ATTACHMENT A

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

PART 1: ACO SUMMARY

General Information

Full ACO Name:	Partners HealthCare Choice
ACO Address:	399 Revolution Drive, Somerville MA

Part 1. Executive Summary

1.1 ACO Composition and Governance Structure

1.1.1 A. Governance Structure

Partners HealthCare Accountable Care Organization, LLC, was recently formed by Partners and Partners Community Physicians Organization, Inc. (PCPO) to manage both its Medicare and MassHealth ACO programs. The Partners HealthCare Accountable Care Organization, LLC Board of Managers (the "ACO Governing Board") will oversee the new public-payer ACO contracts and programs and will meet all requirements of the MassHealth ACO RFR. The Certificate of Organization of Partners HealthCare Accountable Care Organization, LLC is attached.

Partners providers participate in value-based contracts with commercial healthcare insurers through contracts executed and managed by Partners and PCPO. Partners and PCPO formed Partners HealthCare Accountable Care Organization, LLC to manage the Medicare and MassHealth ACO programs because neither Partners nor PCPO have a governing body that meets the governing body requirements of the Medicare and MassHealth ACO programs.
A variety of provider types are represented on the ACO Governing Board, including primary care providers practicing at both academic medical centers and in the community. The ACO Governing Board is also comprised of Partners senior managers and a consumer advocate. The list of individuals who currently serve on this the ACO Governing Board is below.

At all times during the Contract Term, the ACO Governing Board membership will be seventy-five percent controlled by providers or their designated representatives and will include representation from at least one consumer or consumer advocate. Membership will be expanded to include representation from mental health and substance use disorder treatment providers to comply with MassHealth ACO requirements. The Governing Board may also add a second consumer or consumer advocate who is a MassHealth member and the Board will strive to include advocates with experience representing consumers with disabilities.

Regina Villa, the current consumer advocate on the Governing Board, has had a long and distinguished career in health care. She started her professional life as a Registered Nurse and worked as an advocate for equitable disability policy and consultant before starting her own media business. Ms. Villa has served as the Executive Director of Massachusetts Nurses Association, a Congressional staffer, and as president

and owner of her own firm. The ACO Governing Board will review the professional background and work history of any additional consumer or consumer advocate representatives that are considered for the ACO Governing Board. Once a member of the ACO Governing Board, the role and specific duties of the consumer or consumer advocate will include general obligations of other members and application of fiduciary duty and consumer advocacy. Formal education will not be required for this role but many opportunities for informal training will be provided. Typical activities will include attendance and participation at scheduled ACO Governing Board meetings.

All ACO Governing Board members have equal voting rights and are empowered to make recommendations regarding key clinical and operational matters. The ACO Governing Board makes decisions on matters affecting the ACO, including those that may impact different Affiliated Providers and Network Providers in different ways, after receipt of input and recommendations from the Partners provider management infrastructure through the Partners Operating Units Committee and from the advisory committees described below.

Following review and approval by the ACO Governing Board, decisions made by the ACO Governing Board are transmitted to participating providers for execution. The senior vice president and the vice president of Population Health Management for the ACO, who also serve as senior vice president and vice president of Population Health Management for Partners, lead these communications. They also utilize the management infrastructure of Partners' Department of Population Health Management to properly execute the decisions.

There are several advisory committees for the Partners system which the ACO Governing Board leverages to introduce and vet new strategic priorities. Among these committees, the Performance Oversight Committee is comprised of senior medical and financial leaders from across the Partners system and provider network. These leaders are listed below. They have the authority to make system-wide recommendations around all medical and financial matters within the provider network.

The Performance Advisory Committee and the Community Performance Oversight Committee are comprised of managers responsible for medical management and the performance risk-based contracts across the network. These committees review strategies and priorities and make recommendations to the Performance Oversight Committee regarding risk based contracting related matters. A separate system-wide committee for primary care provides additional input related to primary care matters for risk-contracts. In addition to the system-wide committees, the leadership of Partners Population Health Management meet with local clinical management teams of provider groups participating in the ACO.

Lastly, the ACO Governing Board has a Quality Committee comprised of clinical experts from each participating Partners organization/affiliate. The ACO Governing Board will expand membership to include representatives from additional specialties and sites, including community health centers. As part of participation in the MassHealth ACO, the ACO Governing Board will develop more direct partnerships with the existing Patient and Family Advisory Committees at each facility.

Governing Board:

NAME	TITLE
Sree Chaguturu, MD	VP, Population Health Management, Partners HealthCare, MGH and MGPO
Sandhya Rao, MD	Medical Director, Medicare ACO, Partners HealthCare
Eric Weil, MD	Medical Director, Medicaid ACO
Stephen Black-Schaffer, MD	Chief of Education, Massachusetts General Hospital
Dave Connolly	Chief Financial Officer, Partners Community Physicians Organization
Jessica Dudley, MD	Vice President for Care Redesign & Chief Medical Officer, Brigham & Women's Physicians Organization
Terry Garfinkle, MD	Chief Medical Officer, PCPO
Peter Markell	Chief Financial Officer, Partners HealthCare
Gregory Martin, MD	Chief Medical Officer, Emerson Hospital
Maury McGough, MD	President, North Shore Health System
Gregg Meyer, MD	Chief Clinical & Safety Officer, Partners HealthCare
Lynn Stofer	President, PCPO
Marshall Moriarity	N/A
Brent Forester, MD	Medical Director, Behavioral Health Integration
Jessica Moschella-Mead	Executive Director, Emerson PHO

Partners Performance Oversight Committee

Chairperson: Sree Chaguturu, MD

Ken Adams, MD, Partners Community Physicians Org., Pentucket Medical practice
Sally Mason Boemer, Senior Vice President for Finance, Massachusetts General Hospital
Joseph Bergen, DO, Physician, Emerson Hospital
Phil Ciaramicoli, Executive Director, Tri-County Medical Associates
Dave Connolly, Vice President of Finance, Partners Community Physicians Org.
Marcela del Carmen, MD, Medical Director, Massachusetts General Physicians Org.
Jessica Dudley, MD, CMO, Brigham and Women's Physician Org.
Christopher Dunleavy, SVP and CFO, Brigham and Women's Hospital
Timothy Ferris, MD, CEO Mass General Physician Organization
Terry Garfinkle, MD, CMO, Partners Community Physicians Org.
Jim Heffernan, CFO and Treasurer, Massachusetts General Physicians Org.
Steve Jenney, CFO, Brigham and Women's Physician Org.
Allen Kachalia, MD, Associate Chief Quality Officer, Brigham and Women's Hospital
Peter Markell, SVP of Finance and Administration and Treasurer, Partners HealthCare
Gregg Meyer, MD, Chief Clinical Officer, Partners HealthCare
Liz Mort, MD, VP of Quality and Safety, Massachusetts General Hospital
Jeff Murphy, VP, Provider Network Performance, Newton Wellesley Physician-Hospital Org.
Mitch Rein, MD, CMO and SVP for Medical Affairs, North Shore Health System
Tom Sequist, MD, Chief Quality Officer, Partners HealthCare
Vinnie McDermott, SVP and CFO, Newton Wellesley Hospital

Mary Shaughnessy, VP of Finance and Planning, Partners Continuing Care

Partners HealthCare Accountable Care Organization Quality Committee

Amy L. Feeney, Partners HealthCare PHM
Sreekanth K. Chaguturu, M.D., Partners HealthCare PHM
Neil Wagle, M.D.,M.B.A., Partners HealthCare PHM
Kathleen Moran Garland, Partners HealthCare PHM
Karl R. Laskowski, M.D.,M.B.A., Brigham and Women's Physicians Organization
Sarah Lenz, Massachusetts General Physicians Organization
Sandra M. O'Keefe, Massachusetts General Physicians Organization
Jennifer Barberio, Newton Wellesley
Kathleen O'Sullivan, North Shore Health System
Nancy Cardin-Jolicoeur, TriCounty Medical Associates
Diane Bradley, Partners Community Physicians Org., Pentucket Medical practice
Denise Mackenzie, Partners HealthCare PHM

1.2 ACO Population Served

The ACO must provide the number of members attributed to the ACO, as provided in Section I of the ACO's PY1 DSRIP Funding Notification Letter, and the Service Area(s) for which the ACO is contracted (Accountable Care Partnership Plans, only). Additionally, the ACO must provide an assessment of the populations and communities that the ACO will serve, highlighting: (1) any unique characteristics of the ACO's population, such as demographic composition, breakdown of disease burden, etc.; (2) an assessment of population- and community-specific needs; and (3) any challenges the ACO anticipates in serving this population. EOHHS is not asking or requiring the ACO to conduct a formal Community Health Needs Assessment. Rather, EOHHS is seeking a descriptive overview of the population and the general needs.

Attributed Members:

104,603.

Mapped Members by Regional Service Organization (RSO):

RSO	Oct Membership
APP (Affiliated Pediatric Practices)	13,184
BWH (Jen Center and health centers)	7,902
BWPO	6,847
Harbor Medical	174
Cooley Dickinson	10,122
Emerson	2,569
MGH (IMA, peds and health centers)	19,681
MGPO	4,080

Martha's Vineyard	1,814
Nantucket	1,221
NSHS	1,352
NSPG	4,945
Pentucket Medical Associates/PCPO	10,875
Tri County Medical Associates	3,763
Total:	88,529

Pediatric Breakdown by RSO:

APP	402	12782	97.0%	13184
Amity Medical Associates (Closed - Formerly Cooley)	37	2	5.1%	39
BWH	3753	4149	52.5%	7902
BWPO	6639	208	3.0%	6847
BWPO/HMA	132	42	24.1%	174
Cooley	7962	2160	21.3%	10122
Emerson	263	2306	89.8%	2569
MGH	7456	12225	62.1%	19681
MGPO	2772	1320	32.3%	4092
MVH	632	1182	65.2%	1814
NCH	537	684	56.0%	1221
NSHS	1328	381	22.3%	1709
NSPG	4423	522	10.6%	4945
PMA/PCPO	4496	6379	58.7%	10875
Tri County	2129	1634	43.4%	3763

Disease Prevalence by Cost Category Early Data from EOHHS:

Table 4.3 - Prevalence of Top 10 Conditions by Members' Cost Group

Top 5% Highest Cost Members		Next 10% Highest Cost Members		85% Lowest Cost Members	
Condition		Condition		Condition	
Drug/Alcohol Abuse, (both Dependence and w/o Dependence)	41%	Drug/Alcohol Abuse, (both Dependence and w/o Dependence)	29%	Asthma	9%
Major Depressive, Bipolar, Paranoid	36%	Major Depressive, Bipolar, Paranoid	29%	Drug/Alcohol Abuse, (both Dependence and w/o Dependence)	8%
Hypertension	28%	Hypertension	20%	Hypertension	8%
Diabetes (w/ Complications and w/o Complications)	20%	Asthma	17%	Major Depressive, Bipolar, Paranoid	6%
Asthma	17%	Diabetes (w/ Complications and w/o Complications)	13%	Depression	5%
Depression	12%	Depression	12%	Attention Deficit Disorder	5%
Chronic Obstructive Pulmonary Disease	11%	Attention Deficit Disorder	10%	Diabetes (w/ Complications and w/o Complications)	3%
Disorders of Vertebrae/Spinal Discs	11%	Disorders of Vertebrae/Spinal Discs	8%	Disorders of Vertebrae/Spinal Discs	2%
Attention Deficit Disorder	9%	Chronic Obstructive Pulmonary Disease	4%	Osteoporosis and Other Bone/Cartilage	2%
Osteoporosis and Other Bone/Cartilage	8%	Osteoporosis and Other Bone/Cartilage	4%	Chronic Obstructive Pulmonary Disease	1%

Key Findings:

- Above our benchmark, with positive trend for IP admits, ED visits, Pharmacy, Radiology, and Lab
- Emergency visits and Inpatient visits are above the benchmark target
- A small number of high-cost members account for a disproportionate share of costs
- The top 15% of high-cost members had higher rates of BH disorders (but no difference between Top 5 and top 10%)
- Partners has lower rates of outpatient (28%) and inpatient (12%) behavioral health utilization (visits), perhaps reflecting underutilization

Opportunities:

- Reduce inpatient and emergency visits
- Increase outpatient behavioral health visits
- Address BH/SUDs needs of high-cost members (top 15%)
- Address lab, radiology, and pharmacy costs

Health, Functional and other Care Needs of Population

Partners has also looked to our Community Health Needs Assessment to identify the needs of the population in our Medicaid ACO. Each Partners Hospital conducts a Community Health Needs Assessment (CHNA) every 3 years for the populations and communities that each Hospital serves. In reviewing these CHNAs several common community health issues become clear.

Access to Care is a key theme evident across all CHNAs. While uninsurance rates remain low across the state, under-insurance and growing out of pocket costs are forcing many to go without care. Additionally, in some regions of the state it can be difficult to find available providers, especially in primary care and mental health. Furthermore, finding transportation to receive care can be especially challenging in non-urban communities.

Mental Health and Substance Use Disorders (SUDs) are pervasive issues that are inextricably linked. Mental Health issues include depression, anxiety, bipolar disorder, post-traumatic stress disorder, anger management issues, and, for elders, Alzheimer's and dementia. Among SUDs, opiate addiction is widely considered the most pressing across the state.

The availability, cost, and cultural accessibility of mental health and SUDs services were cited as challenges for community members needing support. Dealing with the stigma surrounding behavioral health and substance use issues and the lack of insurance coverage for continued treatment were also noted. Among transient populations (such as those who are homeless, very low-income, or recently released from prison), additional challenges arise because it is difficult for service providers to maintain contact with these clients and patients and to coordinate care. In general, there is a lack of affordable behavioral health providers, such as therapists, substance use disorder clinicians, and psychiatrists, in the community. More providers who accept insurance, and more treatment beds, especially in long-term residential treatment programs, are needed. Often current substance users are not eligible for certain community services from which they could greatly benefit.

Although substance abuse and mental health issues can affect all groups of people regardless of race/ethnicity, language, and income, the CHNAs highlighted the role poverty plays in exacerbating behavioral health challenges, particularly among the most vulnerable populations including homeless individuals, the elderly, immigrants and those recently released from prison. Stress from living in poverty can cause or exacerbate behavioral health issues and all too often the amount and quality of behavioral health treatment that an individual can access depends greatly on his or her financial resources.

Chronic Disease is broadly defined as a disease or condition that occurs over a long period and will likely impact an individual for the rest of their lives. They are considered to be a leading cause of mortality and include disease/conditions such as heart disease, stroke, hypertension, diabetes, cancer, asthma and many others. Significant health inequities persist across communities of color for all health conditions examined in these CHNAs.

Obesity and **Healthy Eating/Active Living (HEAL)** are closely related to Chronic disease. Many chronic conditions (i.e. heart disease, diabetes, asthma) can result from obesity, poor nutrition and inactivity. Addressing other unhealthy behaviors, such as **Alcohol** and **Tobacco Use**, can also positively impact chronic diseases in the communities served.

Social Determinants of Health - Even when financial obstacles to health care are removed, social, cultural, linguistic, racial, and socioeconomic barrier, the Social Determinants of Health, can prevent people from seeking care or following through on recommended treatment, and contribute to health inequities. Residents of color typically experience greater poverty, unemployment, lower educational

attainment and greater economic vulnerability. The association of these social and economic challenges with poorer health outcomes clearly points to the need for systemic approaches that provide a pathway to economic stability. In addition, these factors can lead to a culture and climate that fosters unhealthy behaviors and prevents people from living healthy lives. Risk-related behaviors and health outcomes generally have inverse relationships with socioeconomic factors.

Housing and **food insecurity** often go hand in hand, and the physical and emotional effects on children and adults are great. For older children, poor school performance is often correlated with housing and/or food insecurity.

Violence and **Trauma** present throughout some of our communities was a strong theme across both the qualitative and quantitative data, once again demonstrating that these issues disproportionately affect communities of color and individuals living in poverty. Violence impacts more than just the individuals immediately involved; it increases the stress and can result in persistent feelings of anxiety, and safety fears that greatly limit free movement in the community (including outdoor physical activity). It also negatively impacts on community cohesion and raises significant fears for children in the community and their future. These fears can impact youth development and long-term physical and mental health outcomes in adults.

Sexual Health and **Maternal/Child Health** - Significant racial and ethnic disparities persist when examining sexual health and maternal/child health data. Infant mortality and low birth weight rates in recent years have for the most part been decreasing. However, when comparing these by race, mortality amongst Black and Latino infants is twice as high as that of White infants and low birth weights can be 50% more common in Black and Latino infants than in White infants in certain communities. Although teen pregnancy rates have also been declining, certain communities were identified as having significantly higher teen birth rates than the rest of the state.

Environmental Impacts to Health - A growing body of evidence has emerged linking the health outcomes of patients with their surrounding Environment. Effects from extreme heat days (due to global warming), reduced air and water quality and severe storms/floods can cause illness, exacerbate chronic conditions and even be a cause of death.

Health Disparities - Certain vulnerable populations were also highlighted in these CHNAs. Significant Health Inequities persist and disproportionately impact communities of color. While efforts should continue to address specific health conditions, the systemic nature of these inequities necessitates a wider approach to have sustained impact. A racial equity ‘lens’ is key to understanding and working in partnership with communities on these issues.

Seniors are another vulnerable population identified by these CHNAs, and are at greater risk of injury from falls and generally have reduced mobility. These can cause both physical and mental health issues as well as a growing sense of isolation. This is especially prevalent in the Cape and Islands where a significantly larger portion of the population is over 65 than in the rest of the Commonwealth. Access to Senior mental health specialists is often limited.

Caregiver mental health was identified as a specific gap in services. It was noted that caregivers frequently experience depression and burn-out, and that while caregivers could benefit from social support and connections with other caregivers, these types of supports are not currently funded or generally available.

Adolescents - Growing concern about mental health and substance use by Adolescents was highlighted. Often there are not enough adolescent mental health providers and school-based prevention programs

available in the community. Common risk factors identified for children and youth include chaotic home environment, little parental attachment/engagement, academic failure or low academic aspirations, poor social coping skills, parental substance use or mental illness, and perceived external approval of drug use from peers, family or community.

Disabled individuals, defined broadly as any persons living with a variety of conditions (physical, cognitive, mental/psychiatric or perceptual/sensory in nature) that limit their daily activities, are a vulnerable population that requires targeted services and outreach by providers. These limitations can be the result of certain chronic diseases (e.g. Parkinson's Disease, Multiple Sclerosis, etc.) or an adverse health event (e.g. stroke, traumatic brain injury, etc.) and often make it challenging for these individuals to access health care and participate in public health interventions to improve health status.

1.3 Overview of DSRIP Investment Approach

A high-level summary describing how the ACO's investment approach will support the ACO's overall performance and strategy. The ACO should provide a one to two sentence summary for each of the following, briefly describing:

1. ACO Programmatic Strategy, inclusive of:
    a. Overall ACO approach to population health management and provider accountability
    b. Overall ACO approach to total cost of care management and path to sustainability
2. Goals for the DSRIP program that support overall ACO programmatic strategy
3. DSRIP Investment strategy that supports the stated goals
4. Anticipated challenges

Partners' vision for our MassHealth ACO is designed around the goal of improving the quality of care members receive, and their experience of that care, by ensuring more coordination that puts the patient at the center. At the same time, Partners aims to reduce unnecessary utilization such as ED visits and inpatient admissions that do not improve the health of our ACO members, and to ultimately reduce the total cost of care by providing patients with the right supports, in the right settings, and at the right times.

To achieve these goals, Partners plans to expand on our extensive Population Health Management strategy and make necessary adjustments to ensure our programming meets the needs of MassHealth patients. This vision includes expanding our high risk care management program, our behavioral health and substance use disorder integration programs, to engaging and enrolling all appropriate MassHealth ACO members into these programs. These programs are embedded in our primary care settings, supporting primary care providers at our practices and health centers. In addition, adjustments are being made to these programs to meet the needs of the population by adding more Community Health Workers, Social Workers, and SUDs Recovery Coaches. We are also investing in new programs to provide extensive wrap around care management and mobile primary care through a new collaboration with Commonwealth Care Alliance, for our highest risk, most challenging to engage patients. We are also piloting a new ED based position to improve member engagement and coordinate care for members at this critical point of contact. We are also developing a strategy for consistent system wide screening for

social determinants of health, and appropriate referral strategies to connect members too clinically and cost effective, supports. Where necessary we will also bolster our existing health IT, and PCMH infrastructure to implement this strategy. While Partners has made significant investments in these areas over many years, some additional support may be necessary to serve our MassHealth ACO population. It is important to note that we are also relying on our patient centered medical home model, where we are near full NCQA certification status across our primary care practices. This model supports care management across risk stratifications, and particularly for lower

Each of these strategies has been designed around the goals of truly integrated care, member-centeredness, improving care quality and access, and reducing unnecessary utilization and cost. Meeting these goals requires targeting our programs to the appropriate members, and meeting them where they are with culturally, linguistically, and clinically appropriate interventions.

Our vision, outlined above, which focuses on investment on high risk, high cost members, support for rising risk members with co-occurring behavioral health and substance use disorder diagnoses, and an Emergency Department engagement strategy is designed to manage total cost of care. We have found that 12 to 24 months of care management engagement is necessary in most cases to see total cost of care impact, and that longer engagement produces greater impact. Therefore, our sustainability model spreads investment out over the five year contract anticipating several years to find sufficient impact on total cost of care, and needed sustainability of the programs.

We anticipate challenges with regard to the claims data from EOHHs. Data delays and missing elements delayed program implementation in the Pilot, and now the full program. Because Partners providers have a great deal of autonomy, and approaches across the system vary, we anticipate having to continue to work toward programmatic approaches that balance needed uniformity on best practices with local autonomy and innovation. Finally, we have experienced some challenges around hiring given the competitive market for care management jobs, but have so far been able to mitigate these challenges.

1.4 Website

www.partners.org/MassHealthACO