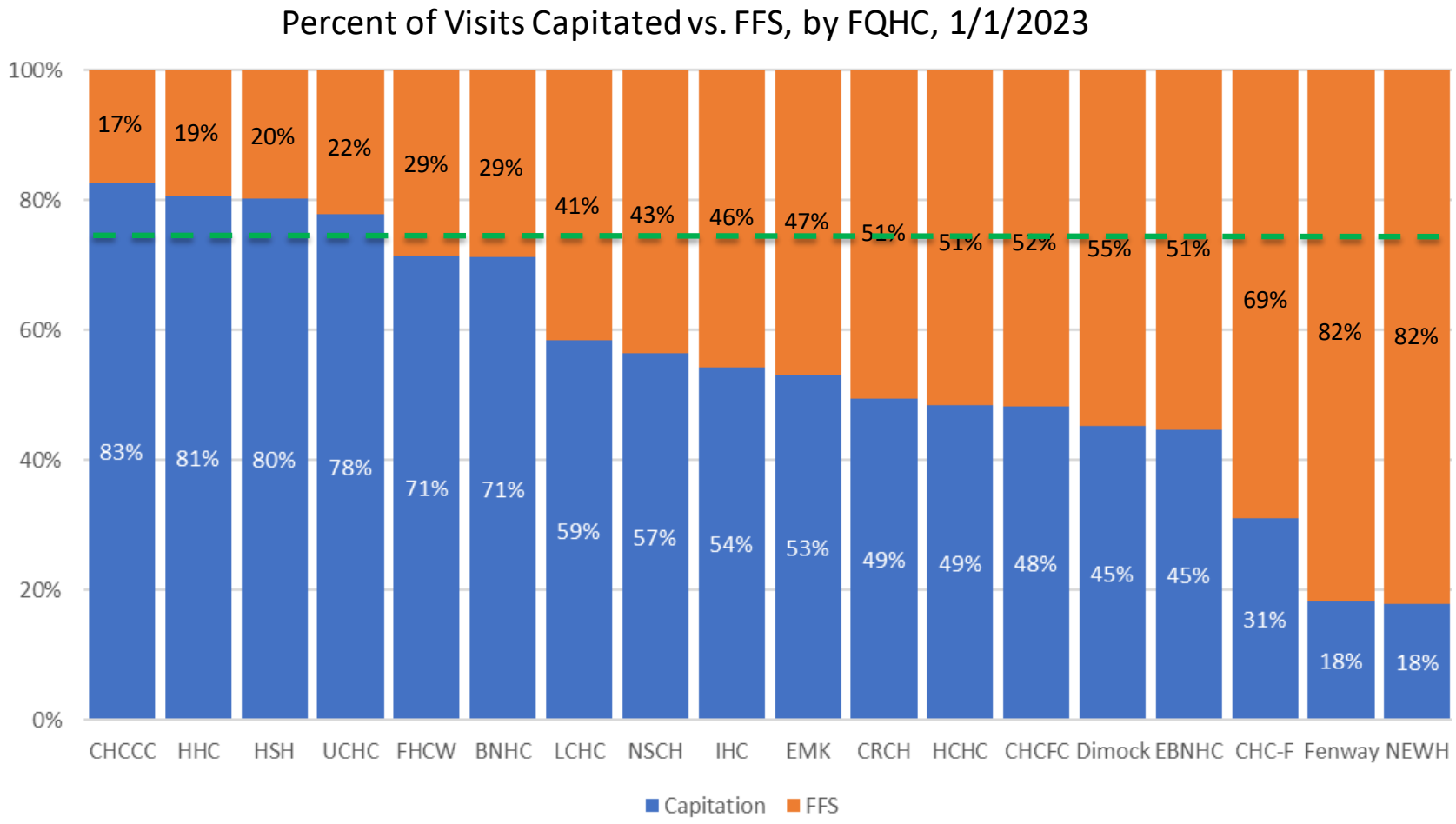
Goal is >70% in Primary Care Capitation



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Finance & Funds Flow

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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

Health Center Risk Taking

Low $ Risk/Low Care Management Delegation

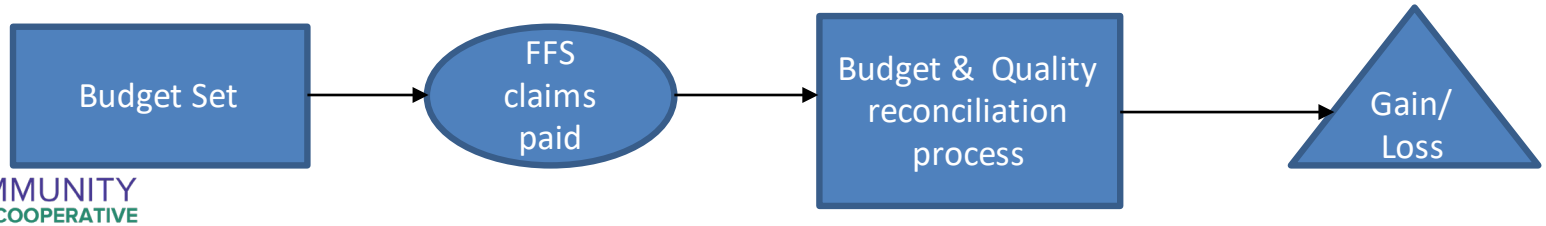
Medium $Risk/Medium Care Management Delegation

High $ Risk/High Care Management Delegation

- We offer three choices for how much risk a health center assumes
- We work to ensure that health center choices match their capabilities based on fiscal position, experience with risk contracts, and overall ability to perform population health and care management work
- The board must approve a health center's risk tier election and has the right to revoke a risk tier election
- This model is summarized in a transparent written policy approved by the Board called the Internal Financial Architecture (IFA)
- Provides pooling and risk transfer to mitigate impact of high-cost claimants
- Budget setting at the health center level

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



Flexible Services Program

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Flexible Services for Food/Nutrition & Housing Supports (2020 Program Start)

Identify Eligible Members

- Use HRSA screen tool to identify needs
- Ensure member meets criteria based on medical/BH complexity

Refer to a Contracted Social Service Organization

- Identified members are referred to a contracted SSO
- SSO fulfills need
- We reimburse SSO

Ensure Service Provided and Measure Success

- Ensure all services have been provided
- Observe changes in clinical outcomes and utilization

Services and goods provided:

- Housing search and transition support
- Housing stabilization through goods/services
- Home modifications to support mobility challenges or environmental concerns

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

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Flexible Services Referrals & Activity

6,657 unique members referred
6,052 received services (91%)

6,250 referrals to Nutrition Programs
1,800 referrals to Housing Programs
- 60% At Risk of Homelessness
- 40% Experiencing Homelessness

1,942 Active Members
- 469 members receiving individualized housing case management and navigation
- 1,700 members receiving nutrition coordination and goods
- 250 members receiving home delivered medically tailored meals

- $8,400,000 for goods and services
- 73% Nutrition Program
- 27% Housing Program

- $2.6M in food vouchers
- 127,000 home delivered meals
- 2,000 members received household items to aid better nutrition

- Leveraged >$600,000 in RAFT/ERAP support to prevent eviction
- $110,000 Move-In Costs
- $48,000 Home modification

"This program is great! With the gift cards and kitchen supplies you sent, I was able to cook more at home, follow recipes, and cook healthier. Thank you so much!"

Flexible Services Program Outcomes

Improvements in Food Insecurity & Food Stability

25% of members served by Food SSO fully food secure at 6 months

Improvements in Housing Instability

- *>300 members now report housing stability*
- *~100 members moved into housing (~13% of members experiencing homelessness)*

Reduction in average Total Cost of Care

- *Preliminary data shows reduction in TCOC vs comparison group after program completion and in pre-post analysis driven by a reduction in medical costs*

Reduction in Utilization

- *Fewer members with high ED utilization in the FS group vs comparison group and lower overall ED visits, inpatient admissions and inpatient days*

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Thank You

Questions?

@C3aco

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