

ATTACHMENT APR

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

PART 1: PY3 PROGRESS REPORT EXECUTIVE SUMMARY

General Information

Full ACO Name:	Mass General Brigham ACO
ACO Address:	399 Revolution Drive, Somerville, MA 02145

Part 1. PY3 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

Mass General Brigham's participation in the MassHealth ACO program was inspired by the desire to reduce total cost of care while at the same time improving quality and access to care. Our aim is to increase care coordination so that unnecessary utilization and admissions may decrease. Our leading indicators, and program goals were designed with our overarching aims in mind.

For the third year of the program, MGB ACO's high level goals include reducing overall PMPM to 1% below market, improving quality performance, improving member experience scoring on the MassHealth annual survey and integration of health-related social needs resources via the Aunt Bertha platform. We strive to achieve these goals by reducing utilization, increasing integration and engagement, and continually working to improve quality. Our program specific metrics are designed to enable analysis on the impacts on the Medicaid ACO population and inform future programmatic development.

ACO program goals	
Goal #	Goal Category & Description
1	Cost and Utilization Mgmt (Medical Trend): Reduce overall PMPM trend for 2020 to 1% below market.
1.a	<i>Sub goal #1: Reduce 2020 rate of Non-SUD related BH IP Admissions for Adults by 5% compared to 2018 performance</i>
1.b	<i>Sub goal #2: Reduce 2020 rate of Non-SUD related BH Ip Admissions for Children by 5% compared to 2018 performance</i>
1.c	<i>Sub goal #3: Reduce utilization trend for Facility Outpatient Emergency Department in 2020 to 2.5%</i>
2	Cost and Utilization Mgmt (Operational efficiency): N/A
3	Quality: Improve performance on Childhood Immunization Measure in 2020 by 2% over 2018 performance*.

4	Quality: Improve performance on Immunization for Adolescents in 2020 by 2% over 2018 performance*.
5	Quality: Improve performance on Controlling High Blood Pressure in 2020 by 1% over 2018 performance*.
6	Quality: Improve performance of A1C Poor Control by 1% over 2018 performance*.
7	Member experience: Increase Knowledge of Patient score for both Pedi and Adult by 1% as measured by MassHealth.
8	Integration of physical health, BH, LTSS, and health related social needs: Successful implementation of Aunt Bertha in 100% of RSOs for Flexible Services and consideration for expansion completed by end of PY3.

*Determine 2021 and 2022 targets based on updated annual performance

Leading Indicators	
Goal #	Indicator
1	Decrease medical trend as measured in the internal quarterly ACO Efficiency Report
3-6	Improve quality metrics as measured in quarterly IPF report
7	Improvement on member experience on our internal Member Experience Report as of July 2020
8	On-time completion of tasks from Aunt Bertha Integration project plan

Program specific metrics	
Program 1 name:	iCMP
Applicable DSRIP Investments:	S/O P/D: 1
Measure #	Measure
1	Enrollment - target # of patients enrolled is 3%-5% of Medicaid ACO population (adult)
2	Care Plan – increase % of completed Care Plans to 95%
3	Post Discharge – increase % of post-discharge follow-up calls for ED and medical in-patients to 75%
4	Inpatient Admissions - Decrease in monthly inpatient admissions
5	Time to enrollment - Decrease # of days from identification to enrollment/engagement to 45 days
Program 2 name:	iCMP PLUS
Applicable DSRIP Investments:	S/O P/D: 4
Measure #	Measure
1	Enrollment - # of patients enrolled (not engaged) through 12/31/2020: 325 patients
2	Inpatient admissions – decrease in monthly inpatient admissions
3	ED visits – decrease in monthly ED visits

4	<i>Post Discharge – increase % of post-discharge follow up calls for ED and medical inpatient to 95%</i>
5	<i>Care Plans – increase % of completed care plans to 90%</i>
6	<i>Time to enrollment – decrease # of days from identification to enrollment/engagement (goal: <90 days)</i>
Program 3 name:	Collaborative Care
Applicable DSRIP Investments:	<i>S/O P/D: 2, 3</i>
Measure #	Measure
1	<i>Enrollment - # of patients enrolled through 12/31/2020: 15% increase</i>
2	<i>PHQ-9 score - avg point change of 3.5 for IMPACT completers in 2019</i>
3	<i>GAD-7 score - avg point change of 4 for IMPACT completers in 2019</i>
Program 4 name:	Community Partners
Applicable DSRIP Investments:	<i>S/O D: 10</i>
Measure #	Measure
1	<i>Assessments - Increase # assessments completed for LTSS patients who are active, benchmark: 50% completion rate</i>
2	<i>Signed Care Plans - Increase in # of care plans signed for LTSS and BH patients who are active, benchmark: 45% completion rate</i>
3	<i>Engagement - Increase in # of patients engaged for LTSS and BH support who have been identified or referred, Benchmark: 45%</i>
Program 5 name:	Recovery Coaches
Applicable DSRIP Investments:	<i>S/O P/D: 2, 3</i>
Measure #	Measure
1	<i>Referrals - # of patients referred through 12/31/2020: 10% increase</i>
2	<i>Enrollment - # of patients enrolled through 12/31/2020:10% increase</i>
3	<i>Outreach - # of patient outreach completed by recovery coaches 12/31/2020: 10% increase</i>
Program 6 name:	ED Navigator
Applicable DSRIP Investments:	<i>S/O D: 5</i>
Measure #	Measure
1	<i>Enrollment – 20 initial patient outreach encounters per week</i>
2	<i>Referrals –1.5 referrals made per patient to PCP sites, PHM programs, community-based resources to address unmet health-related social needs, and other existing resources</i>
3	<i>ED Visits – decrease in re-presentation at ED within 12 months</i>
4	<i>IP admission - decrease in re-presentation at ED within 12 months</i>

Program 7 name:	SDOH Screening and Referral
Applicable DSRIP Investments:	<i>S/O D: 10</i>
Measure #	Measure
1	<i>Increase # of primary care sites screening for SDOH to 133</i>
2	<i>Increase # of patients screened to 113,000</i>

1.2 PY3 Investments Overview and Progress toward Goals

MGB ACO's investment strategy has been to expand our existing Population Health Management infrastructure in addition to incorporating new elements that are specifically designed for the MassHealth population. In PY3, we were able to have all DSRIP funded programs operational and implemented. However, due to COVID, many programs pivoted to support our most at-risk members. This involved educational materials and phone calls, as well as assisting with accessing COVID testing and planning the roll out of the COVID vaccine. Despite these challenges, we were able to progress towards our overarching goals of reducing cost and utilization while increasing member engagement and quality.

In PY3, a significant portion of funding went towards the iCMP Plus program, a program created for the Medicaid ACO in partnership with Commonwealth Care Alliance (CCA). This program provides specialized, intensive home or community-based care management for our most complex Medicaid ACO members. While conducting a formal evaluation in PY3, Medicaid ACO members in our iCMP Plus program showed positive outcomes that directly tied back to our ACO overall goal of reducing cost and providing high quality care.

Another investment that has demonstrated progress towards our goals was the ED Navigator program. In the PY3 evaluation, the ED Navigator program showed positive outcomes when connecting patients back to primary care, as well as less utilization of the Emergency Department. Furthermore, during COVID, the ED Navigator program was able to successfully pivot to a virtual model, while also increasing the number of patients they were able to connect to primary care and social service organization.

Additionally, a significant portion of our funding went towards program management. This investment is for the staff that run the Medicaid ACO program at a central level and at the RSOs. Although there was some turnover and reorganization at the beginning of PY3, staffing has now stabilized, and we are fully staffed for our program management investment. The program management investment ties to all ACO goals, as the funding ensures we are able to accurately staff for the individuals running DSRIP funded programs, ensure our Medicaid ACO members are receiving the best care, and be able to achieve our program enrollment goals.

Lastly, another significant investment that helped the ACO move towards our overarching goals was our Collaborative Care Program. In PY3, the Collaborative Care Program completed an evaluation that showed the programs efficacy for patients with depression and anxiety, tying to our increased member

satisfaction and member's quality of life. In PY4, the program is working internally to improve ED boarding for our members with a behavioral health diagnosis.

1.3 Success and Challenges of PY3

Successes:

In PY3, the ACO was able to ensure Aunt Bertha, our resource navigation platform, was accessible to 100% of the primary care practices in the ACO. Aunt Bertha was integrated into Epic, as well as through a web portal version for sites that are on other electronic health record systems. Aunt Bertha's accessibility for our primary care practices aligns directly with our ACO's goal of integration of physical health, BH, LTSS and health related social needs. Furthermore, Aunt Bertha integration is one of our leading indicators. In PY4, we will look to further utilize Aunt Bertha in our day to day workflows.

A major success in PY3 has been the process improvement work for the Community Partners program. In PY2 and PY3, the CP team utilized Technical Assistance (TA) funding to assess current state of the CP program, as well as complete a preliminary evaluation of the BH CP program. In PY4, the CP program will once again engage with the TA vendor, Health Management Associates, to facilitate patient focus groups to learn more about the patient journey and experience. Furthermore, the central CP team has worked on processes to decrease the time a care plan takes to get signed, fine tuning identification of members who will benefit the most from the CP program, as well as beginning to provide select CPs with read-only access of our electronic health record, thus further integrating them into the patient's care team.

Overall, the ACO is very pleased with the results of their DSRIP funded program evaluations. With the exception of the CP program, all programs studied showed positive outcomes that tied to reduction in total cost of care, quality of life, or better connectivity to their primary care doctors. As noted above, we have been working on process improvements for the CP program.

Challenges:

As with most ACOs, COVID presented us with unique challenges in PY3. This included; how to continue to connect with patients who might not have access to the internet, educating members on the importance of mask wearing and social distancing, and maintaining needed care. Our care teams have been able to ensure that patients can connect virtually, and we were able to develop and disseminate the tools needed to do so. Some programs were not able to scale as once was planned given the pandemic. The ED Navigator program was slated to expand to a community site in PY3. However, due to COVID and the redeployment of many of the existing ED navigators, expansion plans were paused until PY4.

An additional challenge for the MGB ACO was the number of initial partners for the Community Partners program. At the start of the program, the MGB ACO was partnered with all CPs, as we are a statewide ACO. The ACO found that the quantity of partnerships made it difficult to streamline services, as well as work on specific process improvements that could be applied to multiple CPs. The MGB ACO is thankful

that MassHealth implemented preferred CP relationships. Preferred CP relationships have allowed the ACO to better assess their current partners and work on specific aspects of care to improve patients' experience and outcomes. Furthermore, it has allowed the ACO to begin identifying the best patient fit for each CP's unique strengths. In PY4, the MGB CP program will continue their process improvement work from PY3.