MassHealth Delivery System Restructuring: 2019 Update Report

Executive Office of Health & Human Services

July 2021

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Executive Summary

- In 2018, Massachusetts implemented its most **significant Medicaid re-structuring in 20 years to move away from a fee-for-service model by** creating:
  - **Accountable Care Organizations (ACOs)**
  - **Community Partners (CPs),** serving members with complex needs
  - **Delivery System Reform Incentive Payment (DSRIP) Program,** investing in statewide infrastructure
  - *(see Appendix for further background on the 2018 re-structuring)*

- This is the **second public report** on the MassHealth delivery system re-structuring; **it covers its first two calendar years (2018 and 2019)**

- **The first two years of data show that re-structuring has moved the delivery system forward toward a more integrated, value-based care approach**

- **This report is focused on the current 1115 waiver's performance data**. At the time of this report's release, MassHealth is working to develop an 1115 demonstration extension proposal, anticipated for formal submission to CMS later in calendar year 2021. MassHealth will release separate material detailing that proposal

Executive Summary: Key themes from 2018-2019

Over the first two years of restructuring, several trends have emerged *(detail follows on each)*:

1. **Retention and growth in ACO enrollment remained steady**
2. **Delivery system reforms have demonstrated early successes:**
   a) Most DSRIP-funded programs implemented by ACOs (70%) have been effective in improving outcomes in first 2 years
   b) Member engagement in CP programs has increased 3-fold from Year 1 to Year 2
3. **Early data indicate that ACOs are shifting utilization away from emergency/hospital care and towards primary care,** while cost trends remain too early to offer conclusive data
   a) PCP visits increased 2% from 2018 to 2019, and were 12% higher for members enrolled in ACOs versus members in non-ACO plans
   b) ACOs reduced avoidable admissions by 11% from 2018-2019
4. ACOs had **strong and improving clinical quality performance,** and stable member experience scores
5. **Financial performance among ACOs has varied**, driven by shifts in caseload acuity and insurance risk
6. ACOs showed **strong early interest and planning to address health-related social needs**
   a) 37 Flexible Services programs were proposed and approved in 2019 (the first year of this process) in advance of 2020 program launches, representing 13 of 17 ACOs

Retention and Enrollment Remains Steady

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 # MassHealth Accountable Care Organizations (ACOs)
- Partnerships of payers and providers across all geographic regions of the Commonwealth

913,000

 # Members enrolled in ACOs (up 3% from year-end 2018)
- 79% of managed care eligible members (up 2% from 2018)
- ACO membership increased by 28,000 from 2018, reflecting stability and success of ACO program

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 # MassHealth Community Partners (CPs)
- Longstanding community-based organizations with expertise supporting members with complex needs

91.7k

 # Cumulative members enrolled in CPs by 12/31/2019
- These members represent many of MassHealth's most vulnerable
- Up 70% from 2018; cumulative % engaged up by 14 from 2018

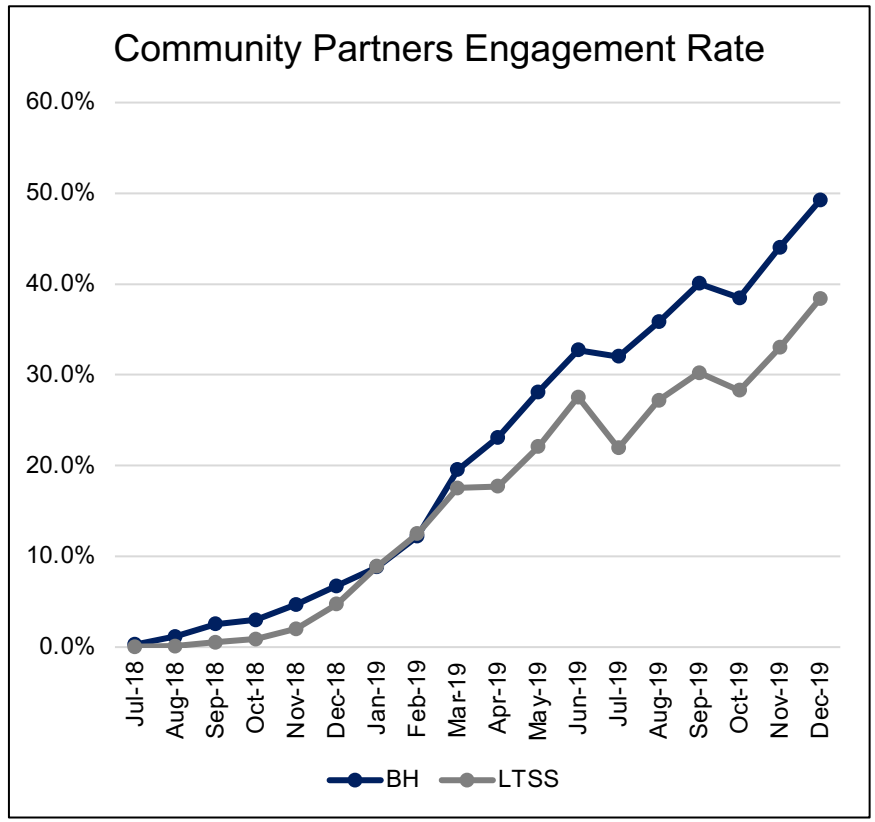
$244M

$ DSRIP funds spent by ACOs and CPs in CY2019
- Funds being used to improve quality and member experience, and reduce total cost of care

Delivery system reforms have demonstrated early successes

- **70% of innovative programs implemented by ACOs led to improved outcomes** across a range of measures (e.g., reduction in avoidable Emergency Department utilization, improved clinical quality scores)
  - Almost all programs focused on **high-touch care coordination for complex members or quality** were successful in improving outcomes

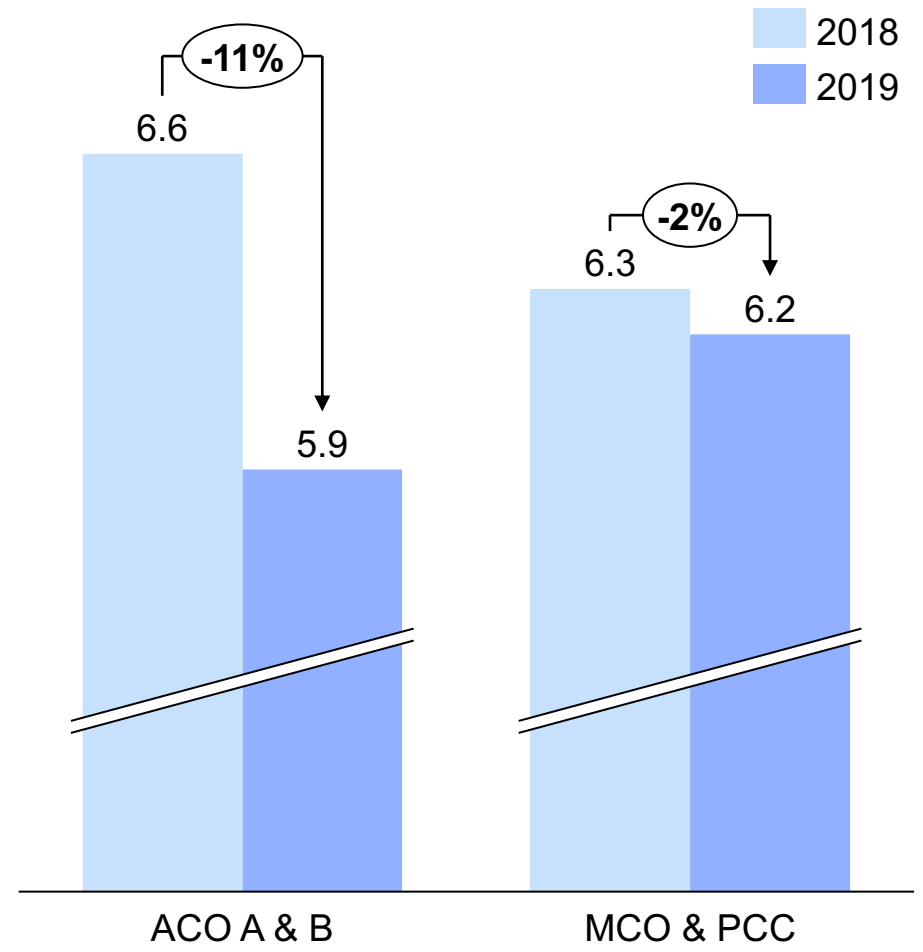
- **Community Partners have enrolled ~92,000 members** with complex needs, and have seen engagement rates increase significantly 2018-2019 (*see graph*)



ACOs seem to be shifting utilization from avoidable emergency and hospital care

- **Unnecessary hospital admissions decreased among members enrolled in an ACO**, compared with non-ACO members (*see graph*)
- At the same time, **primary care utilization increased among members enrolled in an ACO,** both comparing data from 2018 to 2019 among ACO members, and comparing ACO members to non-ACO members
- This data **suggest ACOs are successful in shifting utilization away from more acute settings**, while cost trends remain too early to provide comprehensive insight

Potentially Avoidable Admissions per '000 members



ACOs had strong and improving clinical quality performance; stable member experience scores

- **Quality performance was strong**
  - ACOs met or exceeded attainment threshold in 12 of 13 measures & demonstrated consistent improvement in 9 measures
- **Member experience scores remained stable**, but did not show improvement (detail in later slides)

Measure	Attained threshold in 2019	Improved in 2019
Follow-up after ED for Mental Illness	**Yes**	
Diabetes Poor Control	**Yes**	**Yes**
Follow-up After Hospitalization	**Yes**	
Metabolic Monitoring	**Yes**	**Yes**
Initiation of AOD Treatment	**Yes**	**Yes**
Engagement of AOD Treatment		
Controlling High Blood Pressure	**Yes**	**Yes**
Screening for Depression	**Yes**	**Yes**
Childhood Immunization	**Yes**	**Yes**
Immunization for Adolescents	**Yes**	**Yes**
Timeliness of Prenatal Care	**Yes**	**Yes**
Depression Remission / Response	**Yes**	**Yes**
Health Related Social Screening	**Yes**	
Total	**12/13**	**9/13**

Financial performance has varied; driven by caseload acuity shifts

- **Increased acuity across caseload led to varied financial performance** (*see chart*)
  - ACOs that take "insurance risk", known as ACO Model A's, were most financially affected by the increased acuity and generally experienced losses; Model B ACOs do not take insurance risk and achieved breakeven against their benchmark
- **Average cost of care per member varied significantly by ACO –** 23% difference between highest and lowest member costs
- ACO Model A's had slightly higher per member per month costs, driven by non-medical costs

2019 projected performance against capitation rates/benchmark[1]
# of ACOs

	Model A	Model B
>2% gains	**1**	**0**
+/- 2% of breakeven	**1**	**3**
>2% losses	**11**	**0**
	13	**3**

[1]Projections for Model A core medical spend as of November 2020, subject to final reconciliation, Model B core medical spend represent RY2019 reconciliation values; all percentages presented are prior to risk-sharing

Flexible Services: Examples of Approved Programs

In Dec 2019, MH approved **37 FS programs** that sought to address certain Health Related Social Needs (HRSNs) for ACO members, with the goal of improving quality and reducing TCOC. Examples include:

ACO will partner with a Social Services Organization (SSO) to **support tenancy preservation programs** that it already manages but is at capacity. Additional funding will help them support more members who have **chronic conditions, high ED utilization, and housing insecurity**.

ACO will partner with two SSOs to provide **nutrition services and support, including education on nutrition & food preparation, a medically tailored farm share program, and a food prescription program**. The program will serve ACO members with diabetes and who are at risk for nutritional deficiency/imbalance or food insecurity.

ACO's **home modification program will serve members at risk for homelessness because their current living situation is exacerbating their asthma symptoms**. Following an assessment, an SSO will deliver asthma support supplies, including HEPA vacuums, green cleaning supplies, hypoallergenic pillows/covers, as well as AC units, dehumidifiers, or air purifiers.

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Context: What is the MassHealth re-structuring?

- On June 30, 2017, **MassHealth's federal 1115 demonstration waiver was set to expire,** along with more than $1 billion per year in funding for safety net providers that the federal government would no longer renew without MassHealth making significant reforms

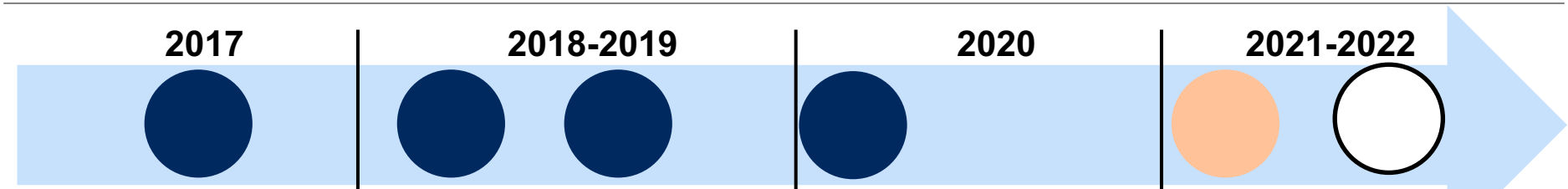
- This provided an **urgent window of opportunity** to re-structure the MassHealth program and negotiate a new waiver with the federal government

- From 2010 to 2016, MassHealth experienced **unsustainable growth**, a fee-for-service model for providers that resulted in **fragmented care**, and a fundamental program structure that **had not changed in 20 years**

- Starting in 2016, MassHealth initiated an **intensive stakeholder engagement and design process** to restructure the program

- MassHealth received approval in 2016 for a **new 5-year demonstration,** effective July 1, 2017 through June 30, 2022, that:
  - Authorized a transition to **integrated, accountable care models** (ACOs and Community Partners)
  - Included **$1.8B of new, one-time investment** for delivery system reform (DSRIP) activities

Context: MassHealth re-structuring timeline



2017

- **July:** New 5-year 1115 waiver effective
- **August:** 17 ACO contracts
- **December:** 27 CP contracts
- **DSRIP investments begin after contracts signed**

2018-2019

- **March-July 2018:** ACO program (March) and CP program (July) formally launch
- **2018 baseline data** gathered on cost, quality, and delivery system reform **(partial performance year)**
- **January 2019:** Member experience surveys
- **First full performance year (CY 2019)**
- DSRIP funding **begins to taper**

2020

- **January:** Report released on 2018 baseline
- **Flexible Services program** launches

2021-2022

- **July 2021:** Update report released on 2019 data
- DSRIP funding **continues to decrease, ending in 2022**
- Further update reports released annually on each performance year
- **2022:** Current 1115 waiver expires in June

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Overview of 2019 cost data and ACO financial performance

Overall spend

- In 2019, the ACO program accounted for $5.2B of MassHealth spending, with an average annual total cost of medical services per member of $5,800
- ACO medical spend per member grew on average by ~7% from RY18 to RY19; trend above HPC benchmark driven by exit of ~60K low-acuity members from the overall MassHealth caseload, resulting in overall acuity increase

Variation in spend

- Average ACO cost continued to vary substantially: for members with similar characteristics, the highest-cost ACO incurred 23 percentage point higher costs than the lowest-cost ACO
- Model A vs. Model B ACOs: while medical spend is very similar, the total PMPM of the Model A ACOs is higher due to difference in administrative costs

Financial Performance

- Most Model A ACOs experienced financial losses in RY19, given that capitations did not anticipate the rise in acuity driven by overall MassHealth caseload reductions
- Model B ACOs, which do not take insurance risk, ended the year much closer to their total cost of care target benchmark

Total cost of care: Overview of medical costs in 2019

~$5.2B Total spent on covered services for ACO members[1]

~$5,800 Average per member per year (PMPY) spending[1]

Average PMPY	With disabilities[2]	Without disabilities[2]
Adults	~$19,900	~$6,700
Children/Youth	~$10,100	~$2,400

Note: PMPM figures are not directly comparable to PMPM estimates in the 2018 Baseline Report, as they have been normalized to different fee schedules and mix of rating categories

[1]January – September 2019 medical expenditures, annualized, price normalized to MassHealth fee schedule; includes medical spend (e.g., Hepatitis C Rx and High Cost Drugs), but excludes add-on services (e.g., ABA, CBHI). Excludes ACO C model.

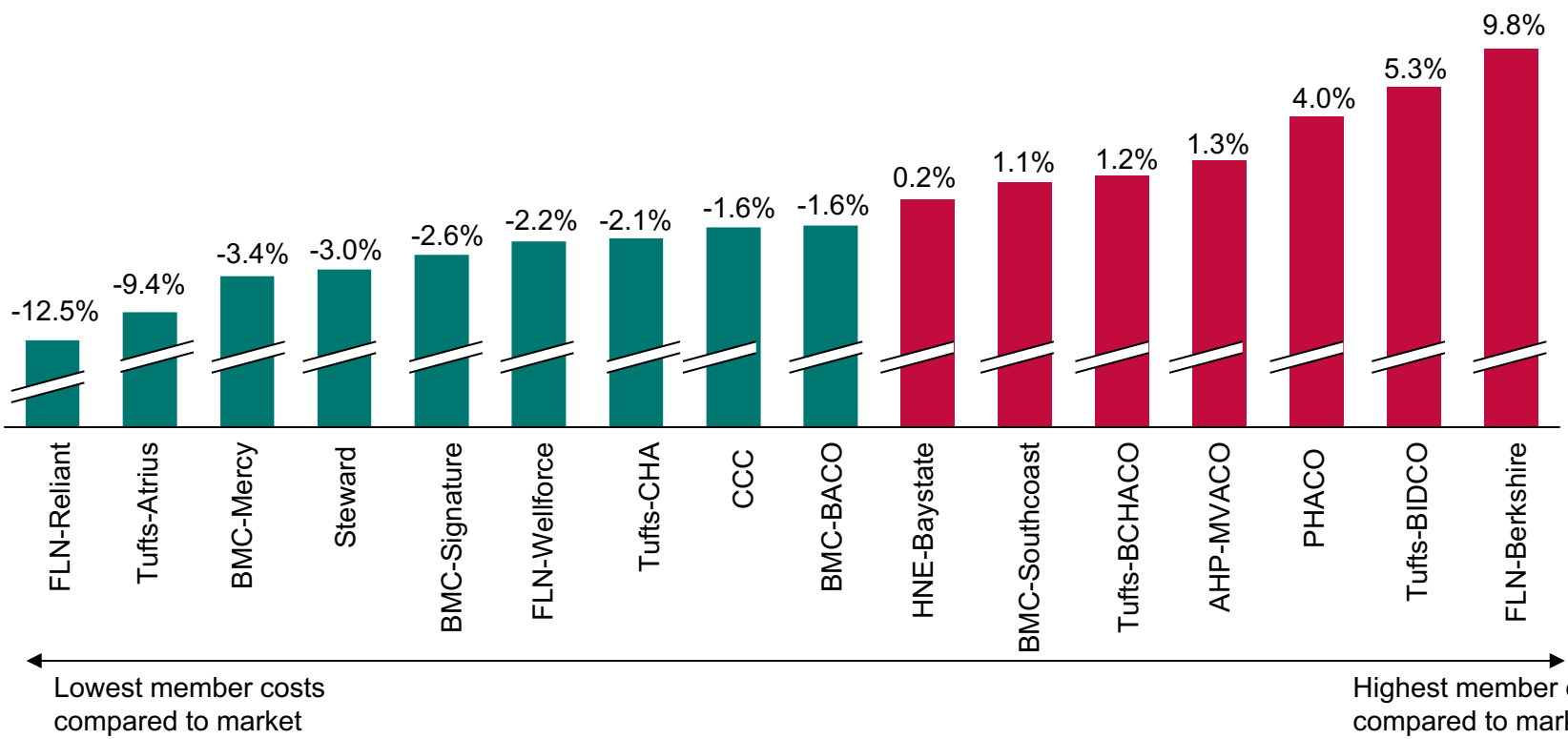
[2]Non-disabled adults include RC IA, RC IX, RC X; disabled adults include RC IIA; non-disabled children include RC IC; disabled children include RC IIC

ACOs' 2019 costs varied, even when controlling for population and price

For members with similar characteristics, the average cost for a member varied by **up to 23 percentage points** across ACOs.

This variation was measured after adjusting for the price of services and member acuity – variation was primarily driven by different **patterns of utilization and sites of care.**

Relative member costs compared to market average[1]



[1]October 2018 – September 2019 medical expenditures, price normalized, risk-normalized and population-mix normalized, annualized; includes medical spend (e.g., Hepatitis C Rx and High Cost Drugs), but excludes add-on services (e.g., ABA, CBHI). Reflects data available to MassHealth as of spring 2020, with actuarial adjustments applied

Model differences: takeaways so far

	Average PMPM before accounting for EOHHS cost (FFY19)		
	Medical[1]	Non-medical[2]	Total
Model A	~$488	~$39	~$527
Model B	~$487	~$11	~$498
Model A / B	100%	342%	106%

- Controlling for differences in population mix and acuity, average PMPM for Model A ACOs is 6%, or ~$29 PMPM, higher than Model B
  - Medical spend is similar; difference driven entirely by higher non-medical payments
- **After accounting for fixed and variable costs incurred by EOHHS above and beyond non-medical payments[3], Model A remains 4% more costly than Model B**

[1] Based on analysis of MMIS claims, MCE encounters, and concurrent member-level risk scores (1.004 normalized score for both Models A and B based on Social Determinants of Health (SDH) 3.1 model) for Federal Fiscal Year 2019; Model B do not consider some offsets from MH purchased Rx

[2] Includes non-medical component of the rate (excluding payor surcharge), care management costs covered by DSRIP, and non-medical component of PCACO MBHP rate; all FFY19 estimates

[3] Key drivers of difference include MassHealth operational costs, vendor costs, and $10 enhanced fee paid to PCACO participating primary care providers

Financial performance: Most ACOs in losses in 2019, driven by acuity shift

2019 projected performance against capitation rates/benchmark[1]
# of ACOs

	Model A	Model B
>2% gains	**1**	**0**
+/- 2% of breakeven	**1**	**3**
>2% losses	**11**	**0**
	13	**3**

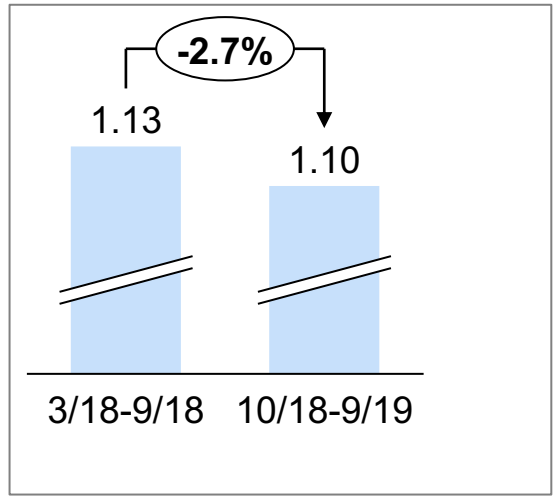
- Due to the rise in acuity, most Model A ACOs experienced financial losses in RY19
- Model B ACOs spent close to their benchmarks after actuarial adjustments accounting for acuity shift
- For 2021 and beyond, EOHHS will ensure that actual funding (i.e., the rate / benchmark) "floats" to meet actual costs for the ACO/MCO program overall; individual ACOs remain incented to "beat the market"

[1]Projections for Model A core medical spend as of November 2020, subject to final reconciliation, Model B core medical spend represent RY2019 reconciliation values; all percentages presented are prior to risk-sharing

Some ACOs were able to improve efficiency from 2018 to 2019

- In 2018, one ACO started the program with **spend about 13% above market**, indicating higher overall utilization of services and/or higher-cost sites of care
- Because **the delivery system is structured to incentivize improvements to cost trends**, the ACO worked with MassHealth to **identify service areas where they could take action to bring costs to market**
    - This included lab and radiology, outpatient facilities, and outpatient surgery
- The ACO **successfully managed to a negative overall cost trend** from 2018 to 2019, reflecting significant savings relative to the market overall and closing the gap to market average by 2.7% of total utilization

Efficiency relative to market



*NVF: Network Variance Factor, calculated during ACO rate setting, reflects the ratio of historical TCOC or medical costs for each plan relative to the market rate (1.0), but excludes differences due to unit pricing and member acuity. For example, 1.13 NVF indicates that the ACO is 13% less efficient compared to the market. Numbers shown reflect NVF calculated using claims experience from 3/18-9/18, and 10/18-9/19.

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Summary of clinical quality and member experience results for 2019

- ACO quality performance in 2019 was **high,** with ACOs surpassing the attainment threshold on almost all measures
- **Performance improved between 2018 and 2019**, with most clinical quality measures increasing in score
- Member experience scores were **comparable** between 2018 and 2019
- Like in 2018, **ACO performance varied significantly** in 2019; the amount of variation was comparable across both years

- 2019 was the **first "pay for performance" year for ACO quality**. The first pay for performance year for CPs was 2020
- ACOs have **20 clinical quality measures** and **2 member experience** measure areas: overall care delivery and integration
  - Of 20 clinical quality measures, this report reflects data on **13**

Clinical quality: summary of 2019 results

- The median ACO score **surpassed the attainment threshold for 12 of 13 measures**

- Performance improved between 2018 and 2019, with **9 of 13 clinical quality measures increasing in score**

- This improvement was likely the result of **several factors in combination:**
  - **Improved clinical performance** by ACOs
  - **Improved data sharing, record-keeping, and reporting** by ACOs for quality metrics
  - MassHealth incorporated **additional data sources** in 2019
  - Expected year to year variability due to statistical methodology

- Five measures were either **lower-performing** in both 2018 and 2019 or had declining performance from 2018 to 2019, representing opportunity for improvement *(detail follows)*:
  - Timeliness of pre-natal care
  - Engagement in Alcohol and Other Drug (AOD) treatment
  - Health Related Social Needs (HRSN) screening
  - Follow-up after hospitalization
  - Readmissions

Clinical quality: summary of 2019 results

Measure	Attained threshold in 2019	Improved in 2019
Follow-up after ED for Mental Illness	**Yes**	
Diabetes Poor Control	**Yes**	**Yes**
Follow-up After Hospitalization	**Yes**	
Metabolic Monitoring	**Yes**	**Yes**
Initiation of AOD Treatment	**Yes**	**Yes**
Engagement of AOD Treatment		
Controlling High Blood Pressure	**Yes**	**Yes**
Screening for Depression	**Yes**	**Yes**
Childhood Immunization	**Yes**	**Yes**
Immunization for Adolescents	**Yes**	**Yes**
Timeliness of Prenatal Care	**Yes**	**Yes**
Depression Remission / Response	**Yes**	**Yes**
Health Related Social Screening	**Yes**	
Total	**12/13**	**9/13**

- ACO performance in 2019 was **high, and improved relative to 2018**
- In 2019, ACOs' median score surpassed the attainment threshold on **12 / 13** clinical quality measures
- **Performance improved** between 2018 and 2019, with **9 / 13** clinical quality measures increasing in score
- 2019 was the **first "pay for performance" year** for ACO quality

Note: Performance above describes the median ACO for each given metric

Clinical quality: quality improvement in action

- One ACO found a linkage **between uncontrolled diabetes and certain social determinants of health**, and a high prevalence of impacted members concentrated within **four Community Health Centers**

- The ACO identified and implemented a set of best practices for **member engagement and care coordination**, focusing on these four centers, such as:
  - Ensuring that each site has a **dedicated diabetes clinic** led by an identified provider and supporting clinical team members
  - Systematically **identifying social risk factors** impacting glucose control through **home visits and assessments**
  - Making **referrals to housing support agencies**, food pantries, and other social service organizations
  - Developing **patient-centered, culturally appropriate plans** for each impacted member, shared among the care team

- **Clinical indicators of diabetes control significantly improved** from baseline in members who were engaged by a Community Health Worker (CHW) and referred to social service agencies that address their identified health-related social needs (HRSN), dropping the percentage of those with poor HbA1C control (>9.0) from **62% to 47%**

Clinical quality: measures of concern

- **Five of the thirteen measures were either low-performing in both 2018 and 2019 or had declining performance from 2018 to 2019:**
  - **Timeliness of pre-natal care:** Medical record retrieval is a challenge on this measure, as prenatal information is more likely to be housed outside of an ACO's primary care based electronic medical record system
  - **Engagement of AOD treatment:** Measure was conceptualized as a priority area for the DSRIP program, and benchmarks set intentionally high relative to baseline
  - **HRSN screening:** Measure is newly implemented for the ACO program, with strict requirements on what is considered compliant screening results. Current scores likely underrepresent degree of HRSN screening happening
  - **Follow-up after hospitalization:** A moderate decline for the ACO program, and a similar decline reported for MCOs; MassHealth, ACOs, and MCOs intend to further investigate drivers of this decrease
  - **Hospital readmissions**: Notable decline in performance for the ACO program, and a similar decline reported for MCOs. The measure is a risk adjusted utilization metric and may be subject to higher levels of variability; MassHealth, ACOs, and MCOs intend to further investigate drivers for this decrease
- These measures will be priority measures for monitoring and improvement efforts in future program years

Clinical quality: measures in progress

- Five measures are subject to ongoing technical negotiations between MassHealth and CMS, with the goal of ensuring accurate and scientifically sound measure calculation:
  - **ED for SMI**
  - **Diabetes admissions**
  - **BH engagement**
  - **LTSS engagement**
  - **Community tenure**

- Two measures are undergoing data validation by MassHealth and MassHealth's quality measurement vendor to ensure the accuracy of 2019 performance scores:
  - **Asthma** (reported in 2018)
  - **Oral health** (was not reported in 2018)

- MassHealth intends to publish an update to this report when these seven measures have valid benchmarks and scores, anticipated later in 2021

Overview of member experience

- **MassHealth continued to contract with Massachusetts Health Quality Partners (MHQP) to survey approximately 30,000 members in 2019 to build on the 2018 baseline** view of their experience of the health care system

- **MassHealth administered three types of surveys for adults and children:**
  - **Primary care:** issued to members who had a primary care visit
  - **Behavioral health:** issued to a subset of members who visited a behavioral health provider
  - **Long term services and supports:** issued to a subset of members who used long term services and supports

- **ACOs are accountable for performance on two member experience measures**:
  - Overall care delivery
  - Integration/ coordination of care

- For 2019, these measures are calculated based on results from a subset of questions **in the primary care survey**, which was based on a nationally validated tool

- Measurement Year 2019 scores were **likely and variably impacted by the COVID period** when the surveys were issued in early 2020

- In future years, MassHealth may incorporate results from additional questions in the primary care survey, and the BH and LTSS surveys, which were **newly developed to support a more complete picture of the experience of the Medicaid population**

Member experience: summary of 2019 results

Performance Measure	2018 Aggregate Statewide Score	2019 Aggregate Statewide Score	Threshold	Goal
Overall Care Delivery	90.0	89.9	75.0	92.0
Integration/Coordination of Care	83.2	83.2	71.25	86.25

- Results were **mostly similar to 2018**
- As in 2018, members expressed **strong levels of satisfaction** with their individual providers, and **the need for increased coordination or help managing behavioral health and other specialists and services**
- **Results were likely impacted by the COVID period**, as the surveys were issued in early 2020
- This 2nd year of performance **identifies opportunities for continued progress**, especially in the **integration and coordination of behavioral health care**, and in the **experience for the LTSS population**

Contents

Delivery system reform: ACOs

- **Over the first two years of the ACO program, several trends have emerged *(detail follows)*:**

  1. ACOs **retained members and increased enrollment over the course of 2019,** growing to a total enrollment of 913,067 (3% growth over year-end 2018)

  2. Most (70%), but not all, of the specific programs and investments ACOs implemented using DSRIP dollars are yielding **improved outcomes** based on initial ACO evaluations

  3. However, other ACO programs seem to be working less well, as **varied program design is accompanied by varied performance;** ACOs are expected to sunset or modify less successful investments as DSRIP funding declines in future program years

  4. Early data indicate that **ACOs are shifting utilization away from emergency/hospital care and towards primary care**
     a) PCP visits increased 2% from 2018-2019, and were 12% higher for ACOs than non-ACOs
     b) ACOs reduced avoidable admissions by 11% from 2018-2019

ACOs retained members and increased enrollment in 2019

ACO Type	Health plan	ACO Name	# of Members as of 12/31/19	% of Members
Accountable Care Partnership Plans ("Model A")	BMC HealthNet Plan	Boston Accountable Community Alliance	116,259	12.7%
		Mercy Medical Center	28,307	3.1%
		Signature Healthcare	18,105	2.0%
		Southcoast Health	16,770	1.8%
	Fallon Health	Health Collaborative of the Berkshires	15,867	1.7%
		Reliant Medical Group	32,979	3.6%
		Wellforce	50,810	5.6%
	Health New England	Baystate Health Care Alliance	38,747	4.2%
	Allways Health Plan	Merrimack Valley ACO	33,078	3.6%
	Tufts Public Plans	Atrius Health	31,956	3.5%
		Boston Children's Health ACO	99,827	10.9%
		Beth Israel Deaconess Care Organization	35,913	3.9%
		Cambridge Health Alliance	28,172	3.1%
Primary Care ACOs ("Model B")	Community Care Cooperative (C3)		124,889	13.7%
	Partners HealthCare Choice		109,239	12.0%
	Steward Health Choice		122,406	13.4%
MCO-Administered ACO ("Model C")	Lahey Health*		9,743	1.1%
ACO Total			***913,067***	***100%***

3% growth over year-end 2018 ACO enrollment (885,401)

*Enrollment as of 12/31/19, data pulled on 1/17/20

Most, but not all, ACO programs are yielding improved outcomes

- As ACOs' time-limited DSRIP funding declines in each successive year of the reform, ACOs have been working to evaluate and compare their DSRIP-funded investments to make **data-driven choices about which to scale/sustain and which to sunset**

- ACOs evaluated 76 programs as of December 2019. Of these, **53 (70%) demonstrated improvement in at least half of outcomes measured**, while 23 (30%) demonstrated little/ no conclusive outcome *(detail next)*

- The most common program type evaluated by ACOs was **high-touch care coordination for complex members**
  - Of 20 programs of this type, **16 (80%) showed improvement in at least half of their measures**
  - **Quality-focused programs** were also nearly all successful

- These results indicate that the kinds of programs funded by DSRIP (particularly care coordination and quality improvement efforts) warrant **sustainable funding after this demonstration ends**. They also indicate that ACOs can be **more efficient with future funds** by incorporating lessons learned from this demonstration

Detail: distribution of ACO program evaluations to-date

70% of DSRIP-funded programs (53 / 76) worked, improving at least half the measures they were evaluated on. **Care management** (80%) and **quality** programs (89%) had particularly high success rates. These results indicate some DSRIP-type programs warrant **sustainable funding** going forward

Program Type	Improved outcomes: All/ almost all measures	Improved outcomes: About half of measures	Little / no improvement	Total
CCM: Care management for the most complex members, with multiple chronic diagnoses	11	5	4	*20*
BH: Care coordination or management specifically designed to address BH needs	5	5	4	*14*
Quality: Programs that are specifically oriented toward improving quality scores	7	1	1	*9*
DM: Programs that provide specific supports to members with certain diagnoses	3	2	4	*9*
Other: Not patient-facing programs, such as data & analytic support	4	0	0	*4*
Transitions of care: Short-duration programs meant to coordinate care around an admission or ED visit	3	1	4	*8*
Light Touch: Lower intensity care management for less complex members	1	3	4	*8*
Rx: Programs intended to contain pharmaceutical costs & compliance with treatment	2	0	2	*4*
Total	*36*	*17*	*23*	*76*

Examples of ACO population health programs with varied success

Example programs that have demonstrated success

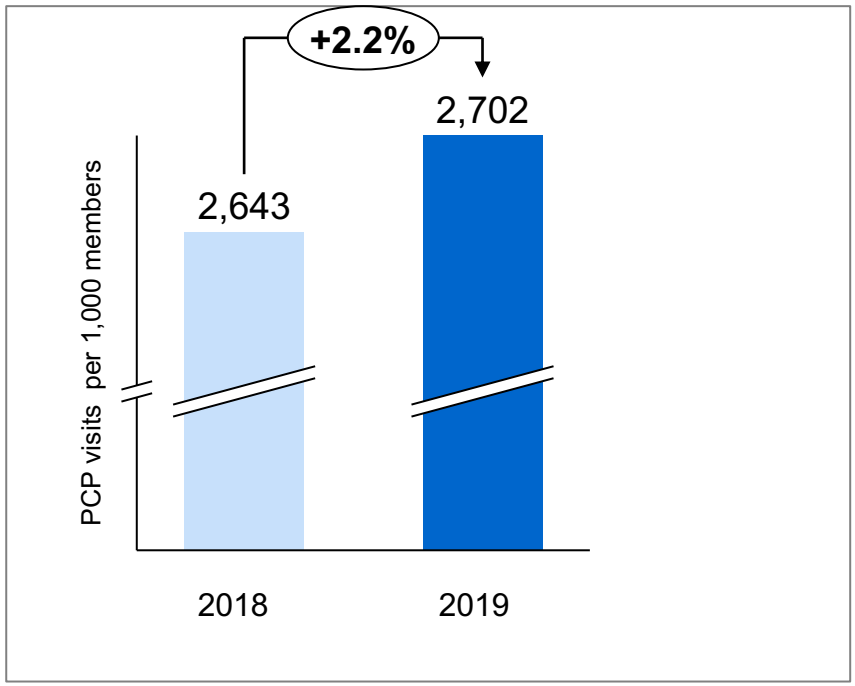
- Support for members to use **self-management skills to address their needs and engage in outpatient care**, as well as connection to community-based supports
  - Resulted in **40-60% reduction in emergency and hospital utilization** compared to pre-enrollment
- Program focused on **early identification of behavioral health needs through primary care integration and coordinated follow up care**
  - Those who received supports were **less likely to have a depression or anxiety assessment during follow-up** compared to those who did not

Example program that has not demonstrated success

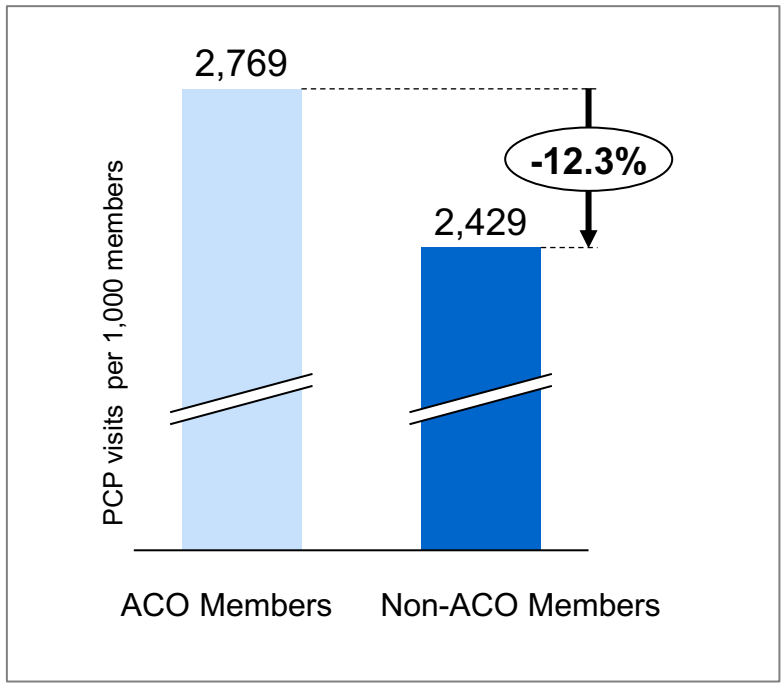
- Program **offering complex care management for high-risk members with behavioral health and social determinants of health needs**, approximately 10-12% of the ACO's population
  - Members enrolled in this group had **slightly higher hospital utilization and costs**
  - While results could indicate members receiving care for previously unmet needs, ACOs are expected to **closely examine programs like this one and modify or sunset them**

Primary Care Utilization increased 2018-2019, and is higher for ACO members than non-ACO members

PCP visits increased 2018-2019 for managed care members in general

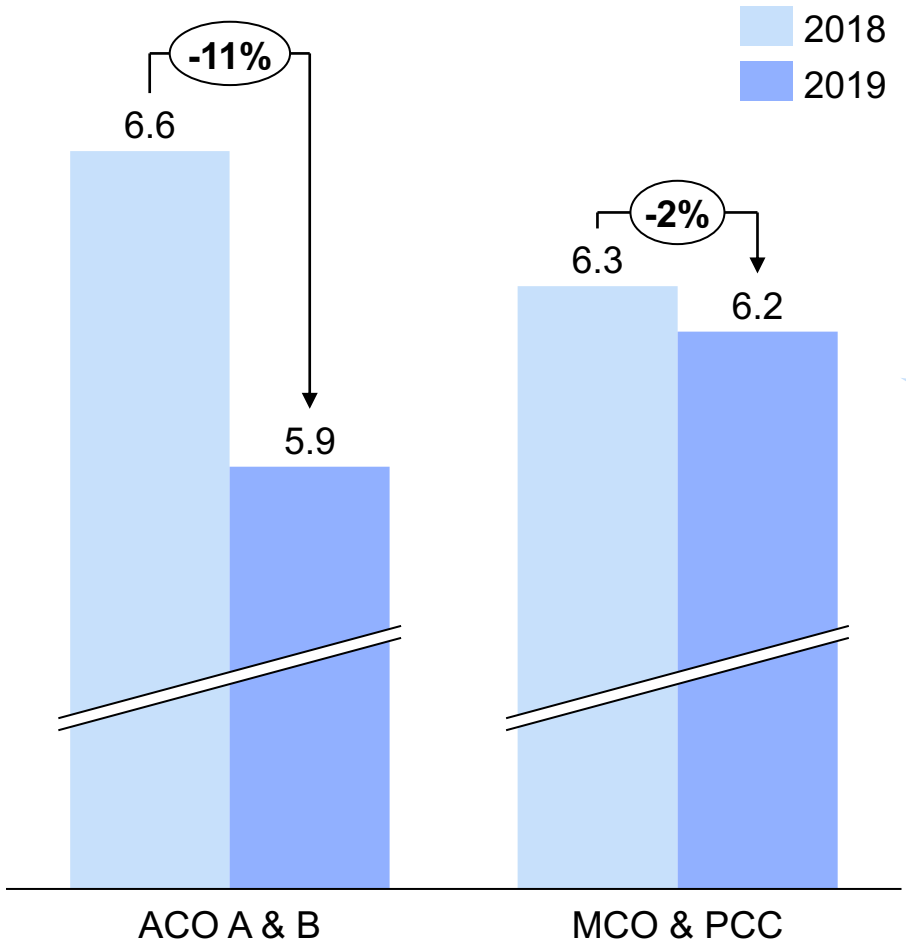


PCP visits were 12% higher for ACO members than non-ACO members in 2019



ACOs' potentially avoidable admissions fell from 2018 to 2019

Potentially Avoidable Admissions per '000 members



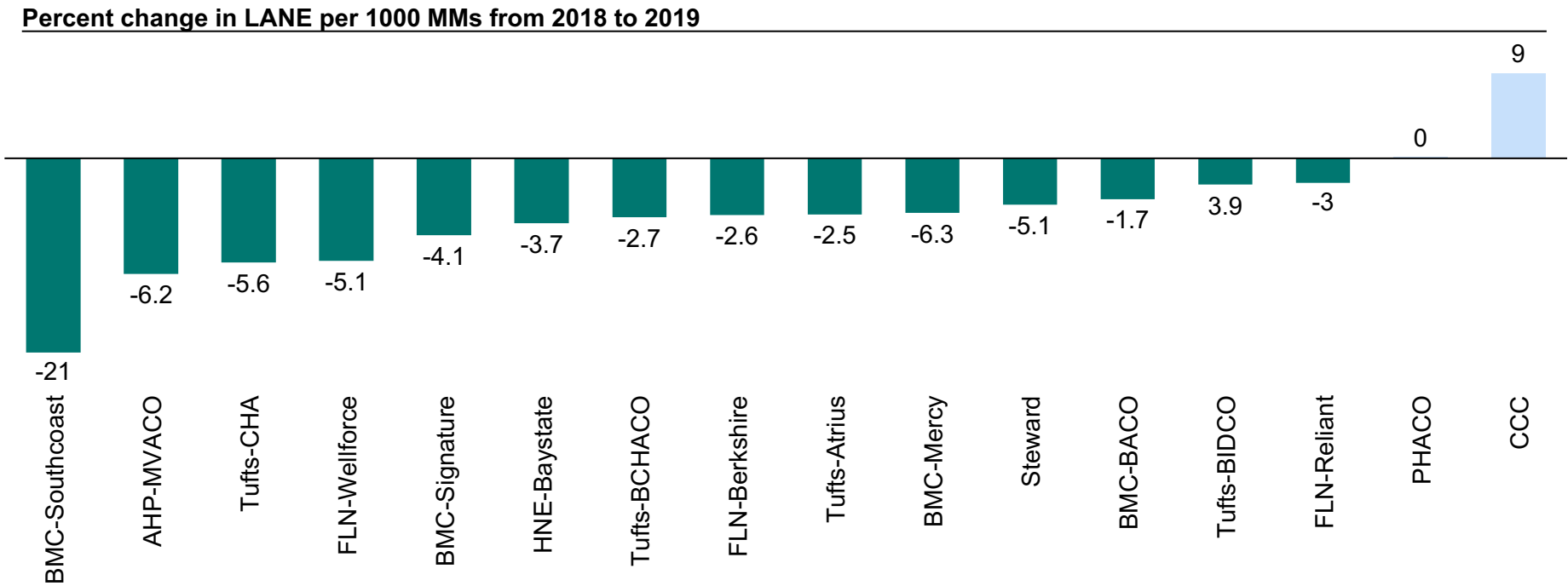
Certain ACOs had even steeper drops from 2018-2019, e.g.:

- HNE-Baystate: -33%
- FLN-Reliant: -27%

ACOs vary in reduction of low acuity ED visits

One of the key ACO Program goals is to **facilitate integrated care** for members**. Low Acuity Non-Emergent (LANE) Emergency Department Visits** indicate plan utilization that could have been addressed earlier in the care continuum-- before it became an emergency.

Several ACOs have been seen a decrease in LANE from 2018 to 2019. While still early in the program, this may indicate some ACOs finding success in better managing member care.



As ACO program matures, best practices continue to emerge

The most successful ACOs generally . . .

- . . . **know their population and how to best support them.** ACOs that use multiple data sources, including health-related social needs screening data and population health analytics, to identify high- and rising-risk members more effectively design and evaluate programs that improve the quality of care
- . . . **use real-time data, and coordinate multiple members of the care team.** ACOs that use automatic event notification feeds to learn when their members are admitted to an ED or hospital, and can push notifications to staff who can meet the member and support them in real time have better success keeping members engaged and the care team informed
- . . . **proactively evaluate their performance.** Some ACOs routinely compare themselves to market-level benchmarks for quality and utilization (provided regularly by MassHealth reports) to identify potential opportunities, then perform further analysis into practice patterns and care delivery to identify ways to perform better

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Delivery system reform: Community Partners

- CPs **enrolled ~92K members** by the end of 2019, representing ~38k additional members over year-end 2018. Given 2019 was the first full year for the CP program, enrolling and fully engaging members remains a **key start-up challenge of the program**

- However, rates of engagement **steadily improved over 2019** due to operational refinements and the efforts of CPs and ACOs (although **CPs' performance varied)**
  - By the end of 2019, **20% of all members that had been enrolled** in the program had been engaged
  - Of those members still **actively enrolled** in December 2019, **47% were engaged**
  - The number of engaged members was **more than triple** the number from December 2018

- In future reports, MassHealth expects to further evaluate CPs' impact on **member utilization and quality**

BH CPs served ~28K additional members in 2019

BH CP Name	Cumulative members enrolled	
	12/31/2018	12/31/2019
BEHAVIORAL HEALTH NETWORK INC	2,359	3,758
BEHAVIORAL HEALTH PARTNERS OF METROWEST LLC	4,214	7,052
BOSTON COORDINATED CARE HUB	1,032	1,977
BRIEN CENTER COMMUNITY PARTNER PROGRAM	1,370	2,018
CENTRAL COMMUNITY HEALTH PARTNERSHIP	1,853	3,076
CLINICAL AND SUPPORT OPTIONS, INC.	1,022	1,625
COMMUNITY CARE PARTNERS, LLC	4,243	7,182
COMMUNITY COUNSELING OF BRISTOL COUNTY, INC	2,144	3,968
COMMUNITY HEALTHLINK, INC.	1,006	1,696
COORDINATED CARE NETWORK	3,802	6,036
ELIOT COMMUNITY HUMAN SERVICES INC	2,493	4,435
GREATER LOWELL BEHAVIORAL HEALTH COMMUNITY PARTNER	927	1,299
INNOVATIVE CARE PARTNERS LLC	3,138	4,899
LAHEY HEALTH BEHAVIORAL SERVICES	3,547	5,638
RIVERSIDE COMMUNITY PARTNERS	2,550	4,351
SOUTH SHORE COMMUNITY PARTNERSHIP	1,149	1,841
SOUTHEAST COMMUNITY PARTNERSHIP LLC	2,989	4,715
SSTAR CARE COMMUNITY PARTNERS	2,209	4,094
BH CP Total*	***42,047***	***69,660***

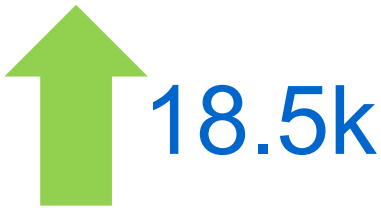
*Enrollment as of 12/31/19, data pulled on 11/16/20

LTSS CPs served ~10K additional members in 2019

LTSS CP Name	Cumulative members enrolled	
	12/31/2018	12/31/2019
BOSTON ALLIED PARTNERS	1,004	2,286
CARE ALLIANCE OF WESTERN MASSACHUSETTS	1,437	2,612
CENTRAL COMMUNITY HEALTH PARTNERSHIP	867	1,485
FAMILY SERVICE ASSOCIATION	1,210	2,546
INNOVATIVE CARE PARTNERS LLC	1,488	1,977
LTSS CARE PARTNERS, LLC	1,436	3,032
MASSACHUSETTS CARE COORDINATION NETWORK	2,365	4,539
MERRIMACK VALLEY COMMUNITY PARTNER	1,128	1,808
NORTH REGION LTSS PARTNERSHIP	855	1,783
LTSS CP Total*	***11,790***	***22,068***

*Enrollment as of 12/31/19, data pulled on 11/16/20

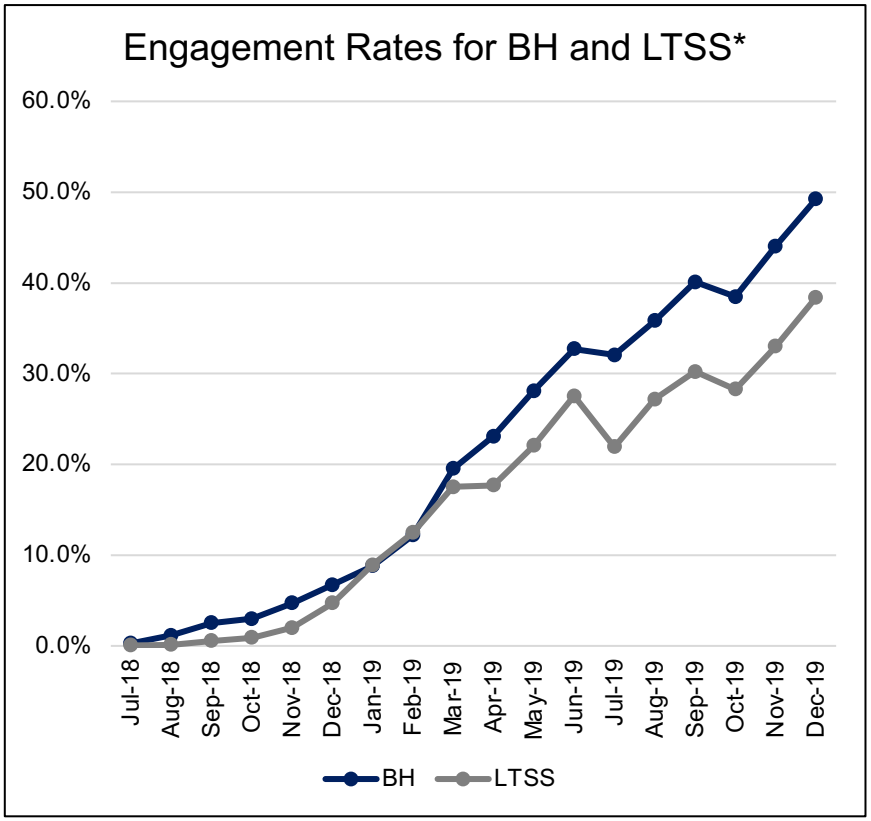
Key takeaways from CP engagement data (cumulative 18 month view)



- As of 12/31/2019, **18.5K members were engaged by CPs since launch of program**
  - This represents 20% of all members enrolled in the program across 2018 and 2019
- As of 12/31/2018, **only 3.0k were engaged, representing 6%** of all those enrolled in the program in 2018
- 2018 was a **partial year** (the program launched in July)
  - CPs and ACOs were dealing with **new relationships** and a **very large volume** of members assigned up-front (the program was designed to launch "at-scale")
- In 2019, **CPs substantially improved** on 2018, engaging many newly enrolled members and also engaging many who were originally enrolled in 2018

See Appendix for additional detail

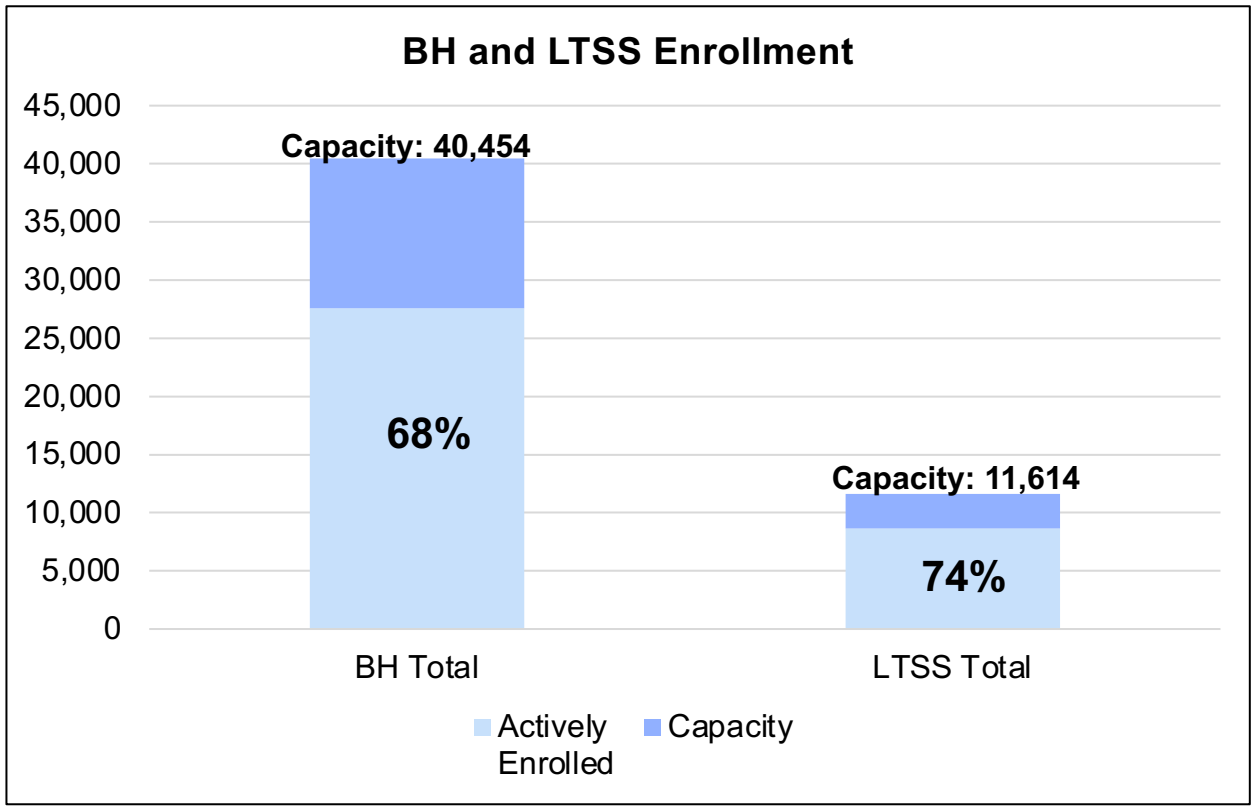
Key takeaways from CP engagement data (snapshot view)



- As of December 2018, 6% of <u>actively</u> enrolled CP members were engaged*
- As of December 2019, **this number was 47%**
- This improvement was due to **improved individual performance** by ACOs and CPs, **improved integration** between them, and **operational improvements** to the program by MassHealth (e.g., sharing member data to support outreach)

* Note: While engagement statistics on slide 42 are shown relative to all members enrolled in CPs since program launch, the engagement rates on this slide represent the % of **<u>actively</u>** enrolled members engaged at least 1 day in that month in a CP. Members who have been dis-enrolled from the program in a given month are not included in the denominator (for that month), explaining the difference in overall numbers. Both methods of measuring engagement show significant improvement in 2019.

CPs have capacity to support more members



- As of December 2019, BH CPs' enrollment was at **68% of their reported capacity**, and LTSS CPs' was at **74%**
- Members who do not reach engaged status after several months are typically dis-enrolled from the CP program, and **engagement challenges have contributed to lower enrollment levels**

Summary of CP engagement challenges

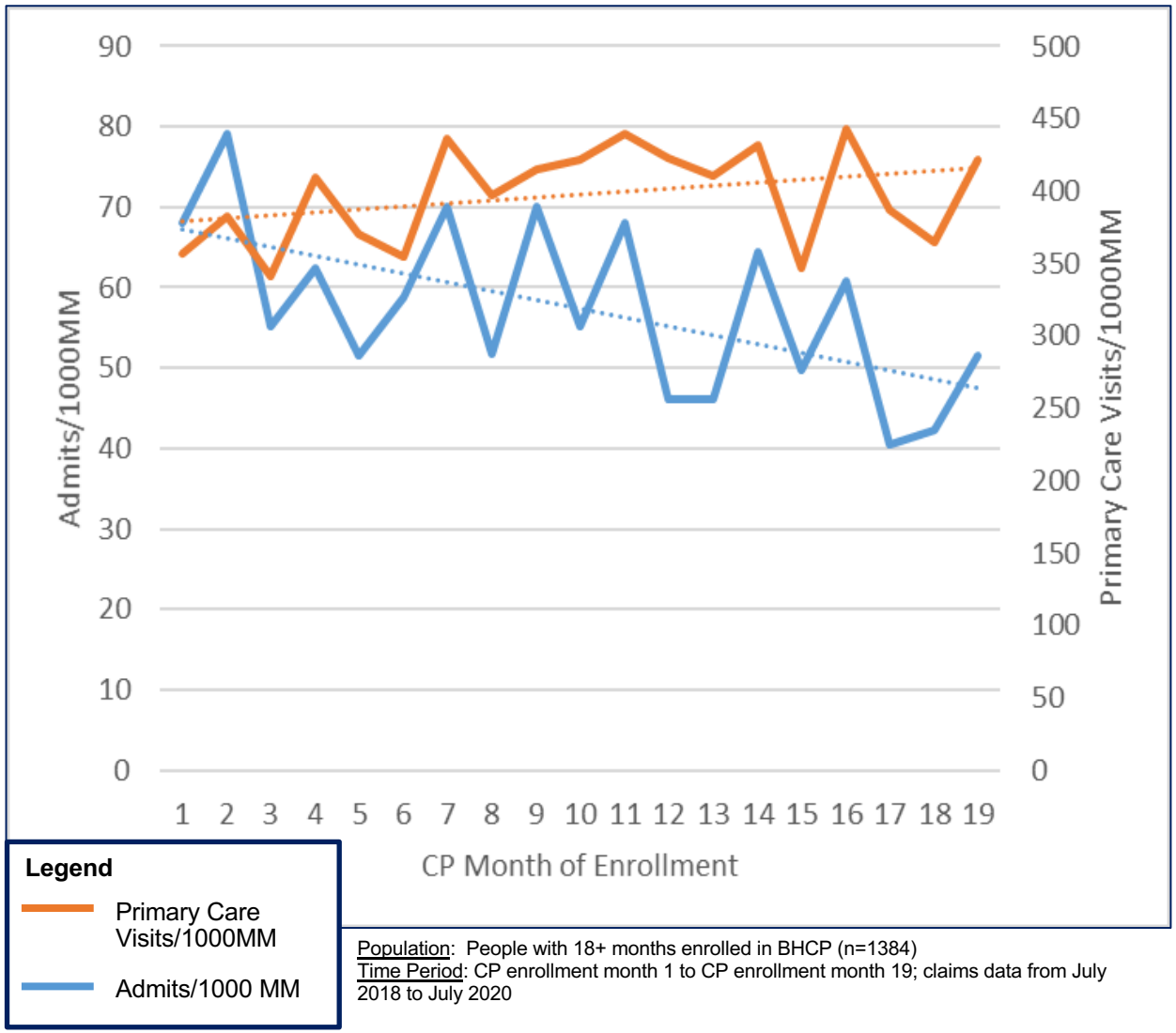
- Engagement is a **multi-step process** that requires outreach, relationship-building, the development of a person-centered assessment and care plan often over multiple discussions, and **close coordination between staff at ACOs and CPs**

- There are several reasons a member may not reach engaged status; the most common include:
  - The member **losing MassHealth or CP program eligibility**
  - The member **declining the program**
  - **Challenges** with efforts from the member's CP and ACO that result in them failing to complete the assessment and care plan in a timely manner

- CPs and ACOs have **"many-to-many" relationships** with each other that create variation and administrative complexity; often some relationships have **more scale, are closer organizational partnerships, and have higher rates of success** than others

- CPs and ACOs **individually vary in their performance** as well
  - Member engagement varies by 48% across CPs
  - Some CPs report **more outreach attempts** than peers; some ACOs complete a **higher % of comprehensive assessments** than peers

Example of CP Success: Community Care Partners (CCP) shows promising impacts on hospitalizations and primary care visits



Population: People with 18+ months enrolled in BHCP (n=1384)
Time Period: CP enrollment month 1 to CP enrollment month 19; claims data from July 2018 to July 2020

- CCP conducted two analyses of claims, enrollment and care coordination data:
  - Comparison of Hospitalizations and Primary Care before/after CP program
  - Longitudinal Analysis of Hospitalizations by CP Member Month
- **Comparison of Hospitalizations and Primary Care before/after CP program saw a 10% decrease in hospitalizations and a 13% increase in members visiting with PCP**

As CP program matures, best practices continue to emerge

The most successful CPs generally . . .

- . . . **put the member and their priorities first.** CPs that support members with their most pressing social needs, such as homelessness, build trust and have more success engaging members to address other wellness goals
- . . . **are of, by, and for their communities.** CPs that build a team that reflects the demographics and spoken languages of their member population have more success building relationships and understanding members' barriers
- . . . **integrate with the healthcare system.** CPs that regularly meet with PCPs and ACO teams to review member cases and discuss how they can support clinical management have more success coordinating with PCPs and ACOs on care plans, transitions of care, and other supports
- . . . **leverage data.** CPs that use the Mass HIway and other mechanisms to share real-time data (e.g., event notification that a member has been admitted to hospital) among the care team can respond faster and more effectively

Contents

Overview of DSRIP Program

- DSRIP funding ($1.8B total) is **time-limited and decreases over 5 years**
- ACOs and CPs use DSRIP funds to **design and test innovative programs**, with the expectation that they measure those programs' outcomes, **and to stand up infrastructure required for population health management**
- In CY2019, **ACOs and CPs spent $244.1M** in DSRIP funding:
  - **$173.7M** by ACOs*
  - **$70.4M** by CPs
- This ACO spending does not include any spending on the Flexible Services Program, which launched in 2020
- ACOs and CPs had to receive MassHealth approval for **investment plans** by demonstrating that their investments would support **population health management**, not duplicate other available funds, and be measurable
- Additionally, **$25.5M of DSRIP funding was used for Statewide Investments in 2019** to support workforce development (training, hiring, retention), technical assistance for ACOs and CPs, and related initiatives. This was an increase of ~18% over the $21.6M spent on Statewide Investments programs in 2018

Detailed DSRIP funding charts by ACO, CP, and Statewide Investments programs included in appendix

* Certain ACOs also received an additional **$76.3M** for safety net hospital (DSTI) glide-path funding

2019 DSRIP investments: by the numbers

264

# of different ACO investments/programs supported by DSRIP in 2019

- Initiatives implemented by ACOs to improve quality of member care and lower total cost of care

$117M

$ spent on personnel/staff by ACOs in 2019

- Significant investment in workforce to support ACO efforts

$35.1M

$ spent on infrastructure by CPs in 2019

- Build out infrastructure to implement CP program, such as establishing workflows, integrating electronic systems, purchasing tablets to facilitate in-person connections, etc.

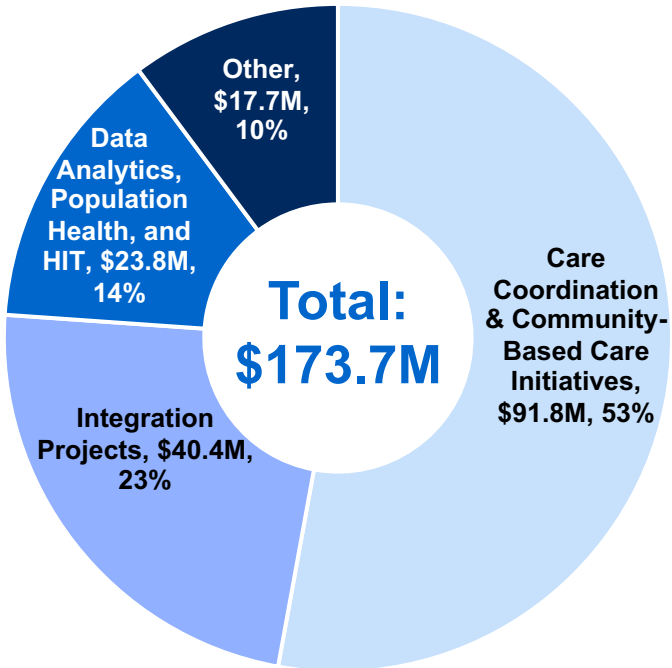
$35.3M

$ paid to CPs for care coordination supports provided between 1/1/19 to 12/31/19

- Payments for outreach, assessing needs, care planning, care coordination, etc.

ACO DSRIP investments: overview by category

ACO DSRIP Startup & Ongoing Expenditures CY2019

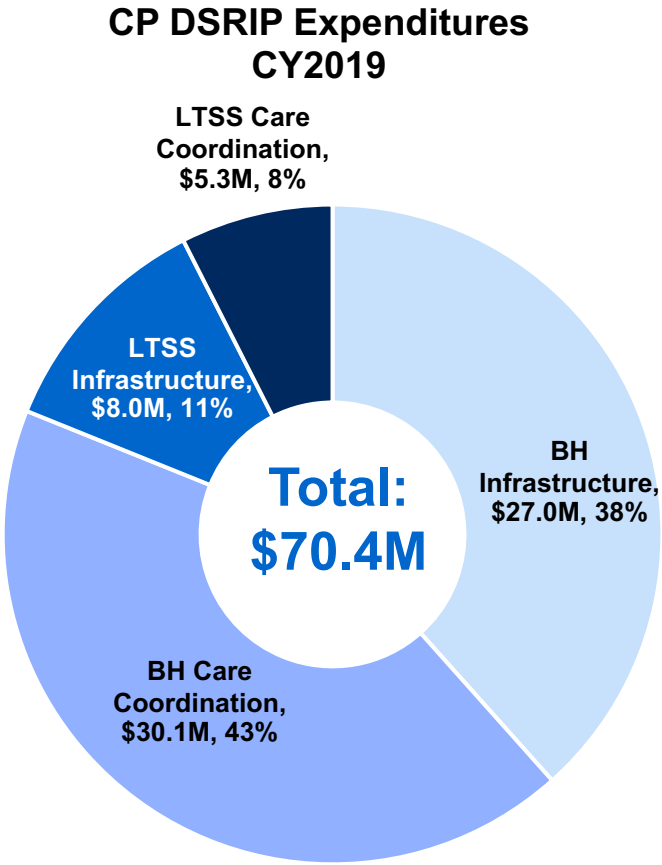


CY2019 expenditure data ($173.7M) reflects a slight decrease from the CY2018 report ($189.3M), which included expenditures from CY2017-2018. ACO DSRIP allocation percentages by category remained relatively constant between 2018 and 2019.

- **Care Coordination & Community-Based Care Initiatives:** Strengthen care coordination/ management and community-based programming
- **Integration Projects:** Increase organizational capacity, as well as integration amongst physical health, BH, LTSS, and health-related social services
- **Data Analytics, Population Health, and Health Information Technology:** Improve data collection, analytic platforms, algorithm development, EHR and care management software improvements, and interoperability
- **Other:** Support workforce development, culturally and linguistically appropriate services, and other investments

DSRIP funding per ACO included in appendix

CP DSRIP investments: overview by category



- **Infrastructure:** Investments in technology, workforce development (e.g., recruitment and training expenses), business start up costs, and operational infrastructure (e.g., data analytics staff)
- **Care coordination**: Payment for outreach, assessing needs, care planning, care coordination, etc.

CY2019 expenditure data ($70.4M) reflects a substantive increase from CY2018 expenditures ($32.4M), largely driven by an increase in care coordination payments. The percentage of total CP expenditures attributed to Care Coordination increased from 24% (CY18) to 50% (CY19). Care Coordination payments did not begin until October of CY2018; therefore, the CY2018 report only included 3 months of data.

DSRIP expenditures per CP included in appendix

Statewide Investments: by the numbers – Workforce

CY18	CY19	
113	71	**# student loans repaid for community-based clinicians**
$2M	$4M	**$ in student loan repayment**
94%		**% total loan repayment recipients from 2018-2019 award cohorts retained** • Empowers and incentivizes clinicians to work at and remain in safety net provider organizations
340	340	**# community health workers and peer specialists trained** • Key members of the extended care team, who help engage members in their care
16	10	**# community health center-based Family Medicine and Family Nurse Practitioner residency training slots supported** • Clinicians trained in community-based residency programs more likely to remain in community upon training completion

DSRIP funding per Statewide Investments program included in appendix

Statewide Investments: by the numbers – Technical Assistance

CY18	CY19	
1	90	**# technical assistance (TA) projects funded at ACOs/CPs**
$90.8K	$9.1M	**$ of technical assistance support** • Provides access to a curated catalog of 47 TA vendors with expertise in 9 different domains
226	3,036	**# average monthly active users of DSRIP TA website*** • High interest from ACOs and CPs since program launch
0	2	**# of half-day SWI Pop Up Events hosted** • Half-day convenings which are attended by ACOs, CPs, and others; first two Pop Ups focused on member engagement

DSRIP funding per Statewide Investments program included in appendix
Differences in # of TA projects and $ funding from CY2018 EOY report due to cancelled and/or scoped-down projects.

* MA DSRIP TA Marketplace: https://www.ma-dsrip-ta.com/

Overview of Flexible Services Program

Throughout CY2019, MassHealth along with ACOs, Social Service Organizations (SSOs), state agencies, and other stakeholders prepared for and launched the **Flexible Services Program (FSP)**

- Flexible Services (FS) is a **focused program** piloting whether ACOs can **reduce total cost of care (TCOC)** and **improve members' health outcomes** by implementing **targeted evidence-based programs** that address certain eligible members' **Health Related Social Needs (HRSN)** in the areas of **nutrition and housing support services and goods.**
- **FS is not an entitlement program nor a covered service.** Not all eligible members will receive FS
- FS is not intended to replace, substitute, or duplicate existing benefits or State/Federal social service programs, but rather is intended to **supplement where appropriate**
- FS is **one innovative tool for** ACOs to identify and address HRSN in an effort to improve health outcomes and reduce TCOC
- Due to delayed CMS approval of the Flexible Services Protocol, MassHealth **launched the FSP in January 2020,** 2.5 years after the current waiver's start

Preparing and Launching the Flexible Services Program

In order to prepare for and launch FSP, MassHealth **educated** stakeholders**, fostered relationships** between ACOs and Social Service Organizations (SSOs), and **obtained policy input through extensive stakeholder engagement.**

- MassHealth strongly encouraged **ACOs to partner with SSOs** (i.e., community based organizations) to deliver nutrition and housing support services and goods to members
- **MassHealth** partnered with MassHousing, Massachusetts (MA) Department of Housing & Community Development, MA Department of Public Health, and MA Department of Transitional Assistance to **offer Housing, Nutrition, and MassHealth "101" informational sessions** to ACOs and SSOs
- MassHealth **supported the development of new relationships** between ACOs and SSOs through **highlighting networking opportunities** and by **facilitating sharing of contact information** between parties
- MassHealth procured a **Social Services Integration Workgroup** to advise its FS program and policy development process – recommendations included ways to simplify the member's FS journey and to standardize FS screening and planning documents

Flexible Services: by the numbers

37

# of different FS programs approved* in December 2019
- **16** Housing, **19** Nutrition, & **2** Housing/Nutrition Programs

38

SSO-ACO partnerships were established
- These partnerships involved **28 distinct SSOs**
  - **17** SSOs for **housing programs**, **9** SSOs for **nutrition programs**, & **2** SSOs for **housing/nutrition programs**

$13.9M

$ budgeted by ACOs in 2019 to spend on FS in 2020
- EOHHS allocated a total of **$32.9M** for 2020
- ACOs have opportunities to seek approval for **new programs and expansions of existing programs** throughout 2020

14

Awards given to SSOs through the SSO FS Preparation Fund
- Administered by MA Department of Public Health, the Preparation Fund supports qualified SSOs delivering FS **to strengthen their interactions with ACOs** (e.g., investments in infrastructure, data exchange, workflow development)

*Upon FS program approval, ACOs entered a "FS Preparation Period," during which they sought MassHealth approval of various operational processes before program launch (e.g., member communications, program integrity plans)

Flexible Services: Examples of Approved Programs

In Dec 2019, MH approved **37 FS programs** that sought to address certain HRSNs for ACO members, with the goal of improving quality and reducing TCOC.

ACO will partner with an SSO to **support tenancy preservation programs** that it already manages but is at capacity. Additional funding will help them support more members who have **chronic conditions, high ED utilization, and housing insecurity**.

ACO will partner with two SSOs to provide **nutrition services and support, including education on nutrition & food preparation, a medically tailored farm share program, and a food prescription program**. The program will serve ACO members with diabetes and who are at risk for nutritional deficiency/imbalance or food insecurity.

ACO's **home modification program will serve members at risk for homelessness because their current living situation is exacerbating their asthma symptoms**. Following an assessment, an SSO will deliver asthma support supplies, including HEPA vacuums, green cleaning supplies, hypoallergenic pillows/covers, as well as AC units, dehumidifiers, or air purifiers.

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Next Steps- Current 1115 Waiver (2020-2022)

- Starting in 2020**, DSRIP funding began ramping down for ACOs and CPs**, which impacts programs across the delivery system
  - ACOs are **closely evaluating outcomes for population health programs to determine what works and what does not**
  - Programs that are not sustainable or showing clear improvements in member outcomes are expected to sunset
  - Similarly, **CPs are working to demonstrate engagement and value to ACOs** as DSRIP declines
  - ACOs have **increasing flexibility to partner selectively with preferred CPs** starting in 2020

- **Flexible Services launched in 2020**, supporting certain high-risk members with health related social needs
  - These programs will be evaluated in later years' reports

- **Financial accountability for cost, quality and outcomes increases** in subsequent years
  - 2019 was the first year ACOs had pay-for-performance. The measures and dollars in pay-for-performance increase with each subsequent year of the program
  - Pay-for-performance for CPs began in 2020

Next Steps- Process and goals for 1115 Waiver Extension Request

- **MassHealth anticipates submitting its 1115 Demonstration Waiver Extension Request**, for the waiver period beginning in July 2022, to CMS by Fall of 2021

- MassHealth has begun stakeholder engagement for this process, and anticipates releasing **additional detail** on its 1115 demonstration extension proposal for **public comment in Summer and Fall 2021**

- MassHealth has identified **5 preliminary goals** for the next waiver to build upon success of the current waiver and identify gaps:
    1. Continue the path of restructuring and **re-affirm accountable, value-based care** – holding a high bar for ACOs to refine the model
    2. Make **reforms and investments in Primary Care, Behavioral Health and Pediatric Care** that expand access and move the delivery system away from siloed, fee-for-service health care
    3. **Advance health equity**, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals
    4. **Sustainably support the Commonwealth's safety net** – including level, predictable funding for safety net providers
    5. **Simplify the MassHealth delivery system** for members and providers

Appendix

- Additional context slides on the 2018 re-structuring
- Quality and member experience: additional slides
- Lists of MassHealth CPs, detail on CP engagement
- DSRIP funding detail by entity and funding stream

Context: What are MassHealth Accountable Care Organizations?

- ACOs are health care organizations that are rewarded for **better health outcomes, lower cost, and improved member experience**

- ACOs are responsible for achieving these results through **team-based care coordination** and integration of behavioral and physical health care; ACOs are also responsible for taking a whole person view of their members, including long term services and supports and health related social needs

- MassHealth members enrolled in an ACO select, or are assigned, a **specific primary care provider** and have **access to networks of specialty providers** (e.g., hospitals, specialists, behavioral health providers) that participate in their plan

- ACOs assume **upside and downside risk** and are financially accountable for specific quality measures
  - **The 1115 waiver does not assume savings in the first 2 years** of the ACO program. Starting in the third year (2020), the state is accountable for savings, ramping up to 2.1% savings (off baseline trend) by Year 5

- ACOs represent a **diverse range of provider systems:**
  - Hospital-based and community primary care-based ACOs
  - Large, statewide and regional ACOs
  - Provider-led and provider-health plan partnership ACOs

Context: What are MassHealth Community Partners?

- Community Partners (CPs) contract with ACOs to provide **wrap-around expertise and support for behavioral health (BH) services and long-term services and supports (LTSS)**

- CPs serve **the most complex ACO members**, with serious mental illness, substance use disorders, co-occurring disorders, or disabilities that require long-term services and supports

- CPs are paid to **engage** these members and collaborate with the health care system to **coordinate and improve** their care

- CPs are **community-based organizations** with expertise in supporting the populations they serve

Context: What is the Delivery System Reform Incentive Payment (DSRIP) Program?

- CMS authorized **$1.8B** in **one-time** DSRIP funding for **upfront investments in the delivery system.**

- Funding is divided among **3 main streams** over 5 years:

ACOs	CPs	Statewide Investments
$1B	**$550M**	**$115M**

- ACOs and CPs use funding to **launch innovative programs** and coordinate care for their members. Funding is **tied to performance on quality and the total cost of care**
  - $1B ACO allocation include **$150M allocated for Flexible Services** investments, which provide goods and services to address **health-related social needs**. See p. 41-44 for more detail

- DSRIP funding is **time limited and ends in 2022**

Overview of clinical quality and member experience

- MassHealth identified the ACO and CP measure slates in alignment with CMS and stakeholder input:
  - ACOs have **20 clinical quality** measures and **2 member experience** measure areas: overall care delivery and integration
  - BH CPs have **12 clinical quality** measures and **1 member experience** measure
    - **6 of 12 clinical** measures overlap with the ACO measure slate
  - LTSS CPs have **8 clinical quality** measures and **1 member experience** measure
    - **3 of 8 clinical quality** measures overlap with the ACO measure slate

- 2019 was the first "pay for performance" year for ACO quality. The first pay for performance year for CP quality was 2020
  - In 2018, ACOs were **accountable for reporting** complete and accurate data on all clinical quality and member experience measures
  - In 2019, ACOs were **financially accountable for their performance** on 9 of these measures, which all had benchmarks pre-established.
  - In 2020, CPs were **financially accountable for their performance** on 13 measures *(measurements pending)*

ACO slate: 22 clinical quality and member experience measures

	Measures	First Performance Year
1.	Follow Up After Emergency Dept. Visit for Mental Illness	2020
2.	Poor Control of HbA1c Levels (Diabetes Care)	2019
3.	Follow Up After Hospitalization for Mental Illness	2019
4.	Metabolic Monitoring for Children or Adolescents on Antipsychotics	2019
5.	Initiation and Engagement of Alcohol, Opioid or other Drug Use Treatment	2019
6.	Appropriate Medications for Asthma	2019
7.	Controlling High Blood Pressure	2020
8.	Screening for Depression and Follow Up Plan	2021
9.	Unplanned Hospital Readmissions	2021
10.	Childhood Immunizations	2019
11.	Adolescent Immunizations	2019
12.	Timeliness of Prenatal Care	2019
13.	Health Related Social Needs Screening	2021
14.	Emergency Department Visits for Individuals with Serious Mental Illness or Addiction	2021
15.	Community Tenure	2021
16.	Acute Unplanned Hospital Admissions for Diabetes	2021
17.	Depression Remission/Response	2021
18.	Behavioral Health Community Partner Engagement	2021
19.	Long Term Service and Supports Community Partner Engagement	2021
20.	Oral Health Evaluation	2021
21.	Overall Quality of Care	2019
22.	Integration/ Care Coordination	2021

20 Clinical Quality Measures

2 Member Experience Measures

CP slate: Clinical quality and member experience measures

BH/LTSS #	Measures	BH CP	LTSS CP	ACO Crossover
1	Community Partner Engagement	X	X	X
2	Annual Treatment/Care Plan Completion	X	X	
3	Enhanced Person-Centered Care Planning	X	X	
4	Follow-up with CP after acute or post-acute stay (3 days)	X	X	
5	Follow-up with CP after ED visit	X		X
6	Annual primary care visit	X	X	
7.A	Initiation of Alcohol, Opioid, or Other Drug Abuse of Dependence Treatment	X		X
7.B	Engagement of Alcohol, Opioid, or Other Drug Abuse of Dependence Treatment	X		X
8	Follow-up After Hospitalization for Mental Illness (7 days)	X		X
9	Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication	X		
10	Antidepressant Medication Management	X		
11	ED Visits for Adults with SMI, Addiction or Co-occurring Conditions	X		X
12	Hospital Readmissions	X	X	X
13	Oral Health Evaluation		X	X
14	All-Cause ED visits		X	
15	Member Experience: Member Engagement and Care Planning	X	X	X

Clinical quality: list of 13 measures with benchmarks and scores

	Measure	Description
1	Follow Up After ED for Mental Illness	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge
2	Comprehensive Diabetes Care: HbA1c Poor Control*	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (>9.0%)
3	Follow Up After Hospitalization for Mental Illness	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge
4	Metabolic Monitoring for Children or Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing
5a & 5b	Initiation and Engagement of AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive 2 or more additional services within 30 days of the initiation visit
6	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled
7	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age who had an outpatient visit with a screening for depression and a follow-up plan if the screen was positive
8	Hospital Readmissions*+ ^	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age
9	Childhood Immunizations	Percentage of members who received all recommended immunizations by their 2nd birthday
10	Adolescent Immunizations	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series
11	Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment
12	Depression Remission and/or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score
13	Health Related Social Needs	Percentage of members who were screened for health-related social needs in the measurement year

** Lower score is better* *+ Reported as observed/expected rate* *^Benchmarks pending finalization from CMS*

Note: for purposes of efficiency, some measure titles have been abbreviated

How to read the quality measure charts on upcoming slides

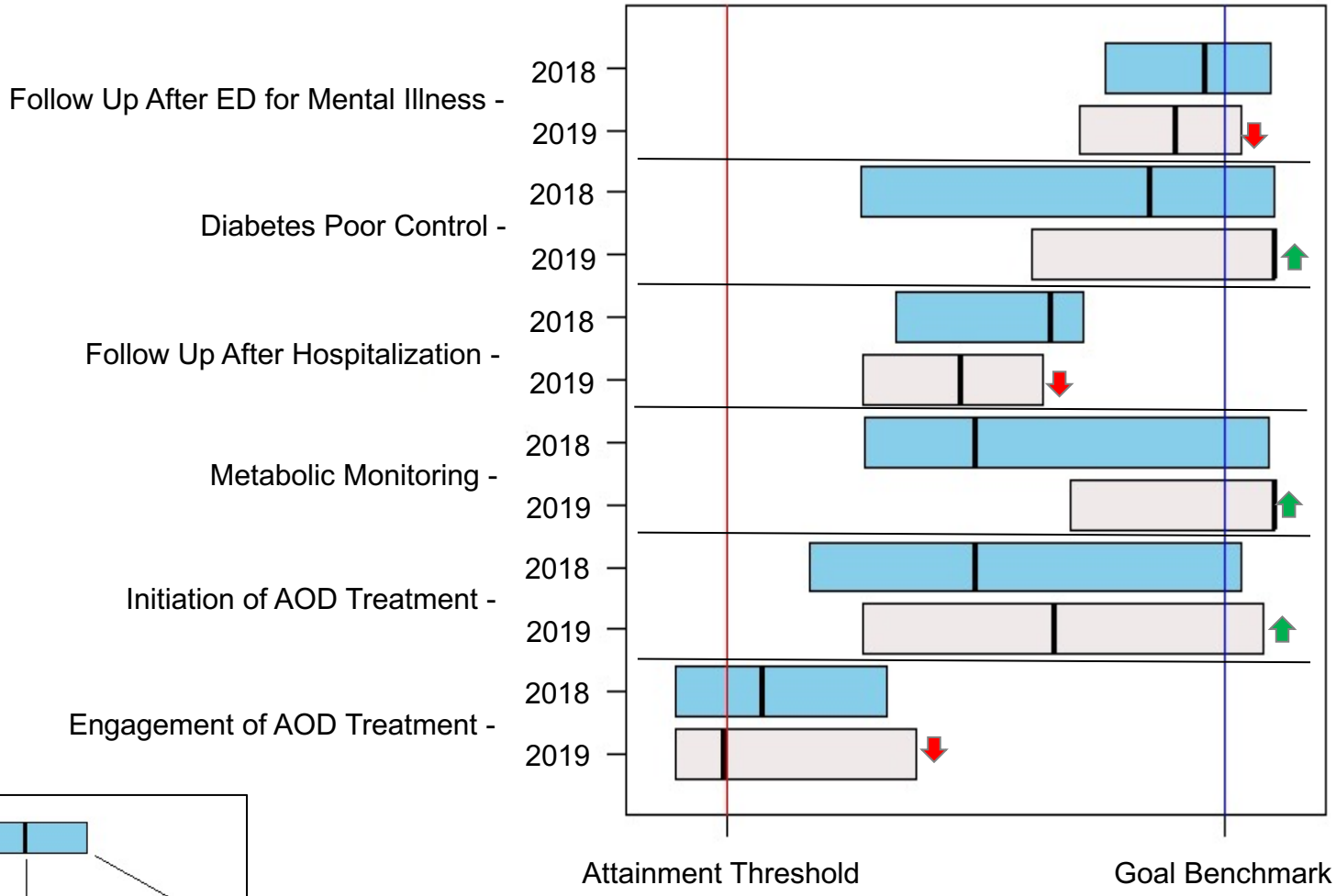
Charts are shown that **summarize key information** about ACO quality performance.

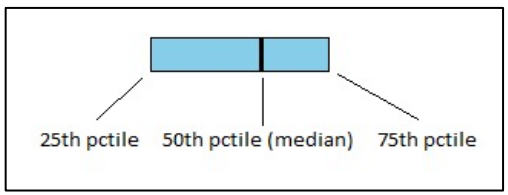
- The **distribution of ACO performance** for each measure is represented by a rectangle; the left bound is the **25th percentile** ACO performance. The right bound is the **75th percentile**; the thick black line in the middle represents the **median.**

- This chart allows easy comparison of this distribution against the **attainment threshold and goal benchmark** by lining these up (the red line and blue line, respectively); because the attainment threshold and goal benchmark values actually **vary from measure to measure**, lining them up like this requires the **scale for each measure to vary as well.**

- Therefore, these charts show how ACOs performed and how they varied **relative to the benchmarks**, but the bars are not to scale with each other and should not be used to determine the **relative performance between one measure and another.**

Clinical quality: Overview of measure scores and comparisons to 2018 (1 of 2)

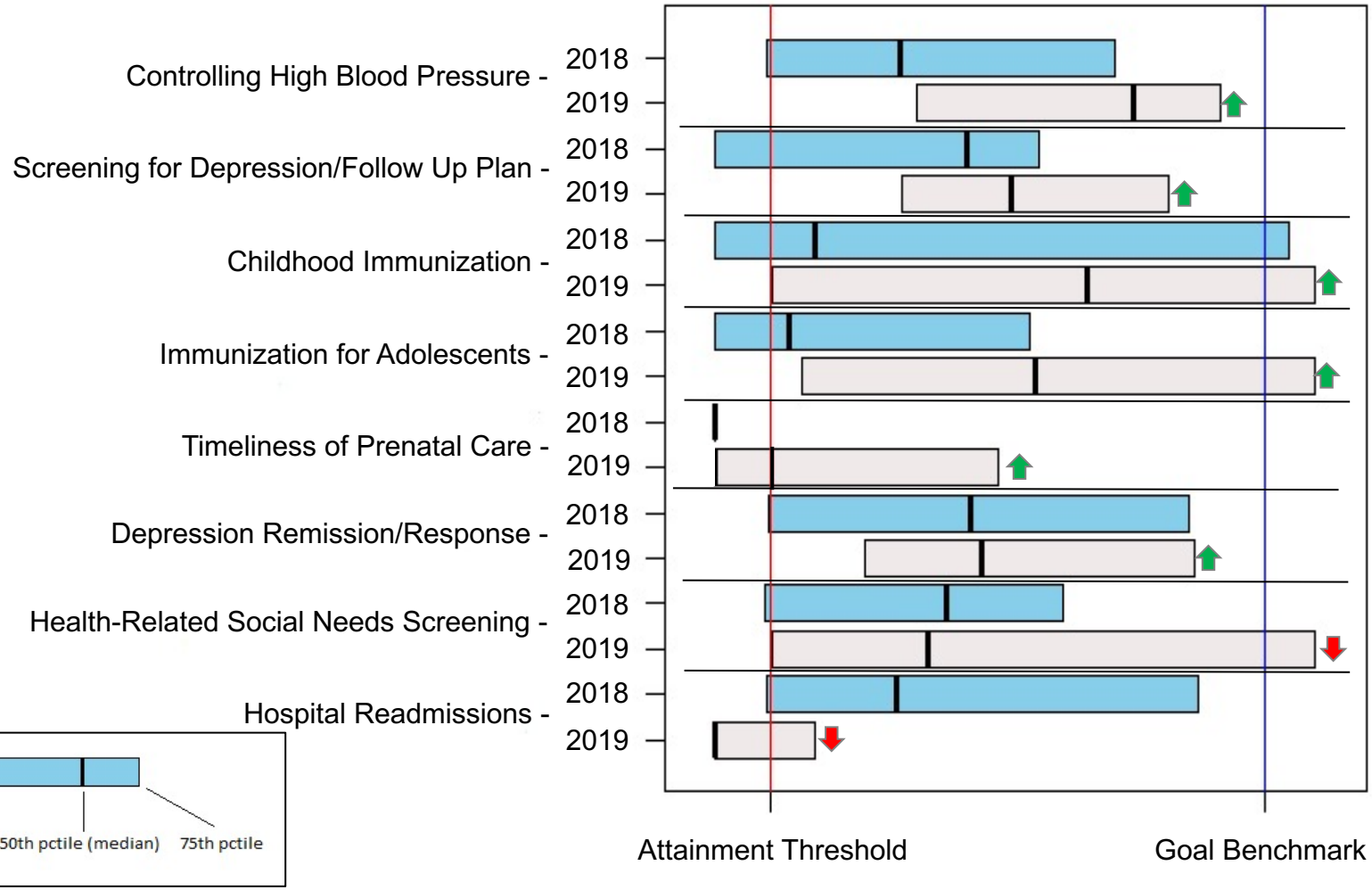




Please note:

- These charts show how ACOs performed and how they varied relative to the benchmarks, but the bars are not to scale with each other, and should not be used to determine the relative performance between one measure and another.
- Initiation and Engagement of AOD Treatment: This measure is reported as 2 rates.
- **For exact values see following slides.**

Clinical quality: Overview of measure scores and comparisons to 2018 (2 of 2)



Please note:

- These charts show how ACOs performed and how they varied relative to the benchmarks, but the bars are not to scale with each other, and should not be used to determine the relative performance between one measure and another.
- Timeliness of Prenatal Care: There is little variation among ACO 2018 scores on this measure; to a large extent (as compared to other measures), this measure requires ACOs to collect data from providers in other healthcare systems, which ACOs reported to be challenging, especially in the transition year of 2018.
- **For exact values see following slides.**

Detailed quality results (1 of 5)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Follow Up After ED Visit	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge	0 – 100	2018	75.8	73.0	77.5	62.6	76.3
			2019	75.6	72.2	77.5		
Comprehensive Diabetes Care: A1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (>9.0%)	0 – 100 *(lower is better)*	2018	31.9	36.7	26.8	39	30.6
			2019	29.3	33.8	26.9		
Follow Up After Hospitalization for Mental Health*	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	0 – 100	2018	51.2	45.5	52.4	39.1	57.7
			2019	48.2	42.7	52.1		
Metabolic Monitoring for Children or Adolescents on Antipsychotics*	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	0 – 100	2018	35.8	33.8	42.3	31	40.5
			2019	46.7	42.6	53.4		

*Indicates statistically significant difference between 2018 and 2019 scores

Detailed quality results (2 of 5)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Initiation AOD Treatment*	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis	0 – 100	2018	43.5	39.0	50.6	36.8	50.2
			2019	45.6	39.5	51.2		
Engagement AOD Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who receive 2 or more additional services within 30 days of the initiation visit	0 – 100	2018	16.9	14.3	18.8	16.4	23.8
			2019	16.3	14.0	19.2		
Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had appropriate medications	0 – 100	2018	62.2	57.9	64.4	57.2	67.5
			2019	TBD	TBD	TBD		

*Indicates statistically significant difference between 2018 and 2019 scores

Detailed quality results (3 of 5)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Controlling High Blood Pressure*	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	0 – 100	2018	67.2	63.6	72.8	63.6	76.7
			2019	73.2	67.6	75.5		
Depression Screen Follow Up Plan*	Percentage of members 12 to 64 years of age who had an outpatient visit with a screening for depression and a follow-up plan if the screen was positive	0 – 100	2018	40.2	19.9	45	28.0	58.3
			2019	42.9	36.2	52.4		
Hospital Readmissions *	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age	0 – 1.0 *(lower is better)*	2018	0.94	1.0	0.8	1.0	0.75
			2019	1.1	1.1	0.98		
Child Immunization*	Percentage of members who received all recommended immunizations by their 2nd birthday	0 – 100	2018	49.9	40.2	60.2	48.9	59.4
			2019	55.7	49.1	63.7		

*Indicates statistically significant difference between 2018 and 2019 scores

Detailed quality results (4 of 5)

Measure	Description	How it is scored	Year	Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Immunizat-ions for Adolescents*	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	0 – 100	2018	32.2	26.9	39.6	31.4	49.4
			2019	41.1	33.2	53.7		
Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	0-100	2018	80.8	71.6	84.7	86	93.6
			2019	86.4	80.3	91.0		
Health Related Social Needs	Percentage of members who were screened for health-related social needs in the measurement year	0-100	2018	9.5	1.5	14.6	1.5	23.5
			2019	6.8	2.4	32.9		
Depression Remission and/or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who received follow-up evaluation with PHQ-9 and experienced response or remission in 4 to 8 months following the elevated score	0-100	2018	4.8	1.6	8.3	1.7	9.2
			2019	4.9	3.2	8.1		

*Indicates statistically significant difference between 2018 and 2019 scores

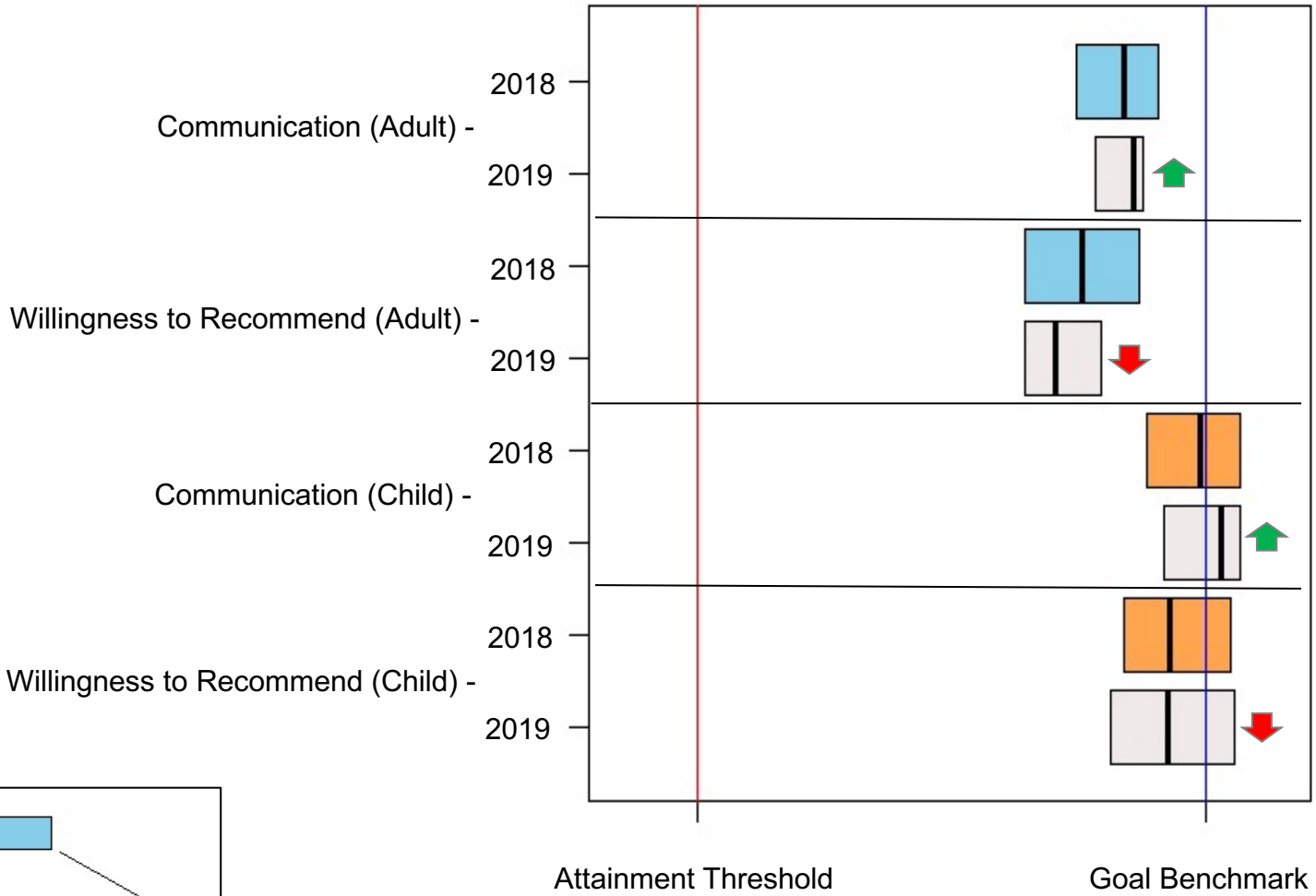
Detailed quality results (5 of 5): MES Performance Measures

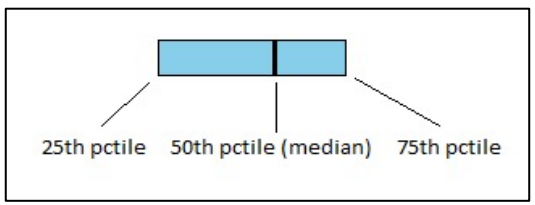
Measure	Description	How it is scored	Survey Group	Year	Median Score	Lowest/ 25th percentile	Highest/ 75th percentile	Attainment Threshold	Goal Benchmark
Willingness to Recommend	Overall measure of the experience and the provider	0 – 100	Adult	2018	87.9	86.0	89.8	75.0	92.0
				2019	87.0	86.0	88.5		
			Child	2018	90.8	89.3	92.8	75.0	92.0
				2019	90.7	88.8	92.9		
Communication	Effective communication between provider and patient or caregiver	0 – 100	Adult	2018	89.3	87.7	90.4	75.0	92.0
				2019	89.6	88.3	89.9		
			Child	2018	91.8	90.0	93.1	75.0	92.0
				2019	92.5	90.6	93.1		
Integration of Care	Effective coordination of services (e.g., labs, referrals, follow-up, and information exchanged between provider, patient, and services)	0 – 100	Adult	2018	79.8	77.7	81.8	70.0	85.0
				2019	79.9	78.0	81.0		
			Child	2018	78.4	77.4	81.1	70.0	85.0
				2019	80.4	77.6	81.0		
Knowledge of Patient	Provider knowledge of important medical information about patient and understanding patient's challenges to staying healthy	0 – 100	Adult	2018	84.1	81.6	85.1	70.0	85.0
				2019	84.1	82.2	84.6		
			Child	2018	87.6	85.5	89.3	75.0	90.0
				2019	87.4	86.4	88.8		

*Indicates statistically significant difference between 2018 and 2019 scores

^Benchmarks pending finalization from CMS

Member experience – Overall Care Delivery: Overview of measure scores and comparisons to 2018 (1 of 2)

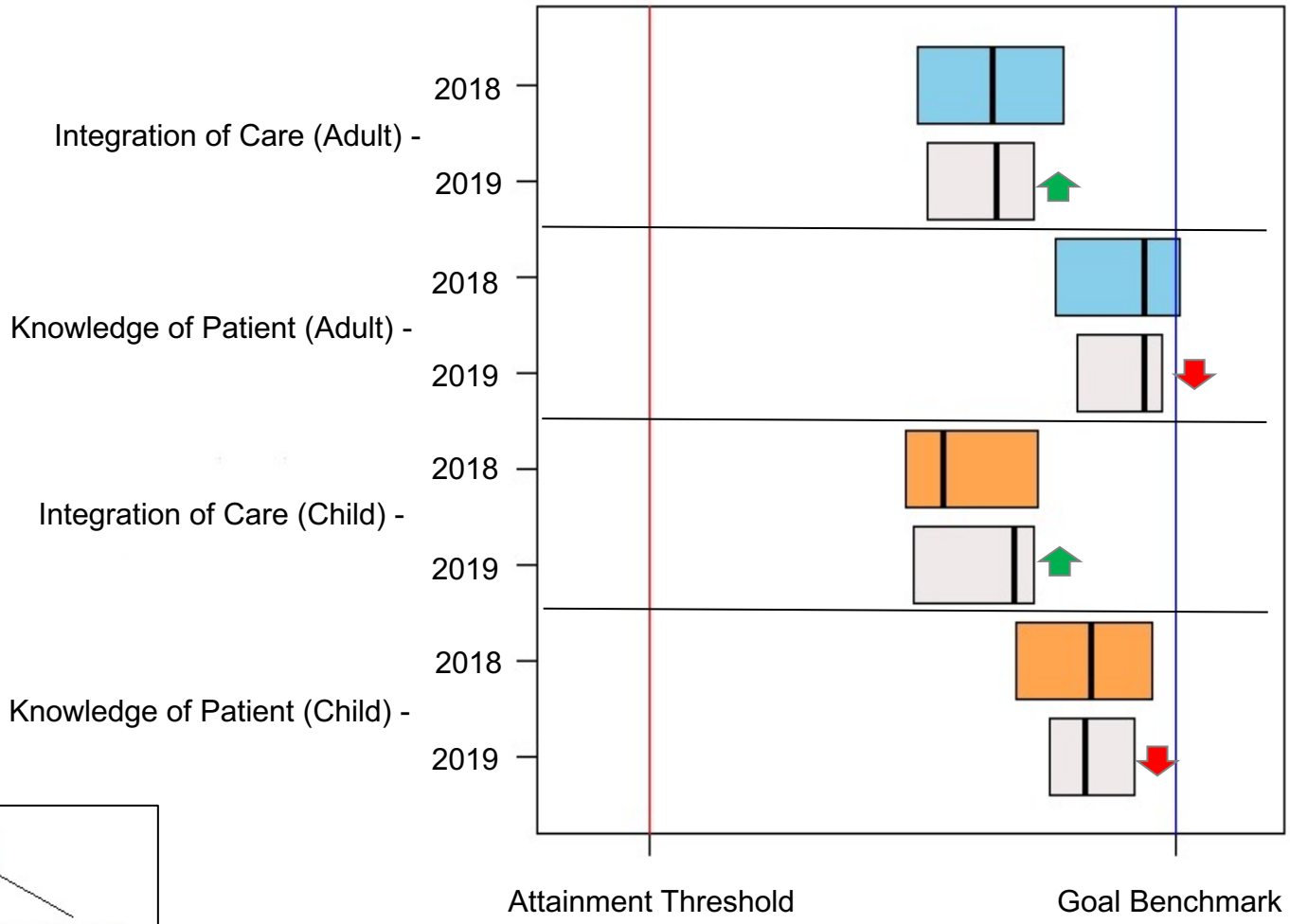


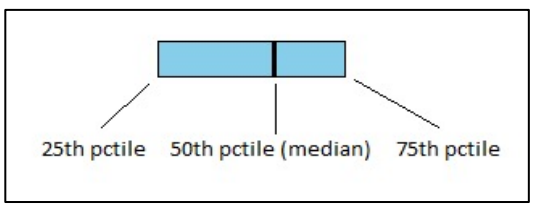


Please note:

- These charts show how ACOs performed and how they varied relative to the benchmarks, but the bars are not to scale with each other, and should not be used to determine the relative performance between one measure and another.
- **For exact values see Appendix.**

Member experience – Integration/Coordination of Care: Overview of measure scores and comparisons to 2018 (2 of 2)





Please note:

- These charts show how ACOs performed and how they varied relative to the benchmarks, but the bars are not to scale with each other, and should not be used to determine the relative performance between one measure and another.
- **For exact values see Appendix.**

Primary Care Member Experience Measure Performance

	Performance Measure	2018 Aggregate Statewide Score	2019 Aggregate Statewide Score	Threshold	Goal
21	Overall Care Delivery	90.0	89.9	75.0	92.0
22	Integration/Coordination of Care	83.2	83.2	71.25	86.25

** 2018 aggregate scores were updated from last year to provide direct comparison to 2019 (unadjusted statewide scores).*

Detail: Overall Care Delivery (#21)

Question Topics	Description	Adult/ Child	Statewide Score		Threshold	Goal
			2018	2019		
Willingness to Recommend	Overall measure of the experience and the provider	Adult	**87.1**	**86.8**	75.0	92.0
		Child	**91.3**	**91.6**		
Communication	Effective communication between provider and patient or caregiver	Adult	**89.2**	**88.9**	75.0	92.0
		Child	**92.3**	**92.4**		

Detail: Integration/Coordination of Care (#22)

Question Topics	Description	Adult/ Child	Statewide Score		Threshold	Goal
			2018	2019		
Integration of Care	Effective coordination of services (e.g., labs, referrals, follow-up, and information exchanged between provider, patient, and services)	Adult	**80.5**	**80.2**	70.0	85.0
		Child	**80.7**	**81.1**	70.0	85.0
Knowledge of Patient	Provider knowledge of important medical information about patient and understanding patient's challenges to staying healthy	Adult	**83.7**	**83.3**	70.0	85.0
		Child	**88.1**	**88.1**	75.0	90.0

Member Experience: Additional Primary Care Composites & Questions

Question topics	Description	Adult/ Child	Statewide Score	
			2018	2019
Self-Management Support	Provider engagement with patients to talk about their goals for their health and things that make it hard to take care of their health	Adult	63.1	63.1
		Child	51.2	54.4
Behavioral Health*	Provider engagement with patients to talk about their behavioral health needs	Adult	64.9	68.0
Child Development**	Provider engagement with patients to talk about their child's physical, emotional and social development	Child	71.0	72.1
Pediatric Prevention**	Provider engagement with patients to talk about their child's home environment (addressing exercise, food, computer, safety etc)	Child	67.3	68.5
Office Staff	Helpfulness of the office staff, and being treated with courtesy and respect	Adult	86.4	86.4
		Child	86.9	87.1
Organizational Access	Access to timely routine and urgent appointments, and same day response to questions	Adult	80.7	80.3
		Child	86.1	85.8
Overall Provider Rating	Rating of provider	Adult	88.3	88.0
		Child	91.1	91.6
Child Provider Communication**	Effective communication between provider and patient	Child	95.7	95.7

*There is no BH Child composite in the Primary Care survey.

**These composites are in the Child Primary Care survey only.

Member Experience: Behavioral Health Composites (Sets of Questions)

For members receiving behavioral health services, **most child composites increased** in scores from MY2018 to MY2019 while more **adult composite scores deceased**

Question topics	Description	Adult /Child	Statewide Score	
			2018	2019
Willingness to Recommend	Overall measure of the experience and the provider(s)	Adult	80.6	79.4
		Child	79.5	81.2
Communication	Effective communication between provider and patient	Adult	86.8	85.6
		Child	87.1	87.8
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information about the patient	Adult	72.2	71.3
		Child	74.8	78.4
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	73.8	69.9
		Child	75.0	71.0
Services Helpful	Services helpful in daily living activities	Adult	59.3	60.4
		Child	64.7	65.3
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	56.2	58.2
		Child	53.4	56.0
Needs Met BH	How well needs for mental health service, substance use treatment, and prescription medication were met	Adult	81.8	72.1
		Child	77.5	70.8
Service Scheduling	Access and availability to services	Adult	75.3	75.2
		Child	74.4	77.0
Overall Rating	Rating of overall behavioral health services in the last 12 months	Adult	75.6	74.7
		Child	75.7	77.0

Member Experience: LTSS Composites (Sets of Questions)

LTSS member experience will be a **priority investigation and improvement area** for ACOs going forward

Question topics	Description	Adult/Child	Statewide Score	
			2018	2019
Willingness to Recommend	Overall measure of the experience with LTSS services	Adult	86.0	84.9
		Child	86.2	82.3
Communication	Effective communication between provider and patient	Adult	86.3	86.3
		Child	85.6	85.5
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information	Adult	76.7	74.3
		Child	75.3	64.2
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	75.9	71.3
		Child	76.3	71.3
Services Helpful	Services helpful in daily living activities	Adult	59.2	58.3
		Child	69.2	63.2
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	75.8	73.8
		Child	71.6	61.4
Needs Met - Core Services	How well needs for core LTSS services were met (e.g., physical therapy, skilled nursing, day programs)	Adult	82.8	74.8
		Child	81.8	71.3
Needs Met – Non-core Services	How well needs for non-core LTSS services were met (e.g., assistive technology, transportation services)	Adult	84.0	78.3
		Child	83.0	77.8
Service Scheduling	Access to and availability of services	Adult	81.7	81.5
		Child	81.0	79.1
Overall Rating	Rating of overall LTSS services	Adult	78.5	75.1
		Child	78.0	74.6

Additional member experience questions: areas for monitoring in primary care survey

Question topics	Description	Adult/ Child	Statewide Score
Self-Management Support	Provider engagement with patients to talk about their goals for their health and things that make it hard to take care of their health	Adult	63.1
		Child	51.2
Behavioral Health	Provider engagement with patients to talk about their behavioral health needs	Adult	64.9
		Child	*Not Applicable
Child Development	Provider engagement with patients to talk about their child's physical, emotional and social development	Child	71.0
Pediatric Prevention	Provider engagement with patients to talk about their child's home environment (addressing exercise, food, computer, safety etc)	Child	67.3
Office Staff	Helpfulness of the office staff, and being treated with courtesy and respect	Adult	86.4
		Child	86.9
Organizational Access	Access to timely routine and urgent appointments, and same day response to questions	Adult	80.7
		Child	86.1
Overall Provider Rating	Rating of provider	Adult	88.3
		Child	91.1
Child Provider Communication	Effective communication between provider and patient	Child only	95.7

*There is no BH child composite in the primary care CAHPS survey. Please note a separate child BH survey was tested this year as part of the ACO program and is under evaluation.

Additional member experience questions: behavioral health survey

MassHealth developed a new tool to survey experience of behavioral health services for the first time.

The tool does not yet have validated benchmarks, but because of the importance of this unique lens on the performance of the healthcare system, MassHealth is **reporting baseline aggregate data** from this survey and may use these composites in future member experience scores.

Question topics	Description	Adult/Child	Statewide Score
Willingness to Recommend	Overall measure of the experience and the provider(s)	Adult	80.6
		Child	79.5
Communication	Effective communication between provider and patient	Adult	86.8
		Child	87.1
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information about the patient	Adult	72.2
		Child	74.8
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	73.8
		Child	75.0
Services Helpful	Services helpful in daily living activities	Adult	59.3
		Child	64.7
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	56.2
		Child	53.4
Needs Met	How well needs for mental health service, substance use treatment, and prescription medication were met	Adult	81.8
		Child	77.5
Service Scheduling	Access and availability to services	Adult	75.3
		Child	74.4
Overall Rating	Rating of overall behavioral health services in the last 12 months	Adult	75.6
		Child	75.7

Additional member experience questions: LTSS survey

MassHealth developed a new tool to survey experience of long term services and supports for the first time.

The tool does not yet have validated benchmarks, but because of the importance of this unique lens on the performance of the healthcare system, MassHealth is **reporting baseline aggregate data** from this survey and may use these composites in future member experience scores.

Question topics	Description	Adult/Child	Statewide Score
Willingness to Recommend	Overall measure of the experience with LTSS services	Adult	86.0
		Child	86.2
Communication	Effective communication between provider and patient	Adult	86.3
		Child	85.6
Care Plan	Effective care planning including identification and assessment of needs, services included in the plan, & member choice of providers and services	Adult	75.9
		Child	76.3
Care Coordinator	Help in obtaining assistance with referrals or services; knowledge of the patient as a person and important medical information	Adult	76.7
		Child	75.3
Teamwork	Effectiveness of teams working together to provide needed care and services	Adult	75.8
		Child	71.6
Services Helpful	Services helpful in daily living activities	Adult	59.2
		Child	69.2
Needs Met - Core Services	How well needs for core LTSS services were met (e.g., physical therapy, skilled nursing, day programs)	Adult	82.8
		Child	81.8
Needs Met – Non-core Services	How well needs for non-core LTSS services were met (e.g., assistive technology, transportation services)	Adult	84.0
		Child	83.0
Service Scheduling	Access to and availability of services	Adult	81.7
		Child	81.0
Overall Rating	Rating of overall LTSS services	Adult	78.5
		Child	78.0

The following HEDIS measures are Adjusted, Unaudited, HEDIS Rates:

- Asthma Medication Ratio
- Initiation and Engagement of Alcohol or Drug Abuse or Dependence Treatment
- Controlling High Blood Pressure
- Childhood Immunization Status
- Prenatal and Postpartum Care: Timeliness
- Immunizations for Adolescents
- Comprehensive Diabetes Care: A1c Poor Control
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Follow Up After Emergency Department Visit for Mental Illness (7-Days)
- Follow Up After Hospitalization for Mental Illness (7-Days)
- Plan All Cause Readmissions

BH CPs

- MassHealth has contracted with eighteen (18) BH CPs throughout the state.
- CPs are contracted to cover certain Service Areas.

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Behavioral Health Network, Inc.		**Western:** Holyoke, Springfield, Westfield
Behavioral Health Partners of Metrowest, LLC	• *Advocates, Inc.* • *South Middlesex Opportunity Council* • *Spectrum Health Systems, Inc.* • *Wayside Youth and Family Support, Family Continuity (FCP), Inc.*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Boston Coordinated Care Hub	• *McInnis Health Group/Boston Health Care for the Homeless Program* • *Bay Cove Human Services, Inc.* • *Boston Public Health Commission* • *Boston Rescue Mission, Inc.* • *Casa Esperanza, Inc.* • *Pine Street Inn, Inc.* • *St. Francis House; Victory Programs, Inc.* • *Vietnam Veterans Workshop, Inc.*	**Greater Boston:** Boston Primary
Brien Center Community Partner Program		**Western:** Adams, Pittsfield
Central Community Health Partnership	• *The Bridge of Central Massachusetts* • *Alternatives Unlimited, Inc.* • *LUK, Inc.* • *Venture Community Services* • *AdCare*	**Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester

BH CPs (cont.)

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Clinical and Support Options, Inc.		**Central:** Athol **Western:** Adams, Greenfield, Northampton, Pittsfield
Community Counseling of Bristol County		**Southern:** Attleboro, Brockton, Taunton
Community Healthlink, Inc.		**Central:** Gardner-Fitchburg, Worcester
Community Care Partners, LLC	• *Vinfen Corporation* • *Bay Cove Human Services, Inc.*	**Greater Boston:** Boston Primary, Revere, Somerville, Quincy **Northern:** Haverhill, Lawrence, Lowell, Lynn, Malden, Salem **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, Wareham
Coordinated Care Network	• *High Point Treatment Center* • *Brockton Area Multi Services, Inc. (BAMSI)* • *Bay State Community Services, Inc.* • *Child & Family Services, Inc.* • *Duffy Health Center* • *Steppingstone, Inc.*	**Greater Boston:** Quincy **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, Wareham
Eliot Community Human Services, Inc.		**Greater Boston:** Revere, Somerville **Northern:** Beverly, Gloucester, Lowell, Lynn, Malden, Salem, Woburn **Central:** Framingham, Waltham

BH CPs (cont.)

BH CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Innovative Care Partners, LLC	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*	**Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
Lowell Community Health Center, Inc.	• *Lowell House, Inc.*	**Northern:** Lowell
Lahey Health Behavioral Services		**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn
Riverside Community Partners	• *Brookline Community Mental Health Center, Inc.* • *The Dimock Center, Inc.* • *The Edinburg Center, Inc.* • *North Suffolk Mental Health Association, Inc.* • *Upham's Corner Health Center*	**Greater Boston:** Boston Primary, Revere, Somerville, Quincy **Northern:** Lowell, Lynn, Malden, Woburn **Central:** Framingham, Southbridge, Waltham
Southeast Community Partnership	• *South Shore Mental Health Center, Inc.* • *Gosnold, Inc.* • *FCP, Inc. dba Family Continuity*	**Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham
South Shore Community Partnership	• *South Shore Mental Health Center, Inc.* • *Spectrum Health Systems, Inc.*	**Greater Boston:** Quincy
Stanley Street Treatment and Resources (SSTAR) Care Community Partners	• *SSTAR* • *Greater New Bedford Community Health Center, Inc.* • *HealthFirst Family Care Center, Inc.* • *Fellowship Health Resources, Inc.*	**Southern:** Attleboro, Barnstable, Fall River, Falmouth, New Bedford, Oak Bluffs, Orleans, Taunton, Wareham

LTSS CPs

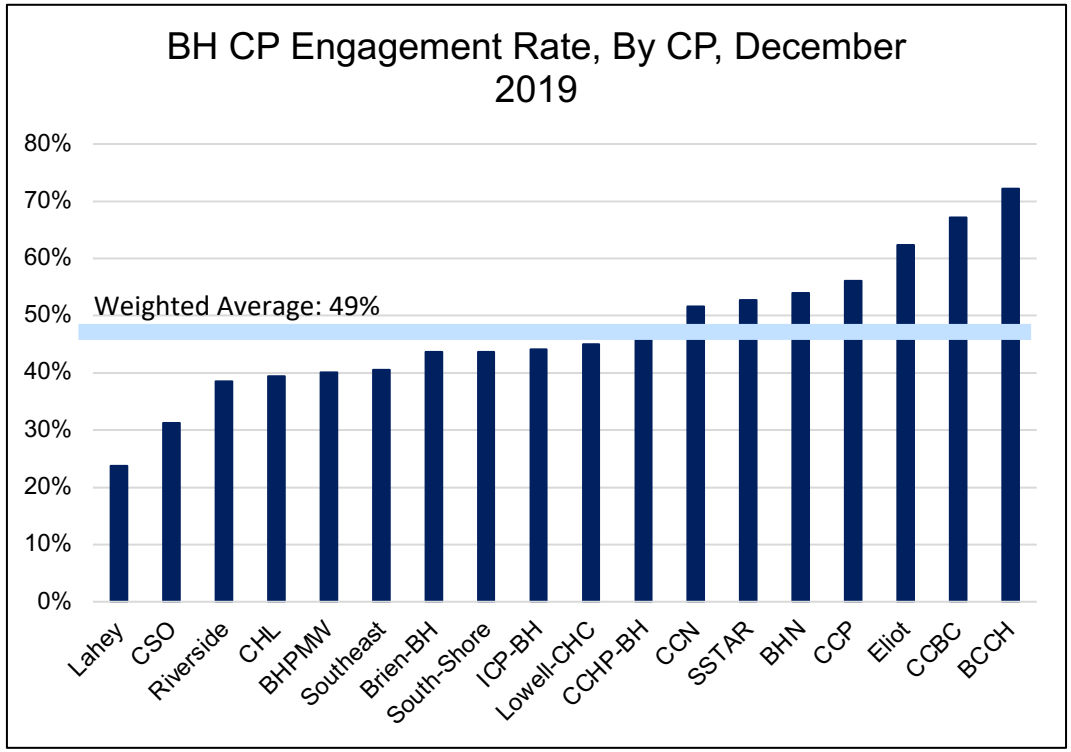
- MassHealth has contracted with nine (9) LTSS CPs throughout the state.
- CPs are contracted to cover certain Service Areas.

LTSS CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Boston Allied Partners	• *Boston Medical Center Corporation* • *Boston Senior Home Care, Inc.* • *Central Boston Elder Services* • *Southwest Boston Senior Services d.b.a Ethos*	**Greater Boston:** Boston-Primary
Care Alliance of Western Massachusetts	• *WestMass Elder Care, Inc.* • *Greater Springfield Senior Services, Inc.* • *Highland Valley Elder Services, Inc.* • *LifePath, Inc.* • *Elder Services of Berkshire County, Inc.* • *Stavros Center for Independent Living* • *Behavioral Health Network, Inc.*	**Central:** Athol **Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
Central Community Health Partnership	• *Alternatives Unlimited* • *The Bridge of Central Massachusetts, Inc.* • *LUK, Inc.* • *Venture Community Services, Inc.* • *AdCare*	**Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester
Family Service Association		**Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham

LTSS CPs (cont.)

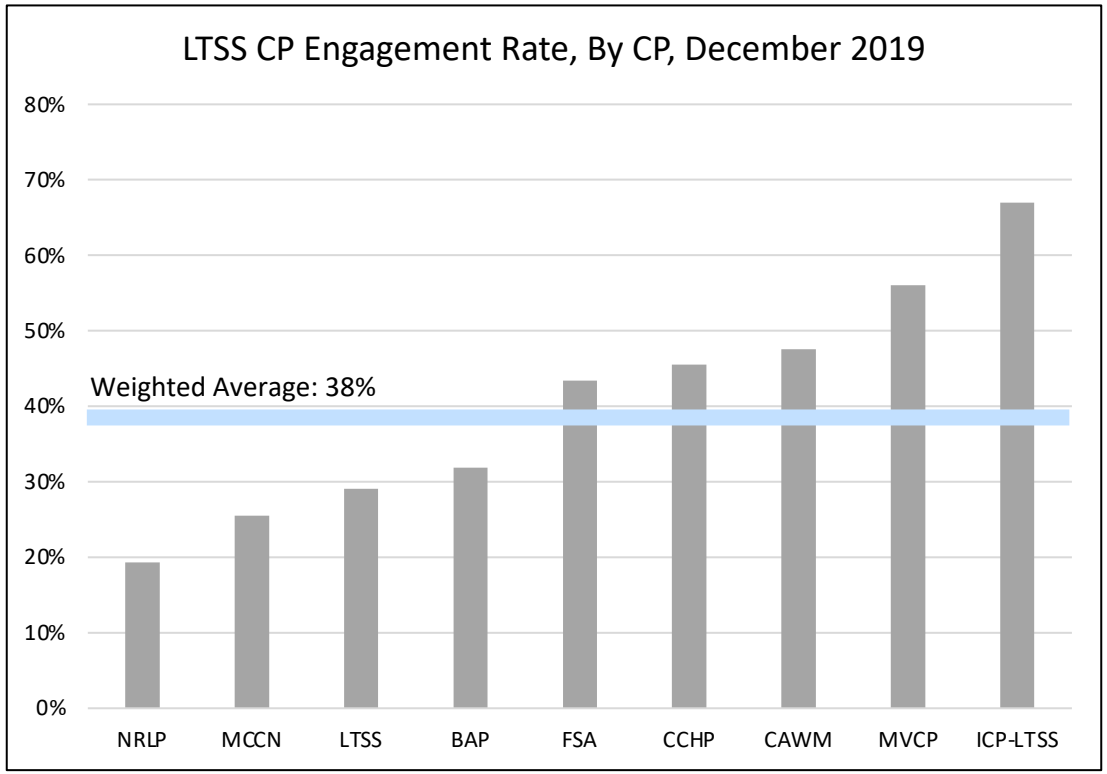
LTSS CPs	Consortium Entities and Affiliated Partners	Service Areas Covered by Region
Innovative Care Partners, LLC	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*	**Western:** Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield
LTSS Care Partners, LLC	• *Vinfen* • *Bay Cove Human Services* • *Justice Resource Institute* • *Boston Center for Independent Living* • *Mystic Valley Elder Services* • *Somerville Cambridge Elder Services* • *Boston Senior Home Care, Inc.*	**Greater Boston:** Boston-Primary, Revere, Somerville, Quincy **Northern:** Malden **Southern:** Brockton
Massachusetts Care Coordination Network	• *Advocates, Inc.* • *Boston Center for Independent Living, Inc.* • *HMEA* • *BayPath Elder Services, Inc.* • *Brockton Area Multi Services, Inc. (BAMSI)*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn **Southern:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham **Central:** Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Merrimack Valley Community Partnership	• *Elder Services of Merrimack Valley* • *Northeast Independent Living*	**Northern:** Haverhill, Lawrence, Lowell
North Region LTSS Partnership	• *Bridgewell, Inc.* • *Northeast Arc, Inc.*	**Northern:** Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn

CPs' performance varies (BH CP)



- BH CPs' rates of member engagement **vary by 48 percentage points** from the lowest (24%) to the highest (72%)
- There are many potential reasons for engagement rates to vary, including variation in the **underlying population**, **geographic spread**, and the rate at which CPs and ACOs **dis-enroll members** they are unable to engage
- Still, this variation indicates **significant opportunity for some CPs to improve** by leveraging best practices

CPs' performance varies (LTSS CP)



- LTSS CPs' rates of member engagement **vary by 48 percentage points** from the lowest (19%) to the highest (67%)
- There are many potential reasons for engagement rates to vary, including variation in the **underlying population**, **geographic spread**, and the rate at which CPs and ACOs **dis-enroll members** they are unable to engage
- Still, this variation indicates **significant opportunity for some CPs to improve** by leveraging best practices

DSRIP Startup/Ongoing Funding by ACO

ACO Name	CY2019 Expenditures*
Atrius Health	$5.5M
Boston Accountable Care Organization	$26.8M
Baystate Health Care Alliance	$8.1M
Boston Children's Health ACO	$13.1M
Health Collaborative of the Berkshires	$3.1M
Beth Israel Deaconess Care Organization	$6.2M
Community Care Cooperative	$26.1M
Cambridge Health Alliance	$7.0M
Lahey Health	$1.5M
Mercy Medical Center	$5.7M
Merrimack Valley ACO	$6.8M
Partners HealthCare Choice	$14.5M
Reliant Medical Group	$4.9M
Signature Healthcare	$4.0M
Steward Health Choice	$26.9M
Southcoast Health	$2.6M
Wellforce	$10.8M
Total	**$173.7M**

*Includes Startup/Ongoing expenditures only, no Flexible Services expenditures

DSRIP Funding by CP

CP Name	CY2019 Infrastructure Expenditures	CY2019 Care Coordination Payments
Alternatives Unlimited, Inc.	$0.6M	$0.3M
Behavioral Health Network	$2.1M	$1.7M
Behavioral Health Partners of Metrowest	$2.7M	$2.6M
Boston Alliance Partners	$0.7M	$0.4M
Boston Health Care for the Homeless	$0.9M	$2.0M
Brien Center	$1.0M	$0.7M
Care Alliance of Western MA	$1.1M	$0.6M
Clinical and Support Options	$0.7M	$0.5M
Community Care Partners	$2.3M	$3.4M
Community Counseling of Bristol County	$1.1M	$3.1M
Community Healthlink	$0.7M	$0.9M
Eliot Community Partner	$2.0M	$2.2M
Family Service Association	$0.9M	$0.5M
Greater Lowell Behavioral Health	$1.2M	$0.9M
High Point Treatment Center	$2.3M	$2.6M
Innovative Care Partners, LLC LTSS	$0.6M	$2.2M
Innovative Care Partners, LLC. BH	$1.5M	$0.6M
Lahey Health and BH Services	$2.5M	$1.5M
LTSS Care Partners	$1.1M	$0.5M
Massachusetts Care Coordination Network	$1.4M	$0.6M
Merrimack Valley CP	$0.8M	$0.3M
Northern Region LTSS Partner	$0.8M	$0.1M
Riverside Community Care, Inc	$0.9M	$1.7M
Southeast	$1.4M	$1.9M
Southshore	$0.9M	$0.7M
Stanley Street Treatment and Resources	$1.4M	$1.9M
The Bridge of Central Massachusetts, Inc.	$1.6M	$1.1M
TOTAL	**$35.1M**	**$35.3M**

DSRIP funding by Statewide Investments program

Program	Funding as of 12/31/19
Community-Based Workforce	
Student Loan Repayment Program	$3,614,105
Behavioral Health Workforce Development Program	$970,560
Community Partners (CP) Recruitment Incentive Program	$230,000
Primary Care/Behavioral Health Special Projects Program	$925,000
Family Medicine/Family Nurse Practitioner Residency Program	$1,955,000
Community Mental Health Center (CMHC) Behavioral Health (BH) Recruitment Program	$1,690,000
Subtotal | Community-Based Workforce	$9,384,665
Frontline Workforce	
Community Health Worker (CHW) Training Capacity Expansion Grant Program	$403,000
Peer Specialist Training Capacity Expansion Grant Program	$258,000
Community Health Worker (CHW) Supervisor Training Grant Program	$181,750
Competency-Based Training Program	$2,078,000
Subtotal | Frontline Workforce	$2,920,750
Capacity Building for ACOs, CPs, CSAs, and Providers	
Technical Assistance Program for ACOs and CPs	$9,308,675.79
Community Health Center (CHC) Readiness Program	$1,000,000
Standardized Online Training for CPs and CSAs	$233,557.37
Alternative Payment Methods (APM) Preparation Fund	$0
Subtotal | Capacity Building for ACOs, CPs, CSAs, and Providers	$9,642,233.16
Initiatives to Address Statewide Gaps in Care Delivery	
Enhanced Diversionary Behavioral Health Activities	$0
Accessibility Improvement Program	$2,600,000
Subtotal | Initiatives to Address Statewide Gaps in Accessibility	$2,554,959.46
Total Statewide Investments Spending Thru 12/31/19	**$25,402,607.62**