NATIONAL ASSOCIATION OF
Community Health Centers

Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

See: https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf

Successful Practices in Accountable Care: Carolina Medical Home Network

ACO Profile

ACO Name: Carolina Medical Home Network

Location: North Carolina

ACO Type: Health Center led (100% board representation)

Member Health Centers: Advance Community Health, Gaston Family Health Services, Goshen Medical Center Inc., Piedmont Health, Roanoke Chowan Community Health Center, Rural Health Group

Medicare Shared Savings Program established: 2015

Number of attributed Medicare lives: Approx. 15,000

Source: Eick, R. (2016 June 3). Telephone Interview

Laying the Foundation

Carolina Medical Home Network (CMHN) is a health center-led accountable care organization (ACO) made up of six North Carolina health centers. Since January 2015, CMHN has participated in the Medicare Shared Savings Program (MSSP), which was established by the Affordable Care Act to "facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs[1]." ACOs in the MSSP are responsible for improving care coordination, increasing quality, and decreasing the cost of care for an attributed population of Medicare patients ("attribution is the process of assigning patients to a primary care physician in a population health program). If they are able to achieve the required level of savings, the Centers for Medicaid and Medicare Services will give the ACO a share of the savings.

The MSSP gives participants an opportunity to test value-based models of care and offers unique benefits and challenges, particularly for health centers. As a fairly new MSSP participant, CMHN has a unique perspective on the application process, the implementation phase of the ACO, and goals for the future. The content of this paper is based on an interview with Dr. Robert Eick, MD, MPH, Executive Director of Carolina Medical Home Network. All data has been shared with permission. Quotes have been edited for clarity.

Why the MSSP?

The North Carolina Community Health Center Association (NCCHCA) has played an important role in the development of this ACO. The process began in 2013 when the PCA formed an independent practice association (IPA) with 27 of its health centers in anticipation of Medicaid Managed Care in NC. The goal

1 Medicare Shared Savings Program. Centers for Medicare and Medicaid Services. Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/sharedsavingsprogram/index.html

was to position health centers to have a stronger collective voice to approach negotiation with managed care plans. In 2014, the PCA and four members of the IPA formed Carolina Medical Home Network. According to Dr. Eick, they decided to pursue the MSSP to "help health centers get their feet wet in value-based care in a way that they have some skin in the game at least from an upside risk standpoint and that they could get shared savings if they performed well."

They also understood that none of the health centers were in a position to participate in a fully capitated model, where they could be subject to large financial losses if they performed below a certain benchmark. By starting with the Medicare population, which is only 12% of the payer mix statewide, health centers could take on a reasonable amount of risk but would not be subject to any risk for at least three years. Additionally, the PCA had also laid important groundwork in terms of IT infrastructure through its Health Center Controlled Network. Because of this work, they were able to look at data on their population and were on the verge of being able to use that data on the ground to directly impact patient care.

Dr. Eick says:

> *"The MSSP aligned with what we saw going forward as being important in terms of bridging the gap between having good clinical and claims data but then actually using that on the ground to improve patient care, utilization, and so on."*

Building the ACO

CMHN considered many options when it came to how to manage its operations and ultimately decided to control it internally and not use a third party administrator, as many other Health Center led ACOs have done. Although they worked with a consultant to prepare the application, the majority of the work for the ACO was done in house. Dr. Eick says that there are several benefits to doing it this way, including having the autonomy to manage the ACO in the way that they wanted, being able to address issues that arise quickly, and having the opportunity to learn the process. Dr. Eick notes that the drawback to this is there are time constraints due to the small size of their team. However, they are currently increasing their capacity. In January 2016, CMHN received ACO Investment Model (AIM) funding from CMMI. This funding has allowed them to hire a dedicated project manger (in process at the time of interview) as well as a care coordination manager who is located at the central office and works solely with 6 ACO members.

A Focus on Care Coordination

Care coordination is a key element of the Medicare Shared Savings Program. Based on managed care discussions held via the PCA, leadership understood early on that in-house care coordination was a priority for health centers. Therefore, in addition to the coordination manager that resides in the central office, there are individual care coordinators at each site dedicated to the Medicare population. Work at the central office focuses on data collection and applying it to care coordination and transitions of care while the staff at the individual health centers focuses on day-to-day operations.

The AIM funding defrayed the cost of implementing this. In fact, over 70% of the $2.5 million dollars in AIM funding went directly to the health centers for care coordination. Dr. Eick says that this funding has been "pivotal in terms of actually enabling the health centers to clinically make a difference on the ground with the patients in the ACO." They are now focusing on how to keep this sustainable once the funding ends. This strategy includes focusing on annual wellness visits, which reimburse well, and chronic care management billing ($42 per member/per month), as revenue sources to support this work long term.

Data and Outcomes

The North Carolina PCA and HCCN have a strong working relationship focused around data utilization. In 2012, the PCA began to connect the safety net data to state health information exchange (HIE) claims. By connecting the HIE and data warehouse they were able to build a central

repository for health center data. Today, about of half the PCA members are connected. The data warehouse contains clinical EMR data and through their analytics partner, they also have access to Medicaid claims data (about 150,000 lives).

By participating in the MSSP, they now also have access to Medicare claims data for their attributed patient population across the across entire spectrum of care. They also have access to hospital feeds, which are updated several times per day, and provide information on admissions, discharges, ER visits and covers 85% of the Medicaid population of the state. Dr. Eick says this has helped them see when dually eligible patients are in the hospital so they can follow up and assist with transitions of care. Moving forward, CMHN is focusing on building internal capacity to analyze data, including claims, census, and UDS, to achieve a more complete picture of population health. This is happening in tandem with the next round of HCCN funding from the HRSA's Bureau of Primary Health Care.

The ACO reported on quality measures for the previous year in March 2016. Although the final results haven't been released by CMS, the preliminary data from quality scores and the patient satisfaction survey looks promising. Dr. Eick notes that of the measures that come directly from the EMR and where there are benchmarks, they performed better than the 50th percentile on the large majority. He also says that there is a benefit to participating as health centers because many of the MSSP measures are similar to what is captured by the Uniform Data System (UDS).

Lessons Learned

Dr. Eick notes that there have been several lessons learned throughout this process.

Lesson 1 - Leveraging health center strengths - When bringing together multiple FQHCs, there are similarities but each also has its own culture and way of doing things. For the beginning of this process, it was evident that a major key to success would be getting them to work together and taking advantage of each health center's strengths. Also, the MSSP application aligns well with what health centers are good at- Patient Centered Medical Home, population health management (particularly engaging subpopulations), and providing more holistic care (primary care, dentistry, behavioral health).

Lesson 2 - Importance of data and applying it on the ground - Dr. Eick says that through this process, they have identified clear areas for the ACO that are important. "For example, 40% of our ACO patients have diabetes, so there are certain measures that are very important because such a large part of our population has that condition and there are many comorbidities that come along with that," Dr. Eick says. Therefore, they have prioritized not only collecting data on these patients, but also using that data to inform their care.

Dr. Eick also highlighted the importance of being able to accurately capture data on patient populations served by health centers. This means focusing on proper coding, billing, and documentation. He says:

> *"From an FQHC standpoint, anecdotally people have been saying 'our patients are sicker and more complex than the average private practice patient'. What we are realizing is it's key to have the data to back that up. It's not sufficient just to have this anecdotal evidence."*

Lesson 3 - The process takes time - Dr. Eick says "You hear people say that it takes about 18 months until you feel like you have your feet under you. We went into it thinking that we would move faster than that, but in actuality, the 18-month timeframe seems pretty true in terms of trying to sort everything out." The lessons learned during the initial months have been invaluable. He says:

> *"This is helping our health centers and us identify and refine skillsets or capacities that are important for succeeding in value based healthcare. This is a relatively low risk way of doing that in anticipation of Medicaid reform… With that in mind, I see our ACO continuing forward, possibly adding other health centers… and continuing to deploy the capacity we are building"*

This document was produced by the National Association of Community Health Centers.

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