

ATTACHMENT APR

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

General Information

Full ACO Name:	Community Care Cooperative, Inc. (C3)
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Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

Community Care Cooperative (C3) is a new Accountable Care Organization (ACO) comprised of 17 federally qualified health centers (FQHCs) that collectively govern our non-profit, 501(c)(3) organization.

- Our Vision: Transforming the health of underserved communities
- Our Mission: To leverage the collective strengths of federally qualified health centers to improve the health and wellness of the people we serve
- Our Strategy: Achieve a market-leading model of care through community-based innovation

We were organized to participate in the MassHealth ACO program and this remains our primary work. Our investment approach with respect to the MassHealth ACO program is focused on the following goals.

Population Health Management

Our population health strategy is to build on our greatest asset: the foundational capabilities of our FQHCs' patient-centered medical homes (PCMH). The core of this strategy is to strengthen and enhance the population management capabilities of PCMHs for the approximately 95% of members who do not have highly complex behavioral health and/or physical health needs. For the approximately 5% of most complex members, we have proven care management programs and dedicated care management capacity. Care management varies for the subpopulations that make up this "most complex" group. Care management teams are embedded in the FQHCs, working with members' primary care and behavioral health providers and coordinating with Community Partners. The exception to this is care management services provided in other settings, such as acute care facilities, homes and other community based settings.

Provider Accountability

We require meaningful financial accountability for cost of care and quality among all participating health centers. Our objectives for our value-based payment arrangement are to:

- Motivate FQHCs to work toward defined total cost of care and quality goals

- Allow FQHCs to take risk and reward appropriate to their risk tolerance, capabilities and financial position
- Ensure our ACO meets its financial obligations under a wide range of scenarios

All participating health centers choose low, medium, or high levels of ACO risk sharing.

Total Cost of Care (TCOC) Management

Our approach to TCOC management uses data from a wide variety of sources, predictive analytics, and workflow tools to drive assessment, care planning, and team-based care management to appropriately manage TCOC. We are aggregating a large amount of data, most notably very complete EHR data through a market-leading technology vendor in this space and ADT feeds for physical and mental health admits through hospital relationships, MAeHC (a local non-profit and well-respected clearinghouse) and MBHP. This data is analyzed to identify individuals who are most at risk and most impactable. These individuals are then engaged in our complex care management program and/or transitions of care program. Additionally, the data is used to segment the population for a myriad of other population health, care coordination and quality improvement activities.

Path to Sustainability

We expect to generate shared savings by investing upfront in IT resources, clinical programs, primary care transformation and innovations through the care continuum to effectuate TCOC savings and quality improvement.

DSRIP Investment Strategy

DSRIP is a critical funding source for delivering on our goals. Three principles drive our strategy for use of DSRIP funds:

Build on Existing FQHC Care Model Investments. Our FQHCs have made significant investments in advanced primary care that are not only aligned with national standards (e.g. PCMH certification), but are also highly attuned to the needs of the communities they serve. For example, many health centers are national leaders in Behavioral Health Integration, trauma-informed models of care, and Substance Use Disorder services. Our investments will use DSRIP funds, including novel funding streams like flexible services funds, to leverage these strengths to improve care and the health of communities. These improvements will be one key component to reduce medium- and long-term health care costs for members.

Make New Investments to Guide Resource Use. We will make new investments in data, analytics, and workflow to focus scarce care coordination, care management, and care transitions resources where they can have the greatest impact on quality and cost. These new investments, combined with the incentives in our value-based payment arrangements, will drive more efficient and effective use of resources.

Make Consistent, At-Scale Investments in Care Coordination, Care Management, and Care Transitions. We will make investments in care coordination, care management, and care transitions at a scale and consistency that exceeds what most primary care providers, including our FQHCs, have achieved to date

through grants and internally-funded initiatives. These more effective programs – focused on individuals and families who could benefit most – will be another key to reducing health care costs and improving the quality of care for members.

1.2 PY1 Investments Overview and Progress toward Goals

We made significant progress in 2018 toward our goals as an ACO. Here is a brief summary including concrete examples where we have made progress.

Population Health Management

Consistent with our mission, we are investing in the health center as the foundation of our population health strategy. We have worked with our health centers as a team to plan, fund and execute health center-specific projects within our 2018 focus areas of pre-visit planning, care coordination and quality improvement. In addition, we have invested in localized complex care management teams at every health center, most of whom are health center employees with delegated responsibility to lead and manage complex care. Of all our major programs, only Transitions of Care is “centralized” because of the efficiency associated with managing the program in this way. Even so, close coordination with primary care is an essential part of the Transitions of Care team’s work to ensure appropriate follow-up care and avoid re-admission.

Provider Accountability

We have made great strides in bringing to health centers the information and insights necessary for accountability.

Example: The Board reviews regularly a health center-by-health center scorecard of key membership, program, utilization, quality, and financial measures. Similarly, the Board reviews a detailed financial analysis of C3 and health center performance on the risk contract. This level of transparency within an ACO community is something that is not found commonly in the industry. Finally, these insights and deep dives into program performance and utilization are a major part of our semi-annual meetings with leadership at every health center. These semi-annual meetings complement frequent ACO working sessions at each health center. Together, they support provider accountability in the transition to value-based care.

Total Cost of Care (TCOC) Management

Our TCOC management efforts combine data, analytics, and proven methods of outreach, assessment, care planning, and close coordination with primary care to reduce TCOC.

Example: Working with MAeHC, hospital systems, and others ACOs, we now have access to physical health admit data from 8 of our top 10 admitting health systems and for all of our mental health admissions. In our Transitions of Care program, these data feeds are essential to rapidly follow up at the bedside, in the home and in the community.

Example: Complex care management teams, working within health centers, have engaged 2,000 members in our first year of work. This work includes outreaching, assessing, care planning, and connecting or re-connecting members to a primary care home. While it is too early for a formal evaluation, we estimate this work has improved care and quality of life and reduced TCOC.

Path to Sustainability

We estimate that our investments in population health, provider accountability, total cost of care management, and information technology are already having a favorable impact on cost, quality, member experience, and provider experience (a fourth and fundamental aim for our organization). That impact will grow in 2019 and beyond and will help us generate shared savings to re-invest in our mission.

DSRIP Investment Strategy

We are following through on our investment strategy by prioritizing investments that build on the strengths of our FQHCs; leverage data and analytics to manage resources and measure results; and invest at scale in care management.

Example: We have invested \$2M in a Transitions of Care program that leverages our technology investments to transmit real-time information on hospital admissions, meets patients at the bedside whenever possible for both physical and mental health admissions, and supports members return to the community and re-connection to their primary care home and/or Health Home.

1.3 Success and Challenges of PY1

As a new ACO working in an evolving Medicaid delivery system, we identified three critical challenges among others. We share below a brief recap on our response to each challenge and we highlight additional successes of 2018.

Challenges:

Achieving Consistency across FQHCs. While each FQHC has distinct history and capabilities (e.g. different service lines and EHRs), we recognize that certain policies and procedures, systems, and work flows need to be consistent across the network. We have invested to achieve that consistency. We are also evaluating the changing population health IT landscape to continue to improve on how we meet our value-based care goals in the years ahead.

Effectively Leveraging MassHealth Infrastructure and Capabilities. Our success requires a close collaboration with MassHealth since as a Primary Care ACO we rely on MassHealth and its vendors for certain data feeds, network contracting and management, and all aspects of benefit management and claims adjudication. We are creating success in this area, for example, in our partnership with MassHealth's behavioral health carve-out vendor MBHP on notification of mental health admissions. One of our top priorities is to expand appropriately the scope of SUD data Primary Care ACOs receive to help us contribute to management of this public health crisis.

The Underlying Fee-for-Service System. Although the current financial model of the Primary Care ACO program brings in imperative to change, some of our efforts to transform the prevailing model of care are hampered by a continued dependence on fee-for-service revenue. As we move forward, we believe we will all be better positioned to realize the promise of value-based care if we are able to move off of this fee-for-service chassis and into prospective payments for defined services.

Successes:

In addition to progress on the critical challenges above, we highlight below three other areas of meaningful progress in our first 10 months (3/1/2018-12/31/2018) in the MassHealth ACO program.

Primary Care Team. Consistent with our mission, we are investing in the primary care team with a focus on Medical Assistants. Like Community Health Workers in a care management team, Medical Assistants are essential to the success of a value-based primary care team. In recognition, we have developed a Medical Assistant (MA) upskilling initiative. Funded through the MassHealth Technical Assistance funds, we are partnering with CHC, Inc. of Connecticut, a national leader in this area. Our program has two components: one is an MA training program for health center MAs, and the other is a leadership group of a provider champion and nurse leaders or MA supervisors from each health center to shape the work of the primary care team and the supervisory and HR environment around the newly upskilled MAs. We also surveyed 323 MAs and PCPs to establish a care team satisfaction baseline to allow us to measure changes in job satisfaction going forward. This will enable us to determine whether the project met a core goal of improving the quality of work life of providers and the care team.

Home Health Pilot. Our interest in home health started in a dialogue with MassHealth about extremely high utilization in some regions and MassHealth's work to ensure appropriate home health services. We wanted to pilot a different, complementary approach to managing care for these patients. Working with one health center, we engaged an experienced nurse to review all 60-day re-certifications and specific high utilization cases and to work collaboratively with primary care providers, home health agencies, and members to understand the short- and medium-term need for ongoing home health services. Our ability to develop and expand initiatives like this – that address regional differences in utilization and support provider-patient engagement on cost and quality – is key to our long-term success.

Quality. Success in quality is determined in large part by the quality of data infrastructure and systems put in place to support quality-related activities and goals. Since each FQHC has a different EHR instance, we have made significant investments in extraction and validation of EHR data flowing into our data warehouse. Further, we have invested in programming the MassHealth quality measures, creating a 2017 baseline, setting 2019 targets, developing health center specific quality plans to meet those targets, and creating a quality dashboard to monitor our performance on a monthly and quarterly basis.

We look forward to further progress in the months ahead toward our vision of transforming the health of underserved communities.