MassHealth Delivery System Restructuring: 2020 Update Report

Executive Office of Health & Human Services

September 2022

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Executive summary (1 of 2) – context and parameters of this report

- In 2018, Massachusetts implemented its most **significant Medicaid restructuring in 20 years to move away from a fee-for-service model by** creating:
  - **Accountable Care Organizations (ACOs)**
  - **Community Partners (CPs),** serving members with complex needs
  - **Delivery System Reform Incentive Payment (DSRIP) Program,** investing in statewide infrastructure
  - *(see Appendix for further background on the 2018 restructuring)*

- This is the **third public report** on the MassHealth delivery system restructuring; **it primarily covers its third calendar year (2020),** in comparison to the program's first two calendar years (2018 and 2019)

- **COVID-19** was declared a global pandemic in March 2020 and had **significant impacts in 2020** and beyond on health care delivery and outcomes. This report summarizes the impacts on MassHealth's delivery system restructuring; it is not intended to be a comprehensive report either on the pandemic or on MassHealth's response to it

- **This report is focused on the current 1115 demonstration's performance data**. At the time of this report's release, MassHealth has submitted an 1115 demonstration extension proposal to CMS. This report does not cover this extension request, which is available here.

Executive summary (2 of 2) – content of this report

- The COVID-19 pandemic **impacted performance data** in several ways. It is difficult to determine which changes in cost, quality, or outcomes from 2019 to 2020 represent "true" performance
  - **Cost and utilization significantly decreased** in 2020, while **MassHealth caseload and ACO enrollment significantly increased** due to Medicaid coverage protections during the federal Public Health Emergency. As a result, most ACOs experienced financial gains in 2020.
  - MassHealth and CMS made **temporary changes to quality scoring methodology** to address the non-usability of 2020 data for performance evaluation purposes, which resulted in increased quality scores (although actual performance on some measures declined)

- ACOs re-prioritized in response to the pandemic and focused on **rapid expansion of telehealth, member outreach and education, and COVID testing and treatment access**

- Two stand-out successes in 2020 were the **Community Partners** (CP) program, which provides community-based care coordination for members with significant behavioral health (BH) and long-term services and supports (LTSS) needs, and the **Flexible Services Program,** which launched in 2020 and provides housing and nutrition support to certain members
  - CPs continued to make **gains in member outreach and engagement** in spite of the pandemic's challenges, enrolling and engaging **~10,000 additional members**
  - Program-wide data began to show **sustained impacts** CPs were having on cost and other outcomes, including a **20% decline in ED visits,** which pre-dated decreases attributable to the COVID-19 pandemic
  - Flexible Services experienced exponential growth in its first year. Cumulative dollars spent on housing and nutrition supports increased from **$0.2M in Q1 of the calendar year to $6.8M in Q4 (a 34x increase)**, and the program provided nearly 10,000 services to over 6,000 members

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MassHealth's 1115 Demonstration, 2017-2022: Goals and key reforms

MassHealth's current 1115 demonstration (2017-2022) was designed to **restructure the delivery system toward integrated, value-based and accountable care.**

Goals of current demonstration

- Enact **payment and delivery system reforms** that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care
- **Improve integration** of physical, behavioral health and long-term services
- **Address the opioid addiction crisis** by expanding access to a broad spectrum of recovery-oriented substance use disorder (SUD) services
- Sustainably **support safety net providers** to ensure continued access to care for Medicaid and low-income uninsured individuals

Key reforms

- Significant restructuring of MassHealth delivery system:
  - Launched **MassHealth ACO program** in 2018 with accountability for cost, quality, and member experience
  - 17 of the state's biggest provider systems became ACOs, enrolled >80% of eligible members
- Unprecedented partnership across delivery system silos:
  - Created **Behavioral Health and Long-Term Services & Supports Community Partners** in 2018 to provide enhanced care coordination for highest risk members
  - Launched **Flexible Services** program in 2020 to provide targeted housing- and nutrition-related supports
- **Expanded substance use disorder (SUD) treatment coverage** and added new beds, recovery coach benefit, other investments
- Established **sustainable safety net hospital funding structure** tied to ACO performance and preserved **near-universal coverage**

Prior to the COVID-19 pandemic, MassHealth's restructuring efforts were already showing early promising results

Key examples of progress *(early indicators)*

- **ACOs are strengthening member connection to primary care**. PCP visits increased 2% from 2018-2019, and were 12% higher for ACOs than non-ACOs
- **ACOs are reducing preventable acute utilization.** Reduced avoidable admissions by 11% from 2018-2019
- **ACOs are improving clinical quality.** Scores were high and increased in 2018-2019 on a majority of measures
- **ACO care coordination programs funded by DSRIP are working.** Seventy percent of these programs improved outcomes in the first two years
- **Community Partners are succeeding at engaging the hardest-to-reach members** with complex behavioral health and long-term service and supports needs**.** CPs have actively engaged ~20k members in care, with promising early impacts
- Implemented risk-adjustment methodology that **accounts for social complexity/risk in ACO rates**
- **Through the Flexible Services program,** ACOs partner with social service organizations to provide housing and nutritional supports aimed at improving health outcomes and/or reducing health care costs

Context for restructuring progress in 2020: the COVID-19 pandemic

- **COVID-19** was declared a global pandemic in March 2020 and had **significant impact in 2020** and beyond on many aspects of MassHealth's delivery system restructuring
- The pandemic significantly changed underlying factors such as **patterns of care, clinical norms, MassHealth enrollment, and the healthcare workforce**
- MassHealth, in partnership with CMS, its ACOs, CPs, and other providers involved in the restructuring, collaborated throughout 2020 to:
  - **Preserve the core policy goals** of the restructuring and DSRIP demonstration,
  - **Modify program design where necessary** to account for the pandemic's impacts, and
  - Leverage the **innovations and flexibilities** that are part of the restructuring to **assist with pandemic response** where possible
- This report provides further detail on these efforts. In addition, it includes **updated metrics on the reform's progress in 2020** (mirroring data shared in previous reports covering 2019 and 2018)
- Note: this report is **not intended to be a comprehensive summary** of the COVID-19 pandemic nor of MassHealth's or EOHHS' pandemic response efforts. This report focuses primarily on the pandemic and response efforts as they **directly relate to the delivery system restructuring**

Key impacts of the COVID-19 pandemic on MassHealth restructuring

Specifically, the COVID-19 pandemic impacted MassHealth's delivery system restructuring in **four key areas:**

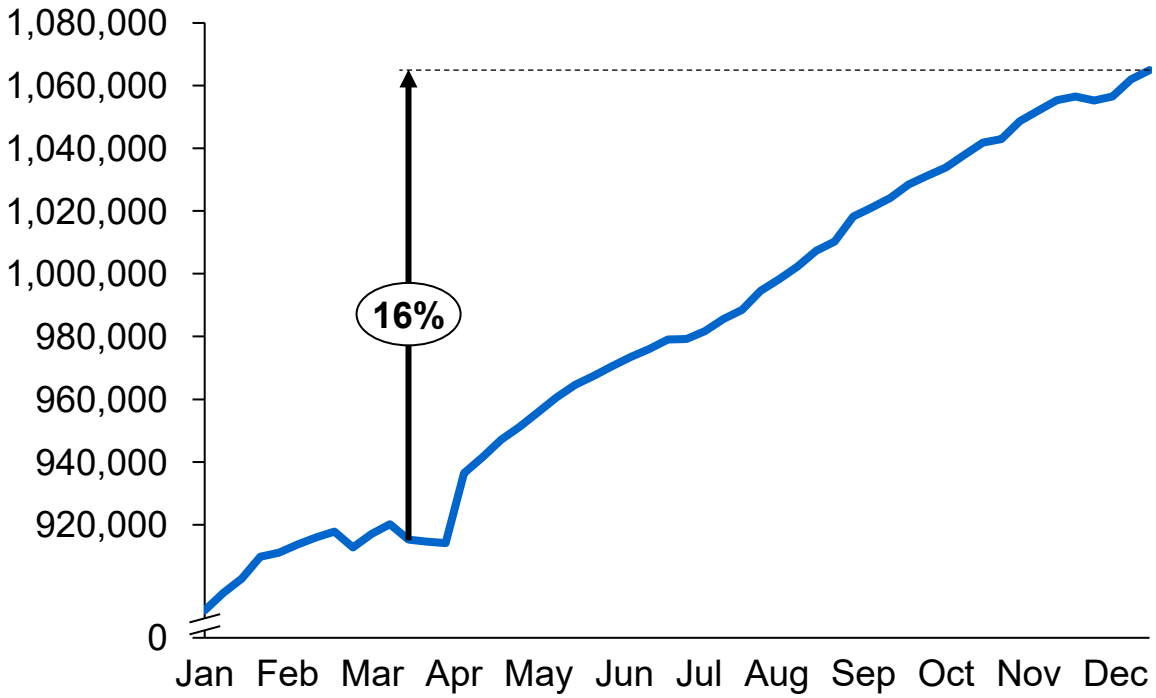
1. **Cost and utilization significantly decreased.** Overall **utilization and per member spend declined** due to holds on elective procedures, postponed non-essential care and members opting to defer care during the pandemic. These macro shifts are reflected in the program's 2020 outcomes
2. **Caseload and ACO enrollment significantly increased.** MassHealth paused routine redeterminations of members' eligibility in accordance with federal guidance starting in March 2020, leading caseload to **increase by >10%** by the end of 2020
3. **MassHealth and CMS made temporary changes to quality scoring methodology**, to account for the pandemic's disruptive impacts on patterns of care and changing clinical guidance. These changes were intended to preserve accountability for performance where possible, while recognizing the inappropriateness of directly comparing 2020 data to 2019 or other baseline years. This report includes both the actual 2020 performance on the program's measures as-is, as well as the scores that were calculated for ACOs, which incorporate the changes agreed upon with CMS

- **MassHealth, ACOs, and CPs** pivoted delivery system reform efforts in response to the pandemic, prioritizing programs focused on **rapid expansion of telehealth** capability, **member outreach and education, COVID testing and treatment**, and addressing **housing and nutrition** needs

Managed care caseload increased significantly during 2020

RY2020 weekly snapshots

# of members (ACO A, ACO B)



	Avg Mbrs[1]	% change[2]
RY18	849,566	-
RY19	889,335	5%
RY20	975,784	10%

Key takeaways:

- Redeterminations were paused in March 2020 as a result of the federal public health emergency (PHE)
- Growth of 16% from March 23rd, 2020, to December 28th, 2020
- Average annual membership growth of 10% over RY2019
- Growth was concentrated in non-disabled groups

[1]January – December 2020 average member months for ACO A and ACO B; Excludes ACO C model.
[2]YOY % change is restricted to the ACO A and ACO B population.
Note: The entire MCE population (ACO A, ACO B, MCO, PCC) decreased from RY18 to RY19. This is driven by the MCO and PCC plans which experienced a decrease, while ACO A and ACO B experienced an increase.

MassHealth and CMS made temporary changes to quality scoring

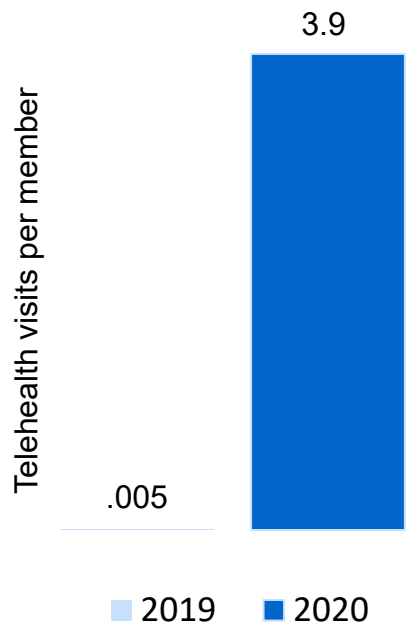
- **Context:** major shifts in utilization patterns and clinical guidance were anticipated to **significantly worsen performance** on the program's quality measures. If not modified, the quality program **would have substantially penalized ACOs and CPs** for performance that:
  - Was **not directly connected to their efforts**
  - Was largely **in line with national experience** of the pandemic's impacts (e.g., reduced screening rates due to canceling non-urgent primary care during the height of the pandemic)
  - And in some cases, was the **direct result of ACOs following best practice clinical and public health guidelines** at the time
  - For example, ACO Diabetes Poor Control performance fell 11% points from 2019 to 2020, reflecting the significant reduction observed nationally with this measure

- MassHealth worked with its DSRIP Quality Advisory Committee and with CMS over the course of 2020 to **develop and implement changes to account for these impacts.** Specifically:
  - MassHealth ran quality measures using 2020 data, for **monitoring and reporting purposes**. Those results are included in this report
  - MassHealth used **2019 data to develop ACO/CP quality scores**, with certain adjustments to account for improvement trends
  - MassHealth and CMS agreed to **revisit several measures' benchmarks for 2021** based on 2020 data and on the progression of the pandemic

ACOs and CPs pivoted delivery system strategies to focus on telehealth, social supports, and community outreach

- **Telehealth utilization skyrocketed**, as ACOs accelerated infrastructure projects and workflow changes to allow them to reach members at their homes
- The **Flexible Services Program**, which provides nutrition and housing support to certain members, **officially launched in 2020**. ACOs and their social service organization partners accelerated the program's launch to meet escalating need. In its first year, Flexible Services served thousands of members, grew exponentially (which persisted into 2021), and began to generate early evaluation data showing impacts on members' cost and outcomes
- **CPs'** relationships with members and community resources allowed them to maintain **high-touch care coordination supports** for members when more traditional access to sites of care was limited. Engagement rates in the program remained high, and program-wide data showed **sustained improvement** on members' cost and outcomes including trends that pre-dated the pandemic's impact on care patterns

Telehealth utilization per member



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Overview of 2020 cost data and ACO financial performance

Overall spend

- In 2020, the ACO program accounted for $5.5B of MassHealth spending, with an average annual total cost of medical services per member of $5,700
- ACO medical spend per member declined on average by approximately 3% from RY19 to RY20:
  - Decline concentrated in child population; adult member per year spend was flat
  - Decreases in outpatient and other routine care offset by increases in pharmacy and temporary provider rate increases

Variation in spend

- Among 13 ACO "Model A" plans (partnerships between providers and managed care plans), performance varied by **up to ~17 percentage points** across ACO As
- Among 3 ACO "Model B" plans (provider ACOs contracted directly with MassHealth), performance varied by **up to ~5 percentage points** across ACO Bs

Financial Performance

- Most ACOs experienced financial gains in RY20, due to decreased utilization during the PHE and an increase in the number of non-disabled, less acute members
- Model B ACOs, which do not take on insurance risk, spent close to their benchmarks after applying a downward adjustment intended to capture the impacts of the COVID-19 PHE

Total cost of care: high-level overview, 2019 vs. 2020

Overall trend[1]

RY19	RY20	
~$5.2B	~$5.5B	Total spent on covered services for ACO members
~$5,900	~$5,700	Average per member per year (PMPY) spending

Trend by population type[2]

	RY19		RY20		YOY % Change	
Average PMPY	With disabilities[2]	Without disabilities[2]	With disabilities[2]	Without disabilities[2]	With disabilities[2]	Without disabilities[2]
Adults	~$20,100	~$6,600	~$20,300	~$6,600	1%	0%
Children	~$10,700	~$2,500	~$10,100	~$2,300	-6%	-11%

While **total spend increased** in RY2020, **average per member per year spending dropped**, driven by the **child population.** Adult member per year spend was flat from RY19 to RY20.

[1]January – December 2020 medical expenditures; includes all medical covered services (incl. maternity supplemental and HCD), and excludes ABA, CBHI, and HCV. Excludes ACO C model.
[2]Non-disabled adults include RC IA, RC IX, RC X; disabled adults include RC IIA; non-disabled children include RC IC; disabled children include RC II C
Notes:

- Total spend and PMPM figures are not directly comparable to estimates previous annual reports
- This RY20 deck utilizes a different data source than the RY19 version. The main differences from RY19 are that this deck utilizes a full year of data (RY19 was annualized with data through Sep 2019), the expenses are not price normalized to the MassHealth fee schedule, HCV is excluded, and maternity supplemental is included.

Total cost of care: category of service breakdown, 2019 vs. 2020

Trend by category of service[1]

Average PMPY	RY19	RY20	% change
Inpatient Hospital	1,248	1,223	-2%
Outpatient Hospital	1,137	971	-15%
IP Behavioral health	221	244	10%
OP Behavioral health	648	649	0%
Professional services	965	861	-11%
Pharmacy	1,379	1,471	7%
All other	270	264	-2%
Total	5,869	5,684	-3%

- IP Behavioral health spend saw the largest increase, driven by temporary provider rate increases
- Outpatient spend saw the largest decrease, down 15% in RY20 compared to RY19
- Total spend in RY20 was impacted by **temporary provider rate increases** implemented in response to the COVID-19 PHE

[1]January – December 2020 medical expenditures. Inpatient includes inpatient physical health maternity and non-maternity. Outpatient includes outpatient hospital, emergency room, and lab and radiology (facility). Pharmacy includes high-cost drugs and excludes HCV. All Other includes DME and supplies, emergency transportation, LTC, home health, and other medical services.

Notes:
- Total spend and PMPM figures are not directly comparable to estimates in previous annual reports
- This RY20 deck utilizes a different data source than the RY19 version. The main differences from RY19 are that this deck utilizes a full year of data (RY19 was annualized with data through Sep 2019), the expenses are not price normalized to the MassHealth fee schedule, HCV is excluded, and maternity supplemental is included.

Financial performance: Most ACOs in gains in 2020, driven by decreased utilization during the COVID-19 PHE

2020 projected performance against capitation rates/benchmark[1]
# of ACOs

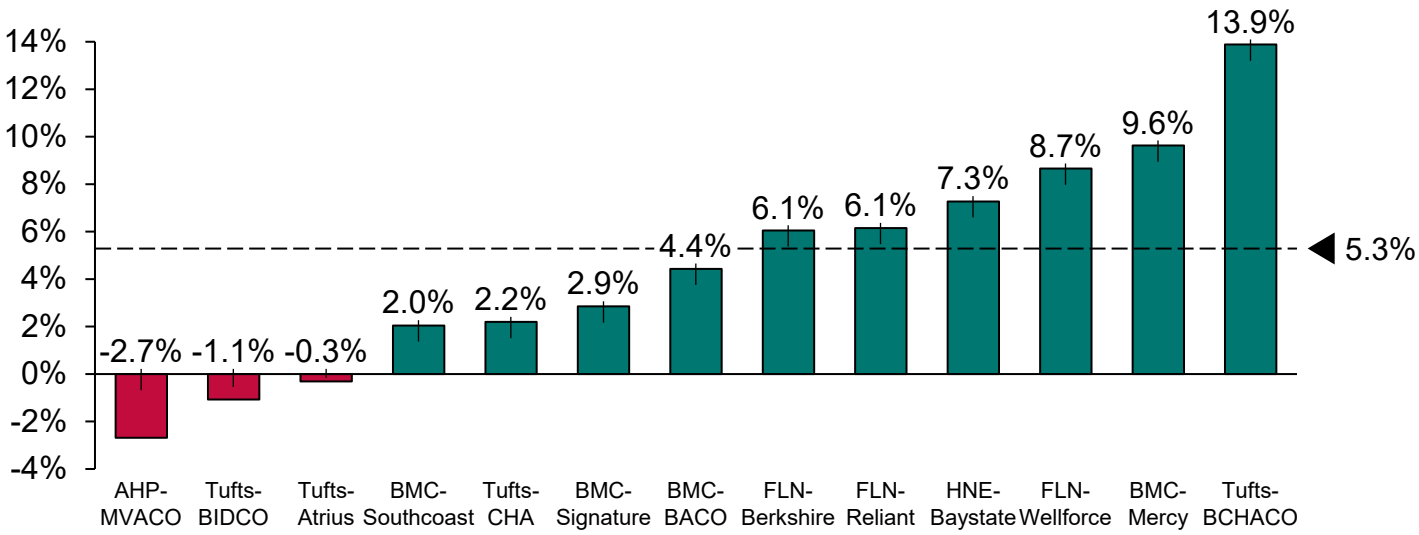
	Model A	Model B
>2% gains	**10**	**2**
+/- 2% of breakeven	**2**	**1**
>2% losses	**1**	**0**
	13	**3**

- Due to decreased utilization during the PHE, most Model A ACOs experienced financial gains in RY20
- Model B ACOs spent close to their benchmarks after applying a downward adjustment to capture the impacts of the COVID-19 PHE
- For 2021 and beyond, EOHHS will ensure that actual funding (i.e., the rate / benchmark) "floats" to meet actual costs for the ACO/MCO program overall; individual ACOs remain incented to "beat the market"

[1]January – December 2020 core medical expenditures. ACO A data sourced from RY20 plan reports and reflects prospective risk scores and ACO B data sourced from RY20 Interim Reconciliation Reports reflects concurrent risk scores. Figures subject to final reconciliation, all percentages presented are prior to risk-sharing.

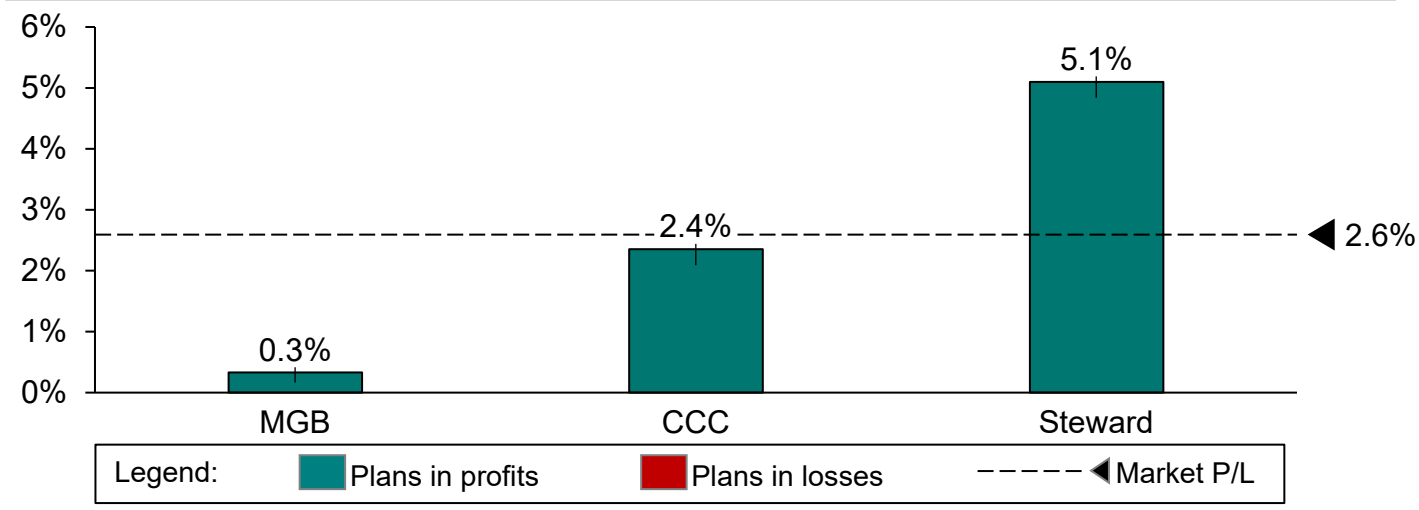
Financial performance: ACOs' 2020 performance varied by plan – up to ~17 percentage points across ACO As, and ~5 percentage points across ACO Bs

By plan profit/(loss) compared to ACO A market profit/loss[1]



- ACO A market experienced 5.3% gains
- Across the ACO A market, performance varied by **up to ~17 percentage points** across ACOs.

By plan profit/(loss) compared to ACO B market profit/loss[1]



- ACO B market experienced 2.6% gains after applying downward COVID-19 adjustment
- Across the ACO B market, performance varied by **up to ~5 percentage points** across ACO Bs.

[1]January – December 2020 core medical expenditures. ACO A data sourced from RY20 plan reports and reflects prospective risk scores and ACO B data sourced from RY20 Interim Reconciliation Reports reflects concurrent risk scores. Figures subject to final reconciliation, all percentages presented are prior to risk-sharing.

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Overview of 2020 quality data and performance

Measure status

- In 2020, **11 of 21** ACO measures and **14 of 22** CP measures were in pay-for-performance status. The remainder were either delayed one year due to COVID or still awaiting benchmark finalization from CMS
- MassHealth and CMS determined 2020 data were not usable for official quality scoring, and **modified the ACO/CP quality program in response to the pandemic**. These modifications meant that official 2020 quality scores were calculated using the higher of a given ACO/CP's 2019 measure results or ACO/CP wide State median results (among other modifications)

ACO and CP quality score performance

- For both ACOs and CPs, quality performance on some individual measures declined when comparing 2019 to 2020 data
- However, using the modified scoring methodology, official quality scores increased (as expected given the "higher of" methodology described above)

Underlying trends in 2020 quality data vs. 2019

- Declines in performance on most measures were likely due to the pandemic, and in line with national trends in quality performance
- Despite this trend, some measures (including **Health Related Social Needs Screening** and **Follow-Up after Hospitalization** for Mental Illness) demonstrated notable increases in measure performance

Quality measure status

- In 2020, **11 of 21** ACO measures and **14 of 22** CP measures were in pay-for-performance status. The remainder were either delayed one year due to COVID or still awaiting benchmark finalization from CMS

- MassHealth and CMS **modified the ACO/CP quality program in response to the pandemic** as follows:
  - **2020 performance data was determined invalid for scoring** due to the pandemic's impacts on utilization and clinical guidelines. 2020's member experience survey was administered during the pandemic, and was similarly determined to not be valid for scoring
  - Therefore, 2020 performance data was not used to directly inform quality scores for 2020. Instead, 2020 scores were based on **2019 performance data**, and 2020 performance data was used to calculate scores for monitoring and reporting purposes only *(see appendix for 2020 performance data)*
  - Using 2019 performance data for 2020's scores (as well as 2019's scores) prevented ACOs/CPs from receiving **Improvement Point** credit for quality improvement efforts they may have taken in response to any low 2019 scores
  - To offset this effect, ACOs/CPs' 2020 performance scores for each measure were calculated using the higher of (1) their 2019 score on that measure, or (2) the 2019 median performance on that measure. ACOs were awarded Improvement Points if either they or the state median met Improvement Point criteria from 2018 to 2019.* For member experience, ACOs were awarded the higher of (1) their 2018 result, or (2) their 2019 result. Member experience measures were not in pay-for-performance status for CPs in 2020, therefore no scoring modifications were required

*CPs were not subject to this same modification as CP improvement point determinations are not conducted at the measure level

Clinical quality: high-level overview of performance, 2019 vs. 2020

ACO	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)
Measures where median ACO passed Attainment Threshold	14/16 (87.5%)	14/16 (87.5%) – *note: mirrors 2019 by definition*	10/16 (62.5%)
Median ACO quality score	75.71%	97.14%	*61.24% (proxy score)*

CP	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)
Measures where median CP passed Attainment Threshold	15/15 (100.0%)	*15/15 (100.0%) - note: mirrors 2019 by definition*	11/15 (73.3%)
Median CP quality score	34.96%	55.53%	*36.92% (proxy score)*

- **ACO/CP clinical quality performance declined for ACOs (75.71% vs 61.24%) or remained largely flat for CPs (34.96% vs 36.92%)** when comparing 2019 performance data to 2020 performance data
- 2020's revised scoring methodology, based on 2019 performance data, produced an **increase in ACO/CP quality scores**. This increase was expected based on the methodology (which used 2019 performance data with COVID-based adjustments)
- The effectiveness of clinical quality improvement efforts from 2019 through 2020 is difficult to determine from these numbers. Further data and monitoring is needed to understand the trajectory of clinical quality pre- and post- the pandemic's disruption

ACO clinical quality: ACO-level comparison, 2019 vs. 2020

ACO	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)
Berkshire Fallon Health Collaborative	67.19	89.34	39.18
Fallon 365 Care	66.52	100	78.76
Wellforce Care Plan	76.90	90.4	53.05
BeHealthy Partnership	85.78	98.96	68.04
My Care Family	90.23	97.97	55.22
Tufts Health Together with Atrius Health	75.71	94.68	68.76
Tufts Health Together with BIDCO	66.83	88.94	34.33
Tufts Health Together with CHA	99.18	100	65.74
Tufts Health Together with Boston Children's ACO	72.19	89.17	71.58
BMC HealthNet Plan Community Alliance	96.01	93.99	61.02
BMC HealthNet Plan Mercy Alliance	66.93	94.53	66.14
BMC HealthNet Plan Signature Alliance	100.00	98.96	61.63
BMC HealthNet Plan Southcoast Alliance	74.55	93.53	70.28
Community Care Cooperative	80.28	95.85	61.24
Partners HealthCare Choice	74.53	93.52	54.93
Steward Health Choice	64.24	90.15	50.19
Lahey	80.82	80.77	45.31

*Score provided for comparison purposes only; not tied to any ACO quality-based payments

ACO clinical quality: progress update on measures of concern

- Recall: in the 2019 report, five ACO measures were deemed **priority areas for monitoring and improvement efforts in 2020** based on 2018 and 2019 performance

- Progress on these measures was mixed with some undoubtedly impacted by the pandemic, whereas others were aided by the usage of expanded telehealth services and data collection efforts

Measure	Performance Monitoring
Timeliness of prenatal-care	Performance declined modestly from 2019 to 2020, likely reflecting impact of COVID-19 on prenatal service utilization
Engagement of alcohol or other drug related treatment	Performance declined modestly from 2019 to 2020, likely reflecting impact of COVID-19 in disrupting delivery of addiction treatment for members
HRSN screening	Performance increased substantially from 2019 to 2020. Current scores likely reflect improved ACO data collection and reporting efforts, and increased focus on HRSN during the first year of the Flexible Services Program
Follow-up after hospitalization	A modest increase from 2019 to 2020, likely reflecting the use of telehealth services in mitigating the impact of COVID-19 on follow-up services
Hospital Readmissions	Performance declined substantially from 2019 to 2020, potentially reflecting COVID-19 impact on essential primary and follow-up services needed to prevent short-term hospital readmissions (as well as COVID-related health complications leading to a hospital readmission)

ACO clinical quality: 2020 measures with substantial performance drop

- Six of the 16 measures demonstrated substantial drops in performance from 2019 to 2020 (using data from 2020)

Measure	Performance Monitoring
Metabolic monitoring for children using antipsychotics	Preventative services are vital to these measures, and therefore performance declines resulted from the pandemic
Diabetes care: a1c poor control	
Controlling high blood pressure	
Oral health evaluation	
Screening for depression and follow-up plan	While this measure allowed for telehealth screening as part of preventative care visit, utilization for preventative care visits declined significantly in 2020, with telehealth visits only partially replacing in-person visits
ED Visits for individuals with mental illness and/or addiction	This risk-adjusted measure may be subject to higher levels of variability, as member risk scores were impacted by COVID-driven changes in utilization patterns overall in 2020

- Performance drops referenced above are similar to declines reported on same or similar measures across Medicaid programs nationally*
- These measures will be prioritized for monitoring and improvement efforts in future program years

*Source: NCQA Quality Compass, National Medicaid: MY2020

CP clinical quality: CP-level comparison, 2019 vs. 2020 (BH)

BH CP	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)*
Boston Coordinated Care Hub	62.88	71.35	43.68
South Shore Community Partnership	30.03	48.59	40.37
Brien Center Community Partner Program	16.70	52.14	27.82
Eliot Community Human Services	60.78	73.52	44.04
Behavioral Health Network, Inc.	64.45	74.79	27.20
Clinical and Support Options, Inc.	34.20	62.63	27.64
Lahey Health Behavioral Services	16.78	32.19	14.90
Community Healthlink, Inc.	25.70	48.84	26.38
Lowell Community Health Center, Inc,	23.25	49.01	58.16
Sstar Care Community Health Center, Inc.	41.45	53.68	64.57
Community Counseling of Bristol County, Inc.	75.05	79.33	57.62
Riverside Community Care	21.85	51.51	21.67
Coordinated Care Network	67.95	67.95	36.92
Central Community Health Partnership	23.40	50.70	19.16
Innovative Care Partners, LLC	26.33	49.57	83.16
Community Care Partners, LLC	45.38	54.41	35.22
Behavioral Health Partners of MetroWest, LLC	32.55	47.29	43.89
Southeast Community Partnership, LLC	44.73	55.37	31.01

*Score provided for comparison purposes only; not tied to any CP quality-based payments

CP clinical quality: CP-level comparison, 2019 vs. 2020 (LTSS)

LTSS CP	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)*
Care Alliance of Western Mass	27.48	55.32	29.59
Merrimack Valley Community Partner	90.44	90.44	49.48
North Region LTSS Partnership	43.52	48.98	48.79
Central Community Health Partnership	42.96	49.50	50.21
Family Service Association	69.12	75.36	22.92
Massachusetts Care Coordination Network	34.96	57.58	39.79
Boston Allied Partners	13.80	55.92	18.79
Innovative Care Partners, LLC	49.08	76.92	62.51
LTSS Care Partners, LLC	27.92	65.54	10.41

*Score provided for comparison purposes only; not tied to any CP quality-based payments

CP clinical quality: 2020 measures with substantial performance drop

- 5 of the 13 measures demonstrated substantial drops in performance from 2019 to 2020 (using data from 2020)

Measure	Performance Monitoring
Annual Treatment Plan	Performance decline potentially reflecting disruption of care coordination efforts needed to formulate and achieve primary care provider sign off of an integrated care plan during first year of pandemic
Diabetes Screening for Individuals w/Bipolar Disorder	Measures reflect expected utilization drop of preventative services as a result of pandemic
Annual Primary Care Visit	
Oral Health Evaluation	
Hospital Readmissions	Performance declined substantially from 2019 to 2020, potentially reflecting COVID-19 impact on essential primary and follow-up services needed to prevent short-term hospital readmissions (as well as COVID-related health complications leading to a hospital readmission)

- These measures will be prioritized for monitoring and improvement efforts in future program years

Overview of member experience

- **MassHealth continued to contract with Massachusetts Health Quality Partners (MHQP) to survey approximately 30,000 members about their 2020 experience** of the health care system **to build on the 2018-2019 baseline view**

- **MassHealth administered three types of surveys for adults and children:**
  - **Primary care:** issued to members who had a primary care visit
  - **Behavioral health:** issued to a subset of members who visited a behavioral health provider
  - **Long term services and supports:** issued to a subset of members who used long term services and supports

- **ACOs are accountable for performance on two member experience measures**:
  - Overall care delivery
  - Integration/ coordination of care

- These measures are calculated based on results from a subset of questions **in the primary care survey**, which was based on a nationally validated tool

- Measurement Year 2020 scores were **likely and variably impacted by the COVID period** when the surveys were issued in early 2021

- In future years, MassHealth may incorporate results from additional questions in the primary care survey, and the BH and LTSS surveys, which were **newly developed to support a more complete picture of the experience of the Medicaid population**

Member experience: summary of 2020 results

Performance Measure	2019 Aggregate Statewide Score	2020 Aggregate Statewide Score	Threshold	Goal
Overall Care Delivery	89.9	88.6	75.0	92.0
Integration/Coordination of Care	83.2	81.8	71.25	86.25

- Results were **mostly similar to 2019, with slight decreases in both measures**
- As in 2019, members expressed **strong levels of satisfaction** with their individual providers, and **the need for increased coordination or help managing behavioral health and other specialists and services**
- **Results were likely impacted by the COVID period**, as the surveys were issued in early 2021
- As with 2019 results, 2020 continues to **identify opportunities for progress**, especially in the **integration and coordination of behavioral health care**, and in the **experience for the LTSS population**

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Delivery system reform: ACOs

In 2020, ACOs grappled with the COVID-19 pandemic which brought with it increased enrollments, declines in traditional service utilization, and a need to ensure member safety and continuity of care. A few themes emerged during this period:

1. ACOs maintained members and **increased enrollment by 10%** between 2019 and 2020, roughly in line with overall caseload growth
2. The ACO program saw **significant utilization declines between 2019 and 2020** driven by the pandemic, particularly in hospital-based services and primary care, and partially offset by significantly increased telehealth
3. **ACOs pivoted programs in response to the pandemic.** In particular, ACOs rolled out initiatives focused on **member outreach, member education, and access to testing**
4. With two years of program experience and evaluation data, and with DSRIP dollars declining in future years, ACOs began to **adapt their population health strategies in response to their learnings**
5. ACOs began implementing the **Flexible Services Program**, which launched in 2020. Flexible Services quickly became a significant part of ACOs' COVID and population health strategies, with **exponential growth and strong early results in its first year** *(see next section of this report for detail)*

1 ACOs retained members and increased enrollment from 2019 to 2020

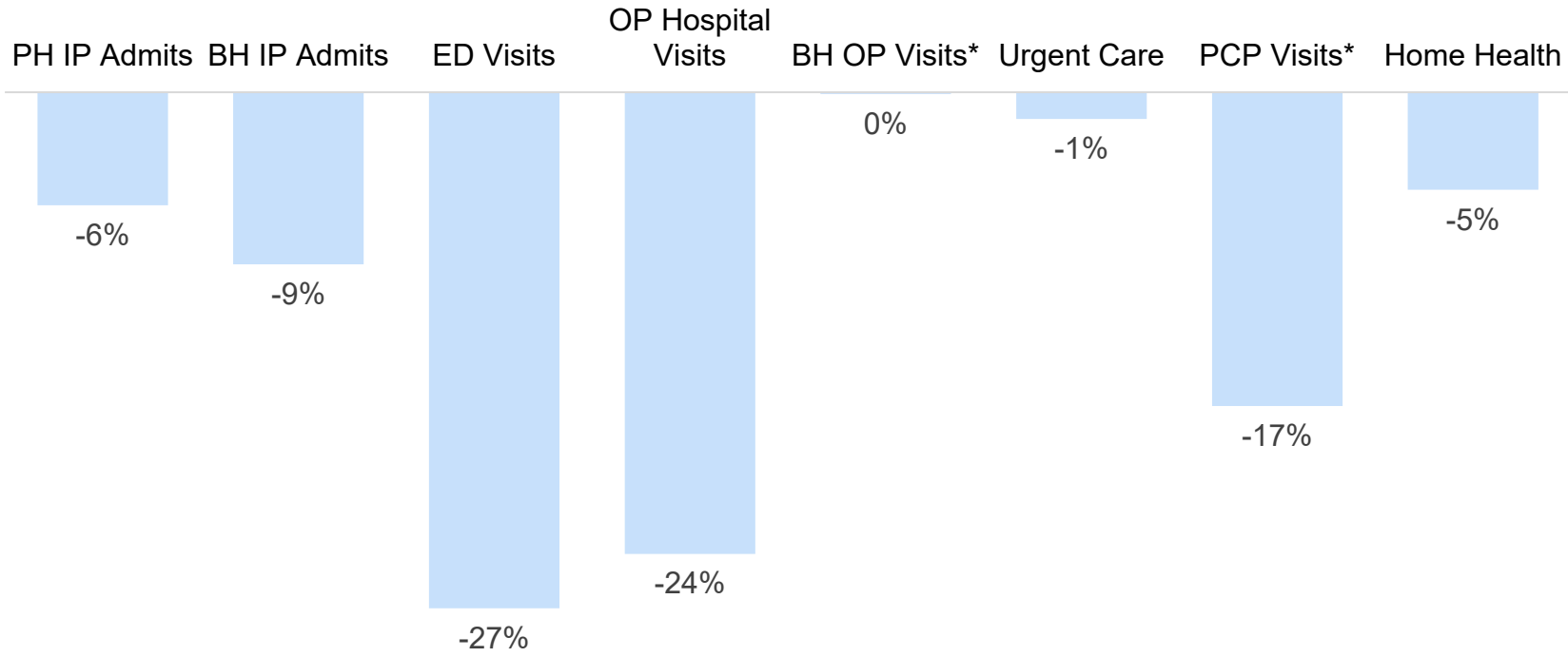
Enrollment data as of 12/31/20						
ACO Type	**Health Plan**	**ACO Name**	**% of ACO Total**	**# of Members**	**% Adults**	**% Children**
Accountable Care Partnership Plans ("Model A")	BMC HealthNet Plan	Boston Accountable Community Alliance	12.7%	125,450	60%	40%
		Mercy Medical Center	3.0%	29,438	58%	42%
		Signature Healthcare	2.0%	19,606	61%	39%
		Southcoast Health	1.8%	17,774	71%	29%
	Fallon Health	Health Collaborative of the Berkshires	1.7%	16,964	72%	28%
		Reliant Medical Group	3.6%	35,620	45%	55%
		Wellforce	5.4%	53,716	52%	48%
	Health New England	Baystate Health Care Alliance	4.1%	40,507	55%	45%
	Allways Health Plan	Merrimack Valley ACO	3.5%	34,967	50%	50%
	Tufts Public Plans	Atrius Health	3.5%	34,353	51%	49%
		Boston Children's Health ACO	11.3%	111,328	3%	97%
		Beth Israel Deaconess Care Organization	3.8%	37,803	71%	29%
		Cambridge Health Alliance	3.0%	29,653	51%	49%
Primary Care ACOs ("Model B")	Community Care Cooperative (C3)		13.9%	137,659	55%	45%
	Mass General Brigham		12.4%	122,600	52%	48%
	Steward Health Choice		13.0%	128,345	53%	47%
MCO-Administered ACO ("Model C")	Lahey Health*		1.3%	12,356	92%	8%
ACO Total			***100%***	***988,140***	***50%***	***50%***

* Enrollment as of 12/31/20, data pulled on 05/06/22.

10% growth over year-end 2019 ACO enrollment (899,078)

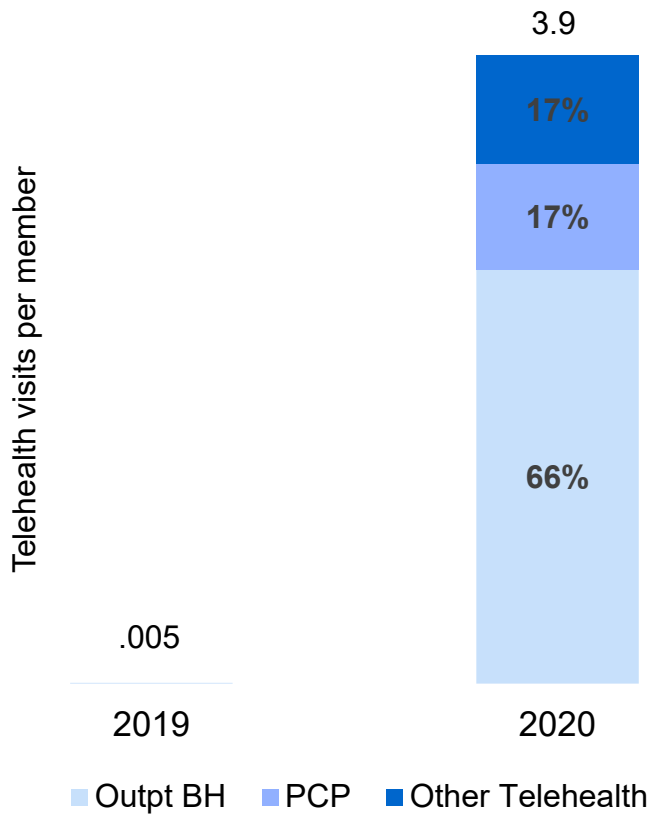
2 There were significant utilization declines from 2019 to 2020 driven by the pandemic and lower member acuity

- Utilization **declines ranged from -5% to -27%** when comparing 2020 to 2019 (behavioral health outpatient visits and urgent care saw minimal declines).
- **Emergency department** visits saw the largest declines.
- Utilization declines driven by holds on elective procedures, members deferring care or seeking care in alternative settings due to the COVID-19 public health emergency and overall lower acuity of the population.



*Includes in-person visits and visits delivered via telehealth. Includes ACO, MCO and PCC Plan utilization.
Note: Utilization trends do not reflect the impact of temporary rate increases implemented in response to the COVID-19 PHE

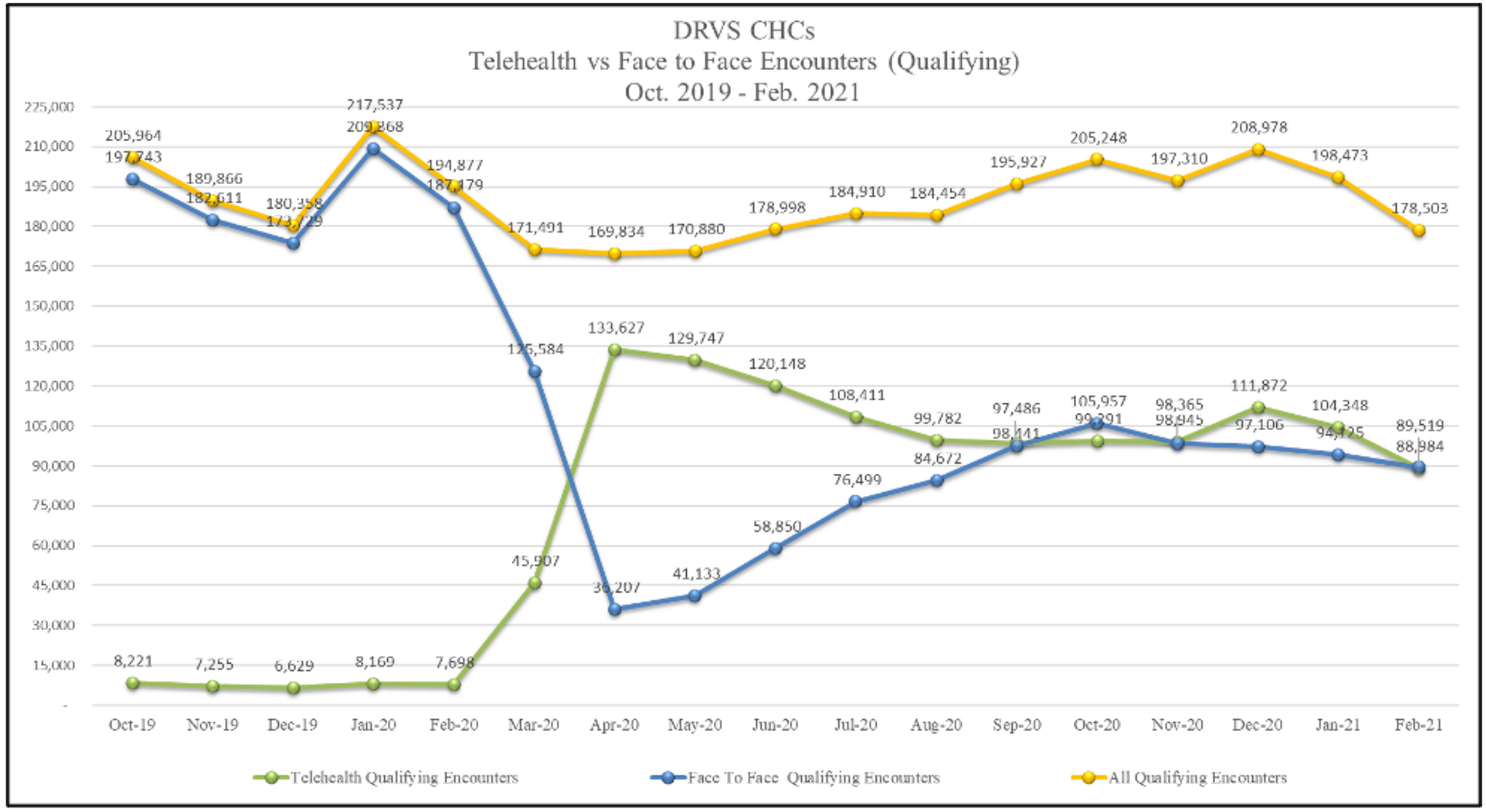
2 Telehealth utilization soared in 2020 for ACO and Non-ACO members



- In 2020, health care providers **pivoted to services delivered via telehealth** amidst the pandemic.
- Telehealth utilization did not vary significantly between members enrolled in ACOs and those enrolled in other managed care plans.
- **Outpatient behavioral health services** accounted for ~66% of total telehealth utilization for ACO and non-ACO members in 2020.

2 Example of ACO initiatives on telehealth offsetting utilization decline: C3's telehealth initiatives

- C3 partnered with the Mass League of CHCs to launch the FQHC Telehealth Consortium and used an FCC grant to purchase electronic devices for telehealth (smart phones, connected blood pressure monitors, etc.)



- Between March and April 2020, in-person encounters at CHCs plummeted while telehealth encounters increased significantly.
- The rapid implementation of telehealth services enabled the total number of patient encounters at CHCs to remain relatively stable throughout 2020.

Note: MLCHC: FQHC: Federally Qualified Health Clinics; FCC: Federal Communications Commission; DRVS: Data Reporting and Visualization System

3 ACOs educated members on best practices to protect themselves against COVID-19 and targeted outreach efforts to high-risk communities

COVID Protection Member Education

Created multilingual educational videos, **offered** webinars, **launched** social media campaigns, **made** radio announcements and **held** community events to promote COVID-19 protection

Boston Children's-Tufts ACO: Hosted multiple webinars on how to manage back to school issues, behavioral health issues, and special education needs

Member Outreach

Distributed COVID Care Packages (food, masks, etc.) and **promoted** flu vaccinations

Established telephone communication channels to address COVID concerns, triage patients, provide education and schedule testing

Cambridge Health Alliance-Tufts: Offered health check-ins to 1000+ patients who had not had a visit with their primary care team within the early months of the pandemic

Expanding Access to Testing

Through strategic partnerships, ACOs **offered** and **provided** guidance on walk up, drive through, and mobile options for COVID testing to members

Baystate-Health New England: Offered 20+ pop up community COVID testing sites in high density and high need public housing areas

4 DSRIP strategies continued to mature, with ACOs testing and expanding successful programs

- As time-limited DSRIP funding declines in each successive year of the reform, ACOs have been evaluating and comparing their DSRIP-funded investments to make data-driven choices about which to scale/sustain and which to sunset.
- ACO DSRIP spending was at its highest in 2018 ($189.3M) and has continually decreased in the years since then ($173.7M in 2019, $135.7M in 2020) as ACOs **decreased spending on Integration Projects and Data Analytics, Population Health, and HIT Projects since 2018.**
- In 2019, the most common program type evaluated was **high-touch care coordination for complex members**. In 2020, **ACOs continued to test and expand programs** that demonstrated success.

Example: In 2020, BMC-Southcoast adapted its population health strategy to address high inpatient admissions

- Southcoast Health initiated new Care Navigation processes to **reduce unnecessary acute care utilization and inpatient readmissions**, including:
  - Developed **daily virtual multi-disciplinary huddles** to identify areas to support patients through inter-team referrals to community health workers, community resource specialists, social workers, pharmacists and nurse care navigators
  - Established **monthly virtual meetings with CPs** to build stronger relationships and more timely member referrals

While plans launched these programs in 2020, **impact cannot yet be assessed due to confounding from the pandemic**. Some programs may have been paused to focus on plans' COVID response.

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Flexible Services Program: summary of 2020 progress

- The Flexible Services Program was **one of 2020's key successes.** Flexible Services allows ACOs to pilot innovative programs to provide nutritional and housing supports, with the goal of improving overall member health and outcomes

- In its first year, the program experienced **rapid and substantial growth**, demonstrated **promising early outcomes,** and played a key role in ACOs' **response to the COVID-19 pandemic**, which further exacerbated existing food and housing insecurity among MassHealth members

- After the program launched at the beginning of the 2020 year, interest and participation increased rapidly:
  - Cumulative dollars spent on housing and nutrition supports under Flexible Services increased from **$0.2M in Q1 of the calendar year to $6.8M in Q4 (a 34x increase)**
  - The program provided nearly 10,000 services to over 6,000 members in its first year
  - The rapid growth the program experienced throughout all of 2020 has persisted in 2021. For example, Flexible Services spending per quarter increased by **~206% from $1.7M (Q4 2020) to $5.2M (Q3 2021).**

- Despite being extremely early in the Flexible Services program, preliminary analyses of individual Flexible Services programs have already begun to show **reductions in A1c levels, ED utilization, and total cost of care**

*MH defines Flexible Services in terms of member-quarters or number of quarters members have received services. A unique member that received services across 4 quarters would count towards 4 services provided.

ACOs Partnered with SSOs to Launch 61 Flexible Services Programs in 2020

In 2020, ACOs partnered with community-based Social Services Organizations (SSOs) to launch **61 Flexible Services programs** focused on nutrition and housing support services and goods. The COVID-19 pandemic prompted several ACOs to launch their FS programs **earlier than anticipated** and other ACOs to **launch COVID-focused programs** to specifically meet the **immediate needs of their members**.

ACOs and SSOs launched 61 programs in the following domains in CY20:

- 27 Housing
- 31 Nutrition
- 3 Housing/Nutrition

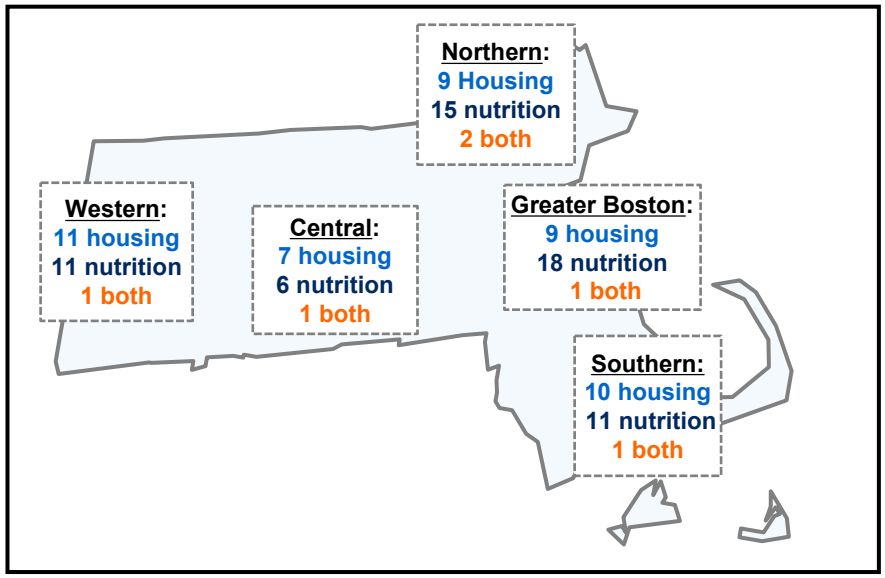
ACOs partnered with **33 SSO partners** to deliver Flexible Services in CY20, including:

- 22 Housing SSOs
- 9 Nutrition SSOs
- 2 Housing/Nutrition SSOs

Despite the COVID-19 pandemic, **16 of the 17 ACOs launched at least 1 program** in CY2020.

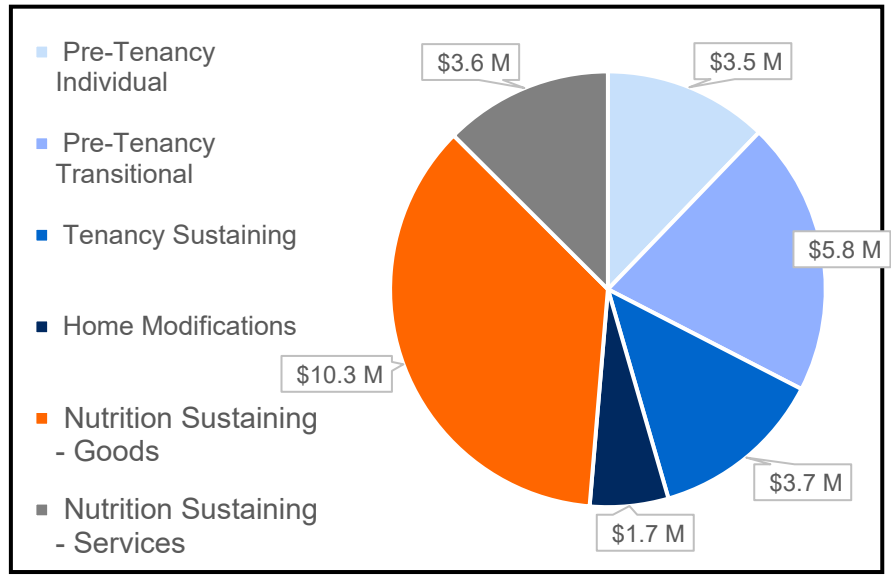
ACOs launched Flexible Services in every geographic region of the state, across the full breadth of supports allowed by the program

Number of FS Programs Serving Each Region By Domain



Note: Several programs operated across more than one region of the Commonwealth and are counted more than once above.

Flexible Services Program Funding Breakdown by Sub-Domain ($M)



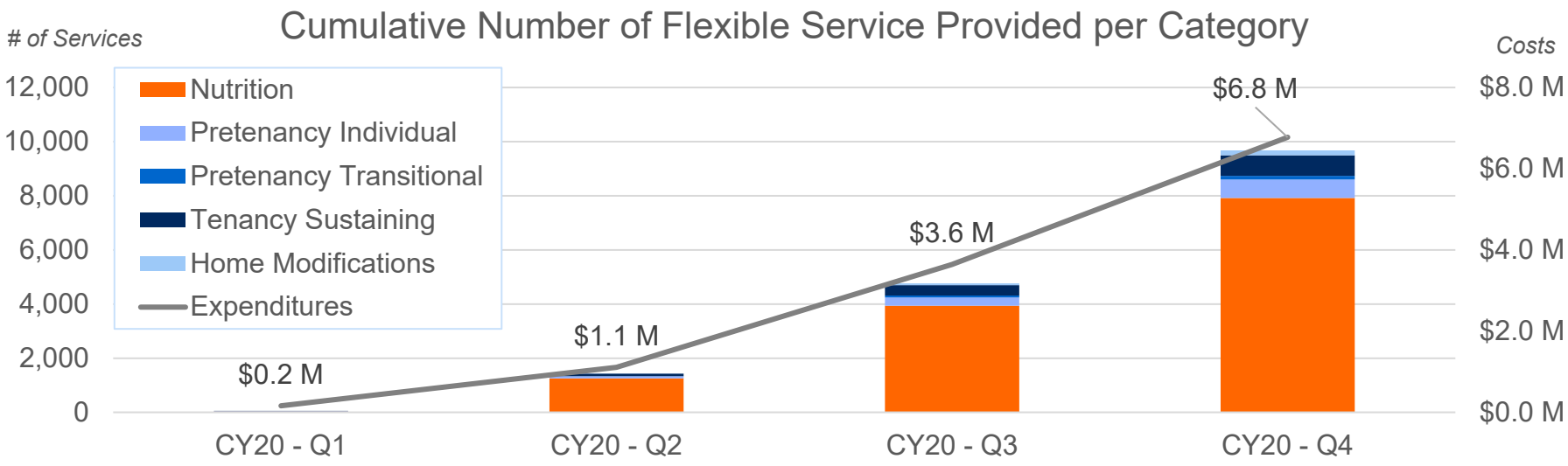
Total CY20 Allocated Funds: $56.5M

Total Budgeted in CY20: $28.6M (~$2.2M for COVID FS Programs)

Note: ACOs received funding allocations for which they had to propose budgets, often which were less than the funding allocations. ACOs only received funds for budgets approved by MassHealth, as reflected in the fact that the "Total Budgeted in CY20" amount is lower than the "Total CY20 Allocated Funds" amount.

In 2020, there was continuous growth in FS uptake each quarter

Despite a delayed start, FS had **significant growth** over the first year of the program and is seeing initial promising outcomes. In total, approximately **9,678 Flexible Services*** were provided for all **CY20.**



Flexible Services - Total CY20 Q1-Q4	
# of Unique Members Served	**$ Spent**
6,134	**$6.8M**

* MH defines Flexible Services in terms of member-quarters or number of quarters members have received services. A unique member that received services across 4 quarters would count towards 4 services provided.

Social Service Organization (SSO) Flexible Services Preparation Fund supported infrastructure and capacity needs of SSOs

Through two procurement rounds, eligible Social Service Organizations (SSOs) were awarded **Flexible Services Preparation Funds** to build capacity to partner with ACOs to administer Flexible Services.

Purpose: Support qualified SSOs that are participating in the Flexible Services program with ACOs through **funding investments in technology, data exchange, business practice elements**, and other areas where close collaborative communication with ACOs is needed.

Goals: To **ensure successful partnerships** with ACOs that:

- **Collaborated on the design and implementation of referral systems** that identify members in need of/eligible for Flexible Services, effectively and efficiently navigate members to services at SSO, and reduce administrative complexity of referral;
- Provided **timely, culturally appropriate, and approved Flexible Services** in the areas of nutrition and/or housing support services and goods that meet the identified needs of members and avoid duplication of services; and
- **Collaborated on the design and implementation of communication and data tracking systems** that standardize data sharing and collection, provide both ACOs and SSOs the information necessary to meet members' HRSNs, and enable the tracking of FS for contract monitoring, evaluation and quality improvement purposes.

At the end of the grant period, **17 of the 19 SSOs grantees were receiving referrals**, enrolling in Flex Services programs, and reporting back to the ACO(s) information on participants. This is **an increase from 9 SSOs** at baseline.

Flexible Services Social Service Organization Preparation Fund Awardees

Social Service Organization Applicant	Housing	Nutrition	SSO FS Prep Fund Amount
About Fresh			$246,454
Community Action Pioneer Valley			$249,900
Community Servings			$250,000
Community Teamwork, Inc. (CTI)			$250,000
Daily Table			$145,417
FamilyAid Boston			$185,249
Father Bill's & Mainspring			$141,537
Food Bank of Western Massachusetts			$143,156
Just Roots			$246,733
MA Coalition for the Homeless			$123,988
Making Opportunity Count			$249,918
Mental Health Association (MHA)			$250,000
Metro Housing Boston			$170,578
Mill City Grows			$104,903
NeighborWorks Housing Solutions			$250,000
Old Colony YMCA			$229,264
Project Bread			$246,193
Project Hope			$234,000
Revitalize CDC			$250,000
Total SSOs: 19 Funded	**Total: 11**	**Total: 8**	**Total Award Amount: $3,967,290**

Flexible Services: Early Promising Results

Individual ACOs are already seeing early improvements in clinical and social outcomes, costs, and utilization. As the program progresses, MassHealth will closely track results and evaluate if specific interventions/models are more impactful than others.

***ACO Highlight:* C3** *observed encouraging initial impacts on health outcomes, cost, and utilization based on their CY2020 members served.*

- **Clinical Improvements**: members w/ both nutrition & housing supports in first half CY20 saw trends towards:
  - **Improvement in diabetes management**
  - Increase members with hemoglobin **A1c levels below 9% (74.8%** to **79.7%)**
  - **Decrease in average hemoglobin A1c levels from 7.7% to 7.3%**

- **TCOC Reduction: $11,309 reduction in annualized TCOC** for members who received nutrition supports (n = 839) vs **$345 reduction in annualized TCOC** for comparison group eligible to receive nutrition supports but did not for various reasons (n = 162; **p=0.013**).

- **ED Utilization: only 8%** of those members receiving nutrition supports had **4+ emergency department visits** vs **31%** for members in comparison group.

Clinical Outcomes	*% HbA1C < 9%*	*Average HbA1C*
Pre-Flex	74.8%	7.7
Post-Flex	79.7%	7.3

Cost and Utilization Outcomes	TCOC Reduction	4+ ED Visits
Received Nutrition Flex	$11,309	8%
Comparison Group	$345	31%

Flexible Services: Early Promising Results (Continued)

Individual ACOs are already seeing early improvements in clinical and social outcomes, costs, and utilization. As the program progresses, MassHealth will closely track results and evaluate if specific interventions/models are more impactful than others.

Member Story: Positive Social Outcomes

A member was **experiencing homelessness** and **food insecurity**. **C3** referred the member to a housing SSO and received several types of support.

Services Provided:

- Housing:
  - ✓ **Housing Search and Placement**
  - ✓ **Assistance with *Residential Assistance for Families in Transition* (RAFT) application** to cover move-in expenses and first & last month's rent;
  - ✓ **Home Modifications** to assure that the home met the member's needs based on her health needs.
- Nutrition:
  - ✓ **Referral to *Supplemental Nutrition Assistance Program* (SNAP) Enrollment**
  - ✓ **Home-delivered medically tailored meals *followed by***
  - ✓ Two months of **home-delivered produce boxes** as well as **food vouchers**

Outcomes: Four months later, she was in her **own apartment** with a **plan for sustaining payment** of rent and expresses her gratitude for the program that helped her through a difficult stretch when she was dealing with physical and behavioral health needs.

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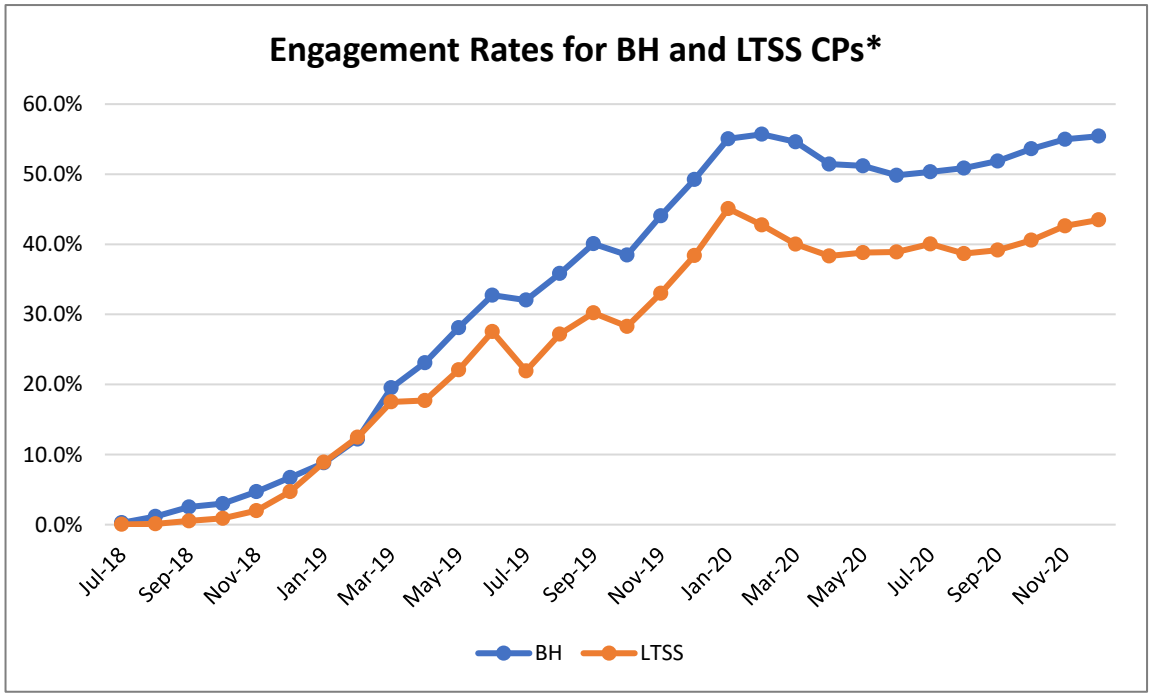
Community Partners: summary of 2020 progress

- The pandemic presented **significant challenges for CPs** in 2020, such as:
  - Transitioning care coordination relationships to telehealth modalities
  - Increased health and social needs among members
  - Staffing challenges
  - New barriers to communication with providers (e.g., difficulty accessing hospitals to provide in-person transition of care support)

- In spite of these challenges, CPs continued to make **gains in member outreach and engagement**. From year-end 2019 to year-end 2020, CPs:
  - Enrolled **~32,000 additional members**
  - Increased the engagement rate of enrolled members **from 47% to 53%**
  - Increased the absolute number of engaged members **by ~10,000**
  - Reduced the average days to a complete care plan (a key indicator of successful coordination with PCPs) from 240 to 176 (**27% reduction**)

- With the program stable and maturing, program-wide data began to show **sustained impacts** CPs were having on cost and other outcomes, such as:
  - BH CP enrollees experienced a **20% decline in ED visits** and a **31% decline in BH inpatient admissions** since the start of the program
  - Reductions in BH admissions correlate with **longer enrollment** in the CP program, and both trends mostly **pre-dated the pandemic**
  - Risk-adjusted TCOC is **19% lower** for BH CP enrollees post-graduation from the program vs. enrollees in the 12 months preceding enrollment

Key takeaways from CP engagement data (snapshot view)



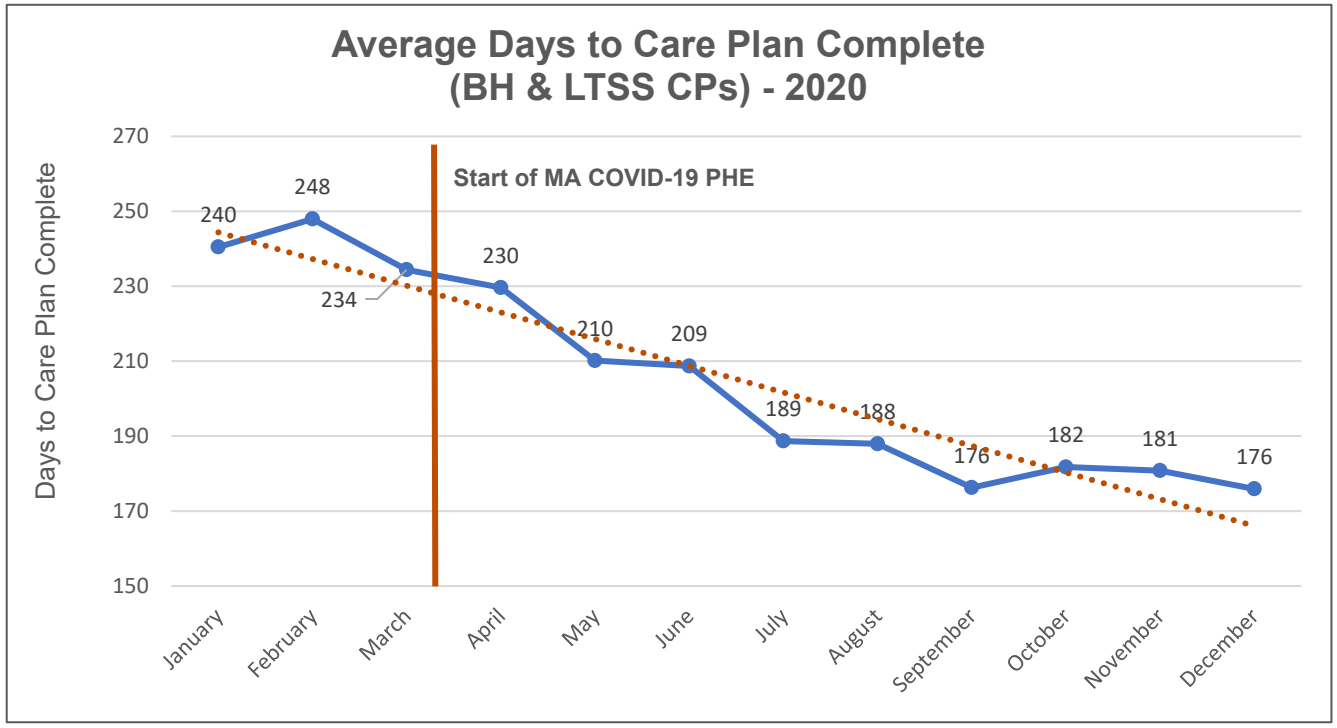
Source: Data Warehouse, March 7, 2022

- As of December 2020, **53% of actively enrolled CP members were engaged***
- This is an **increase from 47%** in December 2019, and 6% in December 2018
- CPs show strong performance in engaging members compared to other similar programs. For example, McKinsey found that payer care management programs typically engage ~10-30% of targeted members**

CPs continued to make gains in engaging members in 2020, despite facing additional challenges related to the COVID-19 PHE. CPs **leveraged COVID-19 flexibilities** to conduct outreach to members through telehealth, including reciprocated text messaging; **strengthened relationships with ACOs and MCOs** to better communicate about referrals; and utilized program reforms such as **daily enrollment functionality** to better track and manage member assignments.

*Note: Engagement rates on this slide represent the % of **actively** enrolled members engaged at least 1 day in that month in a CP. Members who have been dis-enrolled from the program in a given month are not included in the denominator for that month.
**Source: McKinsey & Company, 2021. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-untapped-potential-of-payer-care-management

CPs reduced Days to Care Plan Complete in 2020, building on improvements in outreach and engagement from 2018 and 2019

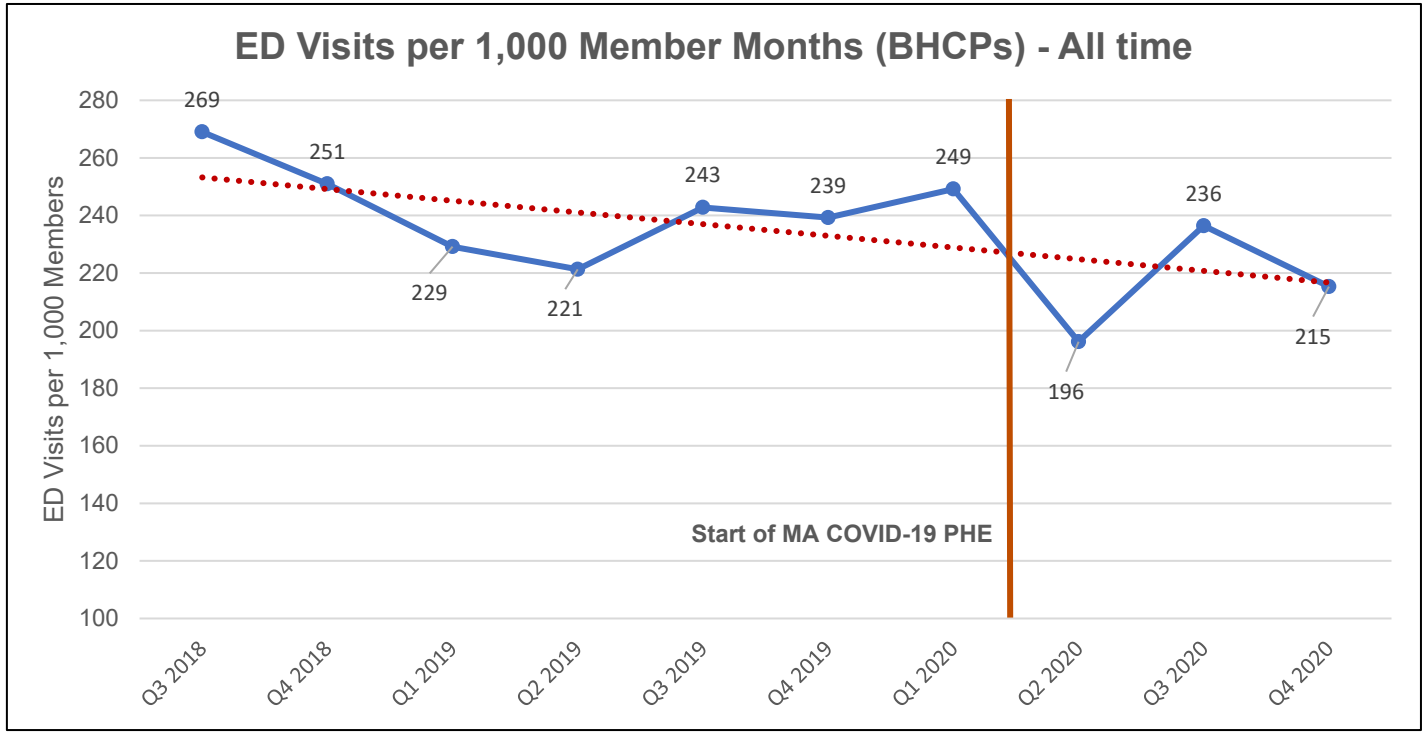


Source: Mathematica, data pulled on 3/10/22

- Members are considered engaged in the CP Program once their Care Plan is completed and approved by their PCP. The Days to Care Plan Complete measure provides insight into how quickly and efficiently CPs are conducting outreach and engaging members and coordinating with other members of the care team

- Despite challenges related to the COVID-19 PHE, **CPs brought down the average number of days to Care Plan Complete in 2020**, from 240 days in January 2020 to 176 days in December 2020.

Emergency Department (ED) Visits among BH CP Members have declined since the start of the program

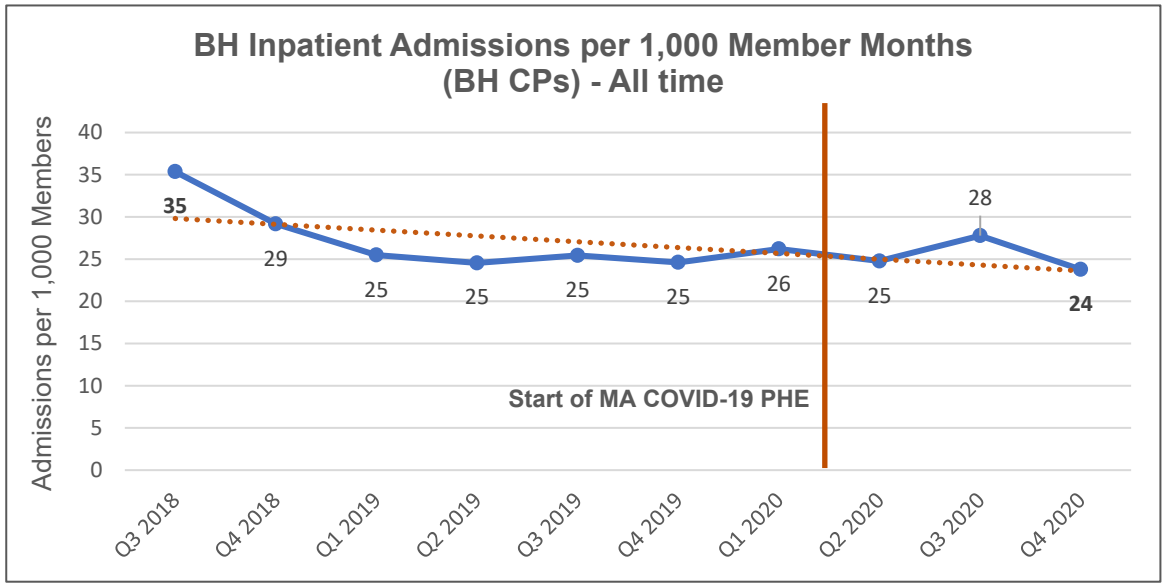


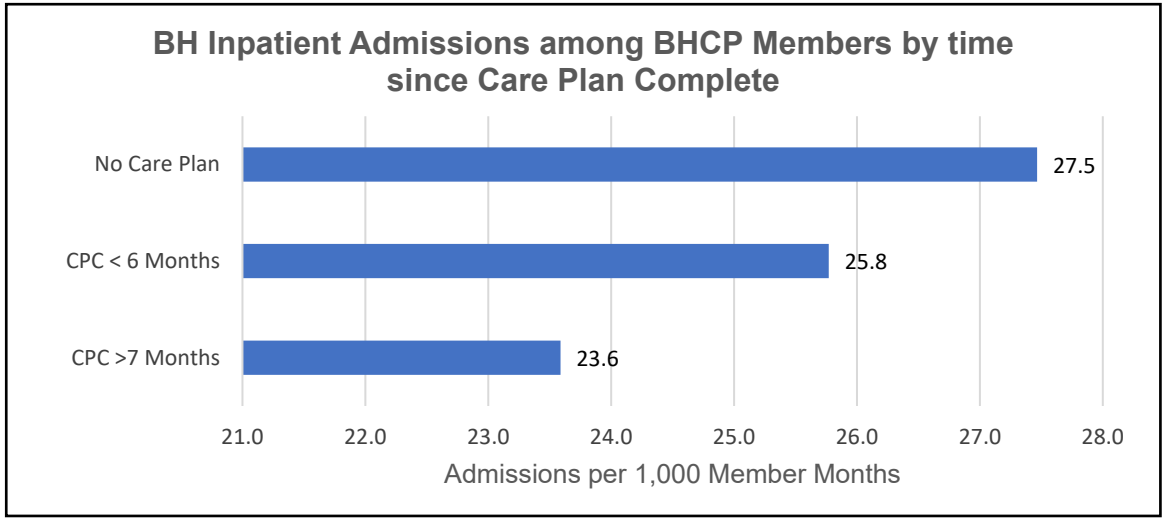
Source: Mathematica, data pulled on 3/10/22

- **ED visits have declined among BH CP Members** since the start of the program, from 269 ED visits per 1,000 Member Months in Q3 of 2018 to 215 ED visits per 1,000 Member Months by Q4 of 2020

- Despite disruptions related to the PHE, the **trend of declining ED visits among BH CP Members** continued in 2020.

Behavioral health (BH) inpatient admissions have also declined, correlated with length of enrollment in CPs



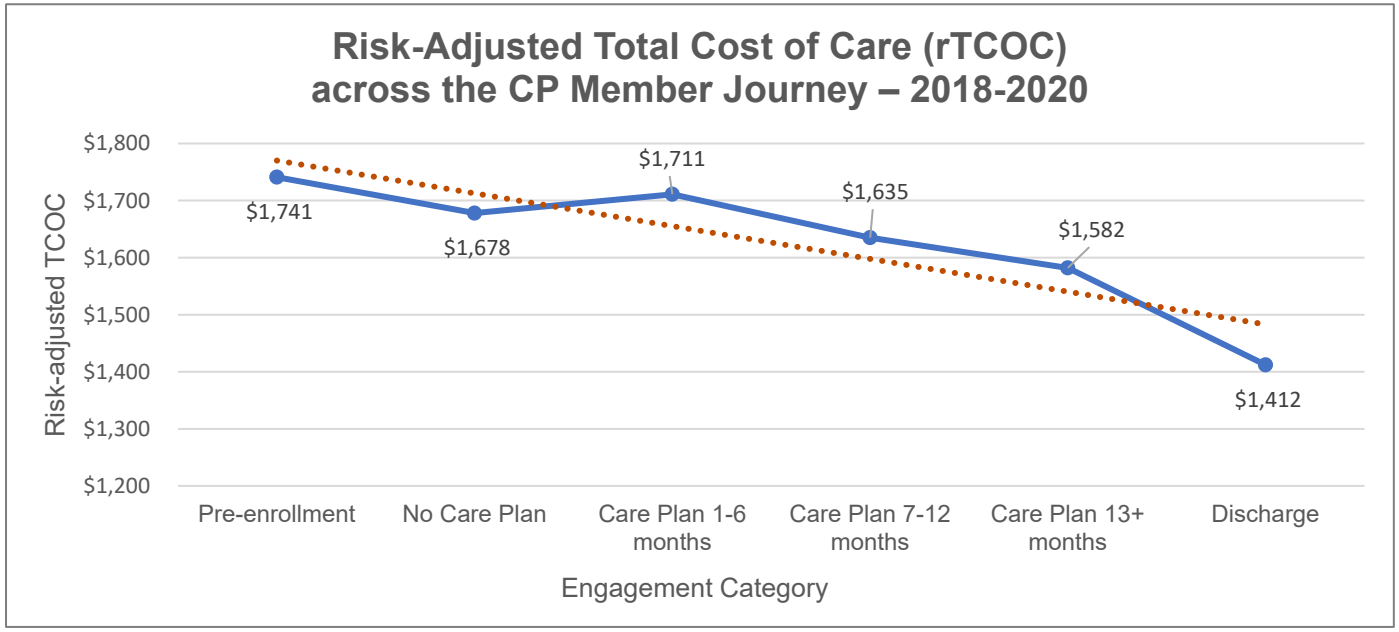


BH inpatient admissions among BH CP members have **declined since the start of the program,** from 35 admissions per 1,000 member months in Quarter 3 of 2018 to 24 admissions per 1,000 member months by Quarter 4 of 2020

In 2020 there were fewer BH inpatient admissions for members who had longer engagements with a BH CP program. Among members with no completed Care Plan, there were 27.5 admissions per 1,000 member months. For members who were 7 or more months post Care Plan Complete, there were 23.6 admissions per 1,000 member months.

Source: Mathematica, data pulled on 3/10/22

Risk-Adjusted Total Cost of Care (rTCOC) declines the longer members are engaged in the CP Program



Source: Mathematica, data pulled on 5/6/22

- **Risk-adjusted Total Cost of Care (rTCOC) declines the longer members are engaged with the CP program**
- rTCOC is the average amount paid on claims by Medicaid and ACOs/MCOs per CP member per month, risk adjusted within the CP population and excluding members who are dually-eligible for Medicaid and Medicare.
- Overall, rTCOC decreases throughout the time that members are engaged with a BH or LTSS CP. On average, members have a **19% lower risk-adjusted TCOC** upon discharge compared to members in the 12 months prior to enrollment ($1,412 vs. $1,741).

Context: summary of 2020 design reforms

- The successes of the CP program in 2020 were in part due to **several changes to the design of the program** that MassHealth, CMS, and CPs made in response to feedback and learnings from the program's first two years

- These reforms addressed several common areas of feedback from ACOs, CPs, and members, such as:
  - ACOs were given **flexibility to determine which members to assign to the CP program**, and which CPs to assign them to, rather than MassHealth prescribing all members lists as had previously been done
  - ACOs and CPs were allowed to **reduce the number of relationships** and focus on a subset of **preferred, higher-scale partnerships**
  - MassHealth rolled out **several technological and operational enhancements** that empowered CPs to track and manage their enrollment in real time, and allowed other providers intaking members for visits to see that those members were CP-enrolled
  - MassHealth also rolled out **program performance reports,** providing CPs and ACOs with standard sets of comparative data on various process and outcomes in the program, which they had previously each had to produce individually

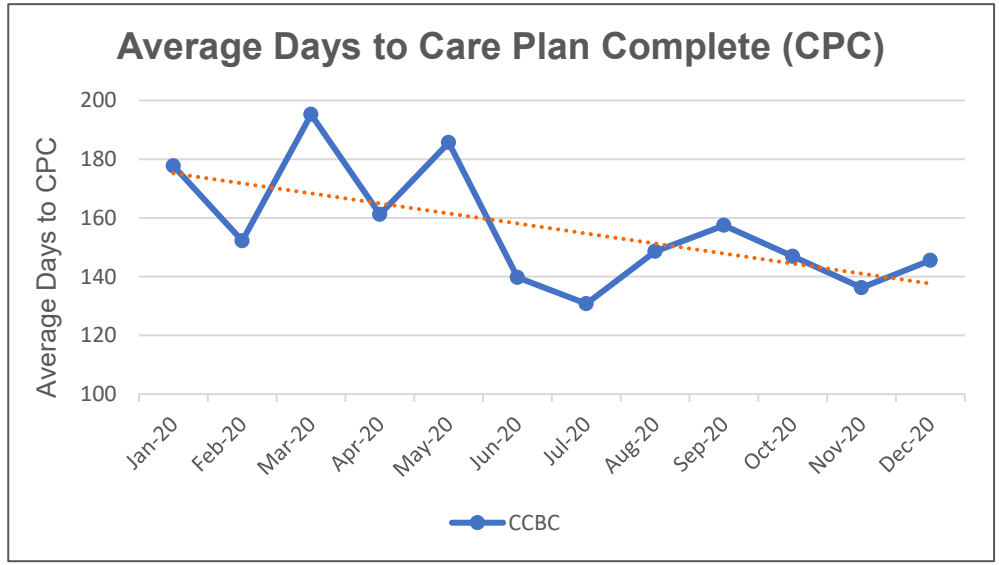
- MassHealth and CMS also implemented **several temporary flexibilities in 2020**, allowing CPs to substitute certain telehealth modalities for normally in-person care coordination activities

Examples of CP Success: CCBC improves collaboration with ACOs, hospitals and PCP offices

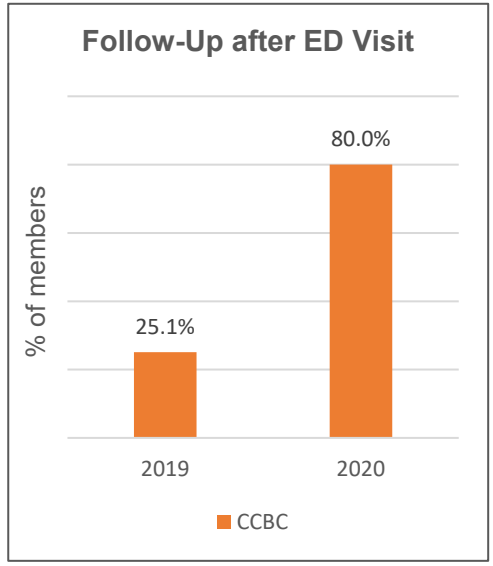
In 2020, CCBC* focused on strengthening its relationships with ACOs, hospitals and primary care offices to better integrate services and coordinate member care.

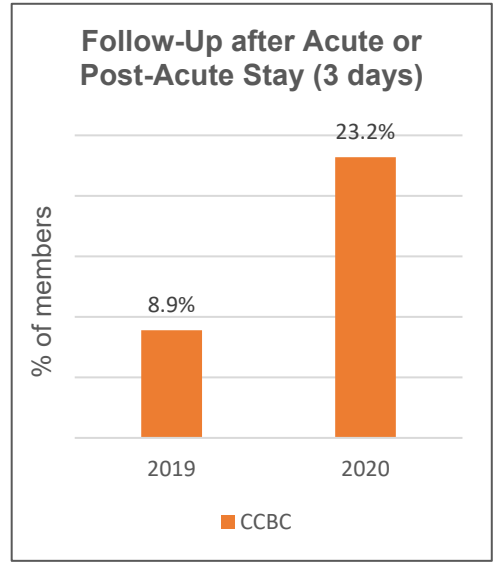
Strategies implemented:

- CCBC established **monthly meetings with select ACOs** to strengthen referral pathways
- CCBC **participated in more nursing and clinical rounds** with ACO Complex Care Managers to provide integrated care coordination and reduce duplication of services
- CCBC **established monthly clinical rounds with high-volume PCP offices**, which resulted in stronger working relationships between CCBC care coordinators and PCP office staff, and reduced the time needed to obtain PCP signatures on care plans
- CCBC invested in **monitoring for members who present at an Emergency Department or hospital** through its refined Event Supervisor role. This allows CCBC to more quickly outreach to members, and **collaborate with providers and members around discharge planning and follow-up**



Source: Mathematica, data pulled on 3/10/22





Source: CCBC 2018-2020 Quality Report, data pulled on 12/17/2021

*Community Counseling of Bristol County

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  - CPs (p. 47-54)
  - **DSRIP (p. 56-61)**
- Next phase (p. 63)

Overview of DSRIP Program

- DSRIP funding ($1.8B total) is **time-limited and decreases over 5 years**
- ACOs and CPs use DSRIP funds to **design and test innovative programs**, with the expectation that they measure those programs' outcomes, **and to stand up infrastructure required for population health management**
- In CY2020, **ACOs and CPs spent $223.2M** in DSRIP funding:
    - **$142.5M** by ACOs*
    - **$80.7M** by CPs
- ACOs and CPs had to receive MassHealth approval for **investment plans** by demonstrating that their investments would support **population health management**, not duplicate other available funds, and be measurable
- Additionally, **$15.97M of DSRIP funding was used for Statewide Investments in 2020** to support workforce development (training, hiring, retention), technical assistance for ACOs and CPs, and related initiatives.

Detailed DSRIP funding charts by ACO, CP, and Statewide Investments programs included in appendix

* Certain ACOs also received an additional $92.3 for safety net hospital (DSTI) glide-path funding from the beginning of DSRIP through 12/31/2020.

2020 DSRIP investments: by the numbers

886

# of different ACO investments/programs supported by DSRIP in 2020

- Initiatives implemented by ACOs to improve quality of member care and lower total cost of care

$96M

$ spent on personnel/staff by ACOs in 2020

- Significant investment in workforce to support ACO efforts

$21M

$ spent on infrastructure by CPs in 2020

- Build out infrastructure to implement CP program, such as establishing workflows, integrating electronic systems, purchasing tablets to facilitate in-person connections, etc.

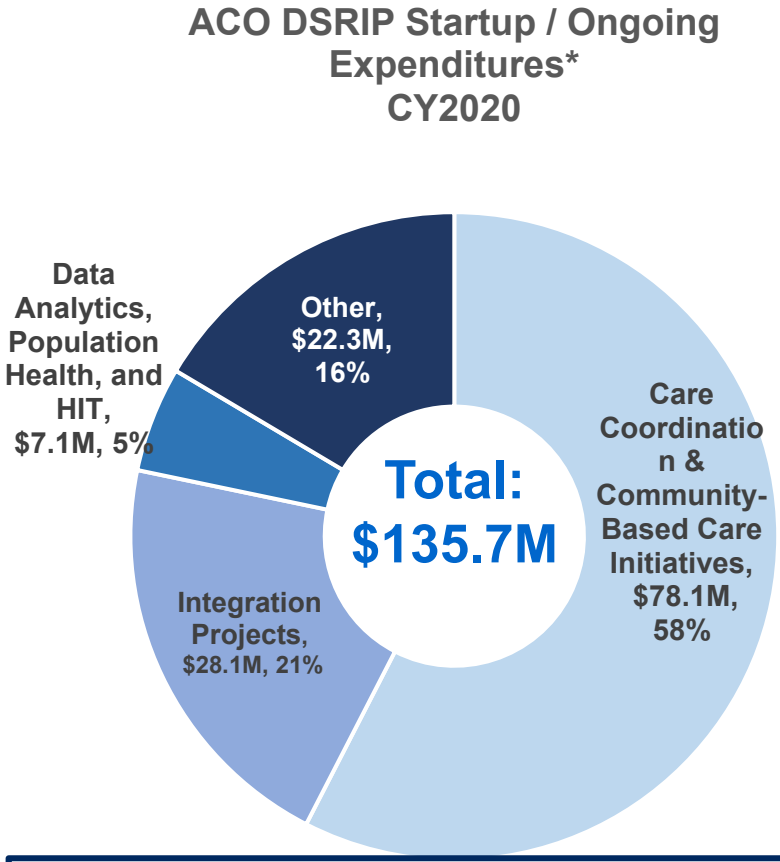
$59.6M

$ paid to CPs for care coordination supports provided between 1/1/2020 – 12/31/2020

- Payments for outreach, assessing needs, care planning, care coordination, etc.

*MassHealth previously reported that DSRIP supported 264 investments/programs in 2019. MassHealth is clarifying that DSRIP funding actually supported 1,188 investments/programs in 2019.

ACO DSRIP Startup / Ongoing investments: overview by category

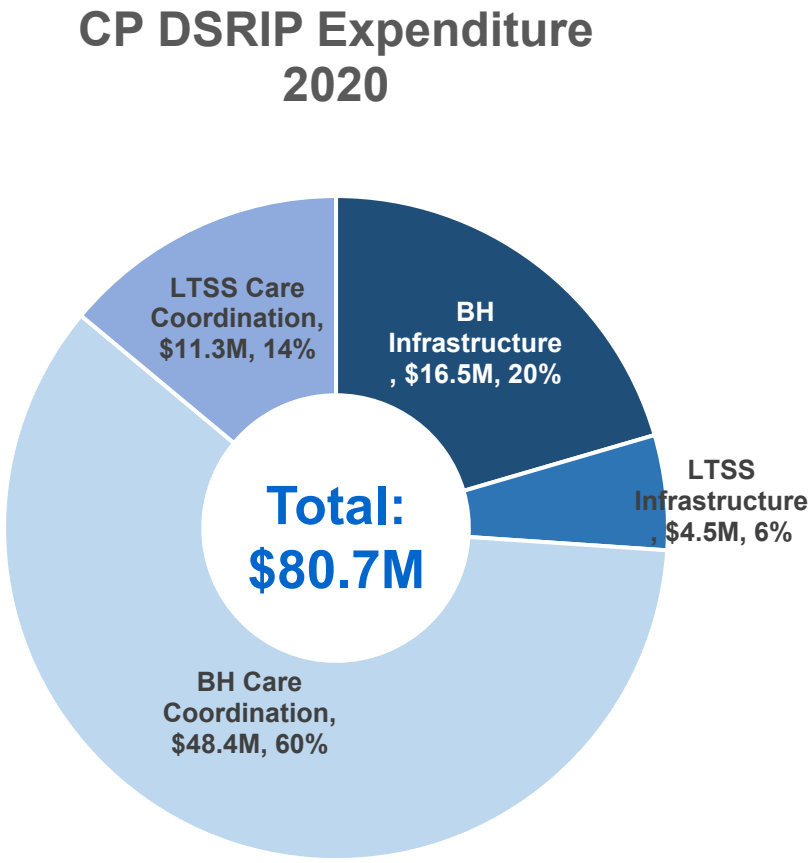


CY2020 Startup / Ongoing expenditure data ($135.7M) reflects a decrease from the CY2019 report ($173.7M) in part because the COVID-19 pandemic resulted in ACOs having to delay programs/investments or shift priorities away from DSRIP. ACO DSRIP allocation percentages by category remained relatively constant between 2019 and 2020.

- **Care Coordination & Community-Based Care Initiatives:** Strengthen care coordination/ management and community-based programming
- **Integration Projects:** Increase organizational capacity, as well as integration amongst physical health, BH, LTSS, and health-related social services
- **Data Analytics, Population Health, and Health Information Technology:** Improve data collection, analytic platforms, algorithm development, EHR and care management software improvements, and interoperability
- **Other:** Support workforce development, culturally and linguistically appropriate services, and other investments

*Expenditures do not include ACO DSTI or ACO Flexible Services Expenditures
DSRIP funding per ACO included in appendix

CP DSRIP investments: overview by category



- **Infrastructure:** Investments in technology, workforce development (e.g., recruitment and training expenses), business start up costs, and operational infrastructure (e.g., data analytics staff)
- **Care coordination**: Payment for outreach, assessing needs, care planning, care coordination, etc.

CY20 expenditure data ($80.7M) reflects an increase from CY2019 expenditures ($70.4M), driven by an increase in Care Coordination payments. The percentage of total CP expenditures attributed to Care Coordination increased from 50% (CY19) to 74% (CY20). The factors contributing to this increase include rate increases for Care Coordination payments and flexibilities in response to the COVID-19 pandemic (including allowing care coordinators to conduct telehealth visits).

DSRIP expenditures per CP included in appendix

Statewide Investments: by the numbers – Workforce

Cumulative through CY19	CY20	
141	75	**# student loans repaid for community-based clinicians**
$5.7M	$2.7M	**$ in student loan repayment**
90%		**% total loan repayment recipients from 2018-2020 award cohorts retained** • Empowers and incentivizes clinicians to work at and remain in safety net provider organizations
453	279	**# community health workers and peer specialists trained** • Key members of the extended care team, who help engage members in their care
16	10	**# community health center-based Family Medicine and Family Nurse Practitioner residency training slots supported** • Clinicians trained in community-based residency programs more likely to remain in community upon training completion

DSRIP funding per Statewide Investments program included in appendix

Statewide Investments: by the numbers – Technical Assistance

Cumulative through CY19	CY20	
91	76	**# technical assistance (TA) projects funded at ACOs/CPs**
$9.2M	$6.1M	**$ of technical assistance support** • Provides access to a curated catalog of 47 TA vendors with expertise in 9 different domains
987	1,026	**# average monthly active users of DSRIP TA website*** • High interest from ACOs and CPs since program launch
2	2	**# of half-day SWI Pop Up Events hosted** • Half-day convenings which are attended by ACOs, CPs, and others; first two Pop Ups focused on member engagement

DSRIP funding per Statewide Investments program included in appendix
Differences in # of TA projects and $ funding from CY2019 EOY report due to cancelled and/or scoped-down projects.

* MA DSRIP TA Marketplace: https://www.ma-dsrip-ta.com/

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Current 1115 Waiver (2021-2022)

Continued recovery from / response to the pandemic

- The pandemic's impact on patterns of care, particularly reductions in routine primary care (including screenings, chronic disease management, etc.) are a key future risk and priority focus area for ACOs, CPs, and MassHealth in the remaining two years of the 1115 waiver
- Efforts to re-engage members, ramp up home- and community-based services, and leverage the innovation and learnings of the pandemic (e.g., substantial telehealth expansion) will be crucial to future success and avoiding long-term detrimental outcomes

Adjustments to program design in response to 2020 data

- Starting in 2021, ACOs will have a "market risk corridor," which will adjust ACO financial performance to ensure that ACOs are primarily accountable for their performance relative to market peers, rather than at-risk for underlying fluctuations in the acuity of the Medicaid population
- The pandemic's continued effect on national and local quality data will likely have continued impacts on the MassHealth quality program, which are still being evaluated and discussed with CMS

Delivery system reform trends expected to continue

- Despite navigating a challenging year, ACOs have continued to iterate and refine their DSRIP spending and population health strategies. DSRIP funding will decline in subsequent years, requiring ACOs to continue to prioritize programs that have demonstrated success and sustainability
- After stabilizing from the initial launch and some key reforms, the CP program made significant progress in 2020. The last two years of the waiver will provide great opportunities for ACOs and CPs to continue deepening relationships that are working, and refining their partnerships based on data
- The Flexible Services Program's first year was characterized by rapid growth. ACOs will use the coming two years to continue to ramp up and expand their programs, while beginning to evaluate their impact on cost and outcomes

Appendix

- Additional context on the 2018 restructuring
- Quality and member experience: detail
- Lists of MassHealth CPs
- DSRIP funding detail by entity and funding stream

Context: What are MassHealth Accountable Care Organizations?

- ACOs are health care organizations that are rewarded for **better health outcomes, lower cost, and improved member experience**

- ACOs are responsible for achieving these results through **team-based care coordination** and integration of behavioral and physical health care; ACOs are also responsible for taking a whole person view of their members, including long term services and supports and health related social needs

- MassHealth members enrolled in an ACO select, or are assigned, a **specific primary care provider** and have **access to networks of specialty providers** (e.g., hospitals, specialists, behavioral health providers) that participate in their plan

- ACOs assume **upside and downside risk** and are financially accountable for specific quality measures
  - **The 1115 waiver does not assume savings in the first 2 years** of the ACO program. Starting in the third year (2020), the state is accountable for savings, ramping up to 2.1% savings (off baseline trend) by Year 5

- ACOs represent a **diverse range of provider systems:**
  - Hospital-based and community primary care-based ACOs
  - Large, statewide and regional ACOs
  - Provider-led and provider-health plan partnership ACOs

Context: What are MassHealth Community Partners?

- Community Partners (CPs) contract with ACOs to provide **wrap-around expertise and support for behavioral health (BH) services and long-term services and supports (LTSS)**
- CPs serve **the most complex ACO members**, with serious mental illness, substance use disorders, co-occurring disorders, or disabilities that require long-term services and supports
- CPs are paid to **engage** these members and collaborate with the health care system to **coordinate and improve** their care
- CPs are **community-based organizations** with expertise in supporting the populations they serve

Context: What is the Delivery System Reform Incentive Payment (DSRIP) Program?

- CMS authorized **$1.8B** in **one-time** DSRIP funding for **upfront investments in the delivery system.**

- Funding is divided among **3 main streams** over 5 years:

ACOs	CPs	Statewide Investments
$1B	**$550M**	**$115M**

- ACOs and CPs use funding to **launch innovative programs** and coordinate care for their members. Funding is **tied to performance on quality and the total cost of care**
  - $1B ACO allocation include **$150M allocated for Flexible Services** investments, which provide goods and services to address **health-related social needs**. See p. 41-44 for more detail

- DSRIP funding is **time limited and ends in 2022**

ACO slate: 21 clinical quality and member experience measures

	Measures	First Performance Year
1.	Follow Up After Emergency Dept. Visit for Mental Illness	2020
2.	Poor Control of HbA1c Levels (Diabetes Care)	2019
3.	Follow Up After Hospitalization for Mental Illness	2019
4.	Metabolic Monitoring for Children or Adolescents on Antipsychotics	2019
5.	Initiation and Engagement of Alcohol, Opioid or other Drug Use Treatment	2019
6.	Appropriate Medications for Asthma	2019
7.	Controlling High Blood Pressure	2020
8.	Screening for Depression and Follow Up Plan	2022
9.	Unplanned Hospital Readmissions	2021
10.	Childhood Immunizations	2019
11.	Adolescent Immunizations	2019
12.	Timeliness of Prenatal Care	2019
13.	Health Related Social Needs Screening	2021
14.	Emergency Department Visits for Individuals with Serious Mental Illness or Addiction	2021
15.	Community Tenure	2021
16.	Depression Remission/Response	2021
17.	Behavioral Health Community Partner Engagement	2021
18.	Long Term Service and Supports Community Partner Engagement	2021
19.	Oral Health Evaluation	2021
20.	Overall Quality of Care	2019
21.	Integration/ Care Coordination	2021

19 Clinical Quality Measures

2 Member Experience Measures

CP slate: Clinical quality and member experience measures

BH/LTSS #	Measures	BH CP	LTSS CP	ACO Crossover
1	Community Partner Engagement	X	X	X
2	Annual Treatment/Care Plan Completion	X	X	
3	Enhanced Person-Centered Care Planning	X	X	
4	Follow-up with CP after acute or post-acute stay (3 days)	X	X	
5	Follow-up with CP after ED visit	X		X
6	Annual primary care visit	X	X	
7.A	Initiation of Alcohol, Opioid, or Other Drug Abuse of Dependence Treatment	X		X
7.B	Engagement of Alcohol, Opioid, or Other Drug Abuse of Dependence Treatment	X		X
8	Follow-up After Hospitalization for Mental Illness (7 days)	X		X
9	Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication	X		
10	Antidepressant Medication Management	X		
11	ED Visits for Adults with SMI, Addiction or Co-occurring Conditions	X		X
12	Hospital Readmissions	X	X	X
13	Oral Health Evaluation		X	X
14	All-Cause ED visits		X	
15	Member Experience: Member Engagement and Care Planning	X	X	X

Clinical quality: list of 18 measures with benchmarks and scores

	Measure	Description
1	Follow Up After ED for Mental Illness	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge
2	Comprehensive Diabetes Care: HbA1c Poor Control*	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (>9.0%)
3	Follow Up After Hospitalization for Mental Illness	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge
4	Metabolic Monitoring for Children or Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing
5a & 5b	Initiation and Engagement of AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive 2 or more additional services within 30 days of the initiation visit
6	Appropriate Medications for Asthma	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater
7	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled
8	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age who had an outpatient visit with a screening for depression and a follow-up plan if the screen was positive
9	Hospital Readmissions*+	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age
10	Childhood Immunizations	Percentage of members who received all recommended immunizations by their 2nd birthday
11	Adolescent Immunizations	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series
12	Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment
13	Health Related Social Needs Screening	Percentage of members who were screened for health-related social needs in the measurement year
14	Emergency Dept Visits for Individuals with Serious Mental Illness or Addiction*+	Number of ED visits for members 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions
15	Depression Remission and/or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score
16	Behavioral Health Community Partner Engagement	Percentage of members 18 to 64 years of age who engaged with a BH Community Partner and received a treatment plan within 3 months (122 days) of Community Partner assignment
17	Long Term Service and Supports Community Partner Engagement	Percentage of members 18 to 64 years of age who engaged with a LTSS Community Partner and received a treatment plan within 3 months (122 days) of Community Partner assignment
18	Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation during the year

** Lower score is better* *+ Reported as observed/expected rate*

Note: for purposes of efficiency, some measure titles have been abbreviated

ACO clinical quality: Measure-level attainment, 2019 vs. 2020

MEASURE	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)
Follow-up after ED for Mental Illness	Yes	Yes	Yes
Diabetes Poor Control	Yes	Yes	
Follow-up After Hospitalization	Yes	Yes	Yes
Metabolic Monitoring	Yes	Yes	Yes
Initiation of AOD Treatment	Yes	Yes	Yes
Engagement of AOD Treatment			
Controlling High Blood Pressure	Yes	Yes	
Screening for Depression	Yes	Yes	Yes
Childhood Immunization	Yes	Yes	Yes
Immunization for Adolescents	Yes	Yes	Yes
Timeliness of Prenatal Care	Yes	Yes	
Depression Remission / Response	Yes	Yes	Yes
Asthma Medication Ratio			Yes
Oral Health Evaluation	Yes	Yes	
Health Related Social Screening	Yes	Yes	Yes
ED Visits for Individuals w/Serious Mental Illness and/or Addiction	Yes	Yes	
Total	**14/16**	**14/16**	**10/16**

Note: Performance above describes the median ACO for each given metric

CP clinical quality: Measure-level attainment, 2019 vs. 2020

MEASURE	2019 Official Quality Score (based on actual 2019 data)	2020 Official Quality Score (based on 2019 data + COVID allowances)	2020 Actual Quality Score (based on actual 2020 data)
BH CP			
Community Partner Engagement	Yes	Yes	Yes
Enhanced Annual Treatment Plan Completion	Yes	Yes	Yes
Annual Primary Care Visit	Yes	Yes	Yes
Diabetes Screening for Ind. w/ Schizophrenia or Bipolar Disorder who are using Antipsychotic Meds	Yes	Yes	
Initiation of AOD Treatment	Yes	Yes	Yes
Engagement of AOD Treatment	Yes	Yes	Yes
Follow Up After Hospital Visit for Mental Illness	Yes	Yes	Yes
ED Visits for Individuals w/Serious Mental Illness and/or Addiction	Yes	Yes	Yes
Hospital Readmission	Yes	Yes	
LTSS CP			
Community Partner Engagement	Yes	Yes	Yes
Enhanced Annual Care Plan Completion	Yes	Yes	Yes
Annual Primary Care Visit	Yes	Yes	Yes
Oral Health Evaluation	Yes	Yes	
All Cause ED Visits	Yes	Yes	Yes
Plan All Cause Readmission	Yes	Yes	
Total	**15/15**	**15/15**	**11/15**

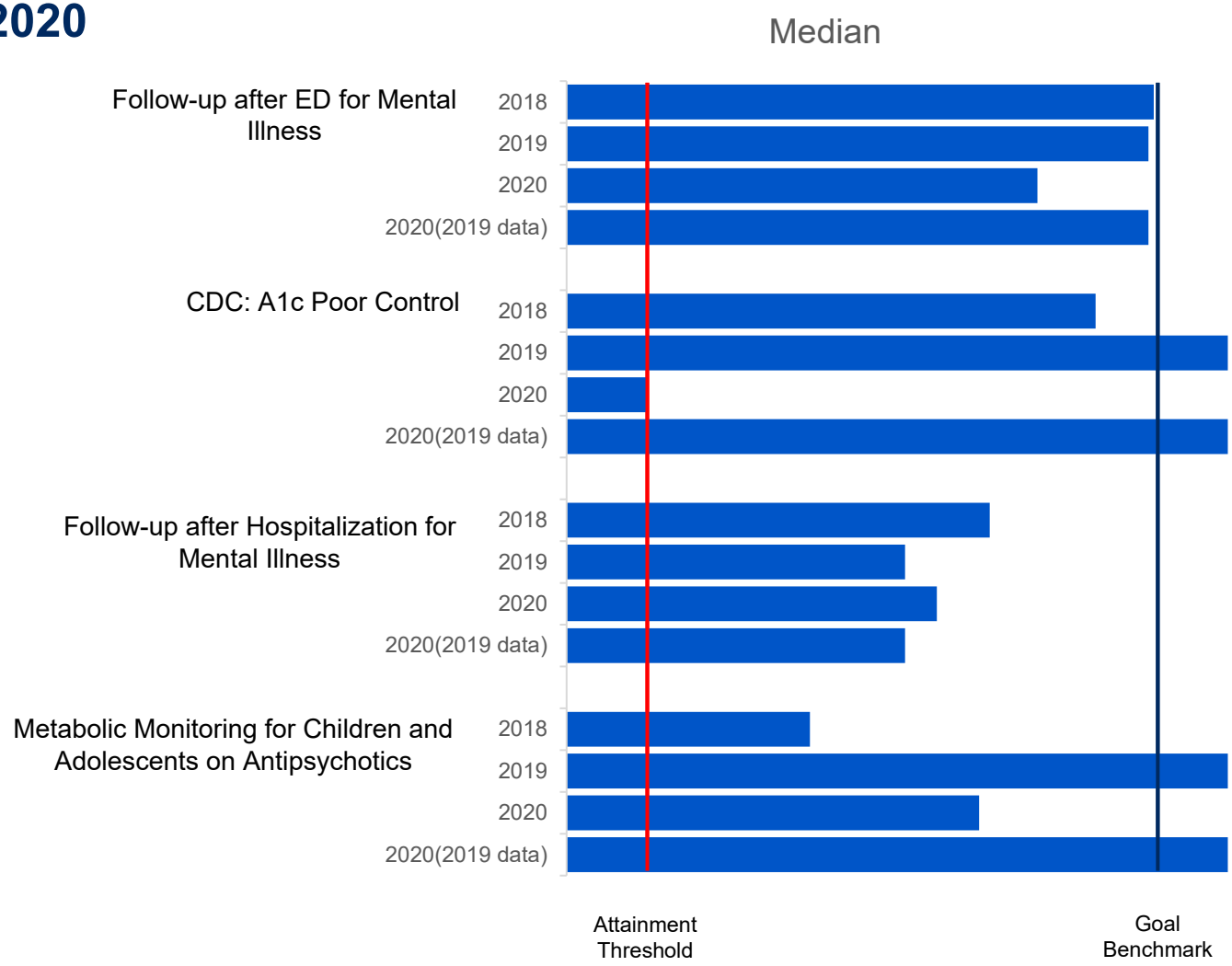
Note: Performance above describes the median CP rate for each given metric

How to read the quality measure charts on upcoming slides

Charts are shown that **summarize key information** about ACO quality performance

- The **median** quality score per measure per year is represented by the bar chart
- This chart allows easy comparison of the median scores against the **attainment threshold and goal benchmark** by lining these up (the red line and blue line, respectively); because the attainment threshold and goal benchmark values actually **vary from measure to measure**, lining them up like this requires the **scale for each measure to vary as well**
- Therefore, these charts show how the medians varied **relative to the benchmarks**, but the bars are not to scale with each other and should not be used to determine the relative performance between one measure and another

ACO Clinical Quality: Overview of measure scores and comparison between 2018-2020



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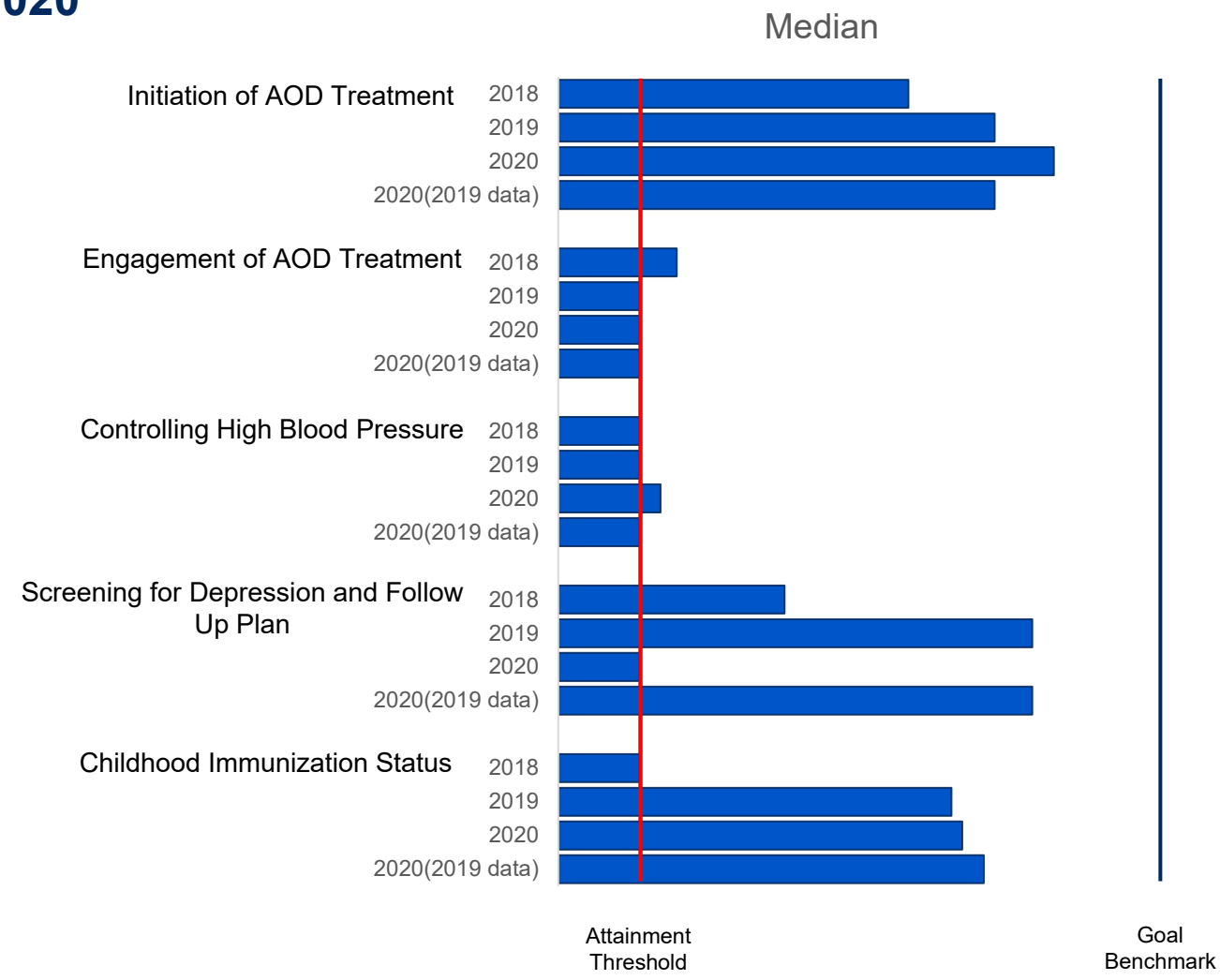

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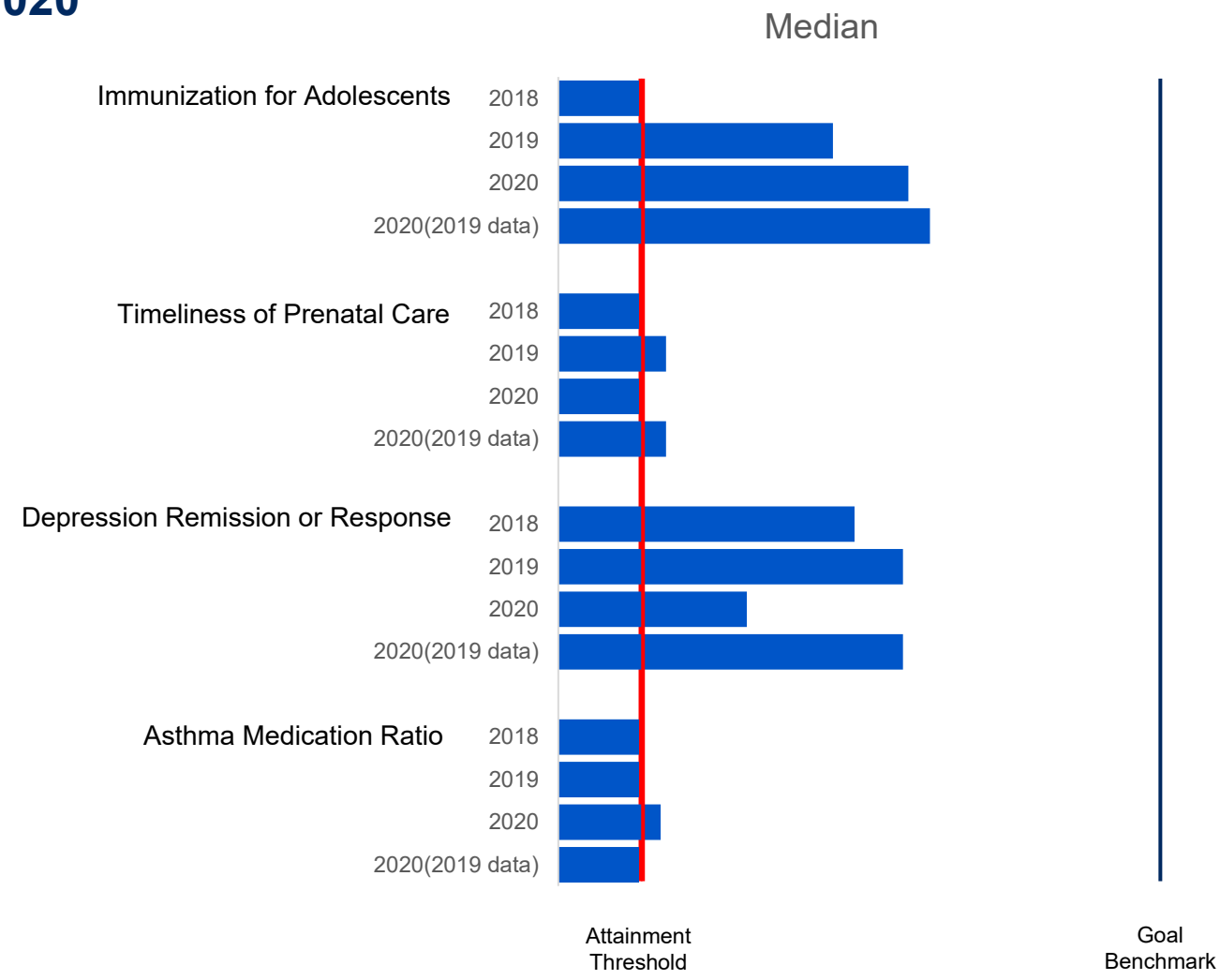

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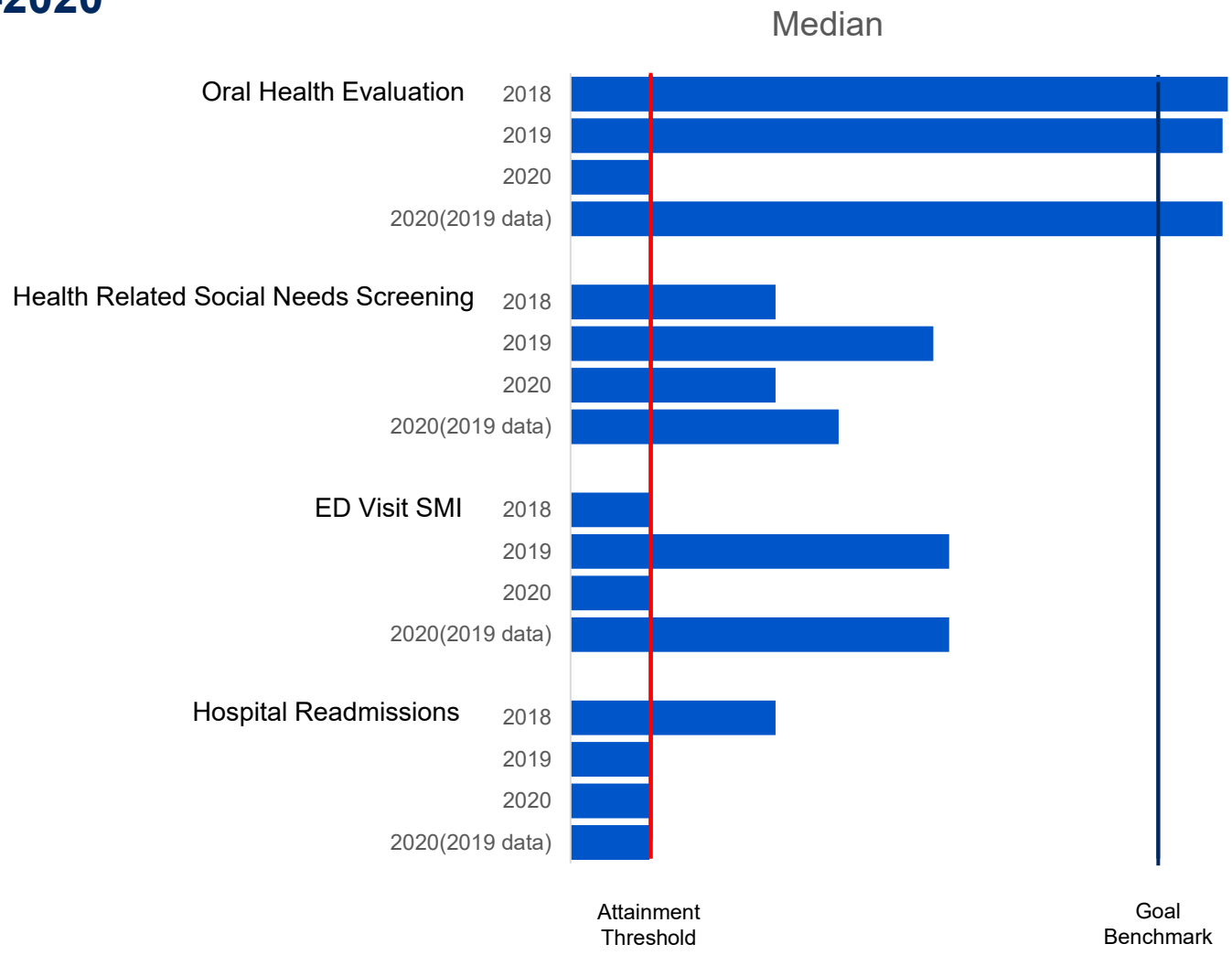
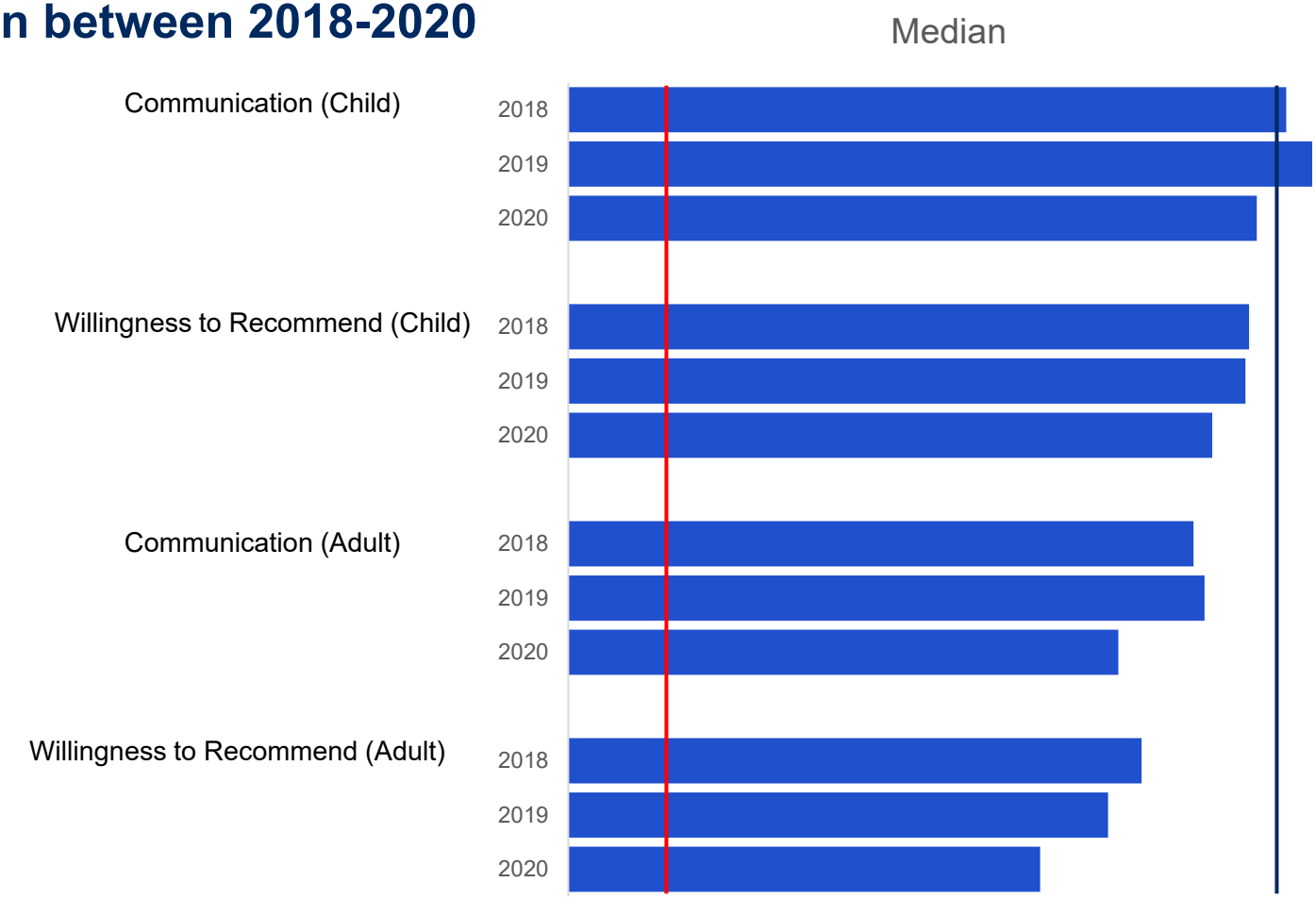
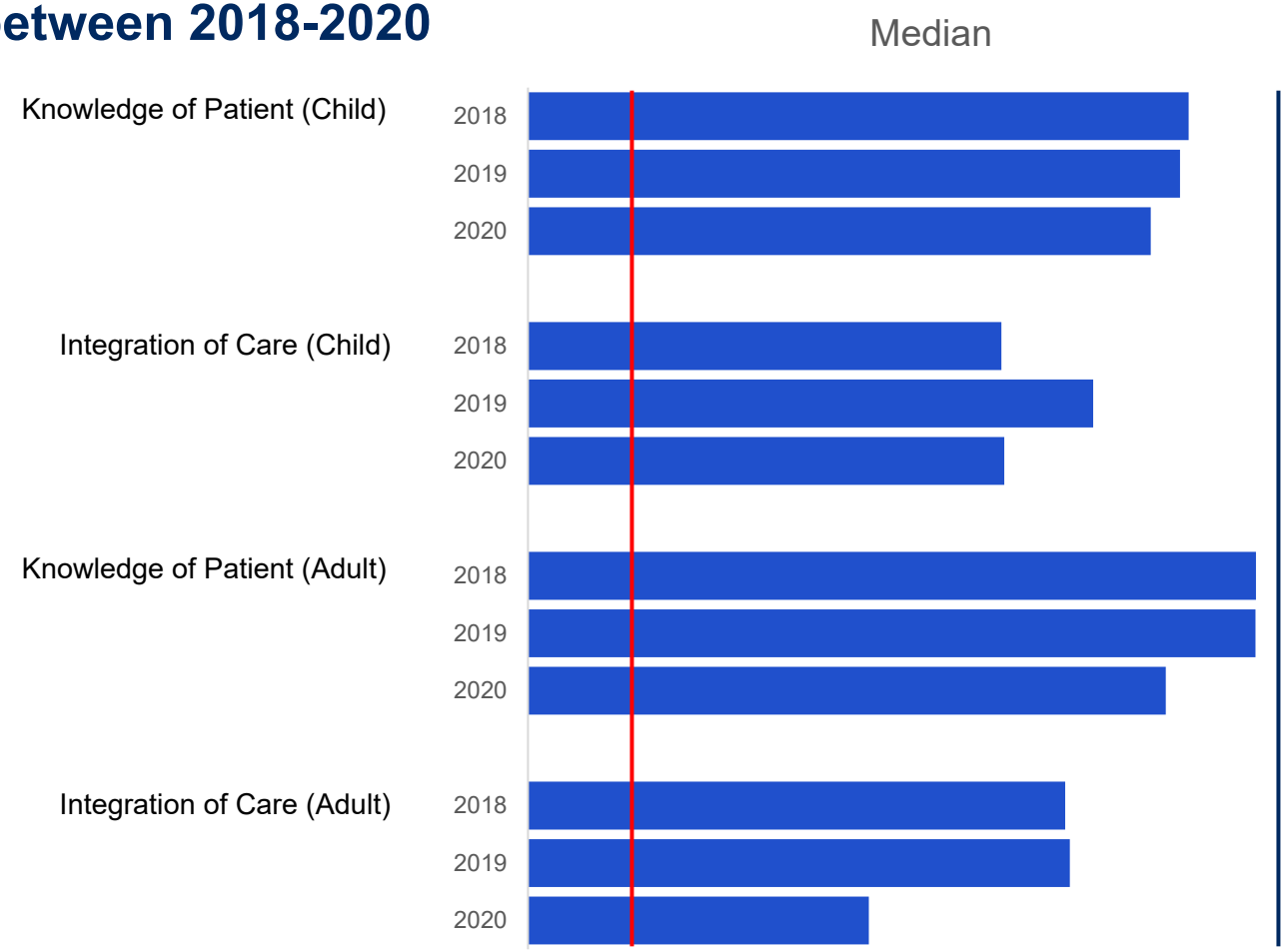


ACO Member Experience: Overview of measure scores and comparison between 2018-2020



ACO Member Experience: Overview of measure scores and comparison between 2018-2020



Detailed quality results (1 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
1. Follow Up After ED Visit	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge	0 – 100	2018	75.8	73.0	77.5	62.6	76.3
			2019	75.6	72.2	77.5		
			2020	72.9	68.9	75.8		
2. Comprehensive Diabetes Care: A1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (>9.0%)	0 – 100 *(lower is better)*	2018	31.9	36.7	26.8	39	30.6
			2019	29.3	33.8	26.9		
			2020	40.3	35.1	42.6		
3. Follow Up After Hospitalization for Mental Health	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	0 – 100	2018	51.2	45.5	52.4	39.1	57.7
			2019	48.2	42.7	52.1		
			2020	49.3	46.6	52.6		
4. Metabolic Monitoring for Children or Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	0 – 100	2018	35.8	33.8	42.3	31	40.5
			2019	46.7	42.6	53.4		
			2020	37.7	33.7	44.9		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed quality results (2 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
5.a Initiation AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis	0 – 100	2018	43.5	39.0	50.6	36.8	50.2
			2019	45.6	39.5	51.2		
			2020	47.1	41.4	55.0		
5.b Engagement AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who receive 2 or more additional services within 30 days of the initiation visit	0 – 100	2018	16.9	14.3	18.8	16.4	23.8
			2019	16.3	14.0	19.2		
			2020	15.5	13.1	17.6		
6. Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had appropriate medications	0 – 100	2018	62.2	57.9	64.4	57.2	67.5
			2019	52.0	51.4	57.4		
			2020	57.6	54.2	65.5		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed quality results (3 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
7. Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	0 – 100	2018	67.2	63.6	72.8	63.6	76.7
			2019	73.2	67.6	75.5		
			2020	60.6	58.2	68.6		
8. Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age who had an outpatient visit with a screening for depression and a follow-up plan if the screen was positive	0 – 100	2018	40.2	19.9	45	28.0	58.3
			2019	42.9	36.2	52.4		
			2020	33.9	25.0	39.3		
9. Hospital Readmissions	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age	0 – 1.0 *(lower is better)*	2018	0.94	1.0	0.8	1.0	0.75
			2019	1.1	1.1	0.98		
			2020	1.25	1.3	1.1		
10. Childhood Immunization	Percentage of members who received all recommended immunizations by their 2nd birthday	0 – 100	2018	49.9	40.2	60.2	48.9	59.4
			2019	55.7	49.1	63.7		
			2020	56.4	48.3	61.3		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed quality results (4 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
11. Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	0 – 100	2018	32.2	26.9	39.6	31.4	49.4
			2019	41.1	33.2	53.7		
			2020	43.0	35.0	55.9		
12. Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	0-100	2018	80.8	71.6	84.7	86.0	93.6
			2019	86.4	80.3	91.0		
			2020	82.5	77.1	89.0		
13. Health Related Social Needs	Percentage of members who were screened for health-related social needs in the measurement year	0-100	2018	9.5	1.5	14.6	1.5	23.5
			2019	6.8	2.4	32.9		
			2020	13.4	5.6	18.7		
14. Emergency Department Visits for Individuals with Serious Mental Illness or Addiction*+	Number of ED visits for members 18 to 64 years of age with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	0.00-1.00	2018	1.28	1.11	1.42	1.14	0.88
			2019	.99	.93	1.14		
			2020	1.40	1.31	1.53		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed quality results (5 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
15. Depression Remission and/or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score	0-100	2018	4.8	1.6	8.3	1.7	9.2
			2019	4.9	3.2	8.1		
			2020	5.3	2.0	11.7		
16. Behavioral Health CP Engagement	Percentage of members 18 to 64 years of age who engaged with a BH CP and received a treatment plan within 3 months (122 days) of CP assignment	0-100	2018	3.5	2.2	5.1	5.4	12.2
			2019	6.8	4.9	11.2		
			2020	10.6	9.1	12.7		
17. Long Term Services and Supports CP Engagement	Percentage of members 18 to 64 years of age who engaged with a LTSS CP and received a care plan within 3 months (122 days) of CP assignment	0-100	2018	1.3	0.0	2.3	2.9	9.2
			2019	4.1	2.9	7.3		
			2020	5.1	3.9	6.8		
18. Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation during the year	0-100	2018	62.6	58.1	63.5		
			2019	60.8	58.2	63.4		
			2020	44.1	39.6	48.0		

** Lower score is better* *+ Reported as observed/expected rate*

Detailed quality results (6 of 6): MES Performance Measures

Measure	Description	How it is scored	Survey Group	Year	Median Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Willingness to Recommend	Overall measure of the experience and the provider	0 – 100	Adult	2018	87.9	86.0	89.8	75.0	92.0
				2019	87.0	86.0	88.5		
			Child	2018	90.8	89.3	92.8	75.0	92.0
				2019	90.7	88.8	92.9		
Communication	Effective communication between provider and patient or caregiver	0 – 100	Adult	2018	89.3	87.7	90.4	75.0	92.0
				2019	89.6	88.3	89.9		
			Child	2018	91.8	90.0	93.1	75.0	92.0
				2019	92.5	90.6	93.1		
Integration of Care	Effective coordination of services (e.g., labs, referrals, follow-up, and information exchanged between provider, patient, and services)	0 – 100	Adult	2018	79.8	77.7	81.8	70.0	85.0
				2019	79.9	78.0	81.0		
			Child	2018	78.4	77.4	81.1	70.0	85.0
				2019	80.4	77.6	81.0		
Knowledge of Patient	Provider knowledge of important medical information about patient and understanding patient's challenges to staying healthy	0 – 100	Adult	2018	84.1	81.6	85.1	70.0	85.0
				2019	84.1	82.2	84.6		
			Child	2018	87.6	85.5	89.3	75.0	90.0
				2019	87.4	86.4	88.8		

^Benchmarks pending finalization from CMS

Primary Care Member Experience Measure Performance

	Performance Measure	2018 Aggregate Statewide Score	2019 Aggregate Statewide Score	2020 Aggregate Statewide Score	Threshold	Goal
21	Overall Care Delivery	90.0	89.9	75.0	75.0	92.0
22	Integration/Coordination of Care	83.2	83.2	71.25	71.25	86.25

Detail: Overall Care Delivery (#21)

Question Topics	Description	Adult/ Child	Statewide Score			Threshold	Goal
			2018	2019	2020		
Willingness to Recommend	Overall measure of the experience and the provider	Adult	**87.1**	**86.8**	**85.2**	75.0	92.0
		Child	**91.3**	**91.6**	**90.9**		
Communication	Effective communication between provider and patient or caregiver	Adult	**89.2**	**88.9**	**87.1**	75.0	92.0
		Child	**92.3**	**92.4**	**91.2**		

Detail: Integration/Coordination of Care (#22)

Question Topics	Description	Adult/ Child	Statewide Score			Threshold	Goal
			2018	2019	2020		
Integration of Care	Effective coordination of services (e.g., labs, referrals, follow-up, and information exchanged between provider, patient, and services)	Adult	**80.5**	**80.2**	**78.1**	70.0	85.0
		Child	**80.7**	**81.1**	**80.2**	70.0	85.0
Knowledge of Patient	Provider knowledge of important medical information about patient and understanding patient's challenges to staying healthy	Adult	**83.7**	**83.3**	**81.6**	70.0	85.0
		Child	**88.1**	**88.1**	**87.2**	75.0	90.0

Member Experience: Additional Primary Care Composites & Questions

Question topics	Description	Adult/ Child	Statewide Score		
			2018	2019	2020
Self-Management Support	Provider engagement with patients to talk about their goals for their health and things that make it hard to take care of their health	Adult	63.1	63.1	59.2
		Child	51.2	54.4	52.3
Behavioral Health*	Provider engagement with patients to talk about their behavioral health needs	Adult	64.9	68.0	63.7
Child Development**	Provider engagement with patients to talk about their child's physical, emotional and social development	Child	71.0	72.1	68.4
Pediatric Prevention**	Provider engagement with patients to talk about their child's home environment (addressing exercise, food, computer, safety etc)	Child	67.3	68.5	65.3
Office Staff	Helpfulness of the office staff, and being treated with courtesy and respect	Adult	86.4	86.4	84.1
		Child	86.9	87.1	86.2
Organizational Ac cess	Access to timely routine and urgent appointments, and same day response to questions	Adult	80.7	80.3	78.1
		Child	86.1	85.8	84.2
Overall Provider Rating	Rating of provider	Adult	88.3	88.0	86.7
		Child	91.1	91.6	91.0
Child Provider Communication**	Effective communication between provider and patient	Child	95.7	95.7	95.2

*There is no BH Child composite in the Primary Care survey.

**These composites are in the Child Primary Care survey only.

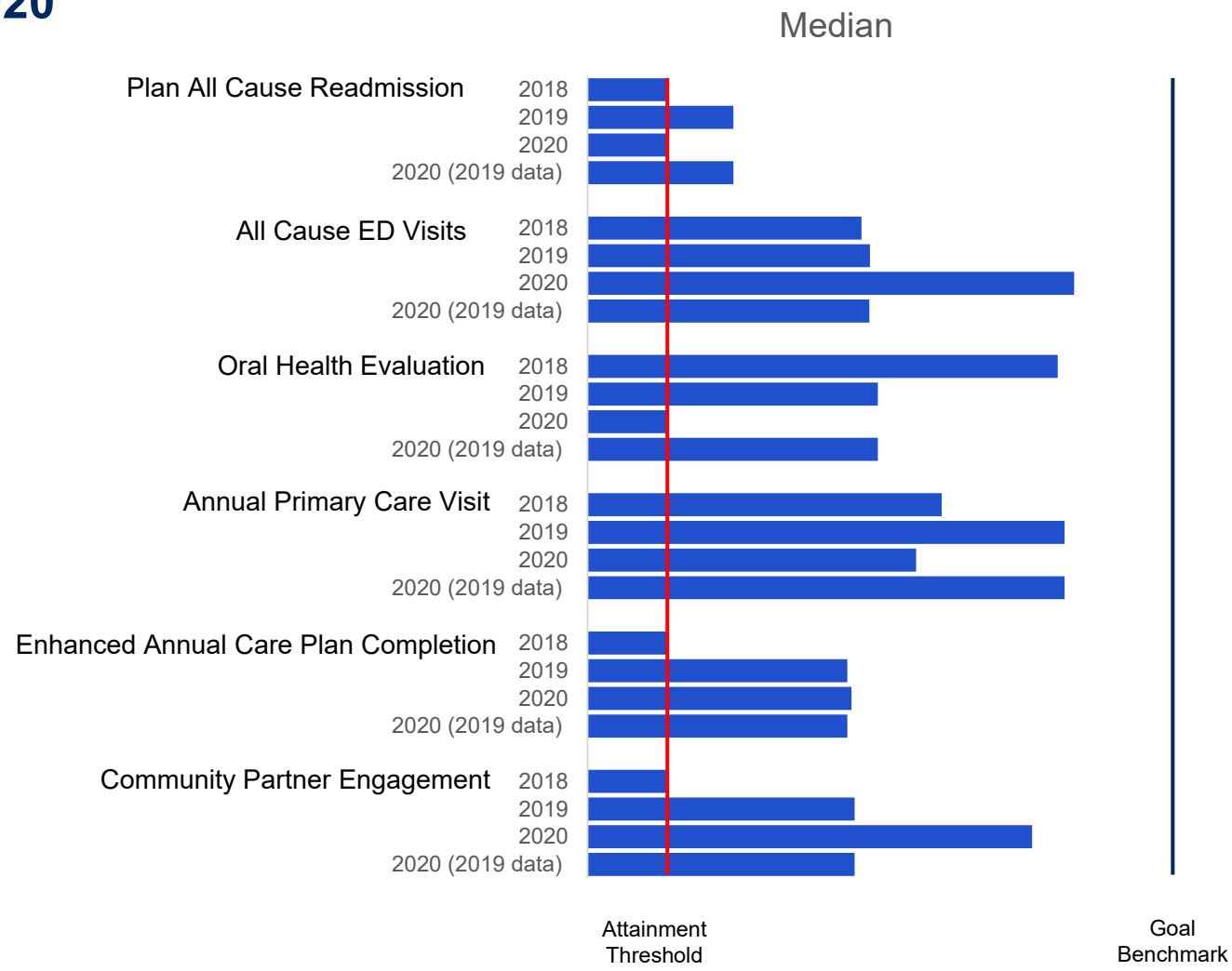
Member Experience: Behavioral Health Composites (Sets of Questions)

Question topics	Description	Adult/ Child	Statewide Score		
			2018	2019	2020
Willingness to Recommend	Overall measure of the experience and the provider(s)	Adult	80.6	79.4	80.1
		Child	79.5	81.2	79.0
Communication	Effective communication between provider and patient	Adult	86.8	85.6	85.5
		Child	87.1	87.8	86.1
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information about the patient	Adult	72.2	71.3	72.2
		Child	74.8	78.4	73.6
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	73.8	69.9	70.1
		Child	75.0	71.0	68.8
Member Engagement w/ Care Team	How often help or advice was received when member contacted someone from care team	Adult	--	--	74.0
		Child	--	--	75.3
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	56.2	58.2	57.3
		Child	53.4	56.0	55.6
Needs Met BH	How well needs for mental health service, substance use treatment, and prescription medication were met	Adult	81.8	72.1	72.2
		Child	77.5	70.8	66.2
Service Scheduling	Access and availability to services	Adult	75.3	75.2	75.6
		Child	74.4	77.0	75.1
Overall Rating	Rating of overall behavioral health services in the last 12 months	Adult	75.6	74.7	75.5
		Child	75.7	77.0	74.4
Healthy Living in Community	Care team support in ability to manage physical & mental health, participate in activities with friends/family, self-care at place of residence	Adult	--	--	68.3
		Child	--	--	70.3

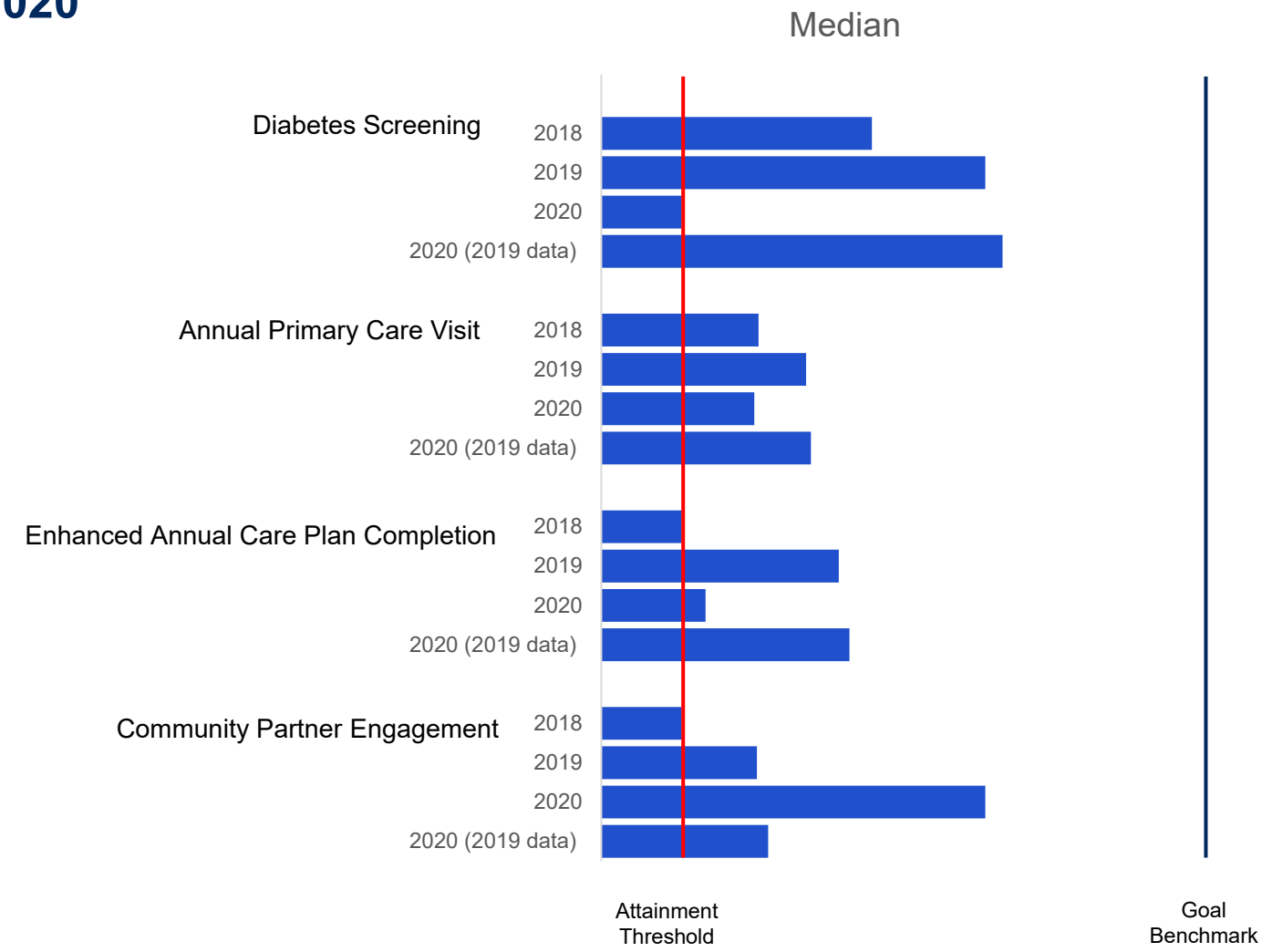
Member Experience: LTSS Composites (Sets of Questions)

Question topics	Description	Adult/ Child	Statewide Score		
			2018	2019	2020
Willingness to Recommend	Overall measure of the experience with LTSS services	Adult	86.0	84.9	84.6
		Child	86.2	82.3	87.3
Communication	Effective communication between provider and patient	Adult	86.3	86.3	87.0
		Child	85.6	85.5	87.3
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information	Adult	76.7	74.3	73.5
		Child	75.3	64.2	73.7
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	75.9	71.3	71.4
		Child	76.3	71.3	71.1
Member Engagement w/ Care Team	How often help or advice was received when member contacted someone from care team	Adult	--	--	74.7
		Child	--	--	72.8
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	75.8	73.8	71.7
		Child	71.6	61.4	70.2
Needs Met - Core Services	How well needs for core LTSS services were met (e.g., physical therapy, skilled nursing, day programs)	Adult	82.8	74.8	74.6
		Child	81.8	71.3	69.2
Needs Met – Non-core Services	How well needs for non-core LTSS services were met (e.g., assistive technology, transportation services)	Adult	84.0	78.3	77.7
		Child	83.0	77.8	74.9
Service Scheduling	Access to and availability of services	Adult	81.7	81.5	80.9
		Child	81.0	79.1	81.9
Overall Rating	Rating of overall LTSS services	Adult	78.5	75.1	78.0
		Child	78.0	74.6	77.1
Healthy Living in the Community	Care team support in ability to manage physical & mental health, participate in activities with friends/family, self-care at place of residence	Adult	--	--	67.6
		Child	--	--	71.7

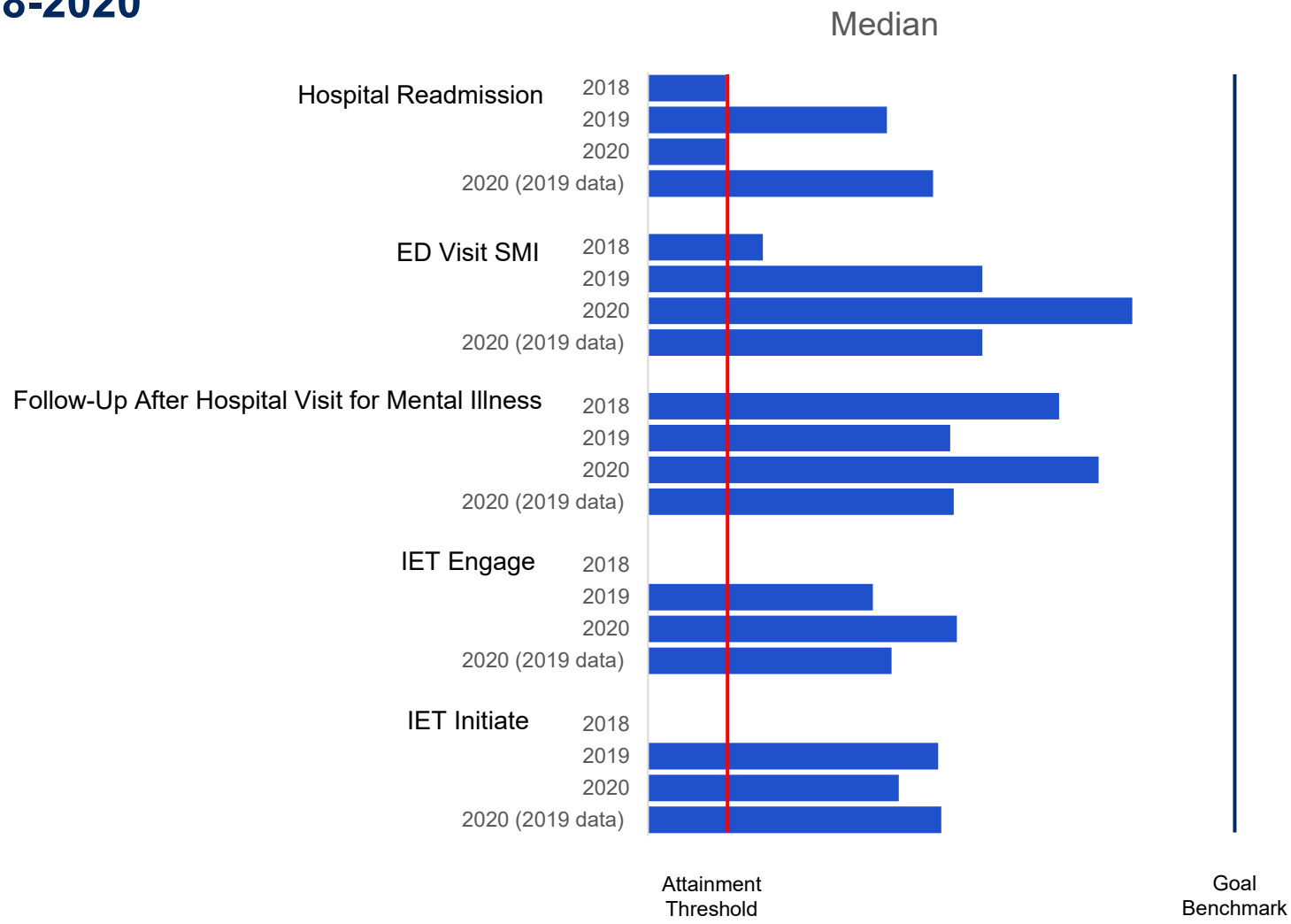
LTSS CP Clinical Quality: Overview of measure scores and comparison between 2018-2020



BH CP Clinical Quality: Overview of measure scores and comparison between 2018-2020



BH CP Clinical Quality: Overview of measure scores and comparison between 2018-2020



Detailed BHCP quality results (1 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Community Partner Engagement	The percentage of Behavioral Health Community Partner assigned enrollees 18 to 64 years of age with documentation of engagement within 122 days of the date of assignment to a BH CP.	0 – 100	2018	2.4	1.0	8.5	4.04	11.71
			2019	5.1	4.0	8.7		
			2020	8.4	6.7	11.2		
Enhanced Person-Centered Care Planning	Percentage of enrollees 18 to 64 years of age with timely completion of a new or updated Care Plan during the measurement year	0 – 100	2018	7.0	3.7	19.0	42.81	64.44
			2019	53.3	45.3	62.3		
			2020	46.5	42.8	62.1		
Follow-up with BHCP after acute or post-acute stay (3 days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a Contractor within 3 business days of discharge	0 – 100	2018	1.0	0.7	2.5	TBD	TBD
			2019	4.9	3.3	8.7		
			2020	15.6	13.1	20.3		
Follow-up with BH CP or provider after ED visit	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within 7 days of the ED visit	0 – 100	2018	.4	.0	1.4	TBD	TBD
			2019	11.5	6.8	23.1		
			2020	31.3	24.6	45.9		

Detailed BHCP quality results (2 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Annual primary care visit	Percentage of enrollees 18 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	0 – 100	2018	52.6	47.4	60.3	49.96	67.91
			2019	54.2	50.0	61.9		
			2020	52.4	48.2	58.4		
Initiation of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of enrollees 18 to 64 years of age who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiated treatment within 14 days of diagnosis	0 – 100	2018	N/A	N/A	N/A	79.16	85.60
			2019	81.8	79.2	83.3		
			2020	81.3	80.0	84.1		
Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of enrollees 18 to 64 years of age who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who received ≥2 additional services within 30 days of the initiation visit	0 – 100	2018	N/A	N/A	N/A	53.16	63.70
			2019	56.1	53.2	62.1		
			2020	57.9	55.5	61.4		

Detailed BHCP quality results (3 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	0 – 100	2018	49.5	45.8	52.1	40.24	54.62
			2019	46.5	40.2	49.4		
			2020	51.2	49.6	55.1		
Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year	0 – 100	2018	87.1	84.6	91.4	84.64	91.66
			2019	88.6	84.6	90.8		
			2020	83.3	79.8	85.9		
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on antidepressant medication treatment	0 – 1.0	2018	N/A	N/A	N/A	42.29	51.78
			2019	N/A	N/A	N/A		
			2020	34.7	30.4	38.2		

Detailed BHCP and LTSS CP quality results (4 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
ED Visits for Adults with SMI, Addiction, or Co-occurring Conditions	The rate of ED visits for enrollees 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions		2018	243.1	267.0	219.4	241.1	179.26
			2019	210.5	241.1	196.5		
			2020	192.7	223.1	176.1		
Hospital Readmissions (Adult)	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age	0-10 (lower is better)	2018	2.7	2.9	2.5	2.15	1.52
			2019	2.0	2.1	1.6		
			2020	2.3	2.5	2.1		
LTSS CP MEASURES								
Community Partner Engagement	Percentage of assigned enrollees 3 to 64 years of age with documentation of engagement within 122 days of assignment to a Community Partner	0-100	2018	1.0	0.8	1.1	2.43	7.45
			2019	4.2	2.4	5.4		
			2020	5.9	3.5	6.2		
Enhanced Person-Centered Care Planning	Percentage of enrollees 18 to 64 years of age with timely completion of a new or updated Care Plan during the measurement year	0-100	2018	6.1	3.4	8.8	48.05	59.74
			2019	52.4	44.2	61.9		
			2020	52.6	48.1	54.1		

Detailed LTSS CP quality results (5 of 6)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Follow-up with LTSS CP After Acute or Post-Acute Stay (3 Business Days)	Percentage of discharges from acute or post-acute stays for enrollees 3 to 64 years of age that were succeeded by a follow-up with a Contractor within 3 business days of discharge	0-100	2018	0.8	0.0	1.7	TBD	TBD
			2019	3.4	1.9	8.5		
			2020	13.8	8.6	23.5		
Annual primary care visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	0-100	2018	59.1	55.9	69.1	49.78	67.46
			2019	63.2	53.2	66.6		
			2020	58.2	49.2	67.1		
Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year	0-100	2018	67.7	57.8	68.7	61.54	69.76
			2019	64.9	61.5	68.5		
			2020	49.0	42.5	50.8		
All-Cause ED Visits	The rate of ED visits for enrollees 3 to 64 years of age	0-100 (lower is better)	2018	66.2	71.6	61.7	74.91	51.50
			2019	65.8	75.0	55.0		
			2020	56.7	63.5	49.3		
Hospital Readmissions	The rate of acute unplanned hospital readmissions within 30 days of discharge for enrollees 18 to 64 years of age		2018	1.6	1.7	1.2	1.49	1.24
			2019	1.5	1.5	1.3		
			2020	1.7	1.8	1.5		

Detailed quality results (6 of 6): MES Performance Measures

Measure	Description	How it is scored	Survey Group	Year	Median Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
BH CP									
Care Team Engagement		0 – 100	Adult	2019	66.9	65.0	69.3		
				2020	66.3	64.8	68.8		
Healthy Living in the Community		0 – 100	Adult	2019	N/A	N/A	N/A		
				2020	66.9	65.3	70.7		
Member Engagement with Care Team		0 – 100	Adult	2019	71.2	69.9	74.9		
				2020	74.2	67.9	75.5		
LTSS CP									
Care Team Engagement		0 – 100	Adult	2019	70.2	68.1	73.0		
				2020	70.8	66.5	72.3		
			Child	2019	70.3	63.7	71.8		
				2020	68.9	66.4	72.4		
Healthy Living in the Community		0 – 100	Adult	2019	N/A	N/A	N/A		
				2020	71.0	69.1	71.2		
			Child	2019	N/A	N/A	N/A		
				2020	70.0	65.0	75.0		
Member Engagement with Care Team		0 – 100	Adult	2019	72.0	68.9	77.8		
				2020	73.2	71.9	76.7		
			Child	2019	66.6	58.8	71.4		
				2020	72.9	69.4	82.3		

BH CPs

- MassHealth has contracted with eighteen (18) BH CPs throughout the state.
- CPs are contracted to cover certain Service Areas.

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Behavioral Health Network, Inc.		**Western:** Holyoke, Springfield, Westfield
Behavioral Health Partners of Metrowest, LLC	• *Advocates, Inc.* • *South Middlesex Opportunity Council* • *Spectrum Health Systems, Inc.* • *Wayside Youth and Family Support, Family Continuity (FCP), Inc.*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Boston Coordinated Care Hub	• *McInnis Health Group/Boston Health Care for the Homeless Program* • *Bay Cove Human Services, Inc.* • *Boston Public Health Commission* • *Boston Rescue Mission, Inc.* • *Casa Esperanza, Inc.* • *Pine Street Inn, Inc.* • *St. Francis House; Victory Programs, Inc.* • *Vietnam Veterans Workshop, Inc.*	**Greater Boston:** Boston Primary
Brien Center Community Partner Program		**Western:** Adams, Pittsfield
Central Community Health Partnership	• *The Bridge of Central Massachusetts* • *Alternatives Unlimited, Inc.* • *LUK, Inc.* • *Venture Community Services* • *AdCare*	**Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester

BH CPs (cont.)

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Clinical and Support Options, Inc.		**Central:** Athol **Western:** Adams, Greenfield, Northampton, Pittsfield
Community Counseling of Bristol County		**Southern:** Attleboro, Brockton, Taunton
Community Healthlink, Inc.		**Central:** Gardner-Fitchburg, Worcester
Community Care Partners, LLC	• *Vinfen Corporation* • *Bay Cove Human Services, Inc.*	**Greater Boston:** Boston Primary, Revere, Somerville, Quincy **Northern:** Haverhill, Lawrence, Lowell, Lynn, Malden, Salem **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, Wareham
Coordinated Care Network	• *High Point Treatment Center* • *Brockton Area Multi Services, Inc. (BAMSI)* • *Bay State Community Services, Inc.* • *Child & Family Services, Inc.* • *Duffy Health Center* • *Steppingstone, Inc.*	**Greater Boston:** Quincy **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, Wareham
Eliot Community Human Services, Inc.		**Greater Boston:** Revere, Somerville **Northern:** Beverly, Gloucester, Lowell, Lynn, Malden, Salem, Woburn **Central:** Framingham, Waltham

BH CPs (cont.)

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Innovative Care Partners, LLC	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*	**Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
Lowell Community Health Center, Inc.	• *Lowell House, Inc.*	**Northern:** Lowell
Lahey Health Behavioral Services		**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn
Riverside Community Partners	• *Brookline Community Mental Health Center, Inc.* • *The Dimock Center, Inc.* • *The Edinburg Center, Inc.* • *North Suffolk Mental Health Association, Inc.* • *Upham's Corner Health Center*	**Greater Boston:** Boston Primary, Revere, Somerville, Quincy **Northern:** Lowell, Lynn, Malden, Woburn **Central:** Framingham, Southbridge, Waltham
Southeast Community Partnership	• *South Shore Mental Health Center, Inc.* • *Gosnold, Inc.* • *FCP, Inc. dba Family Continuity*	**Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham
South Shore Community Partnership	• *South Shore Mental Health Center, Inc.* • *Spectrum Health Systems, Inc.*	**Greater Boston:** Quincy
Stanley Street Treatment and Resources (SSTAR) Care Community Partners	• *SSTAR* • *Greater New Bedford Community Health Center, Inc.* • *HealthFirst Family Care Center, Inc.* • *Fellowship Health Resources, Inc.*	**Southern:** Attleboro, Barnstable, Fall River, Falmouth, New Bedford, Oak Bluffs, Orleans, Taunton, Wareham

LTSS CPs

- MassHealth has contracted with nine (9) LTSS CPs throughout the state.
- CPs are contracted to cover certain Service Areas.

LTSS CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Boston Allied Partners	• *Boston Medical Center Corporation* • *Boston Senior Home Care, Inc.* • *Central Boston Elder Services* • *Southwest Boston Senior Services d.b.a Ethos*	**Greater Boston:** Boston-Primary
Care Alliance of Western Massachusetts	• *WestMass Elder Care, Inc.* • *Greater Springfield Senior Services, Inc.* • *Highland Valley Elder Services, Inc.* • *LifePath, Inc.* • *Elder Services of Berkshire County, Inc.* • *Stavros Center for Independent Living* • *Behavioral Health Network, Inc.*	**Central:** Athol **Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
Central Community Health Partnership	• *Alternatives Unlimited* • *The Bridge of Central Massachusetts, Inc.* • *LUK, Inc.* • *Venture Community Services, Inc.* • *AdCare*	**Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester
Family Service Association		**Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham

LTSS CPs (cont.)

LTSS CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Innovative Care Partners, LLC	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*	**Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
LTSS Care Partners, LLC	• *Vinfen* • *Bay Cove Human Services* • *Justice Resource Institute* • *Boston Center for Independent Living* • *Mystic Valley Elder Services* • *Somerville Cambridge Elder Services* • *Boston Senior Home Care, Inc.*	**Greater Boston:** Boston-Primary, Revere, Somerville, Quincy **Northern:** Malden **Southern:** Brockton
Massachusetts Care Coordination Network	• *Advocates, Inc.* • *Boston Center for Independent Living, Inc.* • *HMEA* • *BayPath Elder Services, Inc.* • *Brockton Area Multi Services, Inc. (BAMSI)*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham **Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Merrimack Valley Community Partnership	• *Elder Services of Merrimack Valley* • *Northeast Independent Living*	**Northern:** Haverhill, Lawrence, Lowell
North Region LTSS Partnership	• *Bridgewell, Inc.* • *Northeast Arc, Inc.*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn

DSRIP Expenditures by ACO (Excluding DSTI Funding)

ACO Name	CY2020 Startup/Ongoing Expenditures	CY 2020 Flexible Services Expenditures	CY 2020 Total DSRIP Expenditures
Atrius Health	$3.0M	$280K	$3.3M
Boston Accountable Care Organization	$19.1M	$74K	$19.1M
Baystate Health Care Alliance	$5.6M	$487K	$6.1M
Boston Children's Health ACO	$14.8M	$945K	$15.8M
Health Collaborative of the Berkshires	$2.2M	$421K	$2.6M
Beth Israel Deaconess Care Organization	$5.0M	$261K	$5.2M
Community Care Cooperative	$24.0M	$2.7M	$26.7M
Cambridge Health Alliance	$3.6M	$226K	$3.8M
Lahey Health	$1.6M	$279K	$1.9M
Mercy Medical Center	$4.6M	$0K	$4.6M
Merrimack Valley ACO	$5.1M	$445K	$5.5M
Partners HealthCare Choice	$13.5M	$285K	$13.8M
Reliant Medical Group	$3.8M	$27K	$3.8M
Signature Healthcare	$2.9M	$51K	$3.0M
Steward Health Choice	$16.2M	$207K	$16.4M
Southcoast Health	$2.0M	$0K	$2.0M
Wellforce	$8.8M	$120K	$8.9M
Total	**$135.7M**	**$6.8M**	**$142.5M**

DSRIP Expenditures by CP

CP Name	CY2020 Infrastructure Expenditures	CY2020 Care Coordination Payments
Alternatives Unlimited, Inc.	$0.3M	$0.7M
Behavioral Health Network	$0.6M	$4.1M
Behavioral Health Partners of Metrowest	$1.6M	$4.4M
Boston Alliance Partners	$0.4M	$1.0M
Boston Health Care for the Homeless	$0.5M	$2.8M
Brien Center	$0.5M	$0.7M
Care Alliance of Western MA	$0.6M	$1.2M
Clinical and Support Options	$0.5M	$0.7M
Community Care Partners	$1.5M	$5.5M
Community Counseling of Bristol County	$1.4M	$5.1M
Community Healthlink	$0.2M	$1.4M
Eliot Community Partner	$1.5M	$3.5M
Family Service Association	$0.3M	$1.2M
Greater Lowell Behavioral Health	$0.2M	$1.3M
High Point Treatment Center	$1.3M	$4.6M
Innovative Care Partners, LLC LTSS	$0.4M	$3.5M
Innovative Care Partners, LLC. BH	$1.0M	$1.2M
Lahey Health and BH Services	$1.6M	$1.7M
LTSS Care Partners	$0.6M	$0.9M
Massachusetts Care Coordination Network	$1.2M	$1.7M
Merrimack Valley CP	$0.3M	$0.6M
Northern Region LTSS Partner	$0.3M	$0.5M
Riverside Community Care, Inc	$1.3M	$3.3M
Southeast	$1.0M	$2.9M
Southshore	$0.5M	$0.9M
Stanley Street Treatment and Resources	$1.0M	$2.5M
The Bridge of Central Massachusetts, Inc.	$0.5M	$1.9M
TOTAL	**$21.0M**	**$59.6M**

DSRIP funding by Statewide Investments program

Program	Funding as of 12/31/2020
Community-Based Workforce	
Student Loan Repayment Program	$8,682,105.00
Behavioral Health Workforce Development Program	$1,700,760.00
Community Partners (CP) Recruitment Incentive Program	$1,102,500.00
Primary Care/Behavioral Health Special Projects Program	$2,933,916.50
Family Medicine/Family Nurse Practitioner Residency Program	$4,155,000.00
Community Mental Health Center (CMHC) Behavioral Health (BH) Recruitment Program	$3,582,288.00
Subtotal | Community-Based Workforce	**$22,156,569.50**
Frontline Workforce	
Community Health Worker (CHW) Training Capacity Expansion Grant Program	$1,166,236.00
Peer Specialist Training Capacity Expansion Grant Program	$445,167.00
Community Health Worker (CHW) Supervisor Training Grant Program	$828,407.00
Competency-Based Training Program	$2,979,943.00
Subtotal | Frontline Workforce	**$5,419,753.00**
Capacity Building for ACOs, CPs, CSAs, and Providers	
Technical Assistance Program for ACOs and CPs	$24,296,899.65
Community Health Center (CHC) Readiness Program	$2,000,000.00
Standardized Online Training for CPs and CSAs	$479,692.97
Alternative Payment Methods (APM) Preparation Fund	$2,200,000.00
Subtotal | Capacity Building for ACOs, CPs, CSAs, and Providers	**$28,976,592.62**
Initiatives to Address Statewide Gaps in Care Delivery	
Enhanced Diversionary Behavioral Health Activities	$1,300,000.00
Accessibility Improvement Program	$5,244,467.62
Subtotal | Initiatives to Address Statewide Gaps in Accessibility	**$6,544,467.62**
Total Statewide Investments Spending Thru 12/31/2020	**$63,097,382.74**