# ATTACHMENT APR

# DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM ACCOUNTABLE CARE ORGANIZATION (ACO) PY3 ANNUAL PROGRESS REPORT RESPONSE FORM

# PART 1: PY3 PROGRESS REPORT EXECUTIVE SUMMARY

## General Information

| | |
|---|---|
| **Full ACO Name:** | Community Care Cooperative, Inc. (C3) |
| **ACO Address:** | 75 Federal Street, 7th Floor, Boston, MA 02110 (mailing) |

## Part 1. PY3 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 18 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: We unite federally qualified health centers at scale to advance primary care, improve financial performance, and advance racial justice

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 $12 million or 2.3%** compared to our benchmark of $534 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, Collective Medical Technologies (CMT) 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 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 served. 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 key components 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 improvements 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 management 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 and are key components to reducing health care costs and improving the quality of care for members.

## 1.2 PY3 Investments Overview and Progress toward Goals

Despite challenges from the Covid-19 pandemic, C3 continued to develop our ACO program and position ourselves for greater success in value-based health care. Key areas include:

Population Health Management

In 2020, C3 significantly advanced its population health strategy and the complex care management and transitions of care teams under the C3 umbrella. All care managers and community health workers were transitioned under either a delegated FQHC partner or C3 itself. As a result of the Covid-19 pandemic and related challenges, care management teams transitioned to a telephonic model, allowing us to enroll 3,483 out of 9,046 (39%) identified members into complex care management.

We also commissioned a cohort analysis of both our Complex Care Management and Transitions of Care programs wherein Milliman examined utilization and total cost of care of identified and enrolled members against a comparison group of similar Medicaid beneficiaries. Results showed a significant reduction in the number of Inpatient Medical Admits (-27%), Inpatient Surgical Admits (-30%), Inpatient Psychiatric Hospital Admits (-41%), and the 30-Day All Cause Readmission Rate (-57%) when comparing Transitions of Care enrollees during the program to the matched cohort. Recognizing the importance of these activities to ACO success and our members, we are using these findings to set goals and make targeted improvements to our care management program as we move forward.

Total Cost of Care (TCOC) Management

In addition to bringing all complex care management under C3, we fully centralized the analytics function in 2020. Understanding the significant of high-quality data in managing TCOC, we continue to ensure access to ADT feeds from admitting hospital systems for physical and behavioral health admissions, which allowed our Transitions of Care team members to respond in real-time to critical events. In addition to the Care Management activities described above, C3 also worked to enhance the level of data shared within the organization and across to our FQHC partners. We believe that the ability to analyze trends across utilization categories and member populations will be critical in managing costs and continue to build out our analytics to meet those needs.

Path to Sustainability

C3 continues to monitor the return-on-investment of its programs and is proactive in managing declining DSRIP to maintain strong ACO operations and meet regulatory requirements.

## 1.3 Success and Challenges of PY3

Challenges:

*Covid-19 Pandemic:* The pandemic posed the most significant challenge in PY3, both to C3 as an ACO, and to the FQHCs with which we are partnered. C3 saw significant barriers to executing on its Care Management and Quality programs as a result of necessary lockdown and social distancing orders. The FQHCs faced a significant challenge with declining revenues and significant attention drawn to revising workflows and providing care to vulnerable populations amidst a host of existing concerns. However, C3 and FQHCs met those challenges with rapid deployment of telehealth at a very large scale, and the continual improvement of telehealth workflows to meet patient and ACO needs.

Successes:

*Flex Services:* For 2020, we would highlight the implementation of our Flexible Services Program as a major milestone and success. In 2020, we were able to:

- Launch 10 out of our planned 11 programs, pls the Covid-response nutrition program
- Implement our Flexible Services online platform (C3Flex.org), a customized Case Management software system to create closed loop referrals between the health center staff & SSOs, and track the VPR form data, service completions, and invoice/financial data
- Trained more than 300 health centers and SSO users to make and accept referrals to Flexible Services
- Served more than 3,500 members total

*Telehealth*: Covid-19 dramatically altered the delivery of care for our FQHCs, significantly reducing the number of in-person visits and interrupting C3's care management workflows. In response, we were able to quickly and effectively respond with a major support initiative (the Massachusetts Telehealth Consortium) that allowed for the adoption of telehealth, despite limited prior experience in this area and higher hurdles presented by digital access issues in our under-served populations. Our efforts directly resourced FQHCs with funds to purchase equipment and created a centralized collaborative alongside the Massachusetts League of Community Health Centers, leading to shared learning and fundraising capabilities. These activities allowed for the ongoing care for our FQHC partners patient populations. October 2020 saw more than 14,000 telehealth visits across C3 sites for MassHealth members, which we believe would have been much less likely in the absence of a coordinated effort and strong commitment from FQHCs. Adoption of telehealth also allowed for the continued operation and success of C3's care management program, and we continue to adopt these changes to maximum effect moving ahead.