



HEALTH | CHOICE

MASSACHUSETTS

Delivery System Reform Incentive Payment
(DSRIP) Program
Accountable Care Organization (ACO)

PY1 Annual Progress Report

General Information

Full ACO Name:	Steward Medicaid Care Network, Inc.
ACO Address:	89 A Street, Needham, MA 02494

Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

Our vision for our Medicaid ACO program aligns closely with MassHealth's stated goals and reflects Steward's overall mission. Through this program, we aim to:

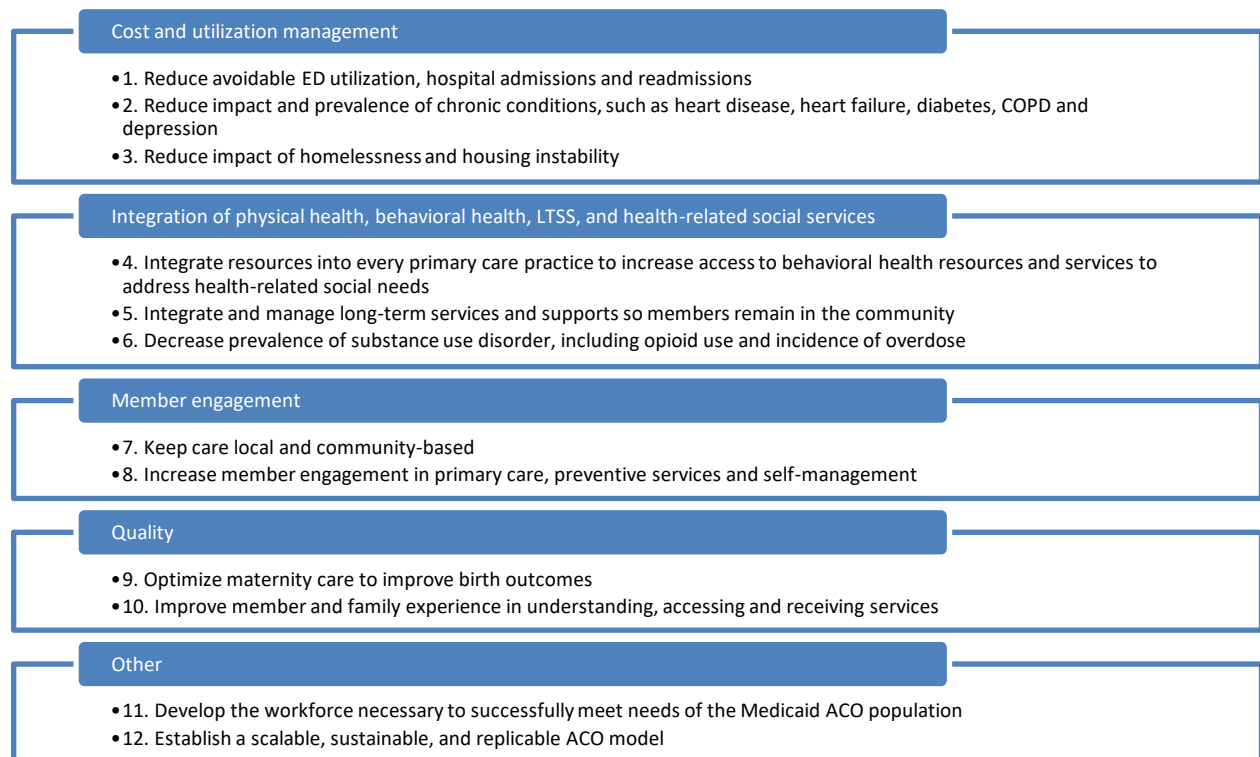
- Deliver world-class health care where members live

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- Advance the Quadruple Aim: improve members' health while improving members' experience and quality of care, reducing total costs and improving providers' administrative burden
- Actively engage a continuum of providers to address the needs of the communities we serve, including physical health, preventive care, behavioral health, and long-term services and supports
- Create and operate a scalable, sustainable, and replicable model that uses sophisticated incentives to engage and align priorities among both ACO providers and members
- Use data and technology to effectively identify needs of both members and practices and efficiently target resources to meet these needs

Our plan below lays out 12 specific goals that extend this vision and that will support our efforts to improve quality and reduce total cost of care.

Figure 2. Steward Health Choice five-year objectives



We developed goals informed by data on our Medicaid ACO population and have evolved them to reflect insight gained from our experience during PY1. We have established specific, measurable targets for each goal as based on the costs and utilization patterns of our ACO members. We will continually use data to focus and drive the programs we implement and the populations we target. We will submit requests to modify these goals and our investment strategy if, during the course of the program, our data suggests we need to adjust our focus to achieve success in managing total cost of care and quality.

1.2 PY1 Investments Overview and Progress Towards Goals

Our PY1 was focused on investments required for Steward and our providers to succeed in this program. We have adapted our investment approach as the program evolves, and as we refine our understanding of the operational requirements and challenges.

Our PY1 investments included the following specific investments from our full participation plan:

ID	INVESTMENT CATEGORY	SPECIFIC INVESTMENT OR PROGRAM
<i>S/O PC: 1002</i>	Care Coordination & Care Management	Hire practice-based clinical staff to support risk adjustment, quality, and patient experience
<i>S/O PC: 1007</i>	Health Information Technology	Expand process and technology to support shared care planning and data exchange for PCPs
<i>S/O PC: 1012</i>	Clinical Integration	Hire and deploy social workers and other clinicians to support connections to behavioral health for PCC practices
<i>S/O PC: 1015</i>	Health Information Technology	Enhance electronic medical records for behavioral health services and other social services to support care coordination between PCPs and BH providers/other service providers
<i>S/O PC: 1017</i>	Culturally and Linguistically Appropriate Services	Expand resources to support PCPs with culturally and linguistically appropriate care
<i>S/O PC: 1019</i>	Care Coordination & Care Management	Invest in primary care practices to improve patient experience of care
<i>S/O PC: 1024</i>	Care Coordination & Care Management	Integrate care coordination staff (community health workers, peer navigators, and health coaches) into practices and care management teams
<i>S/O PC: 1027</i>	Community-Based Care Initiatives	Additional investments proposed by network PCCs and community based organizations partnering with PCPs
<i>S/O D: 2001</i>	Data and Population Health Analytics	Expand population-based risk profiling, predictive modeling, and stratification
<i>S/O D: 2004</i>	Care Coordination & Care Management	Expand current Steward chronic disease care management programs to support Medicaid
<i>S/O D: 2005</i>	Care Coordination & Care Management	Develop care management programs targeted at Medicaid-specific diagnoses/conditions
<i>S/O D: 2006</i>	Care Coordination & Care Management	Expand current transitional care management program
<i>S/O D: 2007</i>	Health Information Technology	Develop and implement robust notification service for member transitions to support continuity of care across the care team
<i>S/O D: 2009</i>	Health-Related Social Needs	Partner with social service and behavioral health organizations to increase housing and other SDOH resources
<i>S/O D: 2011</i>	Clinical Integration	Pilot telemedicine programs for services with limited capacity
<i>S/O D: 2013</i>	Data and Population Health Analytics	Enhance risk stratification and predictive modeling to include LTSS and social needs
<i>S/O D: 2015</i>	Care Coordination & Care Management	Implement referral management and utilization management processes and technology
<i>S/O D: 2016</i>	Other	Develop robust member incentive and engagement strategy incorporating culturally and linguistically appropriate communication channels
<i>S/O D: 2019</i>	Community-Based Care Initiatives	Develop and expand evidence-based wellness program and disease management offerings

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S/O D: 2020	Care Coordination & Care Management	Expand childbirth education classes and parenting classes
S/O D: 2021	Organizational Integration	Build infrastructure to support member services, including call center, CRM, and member collateral
S/O D: 2022	Workforce Development	Enhance network's ability to address Medicaid member needs through training, contracting, and other development activities
S/O D: 2027	Organizational Integration	Integrate additional contracted resources to meet Primary Care ACO contract requirements
S/O D: 2028	Other	Develop financial models, controls, and evaluation program for all ACO-related funding
S/O D: 2029	Organizational Integration	Clinical leadership for medical and behavioral health program
S/O D: 2030	Community-Based Care Initiatives	Provide technical assistance to network to support transformation to value-based care. Additional investments proposed by network PCCs and community based organizations partnering with PCPs
S/O D: 2033	Organizational Integration	Build administrative infrastructure to support implementation, operation, and monitoring of ACO

Examples of progress on initiatives to date:

S/O PC: 1024 Integrate care coordination staff (community health workers, peer navigators, and health coaches) into practices and care management teams

A significant focus of our population health management program in PY1 was integrating care coordination staff into practices with a large number of Medicaid patients. While most practices welcomed the additional resources, we found that practices had varying degrees of readiness to integrate ACO staff into their offices. We encountered challenges ranging from the operational (e.g., ACO staff access to practice EMRs) to the cultural (e.g., physician adoption of referrals to social workers). During the year, we developed a readiness process for practices to complete in advance of accepting ACO staff into the primary care site to ensure success of the care management program. By the close of 2018, embedded care coordination staff enrolled thousands of Steward Health Choice members in our population health management programs, including clinical care management, social supports, and behavioral health care coordination.

S/O D: 2015 Implement referral management and utilization management processes and technology

As part of our efforts to improve member and provider experience by simplifying administration, Steward invested DSRIP resources in centralized referral management staff and technology in PY1. During 2018, we hired a team of referral management coordinators to facilitate coordination of services between primary care practices and specialty services, including behavioral health. This team developed policies and standardized workflows to ensure efficient and effective processing of referrals for members and providers, which was particularly necessary during this transitional year. The referral management team demonstrated particular success processing primary care referrals for behavioral health, including matching members with behavioral health providers according to their needs and preferences and scheduling behavioral health appointments on behalf of members. In addition, Steward

developed and launched a referral management technology solution to document and track referral requests between providers, the ACO, and MassHealth. In the future, we plan to make this tool available to providers to create further simplification in the referral process for providers and members.

S/O D: 2020 Expand childbirth education classes and parenting classes

Since launching our Healthy Beginnings Program in October 2018, we have enrolled nearly 300 pregnant Steward Health Choice members and provided telephonic care coordination to improve maternal newborn health outcomes and increase member satisfaction, including but not limited to:

- Referring members to OB/GYNs, midwives, pediatricians, and other clinical providers and reinforcing the importance of attending appointments
- Identifying and addressing barriers to care utilization by helping connect members with transportation assistance, child care, and financial assistance in collaboration with our behavioral health and social services care management programs
- Connecting members with WIC and community-based resources such as diaper banks, home visiting programs, and breastfeeding support groups based on their needs
- Helping members register for free childbirth education, breastfeeding, and newborn care classes and get their free infant car seat
- Educating members about basic healthy pregnancy behaviors, the benefits of breastfeeding, obtaining a MassHealth-covered breast pump, etc.

1.3 Successes and Challenges of PY1

Our focus in PY1 was implementation of the infrastructure, processes, and program required to advance the ACO while operating new programs. Some of our key successes and challenges in 2018 were:

Successes:

- SMCN developed and expanded care management programs aimed at managing patients' physical, behavioral, and social needs. For example, our Behavioral Health Complex Chronic Patient Management (BH CCPM) program has managed over 1,000 members in 2018. In addition to BH CCPM, our BH Referral team connected over 1,500 Medicaid members with BH providers.
- We successfully launched Steward Community Connection, a web-based platform that allows ACO staff, providers, and patients to access information about where to find resources addressing social needs (food, housing, transportation, legal, etc.). Steward adds to and maintains the database as resources are newly identified.
- Steward has invested significantly in a grant program for primary care practices. The program serves as a funding source for grantees to pilot an innovative idea to reduce spending or improve quality of care or to build capacity or infrastructure to succeed under a value-based payment model.

Challenges:

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- Much of our detailed planning for the program, especially as we designed and built our population health programs, was limited by the fact that we did not have access to detailed historical claims data (including costs) for our Medicaid ACO population. We expect to continually refine our approach to performance as we are able to bring more sophisticated analyses to bear.
- We encountered challenges marshaling the workforce necessary to meet access demands for key services as well as to implement many of the core elements of delivery system reform. This includes a shortage of qualified, culturally competent providers, particularly in outpatient behavioral health, substance use, and care management.
- Steward has invested significantly in the people, process, and technology necessary to launch and support the successful implementation of the Community Partners program for Steward Health Choice members. We have encountered significant complexity in developing arrangements with individual CPs tailored to their specific competencies and service areas across a diffuse CP network. This complexity, coupled with individual CP execution, may lead to appreciable variation in performance across CPs, which could impact member health outcomes.