ATTACHMENT APR

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM
ACCOUNTABLE CARE ORGANIZATION (ACO) PY2 ANNUAL PROGRESS REPORT
RESPONSE FORM

PART 1: PY2 PROGRESS REPORT EXECUTIVE SUMMARY

General Information

Full ACO Name:	Community Care Cooperative, Inc. (C3)
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Part 1. PY2 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

Community Care Cooperative (C3) was founded in 2016 by nine Massachusetts federally qualified health centers (FQHCs) to participate in the MassHealth ACO program and this remains our primary work. Today, C3 is comprised of 19 federally qualified health centers (FQHCs) delivering primary care services and governing 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

Our investment approach with respect to the MassHealth ACO program is focused on the following goals.

Population Health Management

Our population health strategy continues 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 continue to 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

In the first year of our 5-year ACO contract, **we lowered total cost of care by $11 million or 2.1%** compared to our benchmark of $535 million. All participating health centers choose low, medium, or high levels of ACO risk sharing and thereby share in the savings associated with work together.

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 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, further investments in primary care, 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 continue to 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 use DSRIP funds plus novel funding streams like Flexible Services to leverage these strengths to improve care and the health of communities. These improvements are one key component to reduce medium- and long-term health care costs for members.

Make New Investments to Guide Resource Use. We continue to invest 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, drive more efficient and effective use of resources. In 2019, we selected and began the transition to a new population health technology platform, a process which was completed in April 2020.

Make Consistent, At-Scale Investments in Care Coordination, Care Management, and Care Transitions. We are making 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 – are another key to reducing health care costs and improving the quality of care for members.

1.2 PY2 Investments Overview and Progress toward Goals

We made significant progress in 2019 toward our goals as an ACO. Here is a brief summary including concrete examples where we have made progress.

Population Health Management

We continue to invest in the health center as the foundation of our population health strategy. In 2019, we continued our work to fund health center-specific projects in pre-visit planning, care coordination and quality improvement. We improved our execution 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. In 2019, we identified 10,000 of our 125,000 members for complex care and successfully engaged 3,500 individuals in assessment and care planning. Of all our major programs, only Transitions of Care (TOC) 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 TOC team's work to ensure appropriate follow-up care and avoid re-admission. In 2019, we identified nearly 7,000 admitted members for TOC and successfully engaged 2,300 in assessment and care planning.

Provider Accountability

We have made great strides in bringing to health centers the information and insights necessary for accountability. In 2019, we continued to produce a Board-level scorecard of key membership, program, utilization, quality, and financial measures, as well as detailed financial analysis of C3 and health center performance on the risk contract through our actuary Milliman. We also held more than 30 formal reviews with health center executive leaders around the Commonwealth (our semi-annuals) to review performance and potential improvements. This level of transparency within an ACO community is something that is not found commonly in the industry. Together, these insights and deep dives into program performance and utilization support provider accountability in the transition to value-based care. Our new population health platform will enable increased levels of self-service analytics.

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.

For example, working with MAeHC, hospital systems, and others ACOs, we now have access to physical health admit data from all 10 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.

For example, our complex care management teams, working within health centers, nearly doubled the number of members engaged in assessment and care planning in 2019 (3,500 in 2019 vs. 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 2020 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 converted the Transitions of Care program from vendor-led to C3-led, converting all team members to C3 employment on March 1, 2019. This has enabled us to increase our insight and control over operations and improve communication with health center primary care teams.

1.3 Success and Challenges of PY2

As a new ACO working in an evolving Medicaid delivery system, we identified three critical challenges among others. Turning these challenges to strengths is part of our ongoing work.

Challenges:

Achieving Consistency across FQHCs. We continue to build appropriate consistency across FQHCs (while recognizing the distinct history and capabilities of each health center (e.g. different service lines and EHRs). One way we do this is through investment in systems, for example, in implementing a new population health platform that contains scheduling information from each FQHC's EHR so that health center employees working in the platform can see past and upcoming appointment opportunities without having to check the EHR directly.

Effectively Leveraging MassHealth Infrastructure and Capabilities. We continue to work closely 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 have found this to be as much a strength as a challenge, as exemplified by our continued partnership with MassHealth's behavioral health carve-out vendor MBHP on notification of mental health admissions.

The Underlying Fee-for-Service System. Finally, 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 second year in the MassHealth ACO program.

Primary Care Team. Consistent with our mission, we continued our investment 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 in late 2018 a Medical Assistant (MA) upskilling initiative. Funded through the MassHealth Technical Assistance funds, we partnered with CHC, Inc. of Connecticut, a national leader in this area. During 2019, 161 MAs participated in the program along with 20 provider champions, nurse leaders, or MA supervisors from each participating health center. Surveys of MAs, PCPs and other care team members before and after the intervention reported an increase in feeling "like the care team operates like a real team".

Home Health Pilot. We expanded our home health work in 2019 beyond a single pilot health center to include others where home health utilization was much higher than average after accounting for population differences. As shared previously, we began work with one health center using an experienced nurse to review all 60-day re-certifications and specific high utilization cases. This nurse worked collaboratively with primary care providers, home health agencies, and members to understand the short- and medium-term need for ongoing home health services. The pilot health center showed reductions in home health utilization of $3 PMPM without impacting needed services or member grievances, and based on that success we expanded the work to other health centers.

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. In 2018, we achieved a 100% score for our pay-for-reporting data accuracy.

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