ATTACHMENT A

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM ACCOUNTABLE CARE ORGANIZATION (ACO) FULL PARTICIPATION PLAN RESPONSE FORM

PART 1: ACO SUMMARY

General Information

Full ACO Name:	Cambridge Public Health Commission d.b.a. Cambridge Hospital
ACO Address:	1493 Cambridge Street, Cambridge, MA 02139

Part 1. Executive Summary

1.1 ACO Composition and Governance Structure

Composition:

Tufts Health Public Plans, Inc. (THPP) and Cambridge Health Alliance (CHA) have formed an Accountable Care Partnership Plan (ACPP) with the aim of integrating behavioral and physical health and delivering high-quality health care to the MassHealth population. THPP and CHA each meet the structural requirements to operate as an MCO and an ACO respectively. The ACPP's governance structure complies with ACPP requirements and will harness both organizations' experiences, strengths, and history of collaboration to effectively meet the goals of Delivery System Reform. Tufts Health Public Plans, Inc. (THPP) and Cambridge Health Alliance (CHA) currently serve the Medicaid population in Massachusetts and THPP and CHA maintain a Provider Network that includes Primary Care Providers (PCPs), Behavioral Health (BH) Providers, hospitals, specialists, pharmacists, and ancillary service Providers meeting all regulatory requirements.

Service Area:

The ACPP anticipates serving 32,201 Members from CHA's service areas of Boston-Primary, Lynn, Malden, Revere, Somerville, Waltham and Woburn, as defined in Attachment F of the ACPP Contract. The ACPP expects to continue serving current CHA Members and attract new Members by offering Member-centered, high-value care and increased access in underserved communities where CHA has invested in significantly expanding its primary care practices.

Governance:

The principles of the joint governance structure reflect the belief that true partnership is attained through shared governance and risks and rewards between the MCO and the ACO Partner. The Joint Operating Committee (JOC), with equal representation from the MCO and the ACO Partner, will manage the relationship between THPP and CHA. Two committees will report directly to the JOC: (1) the Finance Committee, and (2) the Compliance Committee. The ACPP Governing Board will be responsible for oversight of the operations of the ACPP. This includes without limitation, Provider and care delivery strategy and performance. Two committees report directly to the ACPP Governing Board: (1) the Patient and Family Advisory Committee (PFAC), and (2) the Quality Committee.

Joint Operating Committee:

The JOC consists of six persons, three each from THPP and CHA with equal voting rights. The JOC is co-chaired by a representative from both THPP and CHA. The JOC meets not less than quarterly. JOC summary charter and responsibilities include:

- Ensuring that the ACPP meets all Program requirements, including, without limitation, those related to the Enrollee experience with the ACPP
- Assessing overall performance of the ACPP and compliance with the ACPP Contract and determining strategies for improving overall Plan performance, including determining strategies for increased and improved clinical integration, data integration, network management, and improved Member experience of care
- Monitoring and assessing performance under the ACO Partnership Agreement
- Setting annual budgets and investment strategies, including the application of DSRIP payments, and developing annual and longer term financial plans
- Establishing ACPP growth goals and strategic priorities; and
- Oversight of and decision-making with respect to all recommendations made by the ACPP governance structure

Governing Board:

THPP and CHA created an ACPP Governing Board that meets the requirements of the ACPP Contract. The composition of the ACPP Governing Board may only be changed by majority vote of the JOC and will be consistent with MassHealth requirements.

The ACPP Governing Board is 75% controlled by Providers or their representatives and shall include primary care, mental health and substance use disorder Providers. Members represent multiple clinical disciplines with three primary care, two mental health and substance use, and two specialty Providers. It is co-chaired by CHA's Senior Vice President of Accountable Care and Senior Medical Director of Accountable Care. Meetings have held monthly since the formation of the ACPP and the submission of the RFR in February of 2017. The ACPP Governing Board reports directly to the JOC.

The ACPP Governing Board consists of the following voting members:

1. Nine (9) CHA Providers or Provider representatives, one of whom shall serve as the

Chairperson of the ACPP Governing Board;

2. Two (2) THPP Provider representatives;

3. One (1) consumer advocate, to be jointly selected by THPP and CHA prior to the Contract start date. Required qualifications for the consumer advocate will be jointly determined and support the goal of having a consumer voice in the ACPP governance structure (e.g., a voice around transportation and access issues, language supports, disability accommodations, and the like).

The ACPP Governing Board's charter and responsibilities are consistent with the ACPP's strategic direction and imperatives, as determined by the JOC and other imperatives impacting one or both Parties, such as accreditation standards. The ACPP Governing Board shall primarily:

1. Formulate, recommend and implement the ACPP's strategic direction and imperatives as determined by the JOC

2. Monitor and implement strategies and programs to support the ACPP and any relevant accreditation standards

3. Develop, oversee, and implement strategies to manage the ACPP's clinical performance, ACPP quality performance, and Enrollee experience under the ACPP

4. Assess population needs and social determinants of health and develop responsive strategies to address these issues

5. Oversee and plan with respect to medical and behavioral health (BH) integration, Care Management, medical, Provider level Utilization Management

6. Develop ACPP performance incentive/shared savings or methodologies;

7. Establish Provider and preferred Provider membership and quality and financial performance requirements and evaluate such performance (including variation)

8. Assess ACPP Network adequacy and make recommendations regarding Network Management and development; and

9. Establish budgets and priorities for DSRIP funds, and make recommendations to the JOC on data integration strategies, DSRIP flexible spending expenditures, and overall Plan priorities and strategies.

As of this writing the ACPP Governance structure is fully operational with the Joint Operating Committee, the Governing Board, the Finance, Compliance, Patient Family Advisory and Quality Committees all having formally approved Charters, secured membership with meetings occurring regularly as required. All Readiness Review and DSRIP related items have been jointly reviewed by all

Committees as applicable based on deliverable with the Finance Committee, the Governing Board and the Joint Operating Committee reviewing DSRIP submission materials specifically.

1.2 ACO Population Served

The Accountable Care Plan Partnership (ACPP) will cover Boston, Cambridge, Somerville, Medford, Malden, Everett, Chelsea, Lynn, Revere, Woburn, and Winthrop and the surrounding communities. The ACPP initially anticipated serving 32,000 members based on estimates from EOHHS, but now expects to serve approximately 24,600, based on EOHHS most recent estimates.

CHA's historical active MassHealth primary care panel age mix is 46% children 0–18 and 54% adults >19. Over half, 55%, identify as female, and 45% as male. CHA's active panel is ethnically diverse; it is 29% American, 14% Brazilian, 11% Haitian, 7% Salvadorian, and 5% African American, plus many niche populations including Indian, Asian, Nepalese, Dominican, Bangladeshi, Ethiopian, Pakistani, Cape Verdean, Honduran, and Somali. Forty-three percent of the active MassHealth panel's primary language is not English, with 14% identifying Portuguese and Portuguese Brazilian as their primary languages, as well as12% Spanish and 8% Haitian Creole.

CHA's MassHealth panel is reflective of its communities, which are racially diverse: 61% of the communities' populations are white compared to the statewide average of 75%. The communities' rate of foreign-born residents is more than twice the statewide rate, with 16% of the population Latino/Hispanic, 11% Asian, and 9% Black. The majority of foreign-born residents in half of CHA's communities are Brazilian immigrants. CHA communities also have higher rates of families with children under 18 living in poverty (18%) compared to the statewide average of 13%. The poverty rate is driven in part by a higher percentage of residents with less than a high school education. The income levels, except for Cambridge and Medford, are lower than the statewide median incomes. Four out of CHA's eight primary communities have median incomes less than $56,000, compared to statewide median income of $67,846.

Poverty, racial and ethical disparities, violence, and mental health/substance use are other salient characteristics of the population that inform strategies for improving quality and cost.

The most prevalent conditions for CHA's primary care Members include asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), depression, diabetes, hypertension, obesity, severe mental illness and substance use. CHA estimates that at a minimum 11.8% of CHA's active MassHealth population has a documented diagnosis of asthma, 8.9% are hypertensive, 5% have diabetes, 1.5% has COPD, and 0.4% has CHF. It is also expected that 5%–19% of CHA's panel has some form of mental illness or substance use (MHSU) condition.

Based on prevalence data from the Massachusetts Department of Public Health's 2014 Plan on Behavioral Health, it is estimated that people with some sign of mental illness comprise 17%–19% of the population, with more serious conditions reported for 4%–5% of the population. In addition, substance use disorders are present in roughly 10% of the population. In the CHA service area, a minimum of 5,100 MassHealth panel members would be expected to have some form of mental illness, with nearly 1,300 having a more serious condition, and approximately 2,800 people would be expected to have a substance use disorder. The MassHealth population tends to have a higher incidence of MHSU and other forms of mental illness than available prevalence data typically estimate.

In the CHA service area, 9.6% of residents have a disability. The majority of residents with disabilities are white (60.8%), while the second highest group with disabilities is classified as Hispanic or Latino (16%).

CHA has begun to analyze historical THHP data compared to some of the preliminary data provided by EOHHS. These data are summarized in Appendix 1. Some of our preliminary findings follow. When we compare our current THPP membership to the EOHHS-provided roster data, the anticipated new membership:

- Has a greater proportion of members under 21: 49.1% compared to 43.5%
- Has more male patients overall: 47.0% to 45.3%
- Has a greater proportion of members within rating categories 2 and 10: 11.3% compared to 8.9%
    - Specifically, more disabled children (0.7% to 1.5%)

In examining our THPP claims experience, we found that, by service category

- Facility outpatient accounted for 27% of TCOC
- Retail Pharmacy accounted for 24% of TCOC
- Professional and ancillary accounted for 14% of TCOC
- Inpatient physical health accounted for 13% of TCOC
- Behavioral health facility accounted for 9% of TCOC

When we examined claims dollars by first-listed diagnosis, we found the following distribution:

- Mental and Behavioral Disorders – 21%
- Contact with Health Services – 14%
  (Routine Care, Screenings)
- Pregnancy & Childbirth – 9%
- Musculoskeletal Diseases – 7%
- Respiratory Diseases – 4%
- Digestive Diseases – 4%
- Circulatory Diseases – 4%

As we get more complete data, we will use it to better understand the specific needs of the population.

Given CHA's depth of experience in treating the Medicaid population and our community, we do not anticipate extraordinary challenges in servicing this population beyond the transition challenges of such a large expansion into the ACCP program.

1.3 Overview of DSRIP Investment Approach

To align strategic efforts and DSRIP funding, the CHA and THPP developed a shared vision to drive exceptional outcomes in quality and member experience in a cost-effective manner for members who entrust the ACPP with their healthcare. The following programmatic and infrastructure investments will meet the ACPP's shared vision.

1. **Complex and Transitional Care Management:** Expansion of CHA's primary care based complex care management (CCM), transitional care and post-acute clinical teams. These teams manage the most clinically complicated and high risk/high utilizing populations. The strategy will be to impact and reduce inappropriate utilization, improve engagement in primary care services, and establish connections with social services and other programs as needed.
2. **Mental Health (MH) & Substance Use (SU) Management:** Investments in the expansion of several existing CHA programs, such as integrated primary care based behavioral health; the BH

integrated program (HIP) for the treatment of the seriously mentally ill; specialty psychiatric and substance use resources for members that would not be appropriately addressed in the aforementioned programs; and continued development of CHA's tele-psychiatry and transitional care capabilities.

3. **Medical Oversight, Medical, and Utilization Management:** Development of a program that is integrated with the existing MCO program and also designed to focus more directly on strategies to reduce inappropriate and avoidable utilization (Emergency, Inpatient, Skilled Nursing/Rehabilitation, etc.) in the care delivery setting. The ACPP will develop and enhance real time notification capabilities between the partners and community providers to achieve these objectives.
4. **Disease and Medical Management:** Development and deployment of evidence-based guidelines, disease management, prevention and wellness programs for targeted populations, diseases, and procedures with the goal to improve wellness and health outcomes, reduce variation, and improve quality and total cost of care.
5. **Community & Disparities Assessment and Workforce Development and Training:** Investments in tools and staffing to support the assessment and screening of our attributed population and community for health needs, social determinants and health disparities. Training and development programs will support our care management and disease management programs. A more robust understanding of social determinant factors will allow the ACPP to better provide care that is aligned with flexible services to help resolve social determinant needs.
6. **Quality and Member Experience Performance Improvement:** Expansion of quality and performance improvement infrastructure to ensure quality performance is achieved. This investment will allow for a population health view and management of members with gaps in care that produce deficiencies in quality. Expansion of member outreach and engagement efforts for those members not seen by primary care or who are newly assigned will further improve performance.
7. **Network Management, including Community Partner Management:** Investments in staffing and evaluation tools to support and monitor effectiveness of preferred provider relationships (Visiting Nurses Associations (VNAs), Skilled Nursing Facilities (SNFs), Palliative Care, Aging Service Access Points (ASAPs), Para-Medicine, Behavioral Health (BH), and Long-Term Services and Support (LTSS) Community Partnerships). The ACPP has an extensive network of preferred community partners and relationships which require ongoing support and management. We anticipate growth in this network related to introduction of community partnerships, state agencies, and other preferred partners. The changes anticipated in this is program would add a more rigorous review of all preferred and community partners with the explicit goal to tighten network connections, improve communication, enhance health needs screening and monitor performance.
8. **Infrastructure Support for ACO Partner DOI/HPC/MH/NCQA Requirements:** Resources to support ongoing compliance with contracting and regulatory requirements for the ACO Partner, e.g. Health Policy Commission (HPC) Registered Provider Organization (RPO) and ACO Certification, the Division of Insurance (DOI) Risk-Bearing Provider Organizational (RBPO) and NCQA Accountable Care Organization (ACO) Certification, and annual audits and financial reporting requirements. This will also enable accelerated assumption of delegated responsibilities.
9. **Infrastructure Population Management and Population Health Analytics, Information Technology and Other Investments:** Upgrades to the ACPP's technical infrastructure (data warehouses, analytic and reporting tools, MA-HIway connections) to address the expansion of member attribution and reconciliation processes, numerous data feeds and interfaces with various community partners, member and provider notification processes, enhancements to the electronic health record (EHR) for evidence-based guidelines and clinical protocols, and the expansion of patient-facing technologies.

1.4 Website

Below are the links to two key websites for the CHA-THPP ACPP:

1. THPP Together with CHA microsite:
   https://tuftshealthplan.com/cha

2. CHA website: ACPP-specific page:
   https://www.challiance.org/about/masshealth-aco