# ATTACHMENT APR

# DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM ACCOUNTABLE CARE ORGANIZATION (ACO) PY1 ANNUAL PROGRESS REPORT RESPONSE FORM

## General Information

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| **Full ACO Name:** | Boston Medical Center HealthNet Plan Southcoast Alliance |
| **ACO Address:** | 200 Mill Road, Suite 190<br>Fairhaven, MA 02719 |

## Part 1. PY1 Progress Report Executive Summary

### 1.1 ACO Goals from its Full Participation Plan

**Goal #1**
**Cost and Utilization Management**
Provide wrap-around medical and behavioral support for Medicaid ACO patients to drive down avoidable admissions and the % of 30-day readmissions to 12.8% (all cause, unplanned) over 5 years compared to baseline.

**Goal #2**
**Integration of Physical Health, BH, LTSS, and Health-Related Social Services**
Reduce Behavioral Health costs to the ACO system while improving patient satisfaction and communication among various entities involved in the patient's care and to see a reduction in avoidable admissions, the 30-day inpatient readmissions, ED visits and a decrease in TCoC in the Medicaid ACO population.

**Goal #3**
**Member Engagement**
Ensure that all Medicaid ACO patients leaving an acute or sub-acute facility will have a 5-day post-discharge follow-up (transition of care) appointment with their provider.

**Goal #4**
**Quality**
Practice Quality Coordinators will engage Primary Care Providers in patient quality metrics and help practice clinics optimize patient satisfaction, primary prevention through appropriate screenings as will be demonstrated through optimized quality scores.

**Goal #5**
**Quality**

Ensure patient medical record is properly and comprehensively documented and coded appropriately to ensure continuity of care, facilitate quality chart reviews and communicate gaps with providers.

## 1.2 PY1 Investments Overview and Progress toward Goals

Our initial investments were carried out following an outside review of our strengths and weaknesses by ECG Consultants. It took a very traditional approach to population health management from a medical standpoint and we took our learning from the Chart 1 and Chart 2 grants in approaching behavioral health approaches. These were augmented by building and implementing IT systems to assist in carrying out the work. In retrospect, we might have gone heavier on the IT systems to help with work flow, identification of patients, and work queues for the staff we hired. The staffing approach was to get people immediately focusing on the members of the plan. However, the DSRIP funding is going to taper off. The ability to fund people going forward is dependent on making a profit off the risk. With the state adjusting pmpm payments because of budget constraints, the path to profitability will probably be tenuous and staffing will have to dwindle over the five years. The retrospective thought is that more investment in the support systems that can remain after DSRIP goes away may have been prudent. We are seeing progress as indicated below:

**Goal #1**
**Cost and Utilization Management**
Total losses through September results are showing that the losses and the utilization that drive them are slightly better than the initial actuarial assumptions. This is positive since the ability to know our patients and their needs did not become very visible until the year rolled out. As the needs became evident we were able to create focused plans to assist a very general population health approach. We believe we will see improvements in the next year. Whether that is enough to offset pmpm reductions in payments and changes from reclassifications is unclear.

**Goal #2**
**Integration of Physical Health, BH, LTSS, and Health-Related Social Services**
This is probably a bright spot of the year but not for the obvious reason. We did the standard work with patients including identification of patients that had issues with behavioral health diagnosis and their associated social determinant issues. Bridging their treatment until we could get them long-term providers was helpful. Assisting them with resolution of social deficits was helpful. The bright spot came toward the end of the year when we were dealing with reductions in DSRIP funding. We were going to need to eliminate some LICSW and BH advanced nurse practitioners. We have decided to invest outside of DSRIP on an embedded behavioral health bridge program in several of our large primary care practices. There is a path for them to have a breakeven cost to them. It will require crossing all payer classes to make this work; however, if it works, it will be a path to a more sustainable treatment approach for bridging patients into long-term therapist.

**Goal #3**
**Member Engagement**
The work of getting patients into physician offices within 5 days of a hospital discharge has been harder than anticipated. Primary care physicians already had very busy schedules. It has taken all the first year to create acceptance and a path to guaranteeing the necessary access. We hope to see the benefit in PY 2.

**Goal #4**
**Quality**
It has taken all year to get the accepted metrics from Mass Health and for our quality specialist to develop the avenues to work with the physicians and hospitals to measure and improve the metrics. The second year will hopefully show the benefit of what has been put into place.

**Goal #5**
**Quality**
Likewise, identification of patient risk is essential to appropriate patient identification and intervention. It also took all year to get the processes in place in our Epic system to make it easy for the physicians to put in all the necessary diagnosis to appropriately reflect the severity of the patient's disease state. Along with this was work to have processes and tools to identify the social determinants of health and to create a path to enable a primary care office to know what to do with the information when it was found. We are expecting to see the benefit in the second year.

## 1.3 Success and Challenges of PY1

**Successes:**

1. Embedded behavioral health team in two large pcp offices as a pilot. Work was done in PY1 and went live in PY2.
2. Working with BMCHP has been incredibly positive. They are helpful, supportive, knowledgeable, and assisted us in multiple processes. Additionally, they provided information on patients that had been previously in their plan to help with the lack of helpful reports from Mass Health on patient specific conditions.
3. Physicians appreciated social workers and community health workers showing a path to for dealing with social determinates of health
4. While still cumbersome the ACO reporting expectations has more of a cadence with improved instructions on what is expected.
5. Even though there is more work to happen in year 2, the health provider system is proactively working to identify social determinates of health. Not seen this in the past.

### Challenges:

1. Late entry of the Community partner program and their lack of experience in what they have been asked to do. Still a problem going into year 2.
2. Resistance of primary care physicians to work or refer to ACO staff unless they did the same for all the payers who were not providing resources. They did not understand the need to have DSRIP funded positions just helping Mass Health patients.
3. State reports and data was outdated, not well developed for what was needed, lacked timeliness.
4. In the first year, the reporting requirements were extremely burdensome to carry out.
5. Despite good intentions, MassHealth's learning curve caused numerous changes with short windows of execution. This was most evident in filings.

6. We had Staff leave as they heard about the DSRIP funding reductions. They did not want to be without a job. They left before we could get full coverage at times and may not have been who we would have wanted to leave.