<p style="text-align:center">ATTACHMENT APR</p>

<h1 style="text-align:center">DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM ACCOUNTABLE CARE ORGANIZATION (ACO) PY3 ANNUAL PROGRESS REPORT RESPONSE FORM</h1>

<h2 style="text-align:center">PART 1: PY3 PROGRESS REPORT EXECUTIVE SUMMARY</h2>

General Information

Full ACO Name:	Boston Medical Center HealthNet Plan Southcoast Alliance
ACO Address:	200 Mill Rd, Suite 190, Fairhaven, MA

Part 1. PY3 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

The goals for the ACO are focused on several key areas based on previously identified challenges and barriers. Through effective care management strategies and processes, the ACO expects to improve the appropriate utilization of hospital-based services while lowering costs for patients with medical and/or behavioral health needs. Timely access to follow-up care following hospitalization, combined with a thorough medication reconciliation process are instrumental in reducing the risk of hospital readmission. To drive population health management, teams focus on medical record documentation and associated condition coding, with appropriate care plans to manage health status. Focused efforts to close performance gaps for clinical quality measures will also support population health management and improved outcomes for patients.

Cost and Utilization Management

- **Goal #1**: Provide wrap-around medical and behavioral support for Medicaid ACO patients to drive down avoidable admissions and the percentage of 30-day readmissions to 12.8% (all cause, unplanned) over 5 years compared to baseline. This connects with the TCOC management opportunity related to Complex Care Management and the Emergency Department's Clinical Social Workers and Community Health Workers for outreach and support of patients. This will allow the ACO to develop a holistic, targeted and high-touch care management model for the highest-risk and high-risk members; reduce avoidable admissions and readmissions to lower inpatient costs; reduce avoidable ED visits to reduce emergency room costs; develop integrated medical and behavioral health programs and protocols to address siloed health care. Hospital admissions was identified as an area where our ACO was running above market, therefore this goal is a priority for the ACO.

Integration of Physical Health, BH, LTSS, and Health-Related Social Services

- **Goal #2:** 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. Hospital admissions and emergency room utilization which were both identified as areas where our ACO was running above market, therefore this goal is a priority for the ACO.

Member Engagement

- **Goal #3:** 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. The goal of this is to engage with the patients, reduce readmissions, ensure the provider is the central hub of the patient's care, conduct medication reconciliation, and provide further reinforcement that the provider is the option-of-choice when a Medicaid ACO patient needs medical, behavioral health or social support. Hospital admissions was identified as an area where our ACO was running above market, therefore this goal is a priority for the ACO.

- *Quality*

- **Goal #4:** 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. This will allow the ACO to identify actionable opportunities for performance improvement and work collaboratively toward achieving value-based care and provider accountability and provide appropriate performance feedback to providers and staff. Achievement of the highest possible quality score as a reflection of clinical and satisfaction patient outcomes is a priority goal for the ACO.

- **Goal #5:** 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. The ACO did not have a well-established and comprehensive documentation and associated coding workflow for clinical conditions, thereby making this goal a priority effort for the ACO.

1.2 PY3 Investments Overview and Progress toward Goals

Overview of Investment	Advancement of Goal	Implementation Status	Example of Progress
S/O PC: 1 - Implement team based model of care to meet population health needs	Advance ACO goals of integration of physical health, BH, and social needs to eliminate siloed care and provide more comprehensive care to members	Fully implemented	Daily huddles with multidisciplinary team representation including behavioral health specialties, medical/nursing staff and pharmacists address holistic care needs, identify barriers and ways to remove barriers. This includes access to healthcare appointments, medications and means of transportation. SDOH are reviewed with member and brought to team huddle for designation of appropriate team member to assist member. Team reviews progress at daily huddle to ensure that needs are

			being met in a timely manner and determines when situations need escalation to be resolved.
S/O PC: 2 - Embed nurses into the interdisciplinary care management team to improve coordination of care for the ACOs complex members	Supports goals of reducing costs to the ACO system while improving patient satisfaction and communication among various entities involved in the patient's care	Fully implemented	Medical RN Care Navigators are assigned to each practice to work with patients with one or more chronic diseases. RN Care Navigator is responsible for educating patient regarding management of their disease process as well as identifying barriers to learning and compliance with patient's plan of care. Home visits are completed by a team member at the direction of RN, who is the lead team member for medical cases, as member allows, to assist with recognition of SDOH facing the patients. Costs are reduced when patients have access to the appropriate level of care while the focus remains on the reduced need for ED/UC/PCP visits with better management of chronic condition.
S/O PC: 4: Embed community health workers at primary care sites to support patients with behavioral and social needs	Supports goals of reducing costs to the ACO system while improving patient satisfaction and communication among various entities involved in the patient's care	Fully implemented	Our model is universal for behavioral and medical community health workers except for the focus on behavioral health than then on medical needs. CHWs were instrumental in connecting patients with resources and the implementation of Southcoast Resource Connect (aka Aunt Bertha™).
S/O D:1 – Invest in actuarial support to guide development of programs and initiatives	Supports ACO goals of reducing TCOC and improving quality for patients	Fully implemented with parent organization assuming cost.	The funding for this activity was assumed by the parent organization in PY2. W
S/O D: 2 - Hire social workers to address social and behavioral needs of complex medical patients	Supports goals of reducing costs to the ACO system while improving patient satisfaction and	Fully implemented staff hired and supporting the primary care sites, working closely with CPs and liaising with	LiCSWs were an instrumental part of the members' care team. They aligned with the CP assigned to patient. LiCSWs are aligned with PCP practices and

and work with community partners	communication among various entities involved in the patient's care	state agencies as appropriate	they initiate communications with the CP. LiCSWs continue to build relationships by identifying patients and setting up services through a CP or LTSS service.
S/O D: 3 - Expand support and access to clinical pharmacist for medication mgmt., education, optimization and cost	Supports ACO goals of reducing cost and managing utilization	Fully implemented. Three clinical pharmacists hired and supporting provider practices identify and implement drug cost saving opportunity	Through claims analysis, the pharmacists discovered $100,000 in cost-savings opportunities through dosage form and other types of drug product conversions. To assist providers, communications were distributed that advised on optimal generic drug order descriptions to permit a retail pharmacy to select the lowest cost, available drug product. The pharmacists worked extensively with practices, providers through direct outreach and communications to streamline and facilitate the drug formulary changes.
S/O D:4 - Expand ACO based practice quality coordinators to assist meeting quality metrics	Supports ACO goals of achievement of the highest possible quality score as a reflection of clinical and patient satisfaction outcomes	Fully implemented. Two FTEs hired and managed the PY3 quality metrics with the provider practices	Based on recently available data for ACO quality, the ACO exceeded quality score expectations for PY2, due in large part to the work being done with the provider practices by the PQCs.
S/O D: 8 - Provide ED-based community health workers to engage patients not using their PCPs and address social issues	Supports goals of reducing TCOC while improving patient satisfaction and outcomes by connecting them with appropriate resources	CHW hired and working with the ED team as well as connecting patients back to the Southcoast team or CPs	Community health workers continue to monitor the ED to identify and communicate with high utilization patients that are assigned to CP. CHWs try to make the connection between the designated CP and member. CHWs engage with patients and support them in identifying reasons they are not attending PCP appointments.
S/O D14 - ACO/Medical Management DSRIP Allocation to MCO	Support ACO goals of managing cost and utilization	A portion of program administration is managed by the MCO to support the ACO.	This activity supports routine Pre-Certification, Case Management, Disease Management, Nurse-based Counseling, Health and

			Wellness, Quality Components, Medical Informatics, and Utilization Review as needed. These activities are important to maintaining total cost of care management efforts.

1.3 Success and Challenges of PY3

Despite the impact of Covid-19 on our ACO operations, we did see several successes during PY3 due to the performance management plan's goals combined with the associated investment strategies:

1. Quality: As a result of our hard work on the quality program in PY2, and MassHealth's decision to use PY2 performance for PY3, we anticipate a favorable quality score for PY3. Further, we were able to continue to protect our quality resources (practice quality coordinators) to continue their work on quality through the pandemic, identifying creative ways to succeed in certain quality measures (e.g., leveraging telehealth).
2. Care management:
a. Low Acuity ED Utilization: Due to Covid, LAED utilization among our ACO population dropped significantly. Covid accelerated telehealth adoption among our patient populations, something we will leverage into PY4 strategies for reducing LAED. We are investigating any relevant lessons learned from this, especially whether or not there was behavior change among our members enabling them to seek right-level care (e.g., through telehealth). Beginning in Q4 of PY3, our care management team implemented a workflow to follow-up with patients within 48 hours of a LAED visit.
b. Care navigation: Our care navigation team quickly pivoted to support telehealth services for our most complex populations, in particular by enabling telehealth visits with providers during home visits with the patient. In addition, the team leveraged Care Companion for patients to remotely report their health status to their care team, allowing providers to follow-up in real-time as needed.

The ACO experienced many challenges in PY3 as a result of the Covid-19 pandemic. In particular:

1. Risk coding: With the decline of in person, face-to-face visits, we were unable to identify patients with certain conditions, such as obesity, and provide weight counseling
2. Quality: Though our PY3 quality performance does not have bearing on payment, we lost momentum across several quality initiatives due to resource constraints and reduction of in-person visits encounters (e.g., A1c poor control)
3. Care navigation: We were hindered in our approach to care management as many patients did not feel comfortable with our staff entering their homes. Though the teams were very creative, engaging patients in "window" visits, etc., the teams found it challenging to do their jobs to the fullest while remote.
4. Overall, as all provider organizations experienced in 2020, some resources were redeployed to Covid efforts and/or left the organization. Medical assistant resourcing, in particular, has been a challenge through the pandemic. Much of our population health work and telehealth capability relies on the MA workforce, and without pre-Covid resourcing levels we have found it challenging to meet performance goals in the ACO.