Milliman

CO-OP Point of View

CO-OPs and community health centers: Kindred spirits

Michael Sturm, FSA, MAAA
Helen Blumen, MD, MBA

This newsletter focuses on community health centers as primary care providers for CO-OPs. Do the common values of CO-OP and community health centers create an opportunity for mutual success, or will they simply coexist?

The facts

Under the provisions of the Patient Protection and Affordable Care Act (PPACA), one of the requirements for Qualified Health Plans (QHPs) offering insurance through the exchanges, which includes CO-OPs, is that they must *include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically-underserved individuals.*[1]

The Health Resources and Services Administration (HRSA) provides support to a number of these essential community providers, which include community health centers (CHCs). CHCs deliver primary care in geographically underserved communities and/or to vulnerable populations that have a high need for their services. The *high need* criteria are socioeconomic, demographic, population health (e.g., high infant mortality), inadequate access to care (e.g., financial, cultural, or linguistic barriers), and an inadequate number of primary care providers.

CHCs have a number of common characteristics. They must be patient-directed organizations, with a community board that is comprised of at least 51% of health center patients. In addition, they must address barriers to care by providing services such as transportation, language interpretation, and health education. Although CHCs are required to provide services to everyone without regard to insurance status or ability to pay, the majority of patients are currently insured, either through government or commercial insurance.

According to the National Association of Community Health Centers (NACHC), the insurance status of CHC patients in 2011 was as follows:[2]

- Medicaid/SCHIP, 38.5%
- Medicare and other public programs, 10%
- Private insurance, 14%
- Not insured, 38%

As CHCs serve 20 million patients nationally, the uninsured and privately insured population numbers more than 10 million. This is a population that already receives its care from a *patient-centered* provider.

The potential for a match

The portion of the population currently obtaining its care through CHCs will likely be many of the members a CO-OP enrolls. CO-OPs may want to use CHCs as a vehicle for enrolling members. Whether this makes good business sense for a particular CO-OP will require modeling based on an understanding of the population characteristics and the risk adjustment that is available, as well as an analysis of its managed care initiatives and contract reimbursement rates versus other alternatives.

Most (if not all) CHCs will likely be able to meet the law's requirements to demonstrate that high-quality healthcare is being delivered, given that they are currently accountable to HRSA to meet requirements regarding administrative, clinical, and financial operations. Additionally, they currently must perform provider credentialing, have quality improvement plans, and report HEDIS®-like clinical performance measures.[3] These characteristics

1 Patient Protection and Affordable Care Act (PPACA), Section 1311c. Affordable choices of health benefit plans. Retrieved June 20, 2012, from http://www.healthcare.gov/law/full/.

2 National Association of Community Health Centers (August 2011). America's Health Centers. Fact Sheet #0811. Retrieved June 20, 2012, from http://www.nachc.com/client/documents/America's%20Health%20Centers%20updated%20August%202011.pdf.

3 Health Resources and Service Administration (HRSA). Primary Care: The Health Center Program. About Health Centers. Retrieved June 25, 2012, from http://bphc.hrsa.gov/about/index.html.

should be attractive to CO-OPs (and other health plans) looking for primary care providers with managed healthcare interest and experience.

Conversely, CHCs should be eager to contract with their local CO-OPs (and other health plans), as it will generally result in higher reimbursement for the CHCs. Insurance through CO-OPs will help CHCs reduce the amount of uncompensated care they provide every year when they treat patients who are currently uninsured. For them, the addition of private insurers (including CO-OPs) is an enormous opportunity to increase their reimbursement through payor mix changes.

In summary, the values of CO-OPs and health centers are already in alignment. Both are nonprofit, with consumer-majority governing boards. Their values and service-delivery philosophies will not be at odds with each other. In addition, low-income populations have incentive to purchase health insurance (or be taxed). CO-OPs will be an attractive option for this population, given the common characteristics of CO-OPs and community health centers, the availability of subsidies, and the increased revenue/decreased uncompensated care for community health centers.

An example of this is already apparent. In Maine, Maine Community Health Options has received $62 million to set up a state-wide CO-OP. It is sponsored by the Maine Primary Care Association, a group that represents Maine's community, tribal, migrant, and homeless health centers.[4] The board president is the CEO of one of the community health centers. Clearly, the interest of this CO-OP and its primary care network are already highly aligned for success.

The following Milliman consultants contributed to this edition:

Michael Sturm, FSA, MAAA, is a principal and consulting actuary with the Milwaukee office of Milliman. Contact him at mike.sturm@milliman.com.

Helen Blumen, MD, MBA, is a principal and sernior healthcare consultant with the Indianapolis office of Milliman. Contact her at helen.blumen@milliman.com.

4 Maine Community Health Options. Retrieved June 25, 2012, from http://maineoptions.org/