DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

ACCOUNTABLE CARE ORGANIZATION (ACO) PY2 ANNUAL PROGRESS REPORT RESPONSE FORM

PART 1: PY2 PROGRESS REPORT EXECUTIVE SUMMARY

General Information

Full ACO Name:	Tufts Together with CHA
ACO Address:	1493 Cambridge Street, 7th Floor, Cambridge, MA, 02139

Part 1. PY2 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

CHA and its MCO partner Tufts Health Public Plans have a shared vision of driving strong outcomes in quality, member experience and value for members who entrust our organizations ACPP with their healthcare. As the ACPP program moved into PY 2, we placed greater focus on broader long-term outcome measures in addition to the programmatic and infrastructure investments that were described in earlier participation plans. Our goal is to achieve the sustained success of the program. We believe we made significant progress in all four goal domains in PY2.

In our PY 2 full participation plan, we outlined four broad goals:

Goals (1st Order)	
Goal #	**Goal Category & Description**
1	*Cost & Utilization Management*: Maximize the value of care provided to enrolled patients by managing the total cost of care to 2% below the Mass Health adjusted medical budget benchmark in PY 3 and to 3.5% below the Mass Health in PY 5. This is to be accomplished through the specific programs and activities outlined below.
2	*Quality*: Maximize the quality of care provided to enrolled patients such that CHA's performance exceeds the final quality measures and targets as established by Mass Health.
3	*Member experience and engagement:* Maximize the engagement of attributed but not engaged patients as a key pathway to achieving quality, cost and utilization goals.
4	*Integration*: By the end of PY 5, implement a fully operational community partner integration program.

1.2 PY2 Investments Overview and Progress toward Goals

CHA has made strong progress within each of its broad goals. The following summarizes this progress.

Goal 1 Cost and Utilization Management:

CHA has four programmatic areas under cost and utilization management: individual care management, behavioral health, medical management, and post-acute care. The following summarizes key accomplishments in each of these areas.

Individual Care Management

- CHA earned NCQA accreditation for its complex care management program and was formally delegated to perform care management by CHA's MCO partner;
- Organized and implemented a cross-functional committee to examine opportunities for better managing emergency room utilization;
- Organized and executed a cross-functional committee to understand the impact of homelessness on ACPP cost and utilization. The committee prepared recommendations to improve the use of appropriate healthcare services and initiate strategies to help homeless individuals create a path to long-term stability;
- Maintained the Hospital-to-Home care transitions program, staffed by community health workers supporting high and moderate risk patients in accessing needed post-discharge ambulatory care and reducing readmission rates;
- Maintained the clinical social worker under CHA's Healthcare for the Homeless program to provide care management to homeless patients to access necessary healthcare services as well as in helping to address long standing addiction issues in this very challenging population;
- Implemented an automated risk stratification process that is embedded in the EMR to identify candidates for care management assessment;
- Strengthened management and oversight of the ICM program through the development and implantation of a key process and outcome metrics dashboard;
- Combined funding streams to hire a licensed independent clinical social worker to support the women's health program. This role addresses the psychosocial and social determinant health needs of women with Mass Health coverage;
- Provided ongoing support for Patient Resource Coordinators, assigned to primary care sites and tasked with referring patients with social determinant needs to community-based supports and resources. Nearly 1 in 4 patients screen positive for one or more SDoH needs, largely food and housing insecurity or homelessness. Nearly half of patients screening positive for one or more SDoH needs respond affirmatively to the question, "would you like assistance with any of these needs?" The patient resource coordinators help patients navigate barriers to services and engage with community-based resources;
- Data provided by Medicaid suggest that CHA care management programs have had some impact on broad measures of utilization. CHA adult Medical and Surgical Inpatient Admissions per thousand, for service dates through June 2019, showed a 1.3% reduction compared to March – December of 2018. By comparison, the CHA-generated Johns Hopkins Adjusted Clinical Group (ACG) concurrent risk score models showed an 8% increase from May of 2018 through October of 2019. While the data are not yet complete, and with the understanding that population-wide risk scores are not designed to predict specific utilization rates, the data suggest that CHA achieved some measure of utilization reduction in a context of greater overall population risk; and
- Adult Non-SUD-Related ED visits per thousand for service dates through June 2019 experienced a 4.1% reduction compared to the March – December period of 2018.

Medical Management
- CHA developed evidenced based clinical practice guidelines for COPD, CHF, Diabetes and Alcohol Use Disorder, which were approved by the Nursing and Medical Executive Committees. A hypertension guideline is expected to be approved in April 2020 and an Opioid Use Disorder Guideline in June 2020. These guidelines may be delayed due to the national coronavirus emergency;
- CHA embedded care pathways for selected diseases into clinic practice across the care continuum, including EMR decision supports and training for practice teams in primary care, care management, ambulatory specialty care, the hospital, emergency department and post-acute partners. Development includes patient education materials where applicable and available; and
- Developed condition-specific dashboard reports for performance monitoring for the identified chronic conditions, showing ED and hospital utilization, and total medical expense.

Behavioral Health
- The ICA behavioral health management program continued to mature and expand in PY2. Under this program, three Intensive Clinical Managers provide clinical input and care coordination for high risk patients with inpatient BH readmissions or high rates of avoidable BH ED visits. They provide case consultation to CHA BH clinicians working with these patients. Staff expanded the program to emphasize outreach and engagement of patients with addictions and added clinical consultation on high-risk children;
- Implemented a behavioral-health focused risk stratification model to identify candidates for ICA assessment and management based on predictive risk scores, actual utilization, and clinical assessments;
- Strengthened management and oversight of the ICA program through the development of a key process and outcome metrics dashboard;
- Data generated by Medicaid suggest that the ICA program may have had some impact on broad measures of behavioral health utilization. CHA adult total behavioral health inpatient admissions per thousand for service dates through June 2019 experienced 6.0% reduction compared to the March – December period of 2018. By comparison, the CHA-generated Johns Hopkins Adjusted Clinical Group (ACG) concurrent risk score models showed an 8% increase from May of 2018 through October of 2019. While the data are not yet complete, and with the understanding that population- wide risk scores are not designed to predict specific utilization rates, the data suggest that CHA achieved some measure of utilization reduction; and
- Adult SUD-Related ED Visits per thousand for service dates through June 2019 experienced a 0.5% increase compared to the March – December period of 2018. This was likely in part due to increased utilization of residential and outpatient care.

Post-Acute
- Fully implemented the programmatic elements necessary for post-acute care management: 1) Monitoring patients referred to non-preferred SNFs; 2) Ongoing measurement and evaluation of SNF LOS; 3) Ongoing measurement and evaluation of readmission rates within 30 days discharge from hospital to SNF; and 4) Ongoing measurement of appropriate SNF transfer to Public Hospital when acute transfer is indicated;
- The Post-Acute RN Care Manager was deployed on-site to manage ACPP patients within our preferred SNF network and at the three high volume non-preferred SNFs. Additionally, CHA

made arrangements to have ACPP patients at non-preferred SNFs medically managed by a physician group that has agreed to follow CHA's transition of care protocols; and

- Total SNF days per thousand, as measured by CHA using claims data, for service dates through November 2019 showed a 38% reduction compared to the March – December period of 2018.

Goal 2 Quality:

CHA made significant progress in PY2 including:

- Investments supporting the refinement of quality dashboards, monitoring performance against established targets, assessing and identifying metric risks, and providing support to CHA primary care operations on performance improvement activities;
- CHA brought on a Quality Project Improvement Advisor and a Project Manager to support the metrics managers in the implementation of ACO quality improvement. The performance improvement advisor will work on goals supporting behavioral health measures across the range of multi-disciplinary SMI, SUD and SED teams;
- CHA was fully compliant with all timeliness, accuracy, and completeness requirements set forth by MassHealth; and
- We have preliminary data from our MCO partner that show quality measurements for 2019. Based on this preliminary data, it is estimated that CHA, out of a total of 14 measures, met or exceeded 5 quality measures at the Goal Benchmark standard, and met or exceeded an additional 6 measures at the Attainment Benchmark level.

Goal 3 Member Experience and Engagement:

We have continued implementation of outreach efforts and on refinement of the outreach plan. PY 2 achievements are summarized below:

- Identified, through CHA's risk stratification program, enrolled members who were unengaged or who may have a PCP but are inactive and are at high or rising risk. CHA developed and implemented a strategy to provide priority and outreach to these members;
- Completed a targeted outreach for difficult to contact members, including a community-based outreach for members identified as high risk and in need of preventive care. This effort was successful in contacting new and unengaged members and delivering information on using primary care services. The outreach resulted in primary care appointments for most new, unengaged or inactive members;
- We engaged a technical assistance vendor to recommend improved ways to engage difficult-to-engage members and plan to implement recommendations from the vendor;
- CHA implemented a routine monthly outreach procedure using voice and texting outreach to members not engaged with their primary care provider. In the early fall, we implemented a more targeted outreach to those unengaged members who have preventive or ongoing care needs. This effort was successful in contacting new and unengaged members and delivering information on using primary care services. The outreach resulted in primary care appointments for most new, unengaged or inactive members;

- We implemented a mailing campaign in the second half of PY2. The mailing campaign was an efficient method to remind new or unengaged panel members how to access primary care services;
- CHA achieved outreach to 50% of the unengaged or inactive members attributed to CHA; and
- Increased the percentage of inactive and unengaged members who subsequently engaged with primary care by 1% over baseline.

Goal 4 Integration:

Key integration accomplishments in PY2 include:

- Continuous management of contracts with 6 behavioral health and 4 LTSS community providers;
- Completed cross training of CHA and community partners staff and incorporated criteria and workflows for integrating community partners; established criteria for coordination of care for individuals receiving social services, behavioral health care, and community-based social services through documented processes;
- Integrated community partner care plans into the electronic medical record. Enrollment and eligibility for the community partner program is displayed to CHA clinicians in the EMR;
- Established and maintained quarterly meeting with community partners to address issues and maintain smooth workflows;
- Completed 295 signed care plans for ACPP patients;
- Implemented social determinants of health screening in all primary care and behavioral health outpatient sites. The screenings, transitioned from paper-based, are recorded by patients using tablet devices and are made part of the electronic medical record; and
- CHA completed a pilot to integrate "Aunt Bertha" into the electronic medical record. Aunt Bertha, a social determinants of health web-based electronic platform, provides an inventory of and access to community programs. CHA ACO users made referrals to community agencies through the program.

1.3 Success and Challenges of PY2

The Cambridge Health Alliance (CHA) and Tufts Public Health Plans (THPP) have come together to address the needs of the most vulnerable populations within our community. Our organizations have deep knowledge of the current and evolving medical, behavioral health and social service needs of our members, as well as experience in developing partnerships which leverage the specific strengths of each organization and create efficiencies. We are confident that this history will position us well to meet the objectives of the Quadruple Aim of increasing quality and patient and provider satisfaction while decreasing cost.

Successes:

Strong, Collaborative Performance Management and Monitoring: We created a strong governance structure, including a joint ACPP Governing Board; Patient and Family Advisory Council (PFAC);

and Compliance, Finance, Quality, and Joint Operating Committees, which meet to identify and address challenges and opportunities. We also have various work groups with representatives from CHA and THPP to monitor and address common issues, such as member transition and engagement, disease management, and quality measurement.

Our leadership teams worked together this year to prepare dashboards with real-time performance data, enabling us to manage our members closely and identify and address unfavorable trends.

Functional Integration: Both organizations have significant institutional experience with functional and organizational integration and continue to work together to promote integration and coordination across the enterprise. For example:

- CHA and THPP continue to make progress in risk stratifying our populations and assigning the most vulnerable to experienced case managers who get to know them and address their on-going needs in a comprehensive, integrated manner.
- Our leadership teams worked together to prepare for and achieve Tufts Complex Care Management (CCM) delegation to CHA and NCQA CCM Accreditation. These programs enable our partnership to manage the care of our most vulnerable populations at the provider level.
- We continue to meet regularly to discuss and collaborate on patients with high utilization. The Intensive Care Adviser (ICA) team collaborates with Tufts and the CHA Complex Care Management (CCM) teams both during and outside of these meetings, sharing information that affords optimal ability to strategize and formulate care plans to address high behavioral health utilization.
- We worked closely together over the past year to identify and assign clear functions within the two organizations which avoids duplication, enabling us to work synergistically to support members. We also created systems to identify high risk patients, coordinate care, and address care gaps and conduct on-going training for staff at all levels, and promote functional integration of medical and behavioral health.

It is critical to continue this work moving forward which could be compromised if our concerns outlined below regarding program sustainability are not realized.

Below is a summary of our work in additional discrete categories:

a. Governing Structure / Work Groups:

As noted above, we created a strong governance structure which meets regularly to collaboratively identify and address opportunities for program improvement. In addition, several work groups with representatives from both CHA and THPP convene to address issues of member transition, member engagement, disease management, and quality improvement. These work groups create and adapt joint workflows to avoid duplication and ensure that the member gets the right service, at the right time, and in the right location.

b. IT Upgrades and sharing of information:

Both CHA and THPP worked together to coordinate significant IT upgrades and share critical reports to ensure that members are identified, screened, assessed, coordinated, and managed optimally.

Through DSRIP investments, CHA has achieved claims/EHR integration, automated risk stratification, upgraded care management tools, and tablet-based patient SDOH screening tools.

c. Learning Collaborative:

As mentioned above, CHA and THPP have a long history of collaborating to ensure that its members receive coordinated and integrated care. Both organizations look forward to taking advantage of the State's learning collaboratives to share its experience in identifying and addressing any functional and organizational integration challenges which occur.

Challenges:

Our strength also comes from our collective understanding of the challenges we see based on the second full year of program operation. We outline below our most salient challenges and plans to mitigate its effects.

Program Sustainability:

Tufts Together with CHA experienced various unanticipated issues during RYs '18 and '19, resulting in substantial losses. Despite our substantial investments and highly focused efforts at managing care, we are concerned about the program's long-term sustainability under the current approach to funding global budgets. We recognize and appreciate MassHealth's important 2020 rebasing and investment efforts. However, we believe that further adjustments are needed to enable all ACOs, including Tufts Together with CHA, the opportunity for successful financial performance which we believe is critical not only to us, but also to the long-term viability of the program.

More specifically, we suggest the following:

- For future rate years, we request that MassHealth revise its risk corridor model to offer an aggregate settlement methodology. We believe that this is in concert with actuarial best practice, and addresses concerns based on our experience with year to year volatility in budgets and claims experience at the rating category level. Having an aggregate risk pool will allow ACOs to best manage risk across the entire population without being put at risk for the seemingly inconsistent sub-population budgeting and performance at the rating category level.
- We suggest that MassHealth be clearer and more consistent in its allocation of funds for care management services. We see inconsistency between the historical commitment MassHealth made to care management funding, and the actual allocation of funds for 2020; our analysis suggests that this funding has decreased. We view appropriate care management funding as critical to the long-term sustainability of the program, particularly as DSRIP funding decreases over time. Funding care management through budget surpluses alone is not likely to be sustainable, given the volatility of budgets and medical costs, the need to maintain reserves in a risk environment, and the current budget setting model, which reduces budgets every year if ACOs are successful in reducing costs. We suggest that MassHealth restore the trajectory of care management funding anticipated in its 2019 documentation.

- We suggest that MassHealth increase its transparency regarding the specific data used and calculations for the Risk Adjustment Model 3.0. This will enable us to increase our understanding and management of our population.

We look forward to continuing to meet with MassHealth on a quarterly basis to share information about our joint program efforts and address any challenges together.

Finally, we note that the unanticipated National Health Emergency related to the coronavirus poses a significant challenge to short and long term ACPP sustainability. We look to MassHealth to partner with THPP and CHA in meeting the challenges of this unprecedented event.