MassHealth Delivery System Reform Incentive Payment Program (DSRIP) Midpoint Assessment

Statewide Report

Prepared by The Public Consulting Group

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- As of March 2021, DRAFT remains under CMS Review

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A. EXECUTIVE SUMMARY

INTRODUCTION

The Massachusetts 1115 waiver authorizes $1.8 billion over five years for new Delivery System Reform Incentive Payment (DSRIP) Program funding. DSRIP funds support the restructuring of MassHealth's delivery system to promote integrated, coordinated care and hold providers accountable for both quality and total cost of care. DSRIP funds are used to support transitional activities at Accountable Care Organizations (ACOs) and to establish Community Partners (CPs) to integrate behavioral health services, long-term services and supports, health-related social needs, and funding to support statewide investments to efficiently scale up statewide infrastructure and workforce capacity in support of MassHealth restructuring. In accordance with CMS requirements, the Independent Assessor (IA) conducted a Midpoint Assessment (MPA) to report the 17 MassHealth ACOs and 27 CPs' progress toward achieving DSRIP goals and the implementation of Statewide Investments (SWI). The MPA covers the time period from July 1, 2017 through December 31, 2019, as specified in the DSRIP Special Terms and Conditions.

This report describes the IA's findings for the ACO and CP cohorts, and the IA's review of the Statewide Investments made by MassHealth to support ACOs and CPs.

APPROACH

The question addressed by the midpoint assessment:

> *To what extent have participating entities (ACOs and CPs) taken organizational level actions to transform care delivery under an accountable and integrated care model?*

CPs and ACOs were assessed across several defined aspects of health system transformation. These "focus areas" were derived from the DSRIP logic model (Appendix A), by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement

2. Integration of Systems and Processes

3. Workforce Development

4. Health Information Technology and Exchange

5. Care Coordination and Management[1]

6. Population Health Management (ACOs only)

The IA assessed the progress of each participating entity in each focus area, and then aggregated these results to understand the progress of the ACO and CP cohorts.

To assess each entity's performance in each focus area, the IA drew on the following data sources:

> *Documents submitted by entities to MassHealth covering the reporting period of July 1, 2017 through December 31, 2019:*

- Full Participation Plans (FPPs)

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[1] While recognizing the distinct difference between care coordination (a more wholistic and over-arching approach to optimize the integration of both medical and non-medical) and care management (typically focused on caring for individuals or a subset of patients with a common clinical need such as diabetes or asthma), the focus area assessment combines the two with the understanding that ACO and CP efforts in these areas often overlap or integrate.

- Semi-annual and Annual Progress Reports (SPRs, APRs)

- Budgets and Budget Narratives (BBNs)

Newly Collected Data:

- ACO and CP Administrator Key Informant Interviews

- ACO Practice Site Administrator Survey

Qualitative analysis based on a custom framework was used to assess each entity's progress. The standard for assessment was derived empirically from the IA review of data for all ACOs and CPs. A rating of On track indicates that the entity made progress consistent with the cohort, in accomplishing each of the actions for the focus area. Where gaps in progress were identified, the entity was rated On track with limited recommendations or, in the case of more substantial gaps, Opportunity for Improvement.

FINDINGS AND RECOMMENDATIONS

ACO REVIEW

The IA's review of ACO progress found that the majority of ACOs are On track or On track with limited recommendations for all six focus areas. Seven ACOs were found to have an Opportunity to improve in one or more focus areas. The IA made the following observations and recommendations, by focus area:

Organizational Structure and Engagement: All ACOs established appropriate governance structures, which vary by ACO model. ACOs established centralized processes to identify quality and performance management priorities but allow practice sites to have significant autonomy to pursue improvement efforts. The IA recommends that ACOs expand their efforts to engage MassHealth members through Patient and Family Advisory Committees (PFACs) and systematically integrate PFAC input into leadership decision making.

Integration of Systems and Processes: ACOs routinely share quality and utilization data with practice sites. Administrative coordination with CPs varies; the IA recommends that ACOs integrate CPs into their report sharing as a routine aspect of operations. All ACOs deploy some form of a team model for care management, sometimes embedding teams at practices sites. ACOs vary in their progress in integration of BH care, and the IA recommends ACOs continue working to expand the breadth of behavioral health services, including office-based addiction treatment (OBAT) programs, provided across primary care locations. Among Accountable Care Partnership Plans (ACPPs), all report transitioning complex care management to the ACO as either in process or complete. ACO/MCO partnerships with established institutional relationships predating DSRIP generally have shifted more functions to the ACO.

Workforce Development: Most ACOs appear to have avoided major staffing gaps, though certain positions, including nurse care managers and community health workers (CHWs), have been consistently difficult to fill. Most ACOs offer their staff a wide variety of training opportunities from onboarding to role-specific trainings; often also offering joint ACO-practice site training. The IA recommends ACOs expand the integration of CP staff into care team structures to reduce barriers to effective patient handoffs and further improve the operational infrastructure between ACOs and CPs.

Health Information Technology and Exchange: At some ACOs and practice sites, care management and population health functions are performed within electronic health records (EHRs) using integrated software, while at other sites, care management and population health management functions are handled using separate platforms. Practice sites generally report that they find these platforms useful, and that they improve care coordination. In response to ongoing interoperability challenges, ACOs are finding effective data conduits through member and provider portals, data exchanges and other information sources. These alternatives support privacy compliant, real-time exchange of member

information and support care coordination. Many ACOs note the challenges of sharing SUD-related member information, and are working with MassHealth and data exchange vendors to establish state and federally compliant data sharing methods capable of enabling provider access to patient information necessary for clinical care.

Dashboard functionality varies widely across the ACOs. Some ACOs continue to rely on manual processes of extracting and tracking data related to both care management and population health analysis. The IA recommends that ACOs expand the automation and integration of data management for both care management and population health analysis, including automated creation and tracking of referrals, and generation of registries based on risk stratification. The IA also recommends ACOs extend timely two-way communication to CPs and non-affiliated providers.

Care Coordination and Care Management (CCCM)[2]: ACOs have established processes to identify members appropriate for referral for BH or LTSS services, collaborate with CPs to exchange member information and partner on care coordination when the CP has primary care management responsibility. Designating individuals as a specific point of contact for CPs, and for collaborating with state agencies such as the Department of Mental Health (DMH), was seen to improve communication across the continuum of care. The IA recommends that more ACOs formalize their relationships with state agencies and with CPs through regular meetings and designated points of contact.

Most of the ACOs rely on both IT-enabled and manual outreach efforts to improve the accuracy of member contact information. Most ACOs provide the opportunity for staff to build one-on-one relationships with high-need members, increasing trust between the two parties and facilitating care coordination.. These relationships enable the development of a wider perspective of the member's clinical and non-clinical needs. ACOs typically communicate with recently discharged members and their physicians within 72 hours following an inpatient discharge. Common strategies to support care coordination include embedding staff in or near EDs and systematically pursuing medication reconciliation. Referrals for health-related social needs (HRSNs) and behavioral health (BH) needs are also common, though the processes for making and tracking referrals are sometimes cumbersome. EHR integrated and automated approaches to referrals are used by some ACOs and can support follow-up processes including case conferences. The IA recommends that ACOs work towards increasing standardization of referral processes and follow-up through regular case conferences.

Population Health Management: The IA noted a range in the sophistication of strategies ACOs use for member risk stratification, with more advanced systems typically using multiple data sources to populate final risk categories. The IA recommends that ACOs incorporate multiple data sources (for example data points from EHRs, admission, discharge and transfer feeds, referrals, and HRSN screening) into risk stratification algorithms, and conduct ongoing empirical testing of their results against modified algorithms and actual outcomes.

ACOs conduct standardized screenings for HRSN including housing and food stability as well as access to necessary transportation. All ACOs offer some type of referral or services for members with identified HRSNs. However, they vary in how systematically they screen and how they act on the results. All ACOs provide referrals and services for members with identified HRSNs. Some ACOs have formed partnerships with community-based organizations like food pantries, transitional housing and emergency shelters; and with state agencies like DMH to coordinate services. An average of 39% of practice sites across the ACO cohort indicated that "tailoring delivery of care to meet the needs of patients affected by health inequities" has become easier over the past year, which may reflect the ACOs' growing ability to identify HRSNs and refer members for appropriate services.

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[2] While recognizing the distinct difference between care coordination (a more wholistic and over-arching approach to optimize the integration of both medical and non-medical) and care management (typically focused on caring for individuals or a subset of patients with a common clinical need such as diabetes or asthma), the focus area assessment combines the two with the understanding that ACO and CP efforts in these areas often overlap or integrate.

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CP REVIEW

The IA's review of CP progress found that the majority of CPs are On track or On track with limited recommendations for all five focus areas. One CP was found to have an Opportunity to improve in one or more focus areas. The IA made the following observations and recommendations, by focus area:

Organizational Structure and Engagement: All CPs established an executive board or leadership team that regularly meets with administrative and clinical personnel to discuss operations and program improvement strategies. CPs use insights provided by Consumer Advisory Boards (CABs) to inform strategic decision making in areas related to member engagement, stigma reduction, and strategies for disseminating information to member populations.

Though some CPs successfully recruited MassHealth members for their CAB, the majority experienced inconsistent or low member participation rates; several engaged the DSRIP Technical Assistance (TA) Program[3] to improve CAB participation. The IA recommends CPs expand these efforts and revisit incentives and compensation offered for CAB participation in order to receive a range of perspectives needed to hear a meaningful consumer voice. All CPs maintain a Quality Measurement Committees (QMC) that meets at least quarterly to review performance on current quality initiatives and identify opportunities for new initiatives. The majority of QMCs report their results and activities directly to the CP's governing body.

Integration of Systems and Processes: All CPs established the program's required Documented Processes to exchange member information with ACO/MCO partners. Nearly all CPs exchange care plans, member contact information, and other member files through secure means (typically a secure file transfer protocol, secure email or third-party secure file sharing application). The administrative effort required to exchange member information with ACO/MCO partners is substantial, and some CPs divide administrative and clinical tasks to save time and allow clinical staff to focus on member-facing activities. A majority of CPs have staff dedicated to reviewing ACO/MCO spreadsheets for missing data points, responding to ACO/MCO referral requests, and confirming member contact information with ACO/MCO and primary care partners. The IA recommends that CPs work with ACOs and adopt systems to increase interoperability of member data exchange to reduce administrative burden and improve coordination efforts.

Effectively engaging partners is a major area of focus within the CP cohort. Most CPs established internal points of contact to develop relationships with primary care providers (PCP) and ACO/MCO staff to facilitate care plan approval and sign-off. Most CPs attend routine case review meetings and care planning meetings to share clinical information, identify high-risk members, and facilitate care plan sign-off. A few CPs have staff embedded at ACO/MCO health centers and primary care practices. Staff at these sites work alongside ACO/MCO care teams and have monthly, or daily, meetings to strategize on behalf of members, discuss mutual expectations and refine workflows. The IA recommends that CPs strive to embed staff at practice sites, EDs or other locations with embedded ACO care coordination staff to improve care coordination.

Some CPs were challenged when attempting to engage PCPs directly in care plan review due to a seeming lack of awareness of the CP program within provider communities. As a result, CPs prefer ACO/MCO partners taking an active role in actively facilitating this process.

In response to member transitions, integrated ENS/ADT notifications pushed directly into CP EHRs assist CP care coordinators to review member admissions. Some CPs assign staff to work directly with ACO transition of care teams, ACO nurses, social workers, and/or CHWs located in EDs and inpatient units to assist with discharge planning and follow-up.

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[3] Described in the Statewide Investment (SWI) Review section of this report, and at https://www.ma-dsrip-ta.com/

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Workforce Development: Some CPs struggled to achieve workplace diversity and experienced challenges recruiting non-care coordination staff and masters-level care coordination staff. Multiple CPs cited competition with other CPs and ACOs as a significant barrier to attracting a diverse pool of candidates. However, all CPs adapted to hiring challenges throughout the course of the demonstration and have avoided long-term vacancies in planned staff roles. Nearly all CPs used program SWI funds to further support recruitment and retention efforts. Many CPs reported SWI-supported student loan repayment programs and additional staff certification opportunities as aiding recruitment and retention efforts. CPs also employed a broad range of strategies for recruitment, including partnerships with local universities. The IA recommends that all CPs continue or increase their use of SWI funds to improve recruitment and retention of qualified staff.

All CPs hold regular skills training focused on identifying and disseminating best practices and recent advancements in the field. A majority of CPs hold training on a monthly basis and track attendance and training compliance through reporting logs. In addition to trainings developed by CPs themselves, many use partner organizations and MassHealth training forums available through the SWI program (SWI 4) to expand training opportunities. Some staff participate in joint learning events with ACO/MCO partners, attend CHW training, access trainings offered through educational institutions, and attend external conferences.

Health Information Technology and Exchange: Nearly all CPs use an integrated EHR and care management platform provided by a single vendor. These platforms can typically produce and transmit consolidated clinical document architecture (CCDA) files, query eligibility data from the Executive Offices of Health and Human Services (EOHHS), and submit structured outcomes reports to various state agencies and ACO/MCO partners. Nearly all CPs integrate ENS/ADT notifications from area providers into care management platforms, though some do not receive notifications from all partnering ACOs. Among CPs with integrated ENS/ADT notifications, most have contracted with one or more vendors to push event data for members into the CP's care management platform, allowing care coordination staff to act on information in near real-time. Nearly half of CPs gained access, typically read-only, to ACO/MCO partner EHRs providing information on shared members. Nearly all CPs reported they can bi-directionally share member contact information electronically with the majority of ACO and MCO partners. Most CPs reported they can share member care plans electronically with the majority of PCP partners as well but reported some difficulties with sharing comprehensive assessments and member contact information with PCPs. The IA finds that a combination of file exchange methods helps CPs achieve full interoperability with all ACO/MCO and PCP partners and recommends that CPs continue using multiple complementary methods as needed.

Most CPs developed at least one dashboard, monitored by a multidisciplinary team, to oversee documentation and performance on key quality metrics. Most CPs monitor member engagement metrics such as the number of comprehensive assessments received, care plans signed and time from assignment to engagement. Many CPs combine claims data with EHR/care management platform data to measure progress towards CP quality benchmarks. Some CPs track population health measures such as member utilization and total cost of care (TCOC).

Care Coordination and Care Management[4]: Despite widespread progress, a majority of CPs experienced some challenges in outreach and member engagement. Most CPs have implemented strategies designed to assist staff in providing supports tailored to, and reflective of, the member population racially, ethnically, and linguistically. The IA found that all BH CPs, and many LTSS CPs, were using peer supports and CHWs throughout the provision of services. A majority of CPs send staff to members'

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[4] While recognizing the distinct difference between care coordination (a more wholistic and over-arching approach to optimize the integration of both medical and non-medical) and care management (typically focused on caring for individuals or a subset of patients with a common clinical need such as diabetes or asthma), the focus area assessment combines the two with the understanding that ACO and CP efforts in these areas often overlap or integrate.

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homes, shelters, food pantries, congregate meal sites, treatment centers, affiliated partner (APs')[5] facilities and programs, and EDs to find and engage assigned members. A few CPs have embedded staff within PCP and ACO offices to conduct outreach attempt to engage with assigned members in waiting rooms.

Some CPs convene regular care team meetings with all service providers to discuss member progress and highlight potential gaps in care. All CPs review and update care plans at established points throughout the year, or in response to a change in the member's condition. Nearly all CPs provided evidence of standard processes to manage transitions of care. A few CPs have dedicated teams to manage member transitions of care while others have embedded staff within inpatient facilities to facilitate transitions of care and warm handoffs from inpatient facilities to the CP itself. Most CPs focused on building relationships with inpatient facility staff to improve transitions of care efforts.

While all CPs screen members for health-related needs and connect members to community resources and social services, the processes for doing so are often not automated or standardized. The lack of standardized processes to connect members to community resources and social services was a commonly identified gap. Among CPs with standardized processes to connect members to community resources and social services all use either resource directories developed and maintained on a CP's intranet, or subscription-based databases of local resources. A few CPs created dedicated roles responsible for developing connections to community resource providers and state agencies.

Nearly all CPs implemented a strategy for continuous improvement in quality of care and/or member experience. Some CPs leveraged their CABs to gain information about member experience and identify opportunities for improvement. To evaluate their own performance and identify areas for improvement, a few CPs completed comprehensive program assessments comparing their practices to nationally accredited models. Other CPs conducted strategic planning sessions to evaluate programmatic, financial, and community factors impacting their program.

SWI REVIEW

The IA's review of the Statewide Investments found strong interest in the program. Medical and behavioral health providers in particular actively sought out student loan repayment opportunities targeted to early career professionals working in community-based settings. Workforce training opportunities for CHWs showed high levels of interest and attendance and new residency training opportunities for MDs and NPs were created. Technical Assistance to ACOs and CPs was slower to launch than anticipated. MassHealth continues to modify the program to promote ACOs' and CPs' access to direct Technical Assistance, as well as a timely launch of the learning collaborative focused on ACO and CP integration. The IA notes that where MassHealth has met with delays or found demand for the program to be lower than initially anticipated it continues to modify the program to attempt to increase applications, overcome obstacles and invest in areas that continue to show need.

OPPORTUNITIES FOR MITIGATION

The IA identified several systemic challenges affecting progress towards DSRIP goals, and made the following recommendations for mitigation:

- To mitigate challenges in the interface of ACOs and CPs, the IA recommends increasing standardization of roles and responsibilities.

- To mitigate challenges in recruiting qualified staff, the IA recommends continuing and adapting the workforce development SWI and leveraging the recent expansion in telemedicine.

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5 Some CPs enter into agreements with Affiliated Partners: organizations that have a formal agreement with the CP to provide member supports.

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- To mitigate challenges in member engagement, the IA recommends adoption of best practices in sharing of contact information, community-based member outreach, and reviewing payment methods with an eye to appropriately resourcing outreach activities.

- To mitigate challenges in the use of event notifications, the IA recommends broader participation and integration of Mass HIway.

- To mitigate challenges in payment models, the IA recommends ongoing review of payment models based on ACO and CP performance and feedback from ACO and CP leadership.

OPPORTUNITIES FOR ADVANCEMENT OF PROMISING PRACTICES

The IA Identified integration of HRSNs as a critical area for MassHealth to nurture and promote the adoption of promising practices. The IA recommends MassHealth leverage policy opportunities including the flexible services program, the SWI technical assistance program, and collaborations with other state agencies to support sustainable integration of HRSN as a key aspect of health care system transformation.

B. GENERAL BACKGROUND INFORMATION

1. DESCRIPTION OF THE DEMONSTRATION

The MassHealth Section 1115 Demonstration Project [the "Demonstration"] authorizes $1.8 billion over five years for new Delivery System Reform Incentive Program (DSRIP) funding. DSRIP funds support the restructuring of MassHealth's delivery system to promote integrated, coordinated care and hold providers accountable for quality and total cost of care.

DSRIP funds are used to support transitional activities at Accountable Care Organizations (ACOs), and to establish Community Partners (CPs) to integrate behavioral health, long-term services and supports, health-related social needs, and funding to support statewide investments to efficiently scale up statewide infrastructure and workforce capacity in support of MassHealth restructuring.

 The majority of DSRIP funding is distributed to participating provider organizations to support the transition to value-based care. Approximately 60% of DSRIP funds are available to the 17 ACOs contracting with MassHealth, and 30% to the 27 CP organizations. Another 6% of DSRIP funds is dedicated to the provision of Technical Assistance (TA) and other resources for DSRIP participants through the Statewide Investments. The funds spent by ACOs and CPs are displayed by budget category in Figure 1 and Figure 2. ACOs spend half of their funds on care coordination and care management. Clinical and organizational integration represented approximately one-fifth of ACO spending. For CPs, which had budgets divided into Infrastructure and Direct Program costs, Salaries and Business Start Up[6] were the dominant costs. Additionally, MassHealth utilizes 4% of DSRIP funding to support robust implementation and oversight of the DSRIP program.

DSRIP funding is a one-time federal investment that began at the start of State Fiscal Year 2018 and will end after five years. Over the course of the five years, DSRIP funding will phase down as programs aim to become sustainable and reliance on the DSRIP funding declines.

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[6] The CP spending total for the Business Start-Up category includes Ramp-up costs which reflects the Program Budget Surplus/Shortfall.

FIGURE 1. ACO BUDGET TOTAL EXPENDITURES BY CATEGORY FOR DSRIP YEARS 1 AND 2

DERIVED FROM BUDGETS SUBMITTED BY ACOS TO MASSHEALTH. BUDGET CATEGORIES ARE SPECIFIED IN THE MASSHEALTH BUDGET REPORTING TEMPLATE AND DIFFER BETWEEN ACOS AND CPS.

ACO Year 1 Expenditures

Health-Related Social Needs $3,181,685 2%
Community-Based Care Initiatives $2,884,200 2%
Workforce Development $2,193,387 1%
Culturally & Linguistically Appropriate Services $1,899,235 1%
Community Partners $318,653 0%
Data & Population Health Analytics $12,253,775 6%
Other $15,640,904 8%
Clinical Integration $17,655,543 9%
Health Information Technology $18,271,410 9%
Organizational Integration $29,897,769 15%
Care Coordination & Care Management $90,507,956 47%
Total Spent: $194,704,517

ACO Year 2 Expenditures

Health-Related Social Needs $4,910,047 3%
Community-Based Care Initiatives $4,193,740 2%
Culturally & Linguistically Appropriate Services $1,741,967 1%
Workforce Development $1,535,051 1%
Community Partners $661,352 0%
Data & Population Health Analytics $11,781,432 7%
Health Information Technology $12,024,691 7%
Clinical Integration $13,214,299 8%
Other $14,408,882 8%
Organizational Integration $21,577,492 12%
Care Coordination & Care Management $87,627,427 51%
Total Spent: $174,283,230

Derived from budgets submitted by ACOs to MassHealth. Budget Categories are specified in the MassHealth Budget Reporting Template and differ between ACOs and CPs

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Figure 2. CP Total Expenditures by Category for DSRIP Years 1 and 2

Workforce Development $1,333,468 2%

Indirect Infrastructure $1,237,110 2%

Telecommunications $414,722 1%

Operational Infrastructure $2,936,025 5%

Other $3,780,739 6%

Technology $3,939,606 7%

Indirect Program/Administrative Overhead $3,960,228 7%

Staff Costs $27,156,687 45%

Business Start Up $15,065,304 25%

Total Spent: $59,823,889

CP Year 1 Total Expenses

Telecommunications $2,683,990 3%

Workforce Development $2,048,109 2%

Indirect Infrastructure $1,463,809 1%

Other $5,124,874 5%

Technology $5,221,150 5%

Operational Infrastructure $7,205,903 7%

Indirect Program/Administrative Overhead $7,638,212 8%

Staff Costs $49,531,497 50%

Business Start Up $18,889,938 19%

Total Spent: $ 99,807,481

CP Year 2 Total Expenses

Derived from budgets submitted by CPs to MassHealth. Budget Categories are specified in the MassHealth Budget Reporting Template and differ between ACOs and CPs.

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2. HISTORY AND POLICY CONTEXT OF THE DEMONSTRATION

Since 1997, the Executive Office Health and Human Services (EOHHS), and the state's Medicaid and Children's Health Insurance Program (CHIP) Office (MassHealth) have used authority granted through the Section 1115 waiver of the Social Security Act to expand access to care for MassHealth members, support safety net providers and improve the quality of care provided through various program innovations including the Commonwealth's Managed Care program.

MassHealth, like most payors, has historically operated under a fee-for-service payment model. However, some Massachusetts payors began to shift providers onto Alternative Quality Contracts (AQC) with global budgets in 2009, and further health care payment reform efforts became codified with the 2012 passage of Massachusetts General Law Chapter 224, a landmark health care cost containment law. The state began actively pursuing a transition to alternative payment models. MassHealth collaborated with other state agencies to plan a transformation of the systems for care delivery and payment. MassHealth launched a pilot program with a small number of ACOs in 2016 and used early experience to inform future program requirements and policies. In 2017, the Massachusetts Health Policy Commission (HPC) began to certify provider-led ACOs that met established criteria for demonstrating patient-centered, accountable governance, participation in quality-based risk contracts, population health management, and cross- continuum care. The following year, the 17 HPC-certified ACOs participated in the Demonstration, under one of the three models offered by MassHealth.

The waiver's latest extension, granted in November 2016 and extending through June 30, 2022, authorizes $1.8 billion dollars in Delivery System Reform Incentive Payment (DSRIP) program investments over a five-year demonstration period for the purposes of:

- Creating Accountable Care Organizations (ACO) with accountability for quality, member experience and the total cost of care for targeted populations;
- Developing Community Partners (CP) and supporting Community Service Agencies (CSAs) to assist ACOs and Managed Care Organizations (MCOs) in better integrating care for members with significant behavioral health and Long-Term Services and Supports (LTSS) needs;
- Catalyzing statewide investments in infrastructure and workforce capacity to support the demonstrations goals:
- Supporting robust implementation and oversight of the DSRIP program.

Through the creation of ACOs, linkage of ACOs to their CP and CSA partners, and the strengthening of the state's delivery system infrastructure, the DSRIP program hopes to accomplish three primary goals over the five-year demonstration period:

1) Implement payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care;
2) Improve integration among physical health, behavioral health, long-term services and supports (LTSS) and health-related social services;
3) Sustainably support safety net providers to ensure continued access to care for MassHealth and low-income, uninsured individuals.

3. TIMELINE OF DEMONSTRATION

The Demonstration was first launched in 1997. In the summer of 2016, Massachusetts sought an extension of the Section 1115 Demonstration for July 1, 2017 through June 30, 2022. On November 4, 2016, the Centers for Medicare and Medicaid Services (CMS) approved the sixth extension of the Demonstration for the period July 1, 2017 through June 30, 2022. Amendments to the Demonstration were approved on December 14, 2017 and June 27, 2018.

In accordance with the waiver's revised Special Terms and Conditions (STCs) 74[7], an independent assessment is required at the program's midpoint:

"The independent assessor will complete the mid-point assessment, which will individually and systematically assess the performance of demonstration entities (i.e., ACOs, Community Partners, and key Statewide Investment management vendors as determined by the State), including identification of specific challenges and actionable mitigation strategies for mid-course correction for the State's consideration. The mid-point assessment will cover the time period from July 1, 2017 through December 2019 and the mid-point assessment report will be submitted to CMS by the end of September 2020."

In March 2020, CMS approved MassHealth's request for a 1-month extension of the due date to October 2020; in April 2020 an additional 1-month extension was granted, which set the mid-point assessment report due date to November 30, 2020.

C. OBJECTIVES AND SCOPE

1. THE DEMONSTRATION ENTITIES

The Accountable Care Organizations

In State Fiscal Year 2018, EOHHS contracted with 17 organizations collectively representing service regions covering the entire state. The roles and operating requirements for each entity are defined in the STCs, DSRIP Protocol, health plan and ACO contracts with EOHHS, and additional EOHHS-issued guidance. To accommodate the uniqueness of the Commonwealth's health plans and providers and its existing delivery system structures, the program allows for three separate models of ACOs each with varying partnership requirements and financing structures. Each of the three models described below include some level of two-sided risk and measure performance across total cost of care and 22 separate claims, clinical and member experience measures:[8]

- *Accountable Care Partnership Plan (13): a partnership between a single health plan and a provider-led ACO that receives monthly capitated payments from MassHealth based on enrollment and member risk scores, and takes on full insurance risk[9] for the population*

- *Primary Care ACO (3): a provider-led ACO that contracts directly with MassHealth and uses MassHealth's provider network. Providers receive fee for services payments from MassHealth. These ACOs are accountable for performance risk but not insurance risk[10] for the population.*

- *MCO Administered ACO (1): a provider-led ACO that contracts with one or more of MassHealth's MCOs. The MCO receives capitated payments from MassHealth and pays the ACO according to a MassHealth approved arrangement*

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[7] DSRIP Special Terms and Conditions https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf

[8] DSRIP Protocol. Appendix D.

[9] Insurance risk is defined as the risk that a patient will become sick or that a group of patients will have higher than estimated care needs.

[10] Performance risk is defined as the risk of being unable to treat an illness cost-effectively (unable to control controllable costs). Insurance risk is defined as the risk that a patient will become sick or that a group of patients will have higher than estimated care needs.

TABLE 1. COMPLETE LIST OF THE ACOs INCLUDING THEIR HEALTH PLAN PARTNERS AND ATTRIBUTED MEMBERS:

ACO Model	Health Plan Partner	Provider Partner	Demonstration ACO Product Name/dba	Attributed Members[11]
Accountable Care Partnership Plan	BMC HealthNet Plan	Boston ACO	BMC HealthNet Plan Community Alliance	112,887
Accountable Care Partnership Plan	BMC HealthNet Plan	Mercy Health ACO	BMC HealthNet Plan Mercy Alliance	28,243
Accountable Care Partnership Plan	BMC HealthNet Plan	Signature Healthcare	BMC HealthNet Plan Signature Alliance	18,007
Accountable Care Partnership Plan	BMC HealthNet Plan	Southcoast Health	BMC HealthNet Plan Southcoast Alliance	16,114
Accountable Care Partnership Plan	Fallon Health	Health Collaborative of the Berkshires	Berkshire Fallon Health Collaborative	15,534
Accountable Care Partnership Plan	Fallon Health	Reliant Medical Group	Fallon 365 Care	30,286
Accountable Care Partnership Plan	Fallon Health	Wellforce	Wellforce Care Plan	52,967
Accountable Care Partnership Plan	Health New England	Baystate Health Care Alliance	BeHealthy Partnership	37,563
Accountable Care Partnership Plan	AllWays Health Partners	Merrimack Valley ACO	Merrimack Valley Health Partnership	31,949
Accountable Care Partnership Plan	Tufts Health Public Plans	Atrius Health	Tufts Health Together with Atrius Health	31,867
Accountable Care Partnership Plan	Tufts Health Public Plans	Boston Children's Health ACO	Tufts Health Together With Boston Children's ACO	97,353
Accountable Care Partnership Plan	Tufts Health Public Plans	Beth Israel Deaconess Care Organization (BIDCO)	Tufts Health Together with BIDCO	33,713
Accountable Care Partnership Plan	Tufts Health Public Plans	Cambridge Health Alliance (CHA)	Tufts Health Together with CHA	26,158
Primary Care ACO	n/a	Community Care Cooperative (C3)	Community Care Cooperative (C3)	121,591
Primary Care ACO	n/a	Partners Healthcare Choice	Partners Healthcare Choice	106,210
Primary Care ACO	n/a	Steward Health Choice	Steward Health Choice	123,254
MCO-Administered ACO	n/a	Lahey MassHealth ACO	Lahey MassHealth ACO	10,691

The ACO program began member noticing, the process that notified MassHealth members of the ACO program and outlined their enrollment options, on October 1, 2017. At the end of June 2018, approximately 850,000 MassHealth members had been enrolled across the program's ACOs. MassHealth uniquely provides all members eligible for managed care the opportunity to choose to enroll, not simply attributed, with an ACO health based in their service area (either an Accountable Care Partnership Plan or a Primary Care ACO), or with a managed care organization plan (either BMC HealthNet Plan or Tufts Health Public Plans) or the Primary Care Clinician plan. Members who did not actively enroll with an ACO or choose another enrollment option were passively assigned and given a 90-day period to select from any of their available enrollment options, including opting out of the ACO program. Passive assignment was based on several factors; primary amongst them was the desire to preserve any preexisting relationships with a primary care provider or a participating MCO. EOHHS

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[11] MassHealth generated ACO attribution on June 30, 2018, applicable to 2019 (Performance Year 2).

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expanded their consumer outreach, assistance and support services throughout the enrollment period.[12] ACO service delivery officially began on March 1, 2018.

Community Partners

Community Partners provide enhanced care coordination supports designed to enable providers to deliver more comprehensive care for targeted patient populations.[13] The CP program is subdivided primarily between two types: Behavioral Health (BH) CPs which provide care management and care coordination to members with significant behavioral health needs, including those with severe mental illness and substance abuse disorders, and Long-Term Services and Supports (LTSS) CPs which provide care coordination and navigation to members with complex LTSS needs including individuals with physical and developmental disabilities.

During the DSRIP period CPs receive payments from the state for care coordination; following DSRIP, a potential funding mechanism for CPs is direct payments from health plans and/or ACOs. Approximately 30,000 MassHealth members receive supports from CPs during the DSRIP period. EOHHS projects that upon its full implementation, the CP program will have developed the infrastructure and capacity to provide care coordination for a targeted population of nearly 60,000 MassHealth members.

EOHHS initiated a statewide request for proposal for CPs in February of 2017 and began contract negotiations in 2017, ultimately contracting with 27 CPs (18 BH and 9 LTSS). EOHHS began assigning MassHealth members to CPs based on historic claims experience and alerted those assigned of the service availability. In a process similar to ACO enrollment, members were given an opportunity to switch their assigned CP or opt-out of the CP program all together. Those who are not assigned to a CP were given the option to opt-into a CP prior to January 1, 2019. The CP Program began providing support for MassHealth members on July 1, 2018.

TABLE 2. COMPLETE LIST OF BEHAVIORAL HEALTH COMMUNITY PARTNERS

Behavioral Health CPs	Consortium Entities and Affiliated Partners
Behavioral Health Network, Inc.	
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.*
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.*
Brien Center Community Partner Program	
Central Community Health Partnership (BH)	• *The Bridge of Central Massachusetts* • *Alternatives Unlimited, Inc.* *LUK, Inc.* • *Venture Community Services*

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[12] https://www.masshealthchoices.com/
[13] DSRIP Protocols. Section 1.4.2 Community Partners and CSAs. http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/dsrip-protocol.pdf

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	• *AdCare*
Clinical and Support Options, Inc.	
Community Care Partners, LLC	• *Vinfen Corporation* • *Bay Cove Human Services, Inc.*
Community Counseling of Bristol County, Inc.	
Community Healthlink, Inc.	
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.*
Eliot Community Human Services, Inc.	
Greater Lowell Behavioral Health Community Health Center, Inc.	• *Lowell House, Inc.* • *Lowell Community Health Center*
Innovative Care Partners, LLC (BH)	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*
Lahey Behavioral Health Services	
Riverside Community Partners	• *Brookline Community Mental Health Center, Inc.* • *The Edinburg Center, Inc.* • *Upham's Corner Health Center* • *North Suffolk Mental Health Association* • *Riverside Community Care*
South Shore Community Partnership.	• *South Shore Mental Health Center, Inc.* • *Spectrum Health Systems, Inc.*
Southeast Community Partnership, LLC	• *South Shore Mental Health Center, Inc.* *Gosnold, Inc.* • *FCP, Inc. dba Family Continuity*
SSTAR Care Community Partners	• *SSTAR* • *Greater New Bedford Community Health Center, Inc.* • *HealthFirst Family Care Center, Inc.* • *Fellowship Health Resources, Inc.*

TABLE 2. COMPLETE LIST OF LONG-TERM SERVICES AND SUPPORTS COMMUNITY PARTNERS

Long-Term Supports and Services CPs	Consortium Entities and Affiliated Partners
Boston Allied Partners	• *Boston Medical Center Corporation* • *Boston Senior Home Care, Inc.* • *Central Boston Elder Services* • *Southwest Boston Senior Services d.b.a Ethos*
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 Community Health Partnership (LTSS)	• *Alternatives Unlimited* • *The Bridge of Central Massachusetts, Inc.*

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	• *LUK, Inc.* • *Venture Community Services, Inc.* • *AdCare*
Family Service Association	
Innovative Care Partners, LLC (LTSS)	• *Center for Human Development* • *Gandara Mental Health Center, Inc.* • *Service Net, Inc.*
LTSS Care Partners, LLC	• *Vinfen* • *Bay Cove Human Services* • *Justice Resource Institute* • *Mystic Valley Elder Services* • *Somerville Cambridge Elder Services* • *Boston Senior Home Care, Inc.*
Massachusetts Care Coordination Network	• *Advocates, Inc.* • *Boston Center for Independent Living, Inc.* • *BayPath Elder Services, Inc.* • *Brockton Area Multi Services, Inc. (BAMSI)*
Merrimack Valley Community Partner	• *Elder Services of Merrimack Valley* • *Northeast Independent Living*
North Region LTSS Partnership	• *Bridgewell, Inc.* • *Northeast Arc, Inc.*

Statewide Investment Efforts

The third primary funding stream established in support of the DSRIP program is a set of Statewide Investments (SWI) meant to increase scalable infrastructure and workforce capacity across program participants. The SWI program was established to invest approximately $115M or 6% of the waivers total spend across eight separate investment categories over the program's five years:

1) Student Loan Repayment Program: aims to address the shortage of providers at community-based settings by repaying a portion of providers' student loans in exchange for service commitments at Community Health Centers (CHCs), Community Mental Health Centers (CMHCs), Emergency Services Program (ESPs), CPs and their Affiliated Partners and Consortium Entities, and Community Service Agencies (CSAs);
2) Primary Care/Behavioral Health Special Projects Program: provides support for CHCs, CMHCs, ESPs, CPs and their Affiliated Partners and Consortium Entities, and CSAs to allow providers to engage in one-year projects related to accountable care implementation;
3) Investment in Community-based Training and Recruitment: aims to increase the number of family medicine and nurse practitioner residents trained in CHCs, and BH providers recruited to CMHCs;
4) Workforce Development Grant Program: supports development and training to enable members of the extended healthcare workforce to operate more effectively in a new health care system;
5) Technical Assistance (TA): provides TA to ACOs, CPs, and CSAs as they participate in payment and care delivery reform;
6) Alternative Payment Methods (APM) Preparation Fund: supports providers that are not yet ready to participate in an APM, but want to take steps towards APM adoption;
7) Enhanced Diversionary Behavioral Health Activities: supports investments in new or enhanced diversionary levels of care that meet the needs of members with behavioral health needs at risk for ED boarding within the least restrictive, most clinically appropriate settings;
8) Improved Accessibility for People with Disabilities or for whom English is not a Primary Language: assists providers in delivering necessary equipment and expertise to meet needs of people with disabilities, or for whom English is not a primary language.

The eight initiatives can be broadly grouped based on three separate focused areas for investment.

SWI 1-SWI 4 are principally focused on providing funding at the primary and behavioral healthcare provider organization and frontline/peer workforce development levels through student loan forgiveness programs, funding for special accountable care implementation efforts, funds to support training and professional development, and funds meant to assist with staff recruitment and retention. The state entered into agreements with two vendors during the third quarter of 2018, the Massachusetts League of Community Health Centers and the Commonwealth Corporation, that specialize in identifying and providing workforce development assistance specifically for these provider and staff populations in support of these investments.

SWI 5 and SWI 6 encompass much of the program's Technical Assistance, promoting readiness for greater adoption of APMs through targeted assistance for specific projects, learning collaboratives, the establishment of standardized trainings and the development of learning platforms for use by program participants. EOHHS engaged Abt Associates as the primary vendor overseeing these efforts as they relate to SWI 5 (Technical Assistance).

The final two investments, SWI 7 and SWI 8 were specifically identified to address remaining gaps in the State's delivery system which required a coordinated statewide effort to address. SWI 7 is meant to reduce the levels of patient boarding in emergency departments through the support of diversionary programs.[14] SWI 8 addresses access for individuals with disabilities and for individuals for whom English is not a primary language. EOHHS engaged the University of Massachusetts Medical School to assist in administering SWI 8 through the creation of a provider directory for MassHealth members that details the accessibility accommodations at MassHealth providers. EOHHS engaged Health Resources in Action (HRiA) to administer the Provider Access Improvement Grant Program (PAIGP) which provides grants to support providers in the acquisition of equipment and resources that meet the needs of members with disabilities or for whom English is not a primary language.

2. SCOPE AND TIMELINE OF THE MPA

The Independent Assessor (IA) used document review, a survey of practice site administrators, and key informant interviews (KIIs) to assess progress of ACOs and CPs towards the goals of DSRIP during the time period covered by the Midpoint Assessment; July 1, 2017 through December 31, 2019. The level of assessment is the ACO or CP; this report describes findings at the cohort level. The eight investments of the SWI program were also reviewed.

Progress was defined by the ACO and CP actions listed in the detailed MassHealth DSRIP Implementation Logic Model (Appendix A), organized into a framework of focus areas which are outlined below. This detailed model was developed by MassHealth and the DSRIP Independent Evaluator[15] to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was the basis for the high level logic model which is described in the CMS approved "Independent Evaluation Design Document: Massachusetts 1115 Demonstration Extension 2017-2022".[16]

The question addressed by the midpoint assessment is:

> To what extent have participating entities (ACOs and CPs) taken organizational level actions to transform care delivery under an accountable and integrated care model?

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[14] Massachusetts Health Policy Commission Report on Behavioral Health-Related Emergency Department Boarding in Massachusetts. November 2017.
[15] University of Massachusetts Medical School (UMMS) is the Independent Evaluator (IE) – a distinct role separate from the Independent Assessor – and is responsible for evaluating the outcomes of the demonstration.
[16] https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download

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For the MPA, CPs and ACOs were assessed across several defined aspects of health system transformation. These "focus areas" were derived from the DSRIP logic model, by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes
3. Workforce Development
4. Health Information Technology and Exchange
5. Care Coordination and Management (for CPs, "Care Model")
6. Population Health Management (ACOs only)

The IA assessed the progress of each participating entity in each focus area, as described in Section D. Methodology, and then aggregated these results to understand the progress of the ACO and CP cohorts. This report describes the IA's findings on the cohort level, for ACOs and for CPs, and the IA's review of the Statewide Investments made by MassHealth to support ACOs and CPs.

D. METHODOLOGY

1. KEY DEMONSTRATION ENTITIES

All 17 ACOs certified to contract with MassHealth are participating in the demonstration. The demonstration also includes 27 Community Partner (CP) organizations; CPs are community-based entities that work with ACOs and MCOs to provide care management and coordination to certain members identified by MassHealth, ACOs, and MCOs. Behavioral Health (BH) CPs provide supports to certain members with significant behavioral health needs, including serious mental illness and addiction. Long-Term Services and Supports (LTSS) CPs provide supports to certain members with complex LTSS needs, such as children and adults with physical and developmental disabilities and brain injuries. Of the 27 CPs, 18 provide BH supports, and 9 provide LTSS.

2. ASSESSMENT PERIOD

The midpoint assessment covers the time period from July 1, 2017 through December 31, 2019, as specified in the DSRIP Special Terms and Conditions.

3. MEASUREMENT: FOCUS AREA FRAMEWORK

The MPA assessment findings cover five "focus areas" or aspects of health system transformation. ACOs were assessed on an additional focus area. Given the absence of pre-established benchmarks for progress that would apply to MassHealth ACOs and CPs, this custom framework was derived from the DSRIP logic model, by grouping organizational level actions referenced in the logic model into six domains.

Table 3 shows the ACO/CP actions that correspond to each focus area. This framework was used to assess each entity's progress. A rating of On track indicates that the entity has made appropriate progress in accomplishing each of the actions for the focus area. Where gaps in progress were identified, the entity was rated On track with limited recommendations or, in the case of more substantial gaps, Opportunity for Improvement.

TABLE 3. FRAMEWORK FOR ORGANIZATIONAL ASSESSMENT OF ACOS AND CPS (MPA FOCUS AREAS)

Organizational Structure & Engagement	
ACO Actions	CP Actions

ACOs established with specific governance, scope, scale, & leadership	CPs established with specific governance, scope, scale, & leadership
ACOs engage providers (primary care and specialty) in delivery system change through financial (e.g. shared savings) and non-financial levers (e.g. data reports)	CPs engage constituent entities in delivery system change

Integration of Systems & Processes	
ACO Actions	**CP Actions**
Establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)	Establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)
Establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)	Establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendations
Establish structures and processes for joint management of performance and quality, and conflict resolution	Establish structures and processes for joint management of performance and quality, and problem solving.
Accountable Care Partnership Plans (Model A) transition more of the care management responsibilities to their ACO Partners over the course of the demonstration	

Workforce Development	
ACO Actions	**CP Actions**
ACOs recruit, train, and/or re-train administrative and provider staff by leveraging SWIs and other supports; education includes better understanding and utilization of BH and LTSS services	CPs recruit, train, and/or re-train staff by leveraging SWIs and other supports

Health Information Technology & Exchange	
ACO Actions	**CP Actions**
ACOs develop HIT/HIE infrastructure and interoperability to support population health management (e.g. reporting, data analytics) and data exchange within and outside the ACO (e.g. CPs/CSAs; BH, LTSS, and specialty providers; social service delivery entities)	CPs develop HIT/HIE infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. ACOs, MCOs; BH, LTSS, and specialty providers; social service delivery entities)

Care Coordination & Management	
ACO Actions	**CP Actions**
Develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., DMH)	CPs Develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are

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complementary) with services provided by other state agencies (e.g., DMH)

Population Health Management & Total Cost of Care Management (ACO only)
ACOs develop capabilities and strategies for non-CP-related population health management approaches, which include risk stratification, needs screenings and assessments, and addressing the identified needs in the population via range of programs (e.g., disease management programs for chronic conditions, specific programs for co-occurring MH/SUD conditions)
ACOs develop structures and processes for integration of health-related social needs into their PHM strategy, including management of flex services
ACOs develop strategies to reduce total cost of care (TCOC) (e.g. utilization management, referral management, non-CP complex care management programs, administrative cost reduction)

4. DATA SOURCES AND COLLECTION

The MPA drew on multiple data sources to assess organizational performance in each focus area, including both historical data contained in the documents that ACOs and CPs were required to submit to MassHealth, and newly collected data gathered by the IA and/or Independent Evaluator (IE). The IA performed a desk review of documents that ACOs and CPs were required to submit to MassHealth, including participation plans, annual and semi-annual reports. In addition, the IA developed and conducted an ACO Practice Site Administrator survey to investigate the practices and perceptions of participating primary care practices. The Independent Evaluator (IE) developed a protocol for ACO and CP Administrator KIIs, which were conducted jointly by the IA and the IE.

MPA data sources:

1) Documents submitted by entities to MassHealth covering the reporting period of July 1, 2017 through December 31, 2019:
    - Full Participation Plans (FPPs)
    - Semi-annual and Annual Progress Reports (SPRs, APRs)
    - Budgets and Budget Narratives (BBNs)
2) Newly Collected Data
    - ACO and CP Administrator KIIs
    - ACO Practice Site Administrator Survey

The MPA did not include any outcome data, such as claims, quality metrics, or cost of care analyses; these data sources are part of the scope of the IE.

5. ACO PRACTICE SITE ADMINISTRATOR SURVEY

ACO Practice Site Administrator Survey Methodology

The aim of the ACO Practice Site Administrator Survey was to systematically measure ACO implementation and related organizational factors from the perspective of the ACOs' participating primary care practice sites. For the purpose of this report, "practice site" refers to an adult or pediatric primary care practice location.

The results of the survey were used in combination with other data sources to assess ACO cohort-wide performance in the MPA focus areas. The survey did not seek to evaluate the success of the DSRIP program, or of individual ACOs. Rather, the survey focused on illuminating the connections between

structural components and implementation progress across various ACO types and across the ACO cohort for the purpose of midpoint assessment.

Survey Development: The survey tool was structured around the MPA focus areas described previously, with questions pertaining to each of the six areas. Following a literature review of existing validated survey instruments, questions were drawn from the National Survey of ACOs (NSACO), National Survey of Healthcare Organizations and Systems (NSHOS), and the Health System Integration Manager Survey (HSIMS) to develop measures relevant to the State and appropriate for the target group. Cognitive testing (field testing) of the survey was conducted at 4 ACO practice sites. Following the cognitive testing and collaboration with the State, survey questions were added or modified to better align with the purpose of the MPA and the target respondents.

Sampling: A sampling methodology was developed to yield a sample of practice sites that is reasonably representative of the ACO universe of practice sites. First, practice sites serving fewer than 50 attributed members were excluded. Next, a random sample of 30 sites was selected within each ACO; if an ACO had fewer than 30 total sites, all sites were included. A stratified approach was applied in order to draw a proportional distribution of sites across Group Practices and Health Centers (Health Centers include both Community Health Centers and Hospital-Licensed Health Centers). A 64% survey response rate was achieved; 225 practice sites completed the survey, out of 353 sampled sites. The responses were well-balanced across practice site type (Table 4) and across geographical region (Table 5).

TABLE 4. DISTRIBUTION OF PRACTICE SITE TYPES

Distribution of Sites by Practice Site Type		
	Group Practices	Health Centers
Percentage of Practice Site Types in Survey Sample (N=353)	80%	20%
Percentage of Practice Site Types in Surveys Completed (N=225)	78%	22%

TABLE 5. DISTRIBUTION OF PRACTICES ACROSS GEOGRAPHY

Regional Distribution of Practice Sites					
	Central	Greater Boston	Northern	Southern	Western
Distribution of Practice Sites in Sample (N=353)	16%	22%	25%	24%	13%
Distribution of Practice Sites Responses (N = 225)	16%	19%	25%	25%	14%

Administration: The primary contact for each ACO was asked to assist in identifying the best individual to respond to the survey for each of the sites sampled. The survey was administered using an online platform; the survey opened July 18, 2019 and closed October 2, 2019. Survey recipients were e-mailed an introduction to the survey, instructions for completing it, a link to the survey itself, and information on where to direct questions. Multiple reminders were sent to non-responders, followed by phone calls reminding them to complete the survey.

Analysis: Results were analyzed using descriptive statistics at both the individual ACO level (aggregating all practice site responses for a given ACO) and the statewide ACO cohort level (aggregating all responses). Given the relatively small number of sites for each ACO, raw differences among ACOs, or between an ACO and the statewide aggregate results, should be viewed with caution. The sample was not developed to support tests of statistical significance at the ACO level.

6. KEY INFORMANT INTERVIEWS

Key Informant Interviews (KII) of ACO Administrators were conducted in order to understand the degree to which participating entities are adopting core ACO competencies, the barriers to transformation, and the organization's experience with state support for transformation. The KII aid in the identification of organizational elements that may be tested against the survey results. The interviews may also have been used to fill gaps identified through the desk review process. The interviews were designed to consider the "many to many" nature of ACO to CP relationships and query the ACO on the specific CPs most involved with their own attributed members. Similarly, the CP Administrator interview questions were constructed to reference the specific ACOs with which the CP has the most significant overlap.

7. ANALYTIC APPROACH

The ACO and CP actions are broad enough to be accomplished in a variety of ways by different entities, and the scope of the IA is to assess progress, not to prescribe the best approach. Moreover, no pre-established benchmark is available to determine what represents adequate progress at the midpoint. The need for a realistic threshold of expected progress led the IA to use a semi-empirical approach to defining the status that should be considered On track. Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans separately for the ACO and CP cohorts, which identified a broad range of activities and capabilities that fell within the logic model actions. This provided specific operational examples of how organizations can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item, and relevance to the focus area. A descriptive definition of On track performance for ACOs and for CPs in each focus area was developed from the items that had been adopted by a plurality of entities. Items that had been accomplished by only a small number of entities were considered to be emerging practices and were not included in the expectations for On track performance. This calibrated the threshold for expected progress to the actual performance of the cohort as a whole.

Qualitative coding of documents to focus areas, and analysis of survey results relevant to each focus area, were used to assess whether and how each entity had accomplished the actions for each focus area. The assessment was holistic, and as such did not require that each entity meet every item on a list for a given focus area. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and there are no recommendations for improvement. Where evidence was lacking in the results of desk review and survey, keyword searches of KII interview transcripts were used to seek additional information. Prior to finalizing the findings for an entity, the multiple reviewers convened to confirm that thresholds were applied consistently, and that the reasoning was clearly articulated and documented. ACOs/CPs were given an opportunity to provide a response to the findings, which were also appended to the report.

A rating of On track indicates that the ACO has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated On track with limited recommendations or, in the case of more substantial gaps, Opportunity for Improvement.

8. REVIEW OF STATEWIDE INVESTMENTS

The IA conducted a qualitative review of the Statewide Investments made by MassHealth to support the goals of DSRIP. The question addressed by the review was "*How did MassHealth implement the SWI*

program, in what ways did the program meet or not meet the initial expectations, and what course corrections, if any, would improve the program?"

To collect data, the IA prepared a comprehensive data request for MassHealth, including information on the implementation and results of SWI. The IA received primary documents supplied by vendors who administered the SWI on behalf of MassHealth, including contractually required reports of activities and results, and additional data specifically pulled for the MPA. The IA also received summary and detailed data from MassHealth. The IA reviewed documentation of the application and selection processes used for funding applications, and the outcomes of these processes. The IA followed up with ad hoc requests for clarification or additional data where necessary. The IA also reviewed publicly available information about SWI on the websites of MassHealth and vendors who administered the program. Finally, the IA conducted semi-structured interviews with key vendors and members of the MassHealth team in order to provide context for the IA review.

E. METHODOLOGICAL LIMITATIONS

1. SOURCE LIMITATIONS

The MPA relied heavily on self-reported data from ACOs and CPs for detailed information about their programs and practices. The participating entities attest to the accuracy of the participation plans and progress reports that they submit, and the IA reviews them for completeness, but some limitations are associated with this data source. Entities varied in the level of detail they included in reports, and reports may have been developed by staff members with varying roles at different entities. The IA is not able to independently confirm the information reported, or to know if relevant details, such as a specific process for care coordination that exists at an ACO, have not been mentioned. This can lead to the IA noting an apparent gap in progress as a result of a gap in the entity's self-reporting. The IA attempted to mitigate this challenge by triangulating data sources. When a gap in progress was noted in desk review, survey data (for ACOs) and KII transcripts were examined for evidence that would indicate that the entity has accomplished the item in question.

2. TIME LIMITATIONS

The applicability of the MPA findings are necessarily limited by the time elapsed since the end of the assessment period on December 31, 2019. The annual progress reports covering this time period2019 were originally due March 31,2020, but were delayed by approximately 45 days in 2020 due to the impact of the COVID-19 pandemic on provider organizations across the state, increasing the lag time between the reports and the time period they covered. The ACO practice site administrator survey was conducted in July-October 2019, and KIIs were conducted May-July 2019. As ACOs and CPs have continued their implementation efforts and have experienced ongoing changes, some findings may not represent the current state of DSRIP progress.

3.SAMPLE SIZE AND CONTEXT

The entities covered by the MPA are 17 ACOs, 18 BH CPs, and 9 LTSS CPs. Because every ACO and CP in the Commonwealth is covered by the demonstration, no reference sample is available for comparison. The IA used national data for context where possible, with the caveat that other states are not equivalent in their healthcare landscape, demographics, and policy context.

F. ACO RESULTS

INTRODUCTION

The following section outlines the ACOs' progress across the six focus areas. Figure 3 summarizes findings by ACO, showing that in each focus area, a majority of ACOs are On track or On track with recommendations.

The progress of the cohort is described for each focus area. Each focus area discussion begins with a description of the ACO actions associated with an On track assessment. The list of characteristics of On track organizations for each focus area was developed by the IA as described in section D. Methodology and aligned on with MassHealth. Results from the ACO practice site administrator survey are also presented within the focus area discussions. Survey results are reported at the cohort level, with all ACOs weighted equally regardless of the number of practice sites.

FIGURE 3: ACO FINDINGS BY FOCUS AREA
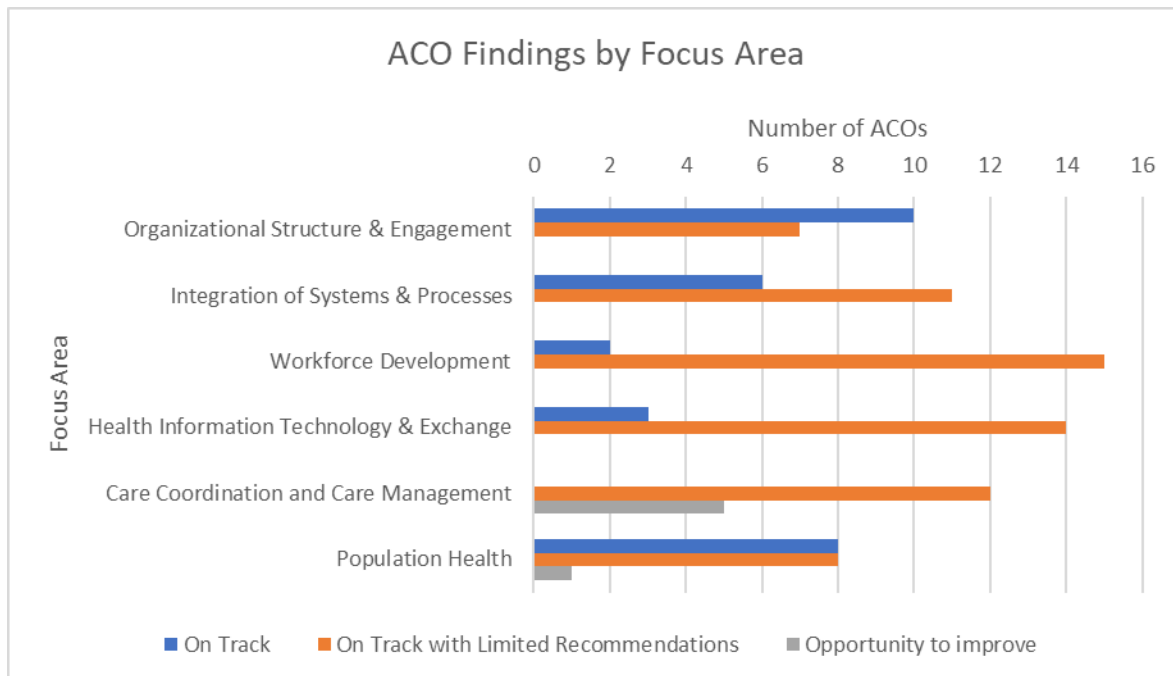
1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

Characteristics of ACOs considered On track:

- ✓ **Established governance structures**
  - ○ includes representation of providers and members, and a specific consumer advocate, on executive board;
  - ○ receives and incorporates, through the executive board, regular input from the population health management team, and the Consumer Advisory Board/Patient Family Advisory Committee;
  - ○ has a clear structure for the functions and committees reporting to the board, typically including quality management, performance oversight, and contracts/finance.

- ✓ **Provider engagement in delivery system change**
  - o has established processes for joint management of quality and performance, including regular performance reporting to share quality and performance data, on-going performance review meetings where providers and ACO discuss areas for improvement of performance, and education and training for staff where applicable;
  - o communicates a clearly articulated performance management strategy, including goals and metrics, to practice sites, but also grants sites some autonomy on how to meet those goals, and uses feedback from providers and sites in ACO-wide continuous improvement for quality and performance.

Findings

For the Organizational Structure and Engagement focus area, the IA found that ten ACOs were On track with no recommendations, and seven ACOs were On track with limited recommendations.

Established Governance Structure:

The ACOs established similar governance structures that vary primarily based on their model type. All ACPPs established leadership structures that include Joint Operations Committees with equal representation from MCO and ACO partners. These senior-most governance committees tend to be comprised predominately of clinicians chosen from each partner. QMCs, largely responsible for providing performance oversight and management, are mostly composed of members that are either practicing or previously practicing physicians. Most ACO population health management leadership regularly reports to senior level governance entities. Directors of population health management programs or medical officers typically serve on key committees overseeing the ACO's greater PHM strategy.

Nearly all ACOs developed protocols to include feedback from at least one Patient and Family Advisory Committee (PFAC) that is in continual operation inside the ACO. Most ACOs appear to use their PFACs as axillary advisors to either Joint Operating Committees (JOCs) or governance committees situated inside of ACO partners. PFACs regularly report to these governance entities on a wide variety of topics. Some ACOs engage their PFACs at a more substantial level, using them as a vetting body for technical proposals related to care management or care coordination. Some, though not all, ACO PFACs include one or more MassHealth members. Those that do include MassHealth members also reported more meaningful levels of engagement with their PFACs. The IA recommends that ACOs should **expand their efforts to engage MassHealth members in their PFACs and systematically integrate PFAC input** into leadership feedback reporting structures and other substantial aspects of ACO operations. ACOs may need to revisit the incentives and compensation that they offer for PFAC participation in order to increase the number of MassHealth members who participate so that they can receive the range of perspectives needed for a meaningful consumer voice.

Provider engagement in delivery system change:

Nearly all ACOs have methods to identify quality and performance management priorities, though some have an opportunity to clarify how these priorities are set. Many ACOs have an established central process but regionally or locally implemented strategy, creating high level organizational improvement priorities and using the ACO's centralized databases to develop regular performance reports for distribution across some type of federated delivery network.

Most ACOs staff quality officers or other improvement technicians who are capable of assisting groups or individual providers with interpreting performance data and implementing remediation or improvement efforts. Some ACOs use centrally staffed resources to communicate leading practices in improvement areas across groups of practice sites. These quality leaders frequently oversee trainings on areas of

importance across the ACO and facilitate learning around quality improvement initiatives specific to local practices or the ACO itself.

Most ACOs allow practice sites to have significant autonomy to pursue improvement efforts. A few ACOs both centrally identify quality improvement opportunities and assign central staff resources to oversee improvement interventions. ACOs can support their practice sites and provider engagement in quality initiatives by setting clear central priorities and defining expectations and available support for practice site level, provider-led, quality improvement (QI) initiatives.

A few ACOs spoke at length of efforts to create a culture of continuous quality improvement. Some ACOs are **purposefully balancing higher levels of regional or local autonomy in improvement prioritization or decision making** with ongoing efforts to train on formal methods for rapid cycle continuous improvement.

Most provider sites reported engaging physicians by regularly sharing performance measures with a focus on clinical care metrics. Most ACOs spoke at length regarding the management of clinical care metrics while only briefly describing certain, and typically, up-side only incentive pools based on cost management metrics. Further reinforcing this focus on clinical performance, an average of just under half (47%) of practice sites across ACOs reported using individual financial incentives for performance management.

FIGURE 4. PROVIDER ENGAGEMENT AND PHYSICIAN PERFORMANCE MANAGEMENT APPROACHES
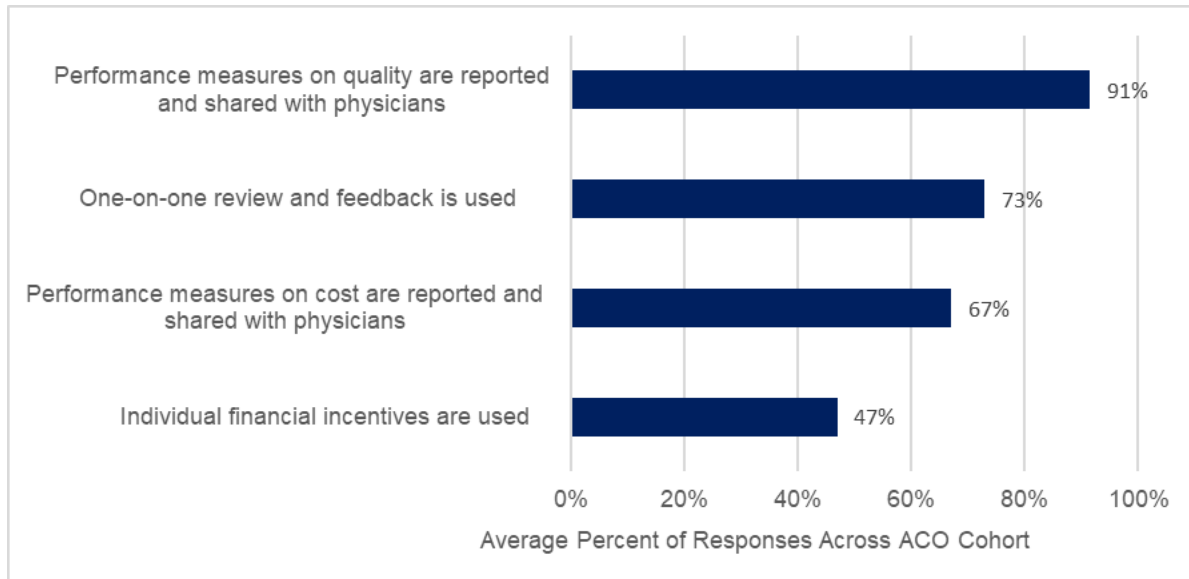
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N = 17
Figure displays responses to Q37. *Which of the following approaches are used to manage the performance of individual physicians who practice at your site? Select all that apply.*
Statistical significance testing was not done due to small sample size.

Survey results also indicated that practice sites perceive that **more standardized approaches to measurement and feedback are being adopted** (Fig. 5). Across the ACO cohort, on average, 53% of survey respondents indicate that performance management of physicians has become a little more or a lot more standardized in the past year, 69% of survey respondents indicate that care processes and team structure has become a little more or a lot more standardized in the past year, 76% of survey respondents indicate that hospital discharge planning and follow-up has become a little more or a lot more standardized in the past year, 48% of survey respondents indicate that recruiting and performance review has become a little more or a lot more standardized in the past year, and 72% of survey respondents indicate that data elements in the electronic health record have become a little more or a lot more standardized in the past year.

FIGURE 5. STANDARDIZATION OF PROCESSES OVER THE PAST YEAR
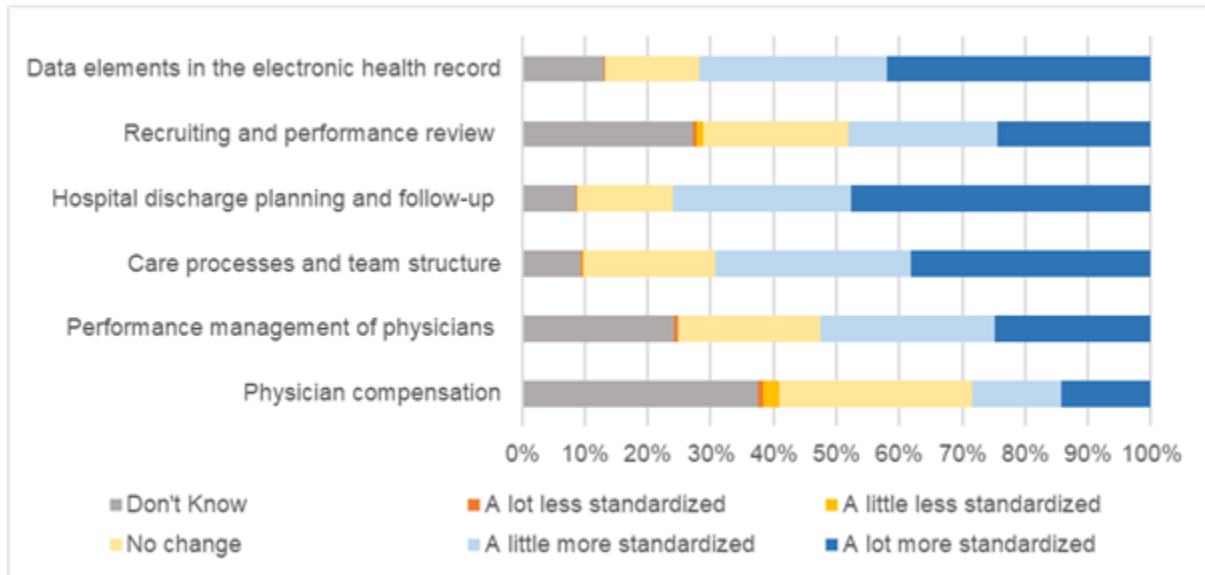
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N = 17
Figure displays responses to Q12. *In the past year, to what degree have the following practices in your clinic become more standardized, less standardized or not changed?*
Statistical significance testing was not done due to small sample size.

2. INTEGRATION OF SYSTEMS AND PROCESSES

Characteristics of ACOs considered On track:

- ✓ **Administrative coordination among ACO member organizations and with CPs**

    - o circulates frequently updated lists including enrollee contact information and flags members who can enroll in or receiving CP supports;

    - o shares reports including risk stratification, care management, quality, and utilization data with practice sites;

    - o practice sites report that when members are receiving care coordination and management services from more than one program or person, these resources typically operate together efficiently.

- ✓ **Clinical Integration among ACO member organizations and with CPs**

    - o deploys shared team models for case management, locating ACO staff at practice sites, and providing both role-specific and process-oriented training for staff at practice sites;

    - o enables PCP access to all member clinical information through an EHR; and sites are able to access results of screenings performed by the ACO;

    - o co-locates BH resources and primary care where appropriate.

- ✓ **Joint management of performance and quality**

- o articulates a clear and reasoned plan for quality management that jointly engages practice sites and ACO staff, and explicitly incorporates specific quality metrics;

- o dedicates a clinician leadership role and ACO staff to reviewing performance data, identifying performance opportunities, and implementing associated change initiatives in cooperation with providers.

- ✓ **ACO/MCO coordination** (at Accountable Care Partnership Plans)

  - o shares administrative and clinical data between ACO and MCO entities, and circulates regular reports including population health and cost-of-care analysis;

  - o is coordinated by a Joint Operating Committee for alignment of MCO and ACO activities, which manages clinical integration and is planning transitions of functions from MCO to ACO over time.

Findings

For the Integration of Systems and Processes focus area, the IA found that six ACOs are On track, and eleven are On track with limited recommendations.

Administrative coordination among ACO member organizations and with CPs:

All ACOs circulate enrollee contact lists with their practice sites to improve administrative coordination. Some ACOs receive this information from their MCO and then distribute it to practice sites. Most ACOs include information about members' potential need for or engagement in CP supports when distributing member information either through reports or an EHR flagging system.

ACOs use a broad variety of tools to coordinate data exchange with CPs. Some ACOs have systems to send electronic alerts and notifications to CPs. Most ACOs conduct **regular case review and coordination meetings with CPs**. A few CPs have access to member information through an ACO's EHR, but this is not common.

Improving quality and coordination of care are hallmarks of the ACO program. To monitor and improve quality, **all ACOs share quality and utilization data with practice sites**. Some ACOs distribute static reports while others create dashboards or scorecards. Risk stratification helps ACOs predict health risk in the population and helps prioritize care coordination activities and interventions. Most ACOs include risk stratification data in reports they share with participating organizations to assist care management coordination efforts, particularly for the highest risk members. A few ACOs share risk stratification information with CPs as well.

The **IA recommends that ACOs integrate CPs into their regular reporting** as a routine aspect of operations. This includes regularly sharing quality reports, contact lists, and risk stratification reports and establishing CP representation at key operational meetings, such as quality committee meetings.

An average of 55% of practice sites across all ACOs indicated in the ACO Practice Site Administrator Survey that they felt care coordination resources usually or always operated together efficiently (Fig. 6).

FIGURE 6. CARE COORDINATION RESOURCES ACROSS MULTIPLE PROGRAMS
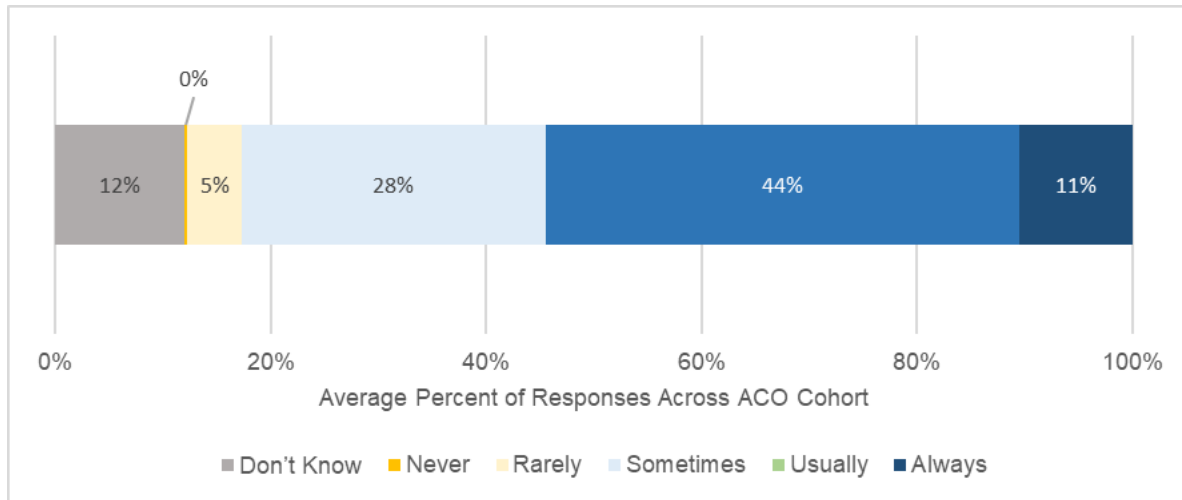
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N = 17
Figure displays responses to Q3. *For your MassHealth members who receive care coordination and management services from more than one program or person, how often do these resources operate together efficiently?*
Statistical significance testing was not done due to small sample size.

Clinical Integration among ACO member organizations and with CPs:

All ACOs deploy some form of a team model for care management that engages member organizations or other partners. Though ACOs developed unique structures to their models, an RN or nurse care manager typically leads most teams. Most ACOs **embed staff at practice sites to perform case management and care management activities** around members' appointment times.

In the ACO Practice Site Administrator Survey, a majority of practices sites across all ACOs (64%) reported that at least a few of their MassHealth members receive care coordination supports from a CP (Fig. 7), and an average of 71% reported that clinicians, staff and/or administrators have sometimes, often or almost always interacted with CP staff in coordinating patients' care (Fig. 8). Additionally, an average of 51% of practice sites across all ACOs reported that the existence of CPs has made it easier some or almost all of the time to provide high quality care, to MassHealth members (Fig. 9). In order to effectively manage care across organizations and avoid duplication, some ACOs conduct joint care management team meetings with CPs.

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FIGURE 7. PERCENT OF MASSHEALTH MEMBERS RECEIVING SUPPORTS FROM COMMUNITY PARTNERS
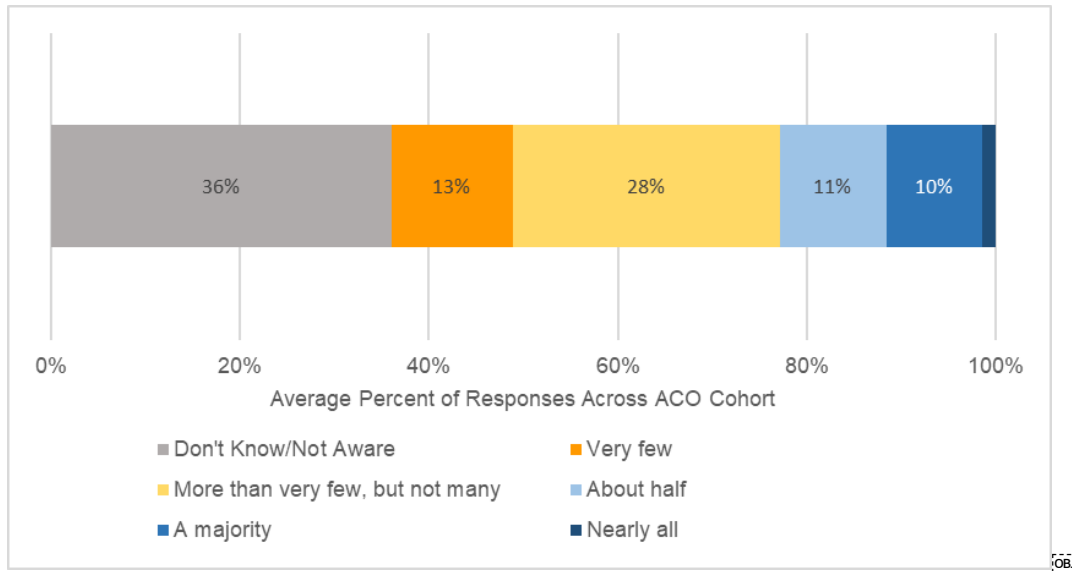
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N = 17
Figure displays responses to Q31. Currently which of the following best describes how many MassHealth members in your practice are receiving care coordination services from a MassHealth designated Community Partner? (Very few, More than very few, but not many, About half, A majority, Nearly all, Don't Know/Not Aware)
Statistical significance testing was not done due to small sample size.

FIGURE 8. PRACTICE SITE INTERACTION WITH COMMUNITY PARTNERS
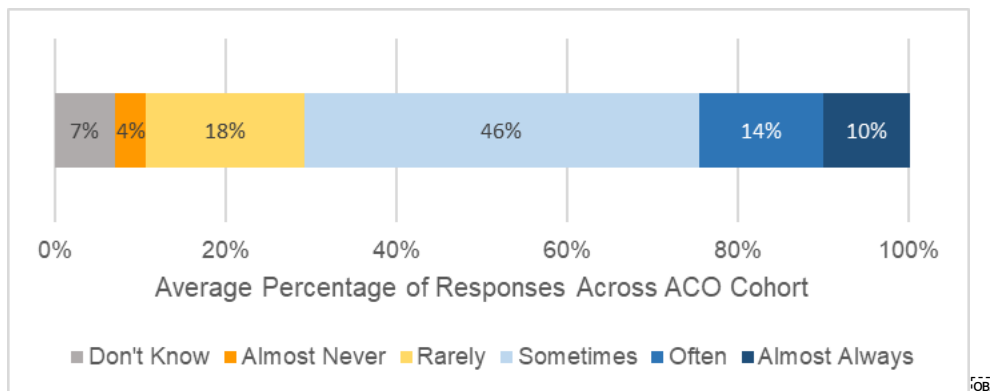
Number of Practices Reporting in the State, N = 225
Figure displays responses to Q32. How frequently have clinicians, staff and/or administrators interacted with Community Partner organization staff in coordinating these patients' care? (Almost Never, Rarely, Sometimes, Often, Almost Always, Don't know)
Statistical significance testing was not done due to small sample size.

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FIGURE 9. COMMUNITY PARTNER IMPACT ON ABILITY TO PROVIDE HIGH QUALITY CARE FOR MASSHEALTH MEMBERS
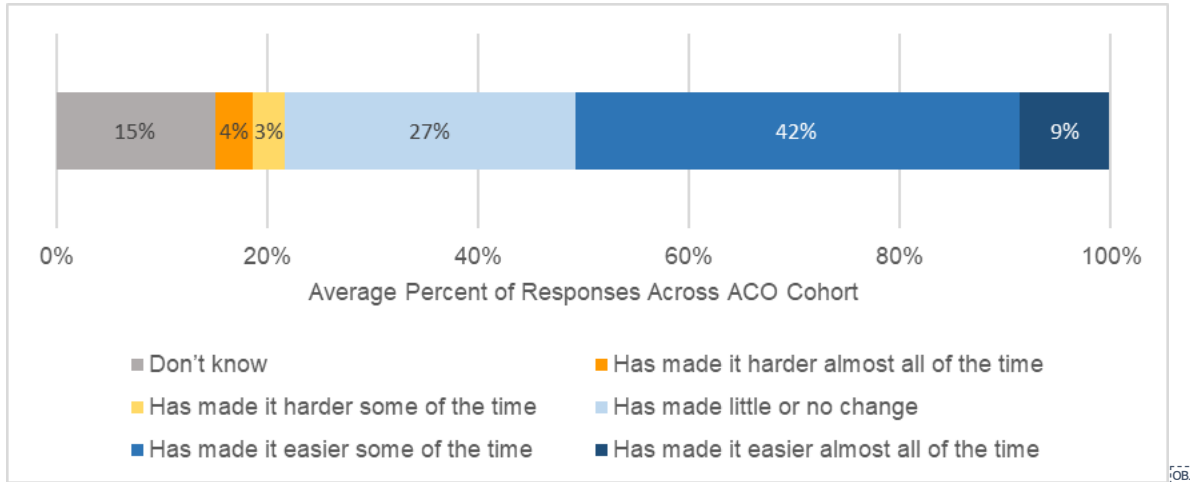
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N = 17
Figure displays responses to Q33. To the best of your knowledge, how has the existence of Community Partners impacted your ability to provide high quality care, for your MassHealth members? (Has made it harder almost all of the time, Has made it harder some of the time, Has made little or no change, Has made it easier some of the time, Has made it easier almost all of the time, Don't know)
Statistical significance testing was not done due to small sample size.

Some, not all, ACOs offered training for staff at practice sites. The frequency and type of education and training varied across ACOs with a few organizations providing resiliency trainings, team building and other process-oriented trainings and trainings to improve the quality of supervisors on staff. The most common form of training most ACOs utilize is community health worker (CHW) training, often supported by the DSRIP SWI 4a Community Health Worker Training Capacity Expansion Grant.

All ACOs use EHRs that give PCPs access to member clinical information, though the degree of network integration varies. Some ACOs have a centralized platform across all sites while some use different platforms across practice sites that have varying degrees of interoperability. A few ACOs provide CPs limited access to EHR data, often in read only mode. Some ACOs expanded their EHR access with CPs by providing access to information on screenings, care plans and population health. At this time, only an average of 43% of practice sites across all ACOs indicated in the ACO Practice Site Administrator Survey that they usually or almost always have access to results of screenings performed outside of the practice site.

Behavioral health integration was a high priority for ACOs rated as On Track. The complexity of integrating these historically distinct systems has presented challenges for much of the cohort, and some ACOs have not yet brought BHI to the forefront. Most ACOs **integrate behavioral health staff on their care teams** and connect members to behavioral health services when needed. Some ACOs have co-located behavioral health services at primary care sites to increase access and improve service integration for members. Some ACOs also co-locate SUD resources at some of their affiliated practice sites. A few ACOs that did not report co-locating behavioral health care at primary care practice sites reported that they are supporting their practice sites achieve PCMH certification, which requires the co-location of BH, indicating that this is an outcome they are working to achieve. Although many ACOs report progress towards co-location of BH services, it is rare that ACOs have achieved comprehensive BH service integration across all sites. The IA recommends that ACOs continue working to **expand the breadth of behavioral health services** provided across all primary care locations.

Practice sites across all ACOs reported offering co-located services to support members with BH needs and HRSN (Fig. 10). The most common co-located services, all offered at one third to one half of practice sites, are any type of care coordinator/manager to address health-related social needs (i.e. housing), counseling therapists, including clinical social workers, and care coordinator/managers to arrange BH care, including SUD treatment. Prescribing clinicians, including psycho-pharmacologists and psychiatrists, are less often co-located (23% of sites).

FIGURE 10. CO-LOCATION OF BEHAVIORAL HEALTH AND HRSN RESOURCES AT THE PRACTICE SITE
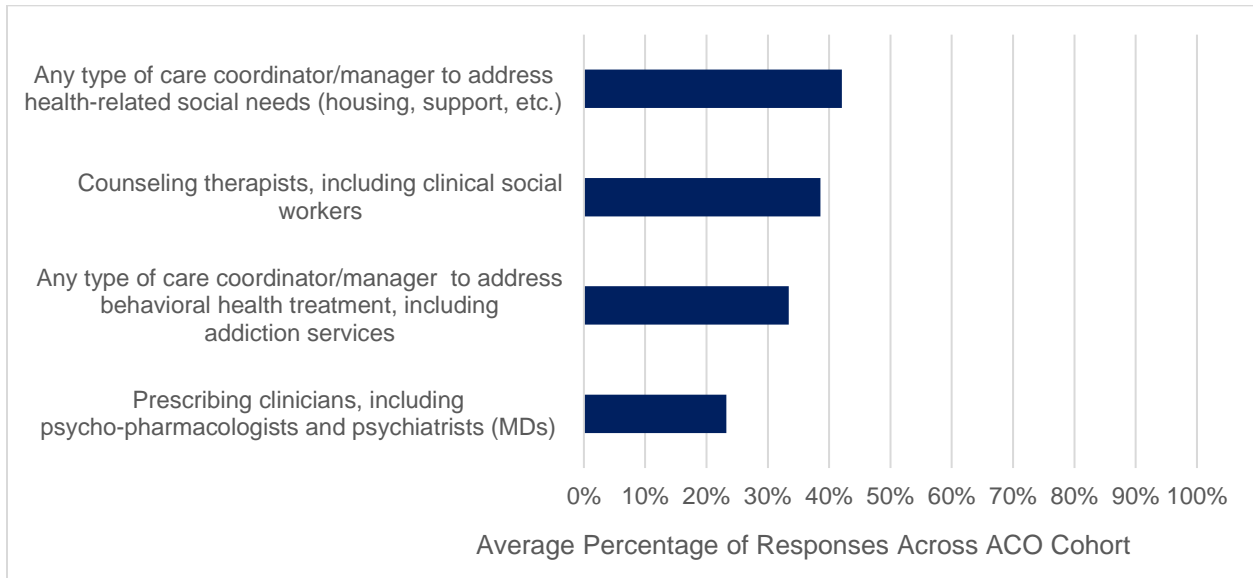
Number of Practices Reporting in the State, N = 225
Figure displays responses to Q8b: For the following Behavioral Health entities, how often are they located within your practice site: prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs), counseling therapists, including clinical social workers any type of care coordinator/manager to address behavioral health treatment, including addiction services, any type of care coordinator/manager to address health-related social needs, such as housing, support, etc.? (Almost Never, Rarely, Sometimes, Usually, or Almost Always within the practice site)
Statistical significance testing was not done due to small sample size.

Joint management of performance and quality:

All ACOs have plans for quality management that incorporate specific quality metrics, including at least those metrics that phased into a pay for performance status in the ACOs' measure slate. Most ACOs **share monthly quality data with practice sites** either through meetings, reports or performance dashboards. Most ACOs provide practice level results and some also share regional as well as individual provider level performance results. The type of leadership staff who review performance data and identify performance opportunities vary across ACOs. Some ACOs assign this responsibility to clinical Medical Directors while others have specialized quality improvement administrative staff in this role. All ACOs report reviewing performance data, identifying performance opportunities, and implementing associated change initiatives in cooperation with providers. Some ACOs embed quality managers at practice sites to serve this purpose while others leverage centralized ACO staff to support providers engaging in quality initiatives. Some ACOs appear to grant autonomy to practice sites to implement their own strategy to meet centralized performance objectives. The majority of ACOs do not include CPs in scorecard reporting, quality reporting and quality committee meetings.

ACO/MCO coordination (at Accountable Care Partnership Plans)

All ACPP ACOs have a Joint Operating Committee to manage clinical integration. Few reported details of how strategy and decision making are shared.

Data sharing is typically robust at ACPPs; all ACPPs share administrative and clinical data between ACO and health plan entities. Most report circulating population health and cost-of-care analytics reports between the two entities. All ACPP ACOs have a Joint Operating Committee to manage clinical integration.

ACPPs vary in their approach to managing and sharing functions. A majority of ACPPs report that **complex care management has been, or is in the process of being, delegated fully or mostly to the ACO**. MCOs often perform risk stratification, and have sometimes retained specific areas of responsibility, such case management for members with SUD or cancer. Transitions have been slower in some partnerships to allow for ACO care management functions to be established and scaled up. One ACPP reported that they are redesigning their approach to care management overall and reconsidering whether transitioning the care management is appropriate. Quality reporting is in some cases delegated along with care management. One ACPP cited data privacy concerns as the reason the MCO continues to handle Healthcare Effectiveness Data and Information Set (HEDIS) reporting specifically for BH and SUD.

Across the five health plans participating in the thirteen partnerships, two are partnering with a single MassHealth ACO, and three are partnering with 3-4 MassHealth ACOs each. Two of the latter group of health plans have distinct arrangements with each of their partner ACOs; influenced by the ACO's capabilities and the duration of the ACO-health plan relationship. The pairs with **established institutional relationships predating DSRIP generally have shifted more functions to the ACO**, though all report that transitioning care management to the ACO is complete or in progress. The four remaining ACPPs, which share the same health plan partner, all report a steady state of joint management of key functions, with no plans to further transition functions to the ACOs

3. WORKFORCE DEVELOPMENT

Characteristics of ACOs considered On track:

- ✓ **Recruitment and retention**

    - o successfully hired and retained staff for care coordination and population health, leaving no persistent vacancies;

    - o uses a variety of mechanisms to attract and retain a diverse team, such as opportunities for career development, educational assistance, ongoing licensing and credentialing, loan forgiveness and leadership training.

- ✓ **Training**

    - o offers training to staff, including role-specific topics such as integrating primary care, behavioral health, health-related social needs screening and management, motivational interviewing, and trauma-informed care;

    - o has established policies and procedures to ensure that staff meet the contractual training requirements, and holds ongoing, regularly scheduled, training to ensure that staff are kept up to date on best practices and advances in the field as well as refreshing their existing knowledge.

- ✓ **Teams and staff roles designed to support person-centered care delivery and population health**

- o hires nonclinical staff such as CHWs, navigators, and recovery peers, and deploy them as part of interdisciplinary care delivery teams including CCCM staff, medical providers, social workers and BH clinicians;

- o deploys clinical staff in population health roles and nontraditional settings and trains a variety of staff to provide services in homes or other nonclinical settings.

Findings

For the Workforce Development focus area, the IA found that two ACOs are On track and fifteen are On track with limited recommendations.

Recruitment and retention

Nearly all ACOs been able to recruit and retain key personnel positions well enough to avoid major or persistent vacancies. Although in aggregate, most ACOs appear to have avoided major staffing gaps, certain positions have been consistently difficult to attract highly qualified talent. Nurses and nurse care managers in particular were positions that often came into conflict with recruiting efforts underway by their ACO's partner providers. This problem seemed particularly evident in areas where the ACOs are competing for talent with the primary health system in the service area. The IA recommends that ACOs should be **mindful of the impact of their hiring practices on practice sites**, particularly in areas where staff shortages may result in highly competitive hiring practices. ACOs can also expand the use of enhanced tuition assistance programs and highly defined career advancement pathways for those seeking roles in care coordination and care management. Aggressively pursuing trainings that can shift non-clinical staff into clinical roles has also emerged as a potential option for overcoming shortages in qualified recruits for hard-to-fill positions.

CHW positions were also difficult to fill for many ACOs. For several ACOs, CHWs were a job category new to ACO provider partners, and therefore requiring significant effort within corporate human resource structures to define new job classes, establish wage levels and define career paths and develop training materials.

Attracting and retaining a diverse care team is a key part of effectively engaging members and providing culturally competent care. Staff diversity was not assessed due to lack of data across the cohort. The IA recommends that all ACOs self-assess, and consider the promising practices listed in Section J under "***Promoting diversity in the workplace.***"

Training

Most ACOs are offering new staff supportive structures to drive career advancement and increase employee retention. Some ACOs develop **cohorts of new employees**, starting several individuals simultaneously to increase group learning opportunities and create a team culture within cohorts. These cohort structures are often complemented by mentoring programs that pair new employees with more senior staff to enable job shadowing or coaching to occur to shorten team integration timelines. This model was particularly evident among care coordination and care management teams where roles can frequently be misunderstood, and handoffs of information are vital to a team's success. Most ACOs use consistent and direct one-on-one feedback to assist newly recruited staff to quickly learn, integrate with teams and begin focusing on career development. Although certification training was often provided either as a reimbursable expense or through DSRIP SWI funds for CHWs inside of ACOs, few reported offering tuition reimbursement for staff seeking additional external formal education. A few ACOs encouraged non-clinical staff to pursue advanced degrees and certifications to shift into clinical roles as a way of filling difficult to recruit positions; however, most did not.

Most ACOs offer their staff a wide variety of training opportunities from onboarding through to role-specific trainings. Most ACOs appear to be using existing **training materials made available by ACO**

provider partners or adopted from other previously used care coordination trainings. Some ACOs have developed their own trainings and as a result may be trading off fewer role-specific trainings for more broadly applicable trainings. Most ACOs complement online and in-person trainings with additional quarterly or monthly group learning sessions that are frequently focused on a promising practice from inside the ACO or simply updates on operational models or other ACO-directed changes. ACOs should continue to focus on developing internal role-based trainings, but also using external professional development resources such as certification programs for CHWs. ACOs should also focus on expanding formal training for frontline workers on rapid cycle continuous quality improvement techniques.

A continued focus on easing the burdens associated with onboarding new staff for complex care coordination and care management teams has emerged as a leading practice. The IA recommends that ACOs continue to seek ways to promote peer-to-peer learning and group training within these complex and vital teams. As care models continue to evolve, ACOs should continue to integrate CP members into CCCM care team structures to reduce barriers to effective patient handoffs and further improve the operational infrastructure between themselves and CPs.

Teams and staff roles designed to support person-centered care delivery and population health

Nearly all ACOs have developed some form of **multi-disciplinary team to conduct care coordination and care managemen**t services for its highest risk populations. Most ACOs report using some mix of nurse care managers, social workers, care managers or patient navigators and CHWs along with behavioral therapists and pharmacists. Some ACOs embed members of Community Partners in their complex care teams to reduce the burden of patient handoffs and enable record continuity. The exact composition and physical location of these teams tends to vary with practice sites.

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

Characteristics of ACOs considered On track:

- ✓ **Infrastructure for care coordination and population health**

    - o uses an EHR to aggregate and share information among providers across the ACO

    - o has a care management platform in place to facilitate collaborative patient care across disciplines and providers;

    - o uses a population health platform that integrates claims, administrative, and clinical data, generates registries by condition or risk factors, predictive models, utilization patterns, and financial metrics, and identifies members to enroll in programs or in need of additional care coordination.

- ✓ **Systems for collaboration across organizations**

    - o has taken steps to improve the interoperability of their EHR;

    - o shares real-time data including event notifications, and uses dashboards to share real-time program eligibility and performance data;

    - o creates processes to enable two-way exchange of member information with CPs and develops workarounds to solve interoperability challenges.

Results

Findings

For the HIT&E focus area, the IA found that three ACOs are On track, fourteen are On track with limited recommendations.

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Infrastructure for care coordination and population health:

ACOs increasingly need to rely on robust HIT systems. All utilize an EHR to track members' clinical data, and most also use a care management platform to track workflow and processes, and a population health platform to create registries and track clinical, quality, and performance metrics. At some ACOs and practices sites the **care management and population health functions are performed within the EHR using integrated software, while at others these are distinct packages**. ACOs continue to develop organization-wide EHR interoperability. Recognizing that transitioning to a universal EHR is often cost prohibitive, the majority of ACOs with multiple systems instead focused on **finding effective data conduits through the use of member and provider portals, data exchanges and other information conduits** enable privacy compliant real-time exchange of member information and promote optimal care coordination. ACOs are prioritizing interoperability as they update or change EHRs, integrate additional system platforms and expand their provider networks; as this interoperability is often a key element to timely care management, a reduction in service gaps and/or service duplications, and a reduction in avoidable ED visits and inpatient Admissions.

Some ACOs continue to utilize a **manual process of extracting and tracking data** related to both care management and population health analysis. Through the automation of both platforms, ACOs can improve their ability to identify high-risk members, coordinate care and social needs, and mitigate service duplication and/or gaps. Additionally, automation allows for more efficient tracking of performance and quality metrics.

All practice sites surveyed (across all ACOs) indicated that they used an Electronic Health Record system. On average, 72% "agree" or "strongly agree" that the Electronic Health Record improves their ability to coordinate care for their MassHealth members (Fig. 11).

FIGURE 11. ELECTRONIC HEALTH RECORDS IMPROVE CARE COORDINATION ABILITY
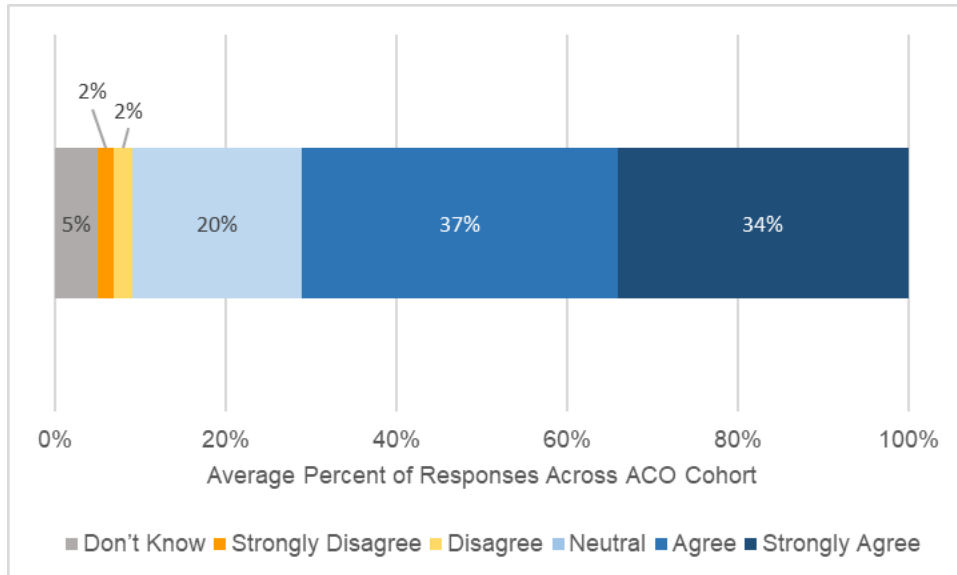
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q13_EHR: To what extent do you agree that the Electronic Health Records Platform improves your ability to coordinate care for your MassHealth members? Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree, IDK
Q13_EHR was only displayed to respondents who indicated they used an Electronic Health Records Platform in Q13 (previous question on the survey)
Statistical significance testing was not done due to small sample size.

Most ACOs recognize the importance of identifying high-risk, high-need members to provide necessary education and resources to mitigate avoidable ED visits and inpatient Admissions. ACOs are using **automated risk stratification, including many ACOs stratifying by HRSN**, to enable CCCM teams and providers to proactively identify and manage high-risk and/or high-need members who may require additional clinical or community-based services. By creating automated referrals, the members are quickly engaged to support the goal of reducing unnecessary ED visits or inpatient Admissions. Bi-directional, real-time data exchange with both affiliated and non-affiliated providers also aids in optimizing member care. Timely Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT) reporting enables care providers to improve member support by minimizing service duplication as they transition between levels of care.

Across the Commonwealth all ACOs utilize an EHR to aggregate and share information among providers throughout the ACO. Often the EHRs offer a variety of support platforms to assist in both individual member care and population health management. These platforms are able to provide seamless data integration into the member's health record resulting in greater data transparency and care coordination across the ACO.

Approximately half of ACO respondents indicate they are using a care management platform. Of those that do, 71% of respondents "agree" or "strongly agree" that the care management platform improves their ability to coordinate care for their MassHealth members (Fig. 12).

FIGURE 12. CARE MANAGEMENT PLATFORMS IMPROVE CARE COORDINATION ABILITY
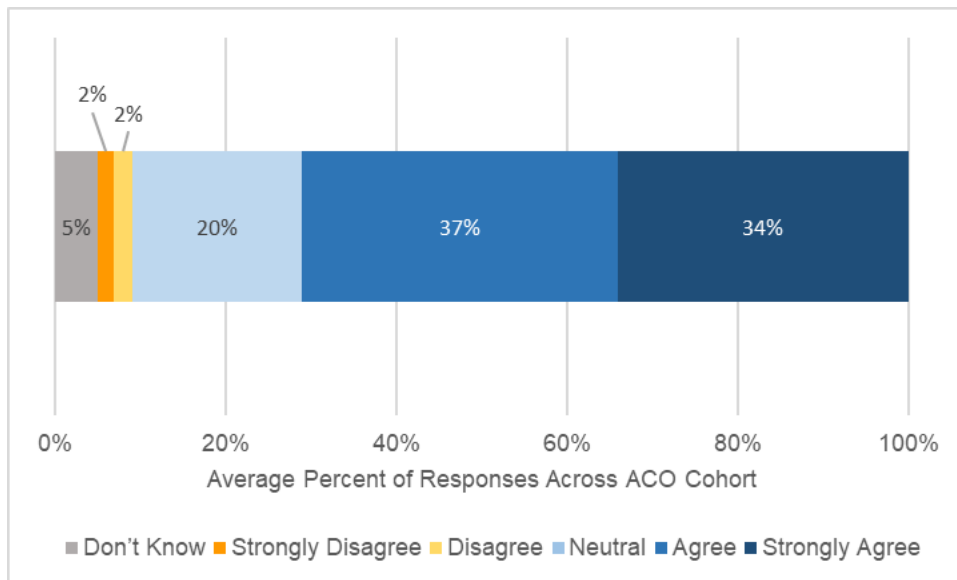
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q13_CMP: To what extent do you agree that the Care Management Platform improves your ability to coordinate care for your MassHealth members? Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree, IDK
Q13_CMP was only displayed to respondents who indicated they used a Care Management Platform in Q13 (previous question on the survey)
Statistical significance testing was not done due to small sample size.

As indicated in the figure above, those ACOs utilizing care management platforms found this technology to enhance the care team's ability to both identify needs and subsequently assist members in accessing and utilizing resources most helpful to their clinical and social needs. ACOs did not report direct integration of CPs into care management platforms, thought a few do provide EHR access to CP staff.

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Most ACOs share information with CPs through SFTP sites, which are typically built into CPs' care management platforms.

Most ACOs also utilize a population health platform that integrates claims, administrative, and clinical data; generates registries by condition or risk factors, predictive models, utilization patterns, and financial metrics; and identifies members in need of additional care coordination. The majority of those utilizing a population health platform agree these platforms also help to improve member care coordination.

Slightly over 60% of ACO respondents, on average, indicate using a population health management platform. Of those that do use a population health management platform, on average, 76% of respondents "agree" or "strongly agree" that the population health management platform improves their ability to coordinate care for their MassHealth members (Fig. 13). The IA recommends that **ACOs expand the use of automated population health management platforms** to aggregate member data and stratify members. Integration of population health analytics with the EHR and/or care management platform enables care teams to more easily identify high-risk and/or high-need members, identify members to enroll for services, and proactively educate and redirect high-risk members to prevent avoidable emergency department visits.

FIGURE 13. POPULATION HEALTH MANAGEMENT PLATFORMS IMPROVE CARE COORDINATION ABILITY
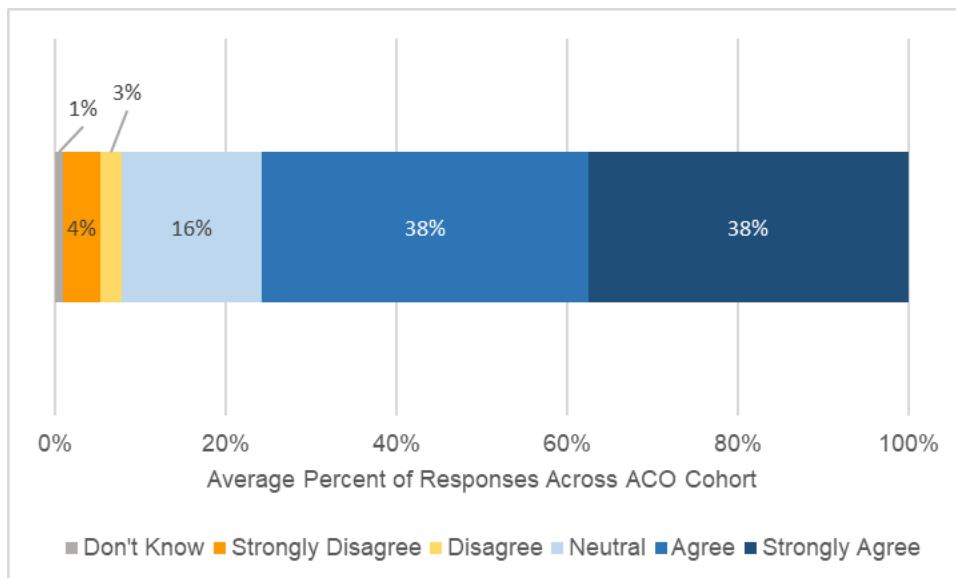
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q13_PHP: To what extent do you agree that the Population Health Management Platform improves your ability to coordinate care for your MassHealth members? Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree, IDK
Q13_PHP was only displayed to respondents who indicated they used a Population Health Platform in Q13 (previous question on the survey)
Statistical significance testing was not done due to small sample size.

Systems for collaboration across organizations:

Most ACOs have taken steps to improve the interoperability of their EHRs, as many do not have a single system-wide EHR. ACOs with providers utilizing a variety of EHRs often do not have the ability to easily provide real-time data exchange, particularly ENS/ADT. This often hinders the care team's ability to impact member care in a timely manner and proactively engage high-risk members who may seek avoidable ED services. To work around this problem, ACOs established a variety of data conduits to effectively communicate across providers and entities utilizing different EHRs and/or outside EHRs. The use of IT conduits, including web **portals,** Commonwealth- sponsored conduits (such as Mass HIway) and collaboratives (such as MAeHC) enable the timely transmission of member information to everyone involved in the member's care plan. This mitigates the time lag often present with fax or paper data transfer, which may result in an increase in service duplication and/or service gaps.

While workarounds are often effective, not all EHRs and/or third-party software vendors can seamlessly integrate systems resulting in access disruption when frequent system upgrades obstruct the data exchange until the EHR and third-party vendor establish an IT patch. This requires ACOs to vigilantly monitor system interoperability, particularly during times of transition and/or upgrade current infrastructure.

For those IT systems and/or EHRs lacking a commercially available conduit, the Mass HIway, the Commonwealth's statewide health information exchange, frequently serves as an integrating venue to enable participating, non-affiliated providers, and the managed care plans to access member data. The use of **Mass HIway as a data conduit is most often found in ACOs utilizing multiple EHRs across the organization**. The use of EHR conduits also provides an avenue for ACOs without fully integrated EHRs by securely transmitting ENS/ADT with which the care team can better manage member care. Regardless of the method of electronic data delivery, ACOs should ensure that timely two-way communication extends to Community Partners and non-affiliated providers, in addition to their participating PCP sites, Specialties and Managed Care Plans. This enables providers across the full continuum of care to view member clinical data and provides for more fully coordinated care.

With these strategies, a majority of ACOs can share member contact information, needs assessments, and care plans across the ACO and with CPs (Fig. 14). About half are also able to share this information with non-affiliated providers.

FIGURE 14. ACO'S ABILITY TO SHARE AND/OR RECEIVE DATA ELECTRONICALLY WITH MOST, ALL OR NEARLY ALL PROVIDERS
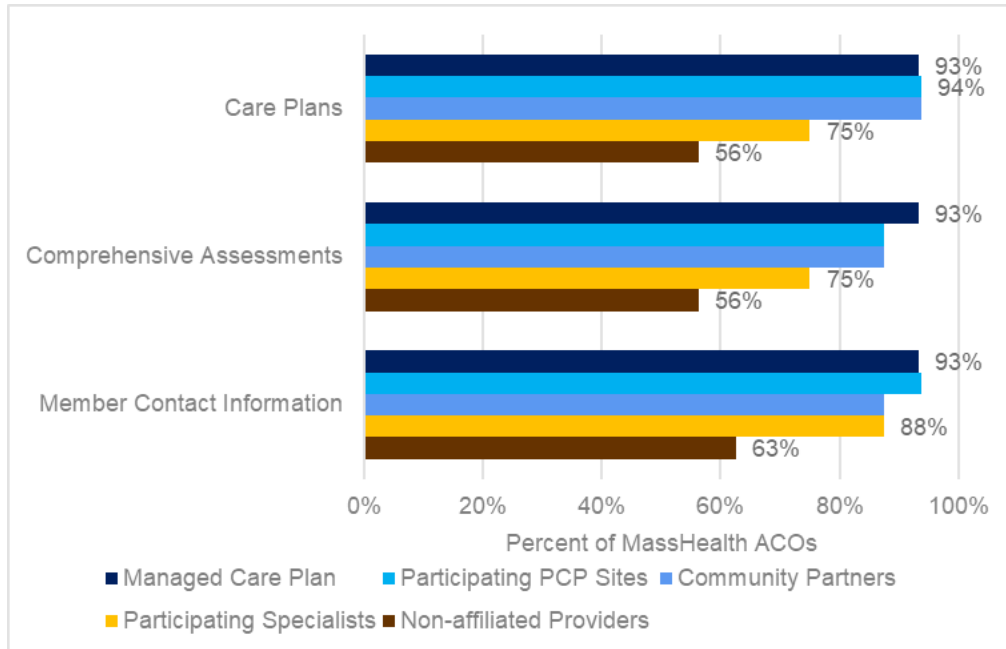
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays "Most" or "All or Nearly All" responses from Part III Implementation Progress Supplement *Q1a. Check one box in each row to indicate how many of each entity type the ACO is able to share and/or receive MEMBER CONTACT INFORMATION with electronically with the understanding that all information should be shared in a secure and compliant fashion;*
Q1b. Check one box in each row to indicate how many of each entity type the ACO is able to share and/or receive COMPREHENSIVE NEEDS ASSESSMENTS with electronically with the understanding that all information should be shared in a secure and compliant fashion; and
Q1c. Check one box in each row to indicate how many of each entity type the ACO is able to share and/or receive CARE PLANS with electronically with the understanding that all information should be shared in a secure and compliant fashion.
Statistical significance testing was not done due to small sample size.

Some ACOs share real-time data including event notifications and use dashboards to share real-time program eligibility and performance data (Fig. 15). **Dashboard functionality varies widely** across the ACOs. Some ACOs have fully integrated their dashboards to enable providers across the ACO to send and receive real-time data to assist in member management and fully informed care plans. Others have static dashboards providing retrospective data which allows for periodic quality review but limits the ACO's ability to dynamically affect the member's care. While not all ACOs have the capacity to provide this type of real-time information through their existing EHR or related IT systems, there are other ways to facilitate the timely access to this type of member data. Specifically, the use of EHR conduits enables some ACOs to send and receive ENS/ADT feeds enabling CCCM staff to provide real-time care management and potentially aid members in avoiding ED visits by redirecting them to appropriate alternative care sites.

FIGURE 15. ADT FEEDS AND REAL-TIME EVENT NOTIFICATION ACCESS INCORPORATE INTO ANALYTICS PLATFORMS AND PRIMARY CARE PRACTICE SITES ACCESSIBILITY.
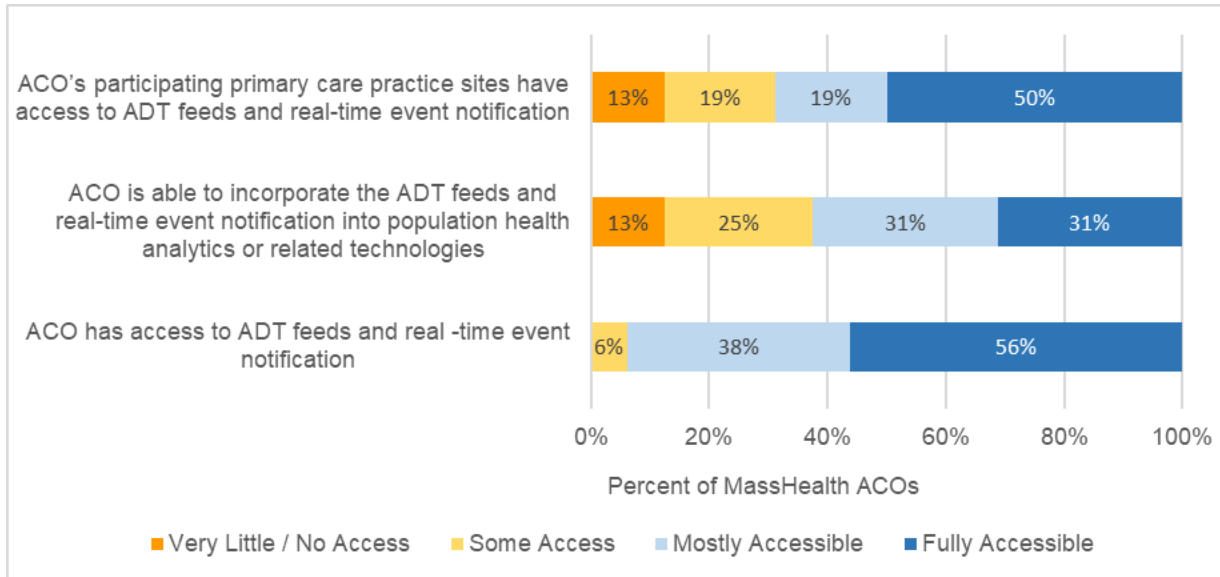
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses from Part III Implementation Progress Supplement Q*1d. Check one box to indicate to what extent the ACO has access to ADT FEEDS/REAL-TIME EVENT NOTIFICATIONS;*
Q1*e. Check one box to indicate to what extent the ACO is able to incorporate the ADT FEEDS/REAL-TIME EVENT NOTIFICATIONS into population health analytics or related technologies; and*
Q1*f. Check one box to indicate to what extent you would estimate that the ACOs participating primary care practice sites have access to ADT FEEDS/REAL-TIME EVENT NOTIFICATIONS.*
Statistical significance testing was not done due to small sample size.

Some ACOs have created processes to enable two-way exchange of member information with CPs and develop workarounds to solve interoperability challenges. Mass HIway and other EHR conduits allow for a secure method of data exchange and care coordination for those EHRs with limited interoperability or lacking provider portals allowing non-affiliated providers and CPs a secure way to view and document in a member's record. Without this transparency, the member is more likely to receive duplicate services and/or develop avoidable care gaps as they transition between levels of care and/or facilities.

ACOs recognize the sensitivity around sharing SUD-related data, but also note the importance of this information in clinical decision making. Several ACOs noted gaps or delays in sharing this data due to privacy and compliance concerns. Many are working with MassHealth and data exchange vendors to establish data sharing methods which complies with state and federal privacy regulations and also enables providers to access necessary information that may impact clinical care.

5. CARE COORDINATION AND CARE MANAGEMENT[17]

Characteristics of ACOs considered On track:

- ✓ **Full continuum collaboration**

  - o collaborates with state agencies such as DMH, DDS, DTA, MRC, and DCF;

  - o has established processes for identifying members to enroll for BH or LTSS services and collaborating with CPs, including exchanging member information, and collaborating for care coordination when CP has primary care management responsibility;

  - o designates a point of contact for CPs to facilitate communication;

  - o incorporates social workers into care management teams and integrates BH services, including OBAT, into primary care.[18]

- ✓ **Member outreach and engagement**

  - o uses both IT solutions and manual outreach to improve accuracy of member contact information;

  - o uses a variety of methods to contact assigned members who cannot be reached telephonically by going to members' homes or to community locations where they might locate the individual (e.g. a congregate meal site);

  - o addresses language barriers through steps such as translating member-facing materials, providing translators for appointments, and recruiting CCCM staff who speak members' languages;

  - o supports members who lack reliable transportation by providing rides or vouchers[19], and/or providing services in homes or other convenient community settings;

- ✓ **Connection with navigation and care management services**

  - o locates CCCM staff in or near EDs;

  - o enables staff to build 1:1 relationships with high-need members, and uses telemedicine, secure messaging, and regular telephone calls for ongoing follow-up with members;

  - o provides members with 24/7 access to health education and nurse coaching, through a hotline or live chat;

  - o implements best practices for transitions of care, including warm handoffs between transition of care teams and ACO team;

  - o implements processes to direct members to the most appropriate care setting, including processes to re-direct members to primary care to reduce avoidable emergency department visits;

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[17] While recognizing the distinct difference between care coordination (a more wholistic and over-arching approach to optimize the integration of both medical and non-medical) and care management (typically focused on caring for individuals or a subset of patients with a common clinical need such as diabetes or asthma), the focus area assessment combines the two with the understanding that ACO and CP efforts in these areas often overlap or integrate.

[18] Behavioral Health Integration is a broad objective of care delivery reform. For the purpose of the MPA, BHI is included in the CCCM focus area, though this topic is not strictly within MassHealth's definition of care coordination and management.

[19] ACOs should utilize the Mass (PT-1) for member needs first as appropriate.

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- ✓ **Referrals and follow-up**
    - ○ standardizes processes for referrals for BH, LTSS, and health related social needs (HRSN), and ability to systematically track referrals, enabling PCPs and care coordinators to confirm that a member received a service, incorporate results into the EHR and care plan;
    - ○ conducts regular case conferences to coordinate services when a member has been referred.

Findings

For the Care Coordination and Care Management focus area, the IA found that no ACOs were On track, twelve are On track with limited recommendations, and five demonstrate an Opportunity to Improve.

Full continuum collaboration:

Most ACOs have established processes for identifying members appropriate for referral for BH or LTSS supports and collaborating with CPs, **including exchanging member information, and collaborating for care coordination** when the CP has primary care management responsibility. By risk stratifying members and determining program eligibility, care teams can direct members to needed services, minimize duplication of services, and facilitate development and completion of care plans. This is further enhanced by the strong collaboration with CPs through the exchange of information and care collaboration which is clearly documented in a mutually accessible member record.

Survey results suggested that practice sites have little difficulty with receiving test results after referring members but are more likely to report difficulty in exchanging information with consulting clinicians (fig. 16). On average, across the ACO cohort, 84% of practice sites indicated that it was rarely or never difficult to learn the result of a test the practice site ordered, 47% of survey respondents indicate that it was rarely or never difficult for staff in the practice site to know that a patient referred by the practice site was seen by the consulting clinician, 48% of survey respondents indicate that it was rarely or never difficult to learn what the consulting clinician recommends for the practice site's patient, 60% of survey respondents indicate that it was rarely or never difficult for staff in the practice site to transmit relevant information about a patient who the practice site refers to a consulting clinician, and 52% of survey respondents indicate that it was rarely or never difficult for staff in the practice site to reach the consulting clinician caring for a patient when the staff needed to.

FIGURE 16. DIFFICULTY IN COORDINATING CARE IN THE PAST 12 MONTHS
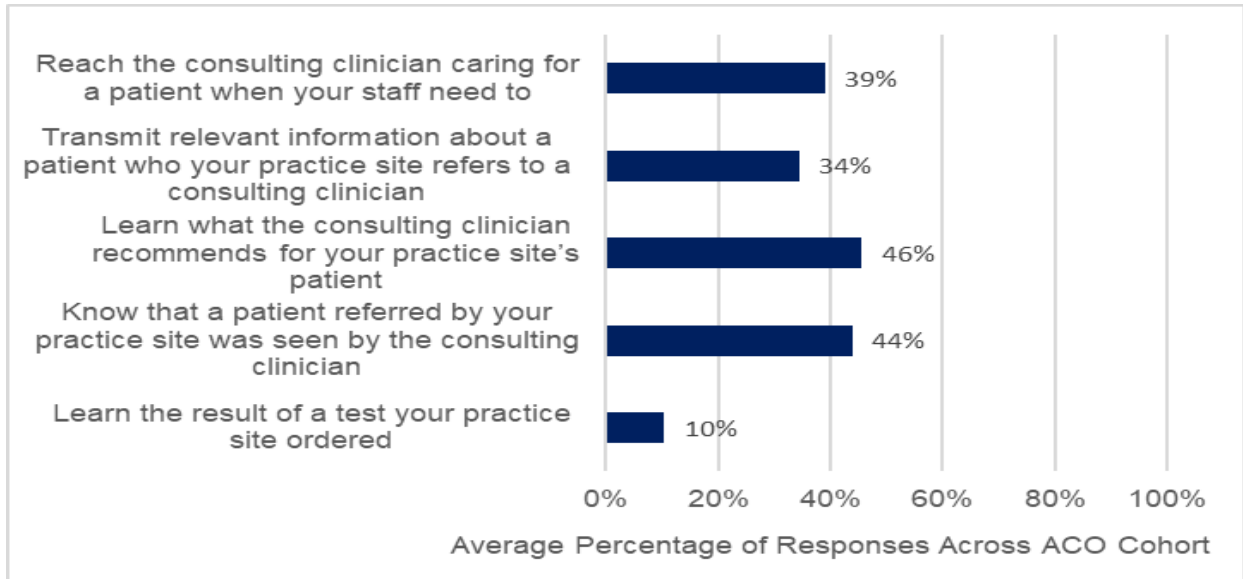
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q4. In the past 12 months, how often was it difficult for staff in your practice site to do each of the following for your MassHealth members: learn the result of a test your practice site ordered, know that a patient referred by your practice site was seen by the consulting clinician, learn what the consulting clinician recommends for your practice site's patient, transmit relevant information about a patient who your practice site refers to a consulting clinician, and reach the consulting clinician caring for a patient when your staff need to?
Statistical significance testing was not done due to small sample size.

Some of the ACOs collaborate with state agencies such as DMH, DDS, DTA, MRC, and DCF and designate a point of contact for CPs to facilitate communication. This level of collaboration suggests a formal established relationship which can provide members with more streamlined care handoffs and access to available resources. By facilitating communication across the ACO, with CPs and with state agencies, the ACO is better able to assist members navigating complex circumstances. Specifically, these relationships prove integral to the care team's ability to provide services to high-risk members who are risk stratified and enrolled in BH and LTSS CP programs. The IA recommends that more ACOs formalize their relationships with state agencies and with CPs through regular meetings and designated points of contact.

Some of the ACOs incorporate social workers into care management teams and integrate BH services, including OBAT, into primary care. The social workers' inclusion in the care team can provide a more holistic review of member needs, often going beyond their clinical needs by identifying contributing external factors impacting their clinical care such as homelessness or access to services. These non-clinical factors can cause members to have more difficulty in meeting care plan guidelines and/or resulting in higher care needs over time.

Practice sites use a variety of staff in CCCM roles (Fig. 17). Across the ACO cohort, on average, 41% of survey respondents reported that their practice has used any type of care coordinator or manager, 66% of survey respondents reported that their practice has used CHWs, 74% of survey respondents reported that their practice has used nurse care managers, 14% of survey respondents reported that their practice has used other care coordination and management resources and 53% of survey respondents reported that their practice has used patient navigators.

FIGURE 17. CARE COORDINATION AND MANAGEMENT RESOURCES USED BY PRACTICE SITES
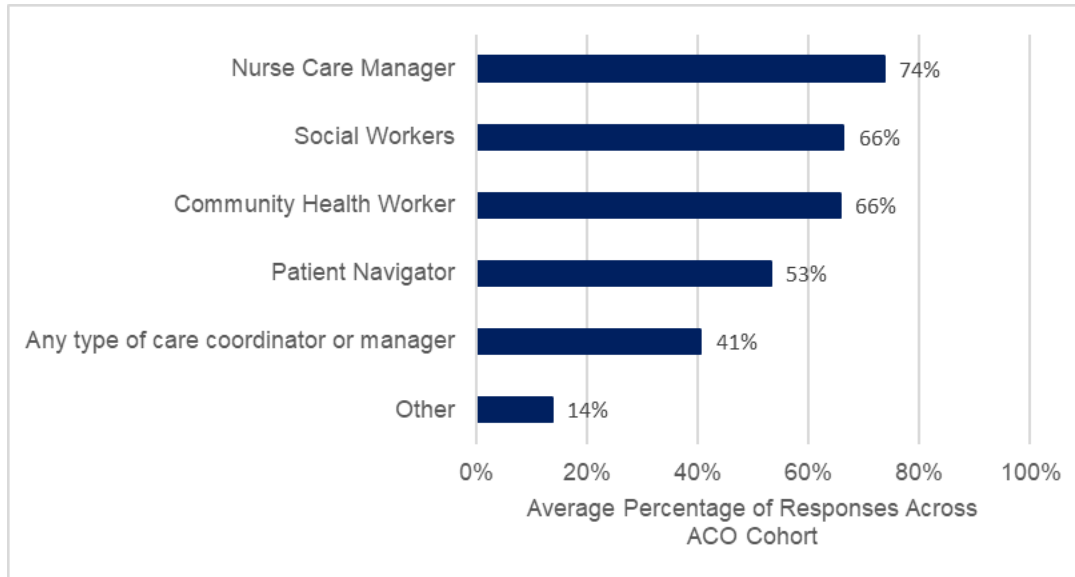
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q1a. *Which of the following care coordination and management resources has your practice used in the past 12 months for your MassHealth members? Select all that apply: any type of care coordinator or manager, Community Health Worker, Nurse Care Manager, Other, Patient Navigator.*
Statistical significance testing was not done due to small sample size.

Member outreach and engagement

Most of the ACOs use **both IT solutions and manual outreach to improve accuracy of member contact information**. By combining efforts through IT and manual solutions, ACOs find they are able to increase the potential for reaching members regardless of how they engage the ACO (via phone, in person, email or through the patient portal) This is particularly important to help reach the high-risk members with HRSN or limited access to stable housing or other resources and who may have frequent changes in their contact information. In addition, most of the ACOs also use a variety of methods to contact assigned members who cannot be reached telephonically by going to members' homes or to community locations where they might locate the individual (e.g. a congregate meal site). By reaching out to members in their communities, the ACOs are able to support members who might otherwise be lost to follow-up and more firmly establish relationships to optimize care plan adherence.

These varied engagement methods are also used to assist members in receiving both care and follow-on services when and where they are needed. Across the ACO Cohort, on average, 96% of respondents reported that they provide scheduling to enable same day appointments, 61% of respondents reported that they provide appointments on weekdays before 8 am or after 5 pm, 43% of respondents reported that they provide appointments on weekends, 29% of respondents reported that they provide home visits carried out by practice staff or a clinician, 36% of respondents reported that they provide clinical pharmacy services provided after Discharge at the practice site, and 64% of respondents reported that they provide care that is provided in part or in whole by phone or electronic media (e.g., patient portal, e-mail, telemedicine technology).

Some of the ACOs address language barriers through steps such as translating member-facing materials, providing translators for appointments, and recruiting CCCM staff who speak members' languages. When considering language barriers, the ACO must first understand their member demographics in order to address not just the language, but also cultural concerns that may be influencing how they prefer to

receive care and from whom. ACOs may see an increase in care plan adherence when addressing language barriers by hiring bilingual staff and drafting culturally sensitive printed materials which allow members to receive information that provides for maximum comprehension.

While MassHealth provides medically necessary nonemergency ambulance and wheelchair van transportation through the MassHealth transportation benefit (PT-1), high need members are often unable to make appointments due to scheduling or transportation concerns not covered by MassHealth transportation benefit (PT-1) services. ACOs can facilitate clinical engagement by providing non-duplicative transportation options, non-traditional hours, and/or home-based visits. Both ACOs and practice sites reported that few of the ACOs support members who lack reliable transportation by providing rides or vouchers, and/or providing services in homes or other convenient community settings (Fig. 18).[20] ACOs also can provide alternative means of communicating with members, such as providing no/low cost cellphones through which the member can make appointments, access secure messaging and allow for easier provider follow-up.[21] The phones provide ACOs a means to reach members who might otherwise be lost to follow-up.

FIGURE 18. PROMISING PRACTICES AND SERVICES PROVIDED BY THE PRACTICE SITE
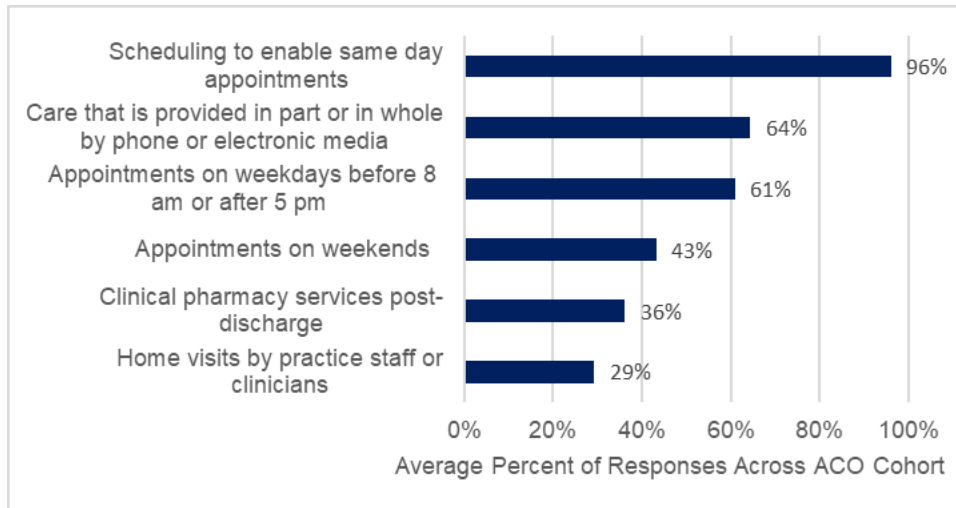
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q18 Does your practice regularly provide any of the following? Select all that apply: scheduling to enable same day appointments, appointments on weekdays before 8 am or after 5 pm, appointments on weekends, home visits carried out by practice staff or a clinician, clinical pharmacy services provided after discharge at the practice site, care that is provided in part or in whole by phone or electronic media (e.g., patient portal, e-mail, telemedicine technology)
Statistical significance testing was not done due to small sample size.

Connection with navigation and care management services:

Most of the ACOs enable staff to build 1:1 relationships with high-need members to provide care coordination. These **relationships allow the care team to develop trust, and a holistic perspective of the member's clinical and non-clinical needs**. Ultimately, this trust supports member care plan adherence and may translate into the member reaching out the care team to proactively request clinical care seeking advice. Use of secure messaging, and/or regular telephone calls for ongoing follow-up with members is widespread, and telemedicine is occasionally employed as well.[22] Most of the ACOs implement processes to direct members to the most appropriate care setting, including re-directing

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[20] CPs should utilize the MassHealth transportation program (PT-1) for member needs first as appropriate.
[21] ACOs should first utilize Lifeline program for members as appropriate.
[22] During the time period covered by the MPA telemedicine was not a reimbursable service except for outpatient BH care.

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members to primary care to reduce avoidable emergency department visits. For example, sending ADT feeds directly to CCCM staff allows them to quickly mobilize to the ED, immediately meet with the member and possibly redirect them prior to the ED visit's full initiation. Additionally, most of the ACOs implement best practices for transitions of care, including warm handoffs between transition of care teams and ACO team when a member transitions between care settings. The established trust is integral to reinforce the care team's ability to guide the member through these transitions.

Several care coordination strategies have been adopted by most ACOs (Fig. 19). On average, across the ACO cohort, for complex, high-needs members, 81% of respondents indicated that the practice often or almost always uses direct communication with the member, typically by phone, within 72 hours of discharge, 21% of respondents indicated that the practice often or almost always uses home visit after discharge, 70% of respondents indicated that the practice often or almost always uses Discharge summaries sent to primary care clinician within 72 hours of discharge, 62% of respondents indicated that the practice often or almost always uses referrals to community-based services, and 79% of respondents indicated that the practice often or almost always uses standardized process to reconcile multiple medications. Home visits after discharge are less frequently employed.

FIGURE 19. COORDINATING CARE FOR COMPLEX HIGH-NEEDS PATIENTS
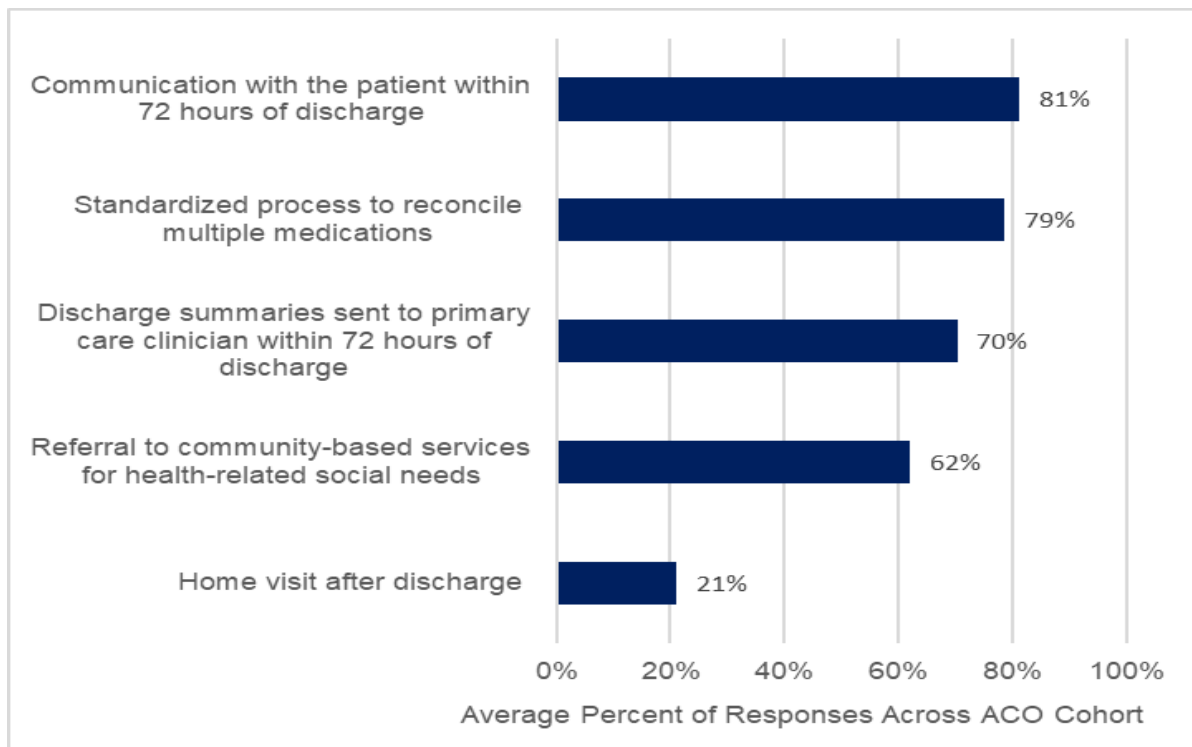
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q7. For complex, high-need MassHealth members, how often does your practice use each of the following resources to help the patient adhere to the care plan: referral to community-based services for health-related social needs, communication with the patient within 72 hours of discharge, home visit after discharge, discharge summaries sent to primary care clinician within 72 hours of discharge, and standardized process to reconcile multiple medications?
Statistical significance testing was not done due to small sample size.

Some of the ACOs **locate CCCM staff in or near EDs**. This enables CCCM staff to more easily engage with high-need members accessing the ED, and potentially redirect members to alternative care sites. Similarly, some of the ACOs provide members with 24/7 access to health education and nurse coaching,

through a hotline or live chat. This service allows members to reach out during times of increased concern and review their needs and options, including alternatives to the ED where appropriate. Both these strategies are aimed at educating members about appropriate care settings, thereby reducing avoidable ED visits and inpatient Admissions.

Referrals and follow-up

Practice site survey results indicated that **routine referral to BH care is increasingly common, though not universal** (Fig. 20). On average, across the ACO cohort, 70% of survey respondents indicated that their MassHealth members requiring BH care were "often" or "almost always" referred to prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs), 80% of survey respondents indicated that their MassHealth members were "often" or "almost always" referred to counseling therapists, including clinical social workers, 67% of survey respondents indicated that their MassHealth members were "often" or "almost always" referred to any type of care coordinator/manager to address behavioral health treatment, including addiction services, and 64% of survey respondents indicated that their MassHealth members were "often" or "almost always" referred to any type of care coordinator/manager to address health-related social needs (housing, support, etc.).

FIGURE 20. ROUTINELY MAKING REFERRALS TO BEHAVIORAL HEALTH ENTITIES
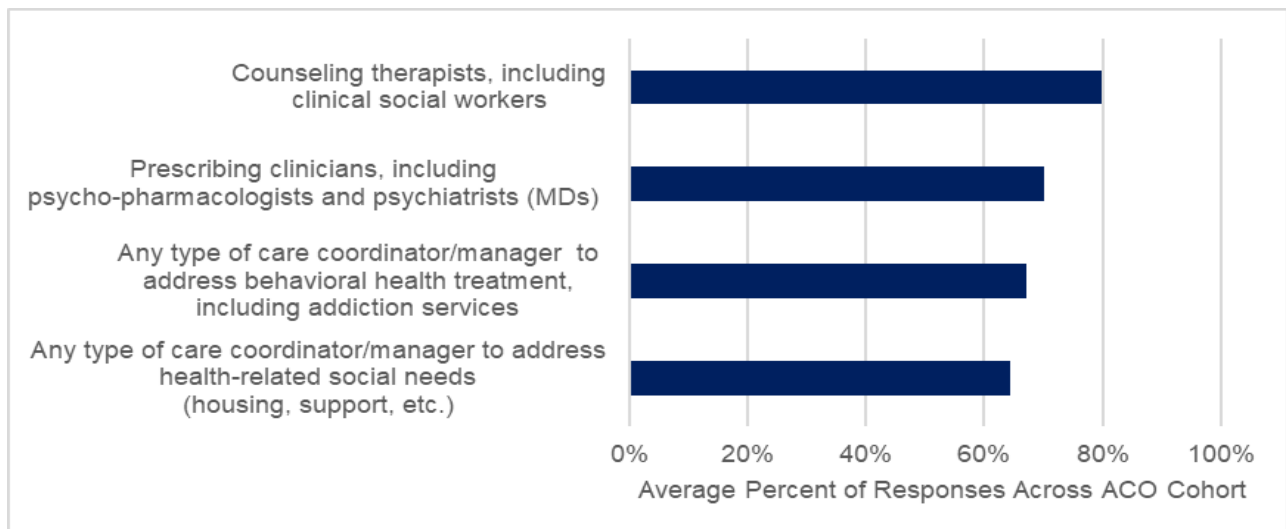
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q8. In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed: prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs), counseling therapists, including clinical social workers any type of care coordinator/manager to address behavioral health treatment, including addiction services, any type of care coordinator/manager to address health-related social needs, such as housing, support, etc.? (Almost Never, Rarely, Sometimes, Often, Almost Always) Often and Almost Always are combined to represent the fraction of practices that routinely makes such referrals.
Statistical significance testing was not done due to small sample size.

Few of the ACOs have fully standardized processes for referrals for BH, LTSS, and health related social needs (HRSN), and ability to systematically track referrals, especially for referrals sent to non-affiliated providers. While many EHRs provide referral tracking options, the lack of a universal, or otherwise fully interoperable, EHR may hinder an ACO's ability to utilize these platforms and/or limit the ability to clearly document status in the member's record. Without a tracking process, members can encounter care gaps, missed service referrals, and/or duplication of services, all of which have both clinical and financial ramifications. A more standardized and automated process would enable PCPs and care coordinators to track the referral from creation through completion, confirm that a member received a service, and to

incorporate results into the EHR and care plan. In the absence of full interoperability, ACOs can adopt systems and conduits which provide non-affiliated providers with web-portal access for their specific members, which allows for more seamless viewing of patient records and systematic referral tracking. By **automating this process of both creating referrals and then following up on referral completion**, the ACO can greatly improve how the member receives care and ensure it is properly documented in the member's EHR. Some ACOs have developed automated referrals to CPs, and others are utilizing a web-based tool that provides care managers, on site or in the field, with a searchable database of available community-based services and enables them to create a HRSN referral that is tracked in the EHR or care management platform. The IA recommends that ACOs leverage these types of integrated and automated approaches more widely.

Due to the non-standardized process for referrals, a regular case conference becomes increasingly important. Yet only some of the ACOs conduct regular case conferences to coordinate services when a member has been referred. This again can result in disjointed care delivery for members who may miss service referrals or end up receiving care from multiple providers due to a lack of care coordination. At standout ACOs, a care team will regularly schedule case conferences for a member to confirm that the referrals are placed, scheduled and services received in a coordinated way to support their care plan as the member transitions between levels of care and/or care sites. During this meeting, the care team should also complete an in-depth review of all new enrollment and a periodic review of established member cases. This serves as an additional touchpoint for the care team to discuss the care plan and additional relevant information that may influence the member's future care. The IA recommends that ACOs work towards **increasing standardization of referral processes and follow-up through regular case conferences**.

6. POPULATION HEALTH MANAGEMENT

Characteristics of ACOs considered On track:

- ✓ **Integration of health-related social needs**

    - o standardizes screening for health-related social needs (HRSN) that includes housing, food, and transportation;

    - o incorporates HRSN with other factors to target members for more intensive services;

    - o Builds mature partnerships with community-based organizations to whom they can refer members for services

    - o has a plan approved for provision of flexible services;

- ✓ **Population health analysis**

    - o articulates a coherent strategy for stratifying members to service intensity and use of a population health analysis platform to combine varied data sources, develop registries of high-risk members, and stratify members at the ACO level.

    - o integrates cost data into reports given regularly to providers to facilitate cost-of-care management.

- ✓ **Program development informed by population health analysis**

    - o offers PHM programs that target all eligible members (not just facility-specific), and target members by medical diagnosis, BH needs (including non-CP eligible), HRSNs, care transitions;

    - o offer interactive wellness programs such as smoking cessation, diet/weight management.

Findings

For the Population Health Management focus area, the IA found that nine ACOs are On track, seven are On track with limited recommendations and one demonstrates an Opportunity to improve.

Integration of health-related social needs:

Recognizing that addressing health-related social needs (HRSN) can impact health outcomes and cost of care, all ACOs **conduct standardized screenings for health-related social needs** (HRSN) including housing, food and transportation (Fig. 21). ACOs vary in how systematically they screen. Some ACOs conduct these screenings at all sites, others at a majority of sites.

On average, a majority of practice sites across ACOs, indicated screening for Medicaid eligibility, transportation needs, interpersonal violence, utility needs, need for financial assistance with medical bills, housing instability, food security or Supplemental Nutrition Assistance Program (SNAP) eligibility, as well as clinical needs including depression, substance use, opioid use, and tobacco use.

Figure 21. Screening Conducted at Practice Sites
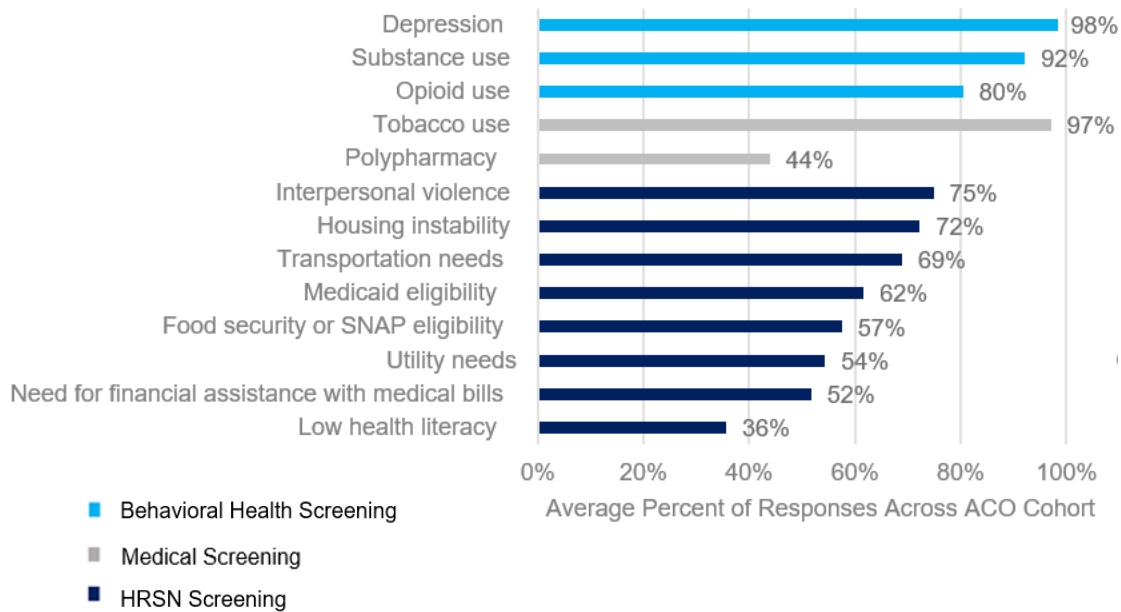
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N = 17
Figure displays responses to Q14: *For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP): tobacco use, opioid use, substance use, polypharmacy, depression, low health literacy, food security or SNAP eligibility, housing instability, utility needs, interpersonal violence, transportation needs, need for financial assistance with medical bills, Medicaid eligibility, none of the above*
Statistical significance testing was not done due to small sample size.

Of the ACOs that conduct HRSN screenings, all combine them with other factors to target members for more intensive services, some for specific needs like transportation vouchers[23], or for larger services like

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[23] ACOs should utilize the MassHealth transportation program (PT-1) for member needs first as appropriate.

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intensive or complex CCCM. Some ACOs have formed partnerships with community-based organizations like food pantries, transitional housing and emergency shelters to address HRSN. To assist members with accessing other resources, some ACOs formed relationships with state agencies like Department of Mental Health (DMH) to coordinate services. An average of 39% of practice sites across the ACO cohort indicated that "tailoring delivery of care to meet the needs of patients affected by health inequities" has gotten a little or a lot easier over the past year (Fig. 22), which may reflect those ACOs' growing ability to identify HRSNs and refer members for appropriate services.

FIGURE 22. PRACTICE SITE ABILITY TO TAILOR DELIVERY OF CARE FOR MEMBERS AFFECTED BY HEALTH INEQUITIES
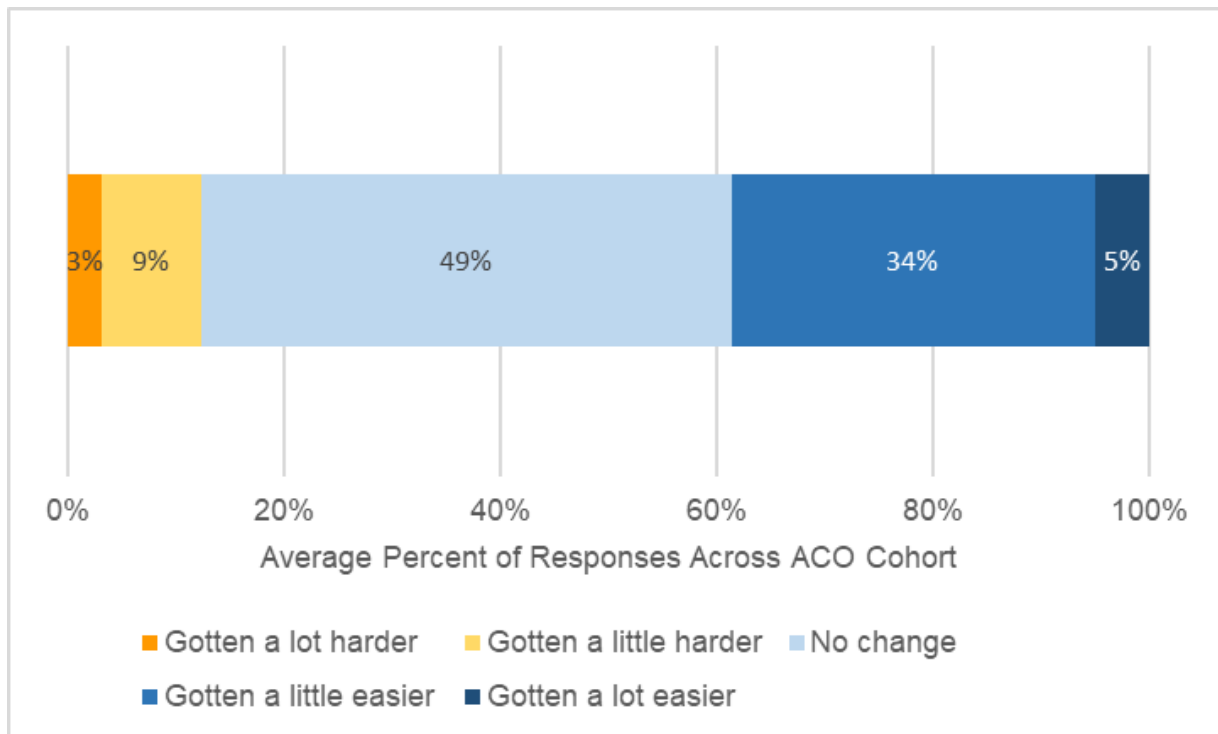
Number of Practices Reporting in the State, N = 225
Number of ACOs Reporting in the State, N =17
Figure displays responses to Q29: *Please select the option below that best describes the change in the past year in your practice site's ability to tailor delivery of care to meet the needs of patients affected by health inequities (e.g., by using culturally and linguistically appropriate services): Gotten a lot harder, Gotten a little harder, No change, Gotten a little easier, Gotten a lot easier.*
Statistical significance testing was not done due to small sample size.

The DSRIP Flexible Services program was approved by CMS near the end of program year 2. This pilot program allows ACOs to use specific DSRIP funds to address food insecurity and housing insecurity in specific ways that are non-duplicative with other programs for certain eligible members in an effort to improve health outcomes and reduce total cost of care for those members. To address these HRSN, almost all ACOs have a plan approved for the provision of health-related nutrition and housing supports to members directly or by connecting members to qualified community-based organizations.

Population health analysis

Expertise in population analysis and management is one of the distinguishing characteristics of an ACO. All ACOs articulated a strategy for stratifying members to service intensity. Approaches vary, but all use a **combination of claims data, most often medical claims, and sometimes pharmaceutical claims with other data sources**. Some ACOs add other information including EHR data, Admission and Discharge data, referral data and HRSN screenings. A few ACOs report using a third-party tool or EHR capabilities to stratify members. Most ACOs use registries of high-risk members; some of the ACPPs have the MCO generate these lists, others are generated by the ACO. Most ACOs use three levels of risk stratification, but one uses two and another uses four levels of risk. According to the practice site survey, an average of 44% of practice sites across ACOs reported receiving risk stratification information from a managed care organization or accountable care organization with which the site is affiliated. Other practices sites identify high risk members themselves, either through systematic stratification (18%) or ad hoc EHR review (15%).

The IA noted a range of sophistication in strategies ACOs use for member stratification with more advanced systems using multiple data sources. The IA recommends that ACOs incorporate more data sources (for example, EHR data, Admission and Discharge data, referral data and HRSN screenings) into their algorithms and conduct **ongoing empirical testing of their results against modified algorithms and actual outcomes.**

Since managing total cost of care (TCOC) is one of the goals of this DSRIP initiative, all ACOs generate TCOC reports. To align the efforts of the ACO and its practice sites towards the same goal, most ACOs **generate and distribute TCOC data on a quarterly or monthly basis to providers** either through reports, interactive scorecards or dashboards. The level of reporting varies; most report being able to drill down to the practice level and some to the provider level.

Program development informed by population health analysis

ACOs need to identify high-risk members, address the HRSN of their population and monitor and control total cost of care. On top of conducting population health analytics, ACOs must operationalize this analysis and create programs that can address the issues they have identified.

Most ACOs have PHM programs targeted at **specific chronic medical diagnoses** including: HIV, diabetes, hypertension, cancer, Congestive heart failure (CHF), and Chronic obstructive pulmonary disease (COPD). Most ACOs offer programs focusing on care transitions. Some ACOs have programs targeted at BH needs, including serious mental illness (SMI), as well as specific mental health and SUD diagnoses including depression, and opioid use disorder. Others have not developed BH-specific programs but do use BH diagnoses as a factor in identifying "high-risk" members. Most ACOs offer programs targeted at HRSN including housing insecurity, nutrition/food insecurity, and health literacy.

Most ACOs offer **interactive wellness programs** including smoking cessation and weight loss programs. Additionally, some ACOs promote community-based wellness resources like farmers' markets, local trails for walking or bicycling to their members.

Population health programs targeted specifically at pediatric members were rarely reported except by BCHACO, which serves a pediatric population exclusively. A few ACOs offer child and family oriented programs such as childbirth preparation and parenting education and provide car seats or bike helmets for children. The IA recommends that MassHealth ask ACOs in future to report on their approach to population health for children, youth, and families.

Integration of HRSN is a complex function that ACOs have struggled to achieve. While all ACOs screen for some HRSN and refer members to community-based resources, **ACOs varied in the extent to which they designed programs specifically for members with BH conditions and/or unmet HRSN**. The IA found that the most frequently identified gap was a **lack of formal partnerships with community-based**

organizations to refer members to for food insecurity, housing insecurity or other HRSN. Some ACOs also lack mature partnerships with state agencies to refer members for services. The IA recommends that ACOs invest in formalizing these partnerships through regular meetings, data sharing agreements, and co-located staff where appropriate to improve collaboration for members' care.

G. CP RESULTS

INTRODUCTION

The following section outlines the CPs' progress across the six focus areas. Figure 23 summarizes findings by CP, showing that in each focus area, a majority of CPs are On track or On track with recommendations.

Each focus area discussion begins with a description of the CP actions associated with an On track assessment. The list of characteristics of On track organizations for each focus area was developed by the IA as described in section D. Methodology and aligned on with MassHealth.

FIGURE 23: CP FINDINGS BY FOCUS AREA
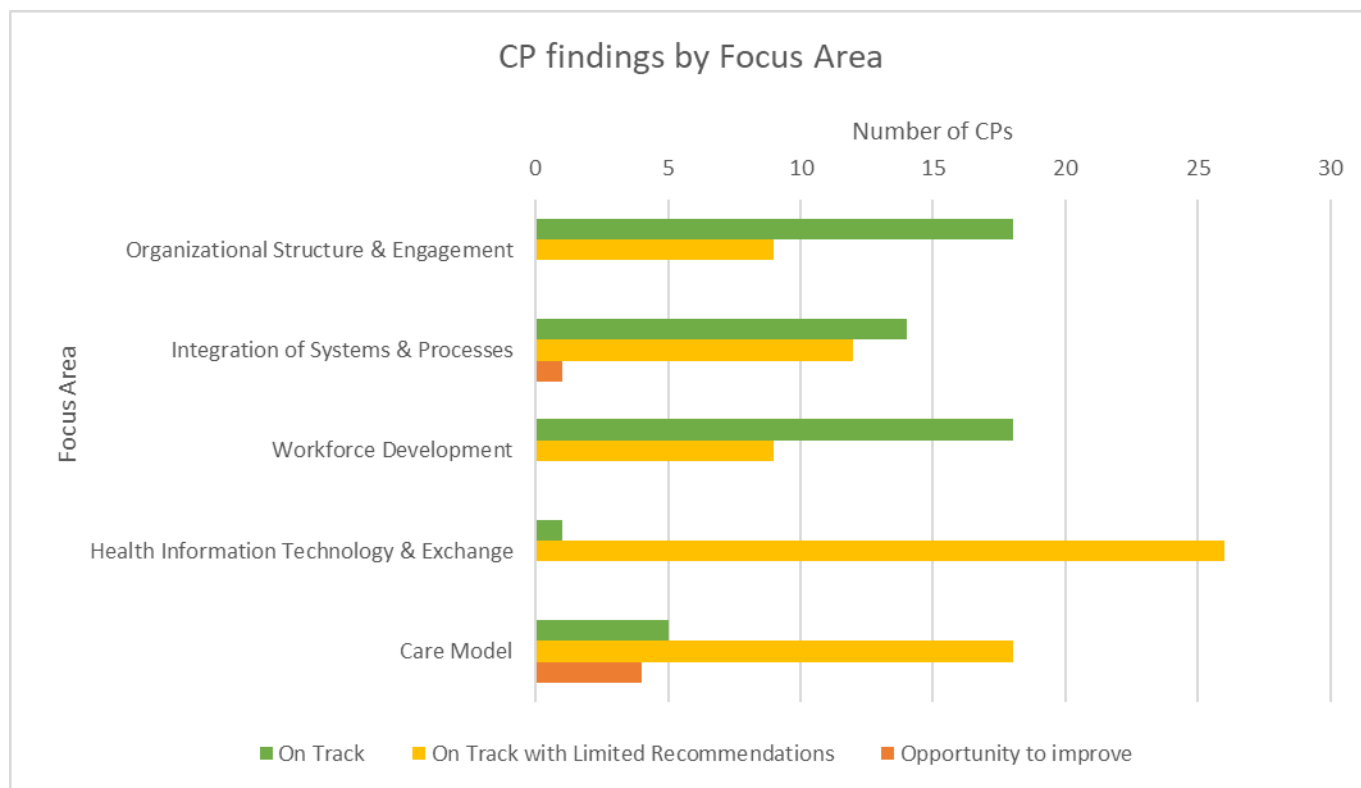
1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

Characteristics of CPs considered On track:

- ✓ **Executive Board**

- o has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies;
- o is led by governing bodies that interface with affiliated partners (APs) through regularly scheduled channels (at least quarterly).
- ✓ **Consumer Advisory Board (CAB)**
    - o has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.
- ✓ **Quality Management Committee (QMC)**
    - o has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Findings

For the Organizational Structure and Engagement focus area, the IA found that eighteen CPs are On track, and nine are On track with limited recommendations.

Executive Board:

Most CPs established an executive board or leadership team that regularly meets with administrative and clinical personnel to discuss operations and program improvement strategies. Many CPs have both an executive board and a leadership team. Executive boards typically oversee the strategic management of the CP including DSRIP budgets, policies and practices, and contract compliance. Leadership teams, comprised primarily of CP staff, tend to be responsible for daily operations, optimizing workflows and monitoring program performance. CP executive boards and leadership teams typically meet on a monthly basis, though frequencies vary from weekly to quarterly.

All CPs with member organizations (MOs), affiliated partners (APs), and constituent entities (CEs) engage with these parties regularly, mostly through executive board meetings which include staff from partner organizations. A few CPs do not integrate these parties into regular leadership meetings, instead maintaining separate weekly workgroup meetings. Meetings typically cover topics like implementation of CP contracts, a review of overall performance and a discussion of opportunities to improve. Most meetings engaging MOs, APs and CEs occur monthly, though the frequency can vary from weekly to quarterly.

Consumer Advisory Board (CAB):

In accordance with the CP contract, all CPs established CABs that collect MassHealth member input from engaged members, family members and other caregivers that reflect the diversity of the CP's service areas and share information related to resource and service availability. CPs use **CAB member insight to help inform strategic decision making in areas related to member engagement**, reduce stigma associated with service use, and to inform how the CP disseminates information related to services with the member population at large.

Though some CPs successfully recruited MassHealth members for their CAB, the **majority experienced inconsistent or low member participation rates.** Most CPs task care coordinators with the recruitment of engaged members and host open house events to engage potential members. Some CPs also recruit members through other service providers and organizations such as hospital member engagement committees, club houses, and day treatment centers. A few CPs provide members with CAB recruitment materials in new member packets.

CPs also recruit **affiliated caregivers and family members, healthcare providers, member advocates, and CP staff themselves to serve on CABs**. Individuals with personal connections to the organization are often more willing to consistently commit their time, but the prevalence of these

connections on CABs suggests they are not receiving the broad range of perspectives that would be valuable. CPs use a variety of incentives to promote member engagement on CABs including providing transportation[24], gift cards to grocery stores, stipends for childcare and meals during meetings. Some CPs provide translated materials and interpreters during meetings. Some CPs work to assure member participation on the CAB by using reminder letters or phone calls prior to meetings and by allowing members to call into meetings. A few CPs have engaged Technical Assistance services to identify additional ways to improve member engagement on their CAB. The IA recommends that CPs build on these efforts and revisit the incentives and compensation that they offer for CAB participation in order to receive the range of perspectives needed for a meaningful consumer voice.

Quality Management Committee (QMC):

Most CPs implemented at least one quality initiative ranging in topics that include improving outreach and engagement efforts in areas like care plan completion, implementing a care management platform, increasing data collection efforts, assessing caregiver strain, analyzing hospital overutilization among engaged members and improving performance on ACO quality measures. CPs rely on numerous data sources to inform their improvement initiatives including: medical record reviews, stakeholder input, member feedback, utilization review, survey data, care plan data, and performance data.

In accordance with the CP contract, all CPs maintain a QMC that meets at least quarterly to review performance on quality initiatives and identify opportunities for new initiatives. The majority of QMCs report their results and activities directly to the CP's governing body. Some CPs generate monthly quality reports and distribute them to leadership and frontline staff. Some CPs developed dashboards to regularly distribute performance data. One CP noted that they have had difficulties with benchmarking and anticipating withheld funds for unmet quality measures due to the volume of protected claims in their monthly claims' files.

2. INTEGRATION OF SYSTEMS AND PROCESSES

Characteristics of CPs considered On track:

- ✓ **Joint approach to member engagement**
    - o has established centralized processes for the exchange of care plans;
    - o has a systematic approach to engaging Primary Care Providers (PCPs) to receive sign-off on care plans;
    - o exchanges and updates enrollee contact information among CP and ACO/MCO[25] regularly;
    - o dedicates staff resources to ensure timely (usually daily) reviews of ACO/MCO spreadsheets to assist with outreach and engagement efforts.
- ✓ **Integration with ACOs and MCOs**
    - o holds meeting with key contacts at ACOs and MCOs to identify effective workflows and communication methods;
    - o conducts routine case review calls with ACOs/MCOs about members;
    - o dedicates staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).
- ✓ **Joint management of performance and quality**
    - o conducts data-driven quality initiatives to track and improve member engagement;
    - o has established comprehensive care plan review processes with ACOs/MCOs to support care coordinators in their effort to engage PCPs in comprehensive care plan review.

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[24] CPs do not provide services that are duplicative with the MassHealth transportation program (PT-1) program using DSRIP funds.

[25] References to MCO in the CP sections refer to Managed Care Organizations that are directly contracted with EOHHS. This does not refer to the entities that are a part of Accountable Care Partnership Plans (AHPPs).

      o   disseminates audit reports to each member organization, in some cases using an interactive dashboard to disseminate data on key quality metrics

Findings

For the Integration of Systems and Processes focus area, the IA found that fourteen CPs are On track, twelve are On track with limited recommendations, and one demonstrates an Opportunity to Improve.

Joint Approach to Member Engagement

CPs engage members in care coordination services by locating assigned members and then documenting member needs in person-centered care plans.[26] CPs communicate with ACO/MCO partners throughout this process to confirm member contact information, complete comprehensive assessments[27] and obtain PCP sign-off on member care plans.

All CPs established Documented Processes to exchange member information with ACO/MCO partners. Nearly all CPs exchange care plans, member contact information, and other member files through SFTP and/or secure email. Many CPs also have processes to exchange member files through a secure file sharing app. A few CPs agreed to exchange member data files with ACO/MCO and PCP partners by fax.

To maintain efficient and timely communication, most CPs employ administrative staff to manage the variety of file sharing methods, file types, and naming conventions that ACO/MCO partners use. Staff that CPs assign to manage these communications vary and include quality assistants, program assistants, intake coordinators, and administrative assistants. Some **CPs divide administrative and clinical tasks to save clinical staff time to focus on member-facing activities.** The IA recommends that CPs work with ACOs and adopt systems to increase interoperability of member data exchange to reduce administrative burden and improve coordination efforts.

Nearly all CPs have a systematic approach to engaging PCPs for sign-off on care plans. Most CPs established internal points of contact who **develop relationships with PCP and ACO/MCO staff in order to facilitate care plan approval** and sign-off. Some CPs, particularly BH CPs, position licensed clinical staff as internal points of contact to provide additional services such as consultation, answering questions from partners about medically complex members, and collaborating on member outreach. A few CPs emphasize the importance of developing local points of contact within PCPs to achieve care plan sign-off in a timely and efficient manner. The CPs who did not meet this indicator described difficulties engaging with PCPs that suggested they had not developed an effective communication strategy at the midpoint. Examples of these difficulties include PCPs consistently asking for releases or information that the CP does not have, or PCPs not signing care plans due to lack of awareness of the CP role. The IA did not find documentation of a clear strategy for rectifying these challenges.

Another way in which CPs engage PCPs is through education and shared learning. Some CPs developed specific marketing strategies, such as the use of a community liaison, marketing brochures, or communication toolkits, to inform PCP staff about the CP program.

Prior to engaging with CPs about care planning, ACO/MCO partners assign members to CPs through the distribution of member spreadsheets. CPs accept assigned members to the full extent of their capacity and then initiate member engagement. The majority of **CPs have a dedicated staff member or team of staff to review ACO/MCO spreadsheets** for missing data points, respond to ACO/MCO requests for information, and confirm member contact information with ACO/MCO and PCP partners.

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[26] The term care plan is used broadly to refer to the person-centered treatment plan completed by BH CPs and the Care Plan used by LTSS CPs.
[27] BH CPs are contractually required to complete the comprehensive assessments for enrollees, while the LTSS CPs receive comprehensive assessments from ACOs.

The frequency in which CP staff review member spreadsheets is a commonly identified gap across the cohort. Some CPs review ACO/MCO spreadsheets at a weekly cadence, but over a third (37%) review less frequently or did not report the frequency of their review. Some CPs struggle to manage referrals due to the lack of standardization in the referral communication system and due to the amount of information CPs must reconcile before member lists become actionable. Many CPs receive ACO/MCO referral files through a variety of data transfer mechanisms without prior notification. In addition, inaccurate member contact information and intermittent changes in member eligibility based on MassHealth status and ACO affiliation prevent CPs from processing ACO/MCO member lists in a timely manner.

Staff that review ACO/MCO spreadsheets often serve as liaisons between ACO/MCO key contacts and internal CP care teams. After reviewing the member lists, they distribute initial contact information to CP care teams, determine member eligibility, and communicate updated contact information and member status outreach reports back to the ACOs/MCOs. Other CPs have separate outreach and engagement teams that review ACO/MCO spreadsheets. CP outreach and engagement teams make the first contact with assigned members on behalf of care coordinators and reconcile eligibility issues prior to initiating the care planning process.

Integration with ACOs and MCOs

CPs meet with key ACO/MCO contacts to identify effective workflows and communication methods that provide the highest quality of care to members. Most CPs achieve this through quarterly meetings with ACO/MCO partners in which participants review the implementation of Documented Processes and address any barriers to integration. A **few CPs have staff that are embedded at ACO/MCO health centers and primary care practices**. Staff at these sites work alongside ACO/MCO care teams and have monthly or even daily meetings to strategize on behalf of members, discuss mutual expectations and refine workflows. The IA recommends that CPs strive to embed staff at practice sites, EDs or other locations with embedded ACO care coordination staff to improve care coordination.

CPs also attend **routine case review meetings** with partners to discuss shared members. Nearly all CPs have case review meetings with at least one of their ACO/MCO partners at least monthly. CPs with embedded staff participate in daily huddles to review cases of shared members who have been admitted, presented in EDs, or who have appointments scheduled for that day. A few CPs focus their case review discussions on the highest-risk members, such as those with medical complexity or with high rates of utilization.

Case review meetings represent an opportunity to share clinical information, identify high-risk members and coordinate care but are also an efficient opportunity to receive swift approval on existing care plans. Nearly half of CPs have weekly to bi-weekly case conferences with PCPs/ACOs to obtain in-person sign-off on care plans.

CPs also use integrated care planning meetings or joint visits to improve integration with partners. Some CPs have staff conduct home visits with members in parallel with ACO care team staff to complete comprehensive assessments and person-centered care plans at the same time. Joint visits clarify roles, reduce duplication of efforts between the CP and ACO and introduce members to all parts of their care team at the same time.

Some CPs use health information technology to enhance integration during care transition planning. Integrated ENS/ADT notifications that are pushed directly into the CP's EHR allow most CP care coordinators to review member Admissions in real-time or within the day. Some CPs assign staff to work directly with ACO transition of care teams, ACO nurses, social workers, and CHWs located in EDs and inpatient units to assist with Discharge planning and follow-up.

Joint Management of Performance and Quality

CPs participating in the DSRIP program have dual performance objectives—to meet MassHealth quality measures that aim to reduce utilization and TCOC among the member population and to improve the efficiency of their operations. Thus, working with ACO, MCO, and PCP partners to improve key performance indicators and strengthen shared workflows is crucial to a CP's success.

Most CPs implemented **data-driven QI initiatives to track and improve member engagement**, but more than a few (14.8%) received a recommendation on this indicator due to the lack of detail in reports for current QI initiatives. Although all CPs monitor KPIs such as engagement rate, comprehensive assessment completion and approval rate, number of care transition activities performed in response to member Discharges, and cycle time for outreach and participation in the CP program, not all CPs established improvement goals with benchmarks of success. Examples of QI initiatives across the cohort with sufficient detail include improving the percent of members who had a follow-up visit with a mental health practitioner within seven days after a psychiatric hospitalization and reducing the time to engage new members within six months of assignment.

Many CPs track progress on CP-determined KPIs through their EHR or through real-time analytic dashboards and share this information with ACO/MCO partners in reports or during regularly scheduled meetings. A few CPs provide ACOs/MCOs direct access to their performance dashboards which is a promising practice that enhances integration and joint management of quality.

A few CPs have also partnered with ACOs on ACO-driven quality initiatives. These CPs track HEDIS metrics within their analytic dashboards and gather outcomes data for ACOs on members enrolled in the ACO's text messaging program.

Nearly all CPs with APs and/or CEs share progress on performance measures internally with these organizations. Many CPs audit care team activities weekly to ensure proper documentation in the care management platform and to confirm that care coordinators adhere to timelines for responding to member needs. CPs share audit reports with program leadership on a regular basis.

A goal of the CP program is to increase the number of members that are engaged in CP supports. Although CPs perform outreach activities for assigned members, member is considered engaged when CP receives care plan sign-off from the assigned enrollee and the assigned enrollee's PCP. To obtain timely sign-off, CPs must develop relationships with PCPs and develop mechanisms to engage PCPs in timely review. Some CPs instituted an internal review process, carried out by clinical or supervisory staff, to improve the quality of care plans prior to sending them to PCPs. Other CPs send weekly updates to PCPs on outstanding care plans or established agreements with PCPs to fast-track new member appointments that help promote timely care plan approval and sign-off. A few CPs (14.8%) reported challenges in trying to engage PCPs in care plan review due to PCPs lacking awareness about the CP program. In addition, some ACO/MCO partners are reluctant to allow CPs to communicate directly with PCP staff or unwilling to serve as an interlocutor between the CP and their PCPs.

3. WORKFORCE DEVELOPMENT

Characteristics of CPs considered On track:

- ✓ **Recruitment and retention**
  - o does not have persistent vacancies in planned staffing roles;
  - o offers a variety of incentives to attract candidates and retain staff, and uses a variety of mechanisms to recruit and retain staff;
  - o employs tactics to ensure diversity in the workplace and design staff incentives and performance bonuses around CP priorities such as enrollee engagement, signed care plans and intensive care coordination.
- ✓ **Training**

- o develops policies and procedures to ensure staff meet the contractual training requirements and offer training to all new staff based on program requirements;
- o holds ongoing (often monthly) training to ensure staff are up to date on best practices and advancements in the field.

Findings

For the Workforce Development focus area, the IA found that eighteen CPs are On track, and nine are On track with limited recommendations.

Recruitment and retention:

Most CPs do not have persistent vacancies in planned staff roles. The remaining CPs most often struggled to achieve workplace diversity and experienced **challenges recruiting non-care coordination staff and masters-level care coordination staff**. Multiple CPs expressed that competition with other CPs and ACOs presented significant barriers to recruiting a diverse pool of candidates. However, all CPs adapted to hiring challenges throughout the course of the assessment period to the extent that they have not experienced long-term vacancies.

CPs reported using a variety of strategies for recruiting. Most use traditional recruitment channels including posting opportunities on job boards, in local newspapers, and on their own or a partner website. Many CPs recruit at career fairs and through community organizations. A few CPs hired human resource recruiters to identify and screen applicants. Many CPs also identify potential candidates internally by engaging staff already employed by the CP's parent organization or at one of the CP's APs, MOs, or CEs. Many CPs pursued partnerships with local higher education institutions to form direct recruitment pipelines or to develop internship programs. Many CPs participating in internship programs frequently hire former interns for full time positions.

Several CPs report incentivizing recruitment through sign-on and employee referral bonus programs funded through DSRIP. Most report that sign-on bonuses have been particularly helpful for filling registered nurse and nurse care manager positions. Certain CPs also offer flexible work schedules as a component of their recruitment and retention strategy.

Nearly all **CPs used DSRIP Statewide Investment (SWI) funds to further support recruitment and retention** efforts. Many CPs reported positive impacts on recruitment and retention through SWI-supported student loan repayment programs and additional certification opportunities for staff. The IA recommends that all CPs continue or begin to use DSRIP SWI to improve recruitment and retention of qualified staff.

CP retention efforts focus on promoting staff development, creating a positive workplace culture, and being responsive to staff feedback. The majority of CPs support professional development through continuing education opportunities, attendance at external conferences, enrollment in certificate programs, and access to specialized trainings. Additionally, many CPs created transparent career ladders with defined performance expectations to retain and promote qualified staff. Some CPs also implemented mentorship programs to facilitate professional development and career progression.

Many CPs view a **supportive workplace culture as a catalyst for employee retention**. CPs host morale boosting events and team cohesion opportunities such as staff recognition meetings, annual performance celebrations, and potluck lunches to demonstrate appreciation for the workforce and make staff members feel valued and supported in their roles. A few CPs implemented staff surveys to better understand CP staff member needs, perceptions, and challenges and have used survey results to inform retention efforts. In response to staff surveys and feedback, some CPs reduced care coordination staff's caseloads and shifted outreach and engagement responsibilities to dedicated staff members. These mitigation strategies allow care coordination staff to spend more time with engaged members and reduce their workload on certain tasks that contribute to burn-out.

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Although many CPs struggled to attract linguistically diverse candidates in the first year of the program, **most successfully recruited and retained a diverse workforce by year two**. Many CPs report successfully recruiting candidates through advertising in media platforms that are targeted towards communities of interest. Many also use job postings that highlight their organization's preference for multi-lingual staff, with some offering increased salaries to multi-lingual candidates. Some CPs attend minority outreach job fairs, recruit at cultural centers, and leverage relationships with student groups focused on diversity issues to help identify candidates. A few CPs reported that their existing staff are particularly valuable assets for recruiting diverse candidates.

Nearly all CPs implemented a performance bonus program tied to the achievement of the CP program's priorities. CPs report that staff are appreciative of these incentives.

Training:

All CPs established policies and procedures to ensure that their staff meet all applicable training requirements for the CP program. The majority of CPs hold in-person orientation sessions for new staff. A few CPs use online learning management systems (LMS) to deliver new staff orientation training and some use a combination of in-person and web-based trainings. Most consortium CPs implemented a centralized new staff training program, where the lead entity provides the majority of orientation training to enable uniform training of new staff.

All CPs hold ongoing trainings focused on best practices and communicating recent advancements in the field. Ongoing training frequency ranges from weekly to annually, with the majority of CPs holding ongoing trainings on a monthly basis. Most CPs track training compliance through reporting logs that are reviewed and approved by staff supervisors and CP leadership, oversight by the CP's training workgroup, or automatic logging of completed trainings through the CP's LMS.

In addition to trainings provided to staff by the CP, many CPs used partner organizations and MassHealth training forums to expand available training. Some staff participate in joint learning events with ACO/MCO partners, attend CHW training, access trainings offered by APs and other educational institutions, invited guest trainers to speak at internal meetings, and attend external conferences and trainings.

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

Characteristics of CPs considered On track:

- ✓ **Implementation of EHR and care management platform**
    - o uses ENS/ADT alerts and integrates ENS notifications into the care management platform
- ✓ **Interoperability and data exchange**
    - o uses Secure File Transfer Protocols (SFTP) or other compliant and secure technology to set monitors and alerts for daily receipt of client files;
    - o uses Mass HIway[28] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.
- ✓ **Data analytics**
    - o develops a dashboard, overseen by a multidisciplinary team, to oversee documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management;
    - o reports progress toward goals to the Quality Management Committee, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

Findings

For the Health Information Technology and Exchange focus area, the IA found that one CPs is On track, and twenty-six CPs are On track with limited recommendations.

Implementation of EHR and Care Management Platform

CP entities are expected to enhance their information technology systems to meet and exceed the requirements of the DSRIP contract. The IA found that all CPs utilize an Electronic Health Record (EHR) and implemented care management tools to serve member populations.

Nearly all CPs are using an integrated EHR care management platform provided by a single vendor. This **platform can produce and transmit consolidated clinical document architecture (CCDA) files, query a database of EOHHS-supplied eligibility info, and submit structured outcomes reports** to EOHHS, other state agencies, and ACO/MCO partners. Many CPs take advantage of additional technological design components, such as the ability to complete standards-based transactions over Mass HIway[28] to facilitate the provision of care management.

The DSRIP contract requires that CPs receive information to support member transitions of care. At the midpoint, CPs reported that ENS/ADT alerts are mostly or fully accessible to them (Fig. 24). Nearly all **CPs integrated ENS/ADT notifications from area providers** into their care management platform and use the notifications daily. Among the CPs with integrated ENS/ADT notifications, most have contracted with one or more vendors to push event data for members into the CP's care management platform, allowing CM staff to act on information in real time. Many CPs with an ENS vendor have data refreshed daily outside of business hours. Some CPs configured their care management platforms to push ENS/ADT data directly into member records, so they show up as alerts in assigned care coordinators' individualized task lists, home dashboards, or team workflows.

All CPs receive notifications from EDs and inpatient units in their service area. Some CPs receive ENS/ADT notifications from rehabilitation facilities, skilled nursing facilities, and substance use levels of care. Some CPs maintain ADT data feeds from ACO and MCO partners to receive direct messages and reports from area providers that are not subscribed to ENS. A few entities that offer clinical services as well as CP supports developed internal ENS with integrated notifications. These systems show admissions to detoxification services and other levels of care within the CP. When a CP member is admitted to these care settings, CP care teams receive an alert in the shared EHR.

CPs that do not have access to integrated notifications employ other strategies to gain access to ENS/ADT data. Some of these CPs contract with one or more ENS vendors to receive real-time ENS/ADT notifications for shared members by email or text message. Email and text notifications are sent directly to care coordinators or to designated staff members who assign follow-up activities to care coordination staff.

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[28] Mass HIway is the state-sponsored, statewide, health information exchange.

FIGURE 24. ADT FEEDS AND REAL-TIME EVENT NOTIFICATIONS ACCESSIBLE TO COMMUNITY PARTNERS
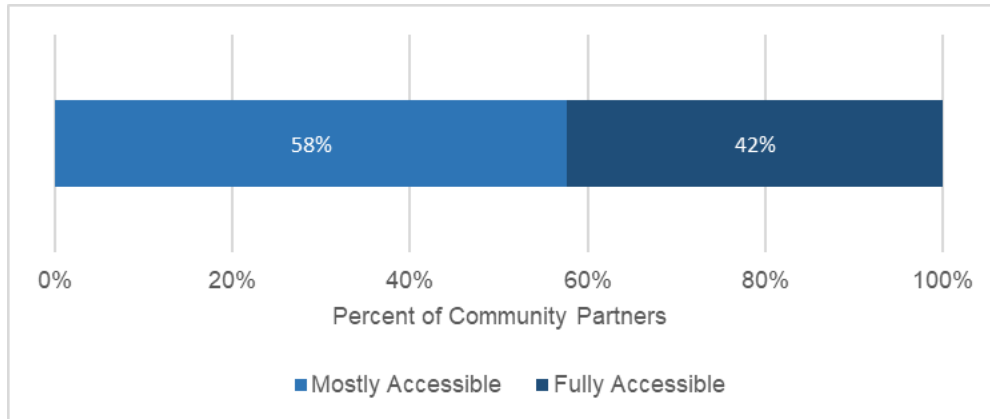
Number of CPs Reporting, N =26
Figure displays responses *from BP2 APR Implementation Progress Supplement Q1d*
Statistical significance testing was not done due to small sample size.

Interoperability and data exchange

CPs need to have secure, reliable methods of data exchange with all ACO/MCO partners. Nearly all CPs use SFTP or other compliant and secure technology for daily receipt of client files. Most CPs use an SFTP server that is hosted by a single EHR and/or care management vendor for file transfer. The platform is equipped to send alerts for transmission and receipt of files. Some CPs retrieve files from ACO/MCO partners' SFTP sites through alternative methods.

All CPs use a combination of data exchange methods to communicate with ACO/MCO partners. In addition to SFTP, nearly all CPs use secure email. Many CPs use secure file sharing apps and fewer than a third use secure fax or secure fax-to-email protocols to send files.

One third of LTSS CPs and nearly half of BH CPs gained access to ACO/MCO partner EHRs to identify information on shared members. Of these CPs, some have read-only access to partner EHRs, and some have full access to providers' EHRs at certain practice sites. A few have access to the entirety of a partner's EHR with at least one of their ACO/MCO partners, but it is unclear what type of access these CPs have, full or read-only. CPs with full access can review members' records, see upcoming appointments, and document activities in member care plans.

A frequently identified gap in the HIT&E focus area was using Mass HIway[29] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners. Most CPs reported being connected to Mass HIway, but some CPs did not describe their use of Mass HIway or report any barrier to connecting to the statewide HIE. A few CPs are connected to regional health information exchanges (HIE), specifically the Pioneer Valley Information Exchange (PVIX), as well as Mass HIway. PVIX serves providers across western Massachusetts.

In the most recent reporting period, the State required CPs to report on their level of interoperability, namely their ability to share and/or receive member data files electronically with ACOs, MCOs, and PCPs (Fig. 25). Key member data files include member contact information, comprehensive assessments, and member care plans. All CPs reported that they share and/or receive comprehensive assessments and member care plans electronically with the majority of their ACO and MCO partners. Nearly all CPs reported that they **can share and/or receive member contact information electronically** with the majority of their ACO and MCO partners. Most CPs reported they can share and/or receive member care

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[29] Mass HIway is the state-sponsored, statewide, health information exchange.

plans electronically with the majority of PCP partners but reported difficulties with sharing and/or receiving comprehensive assessments and member contact information with PCPs. Some CPs elaborated that they have difficulties sharing and/or receiving member data files electronically with PCPs and ACOs that exclusively use fax for data transfer.

The IA finds that a combination of file exchange methods helps CPs achieve full interoperability with all ACO/MCO and PCP partners and recommends that CPs continue using multiple complementary methods as needed. All CPs with full interoperability are connected to Mass HIway and utilize SFTP; nearly all also communicate with their partners via secure email.

FIGURE 25. COMMUNITY PARTNERS HAVE ACCESS TO AND CAN SHARE CARE PLANS, COMPREHENSIVE ASSESSMENTS AND MEMBER CONTACT INFORMATION WITH MOST OR ALL MCOS AND ACOS, AND SOME PARTICIPATING PCP SITES
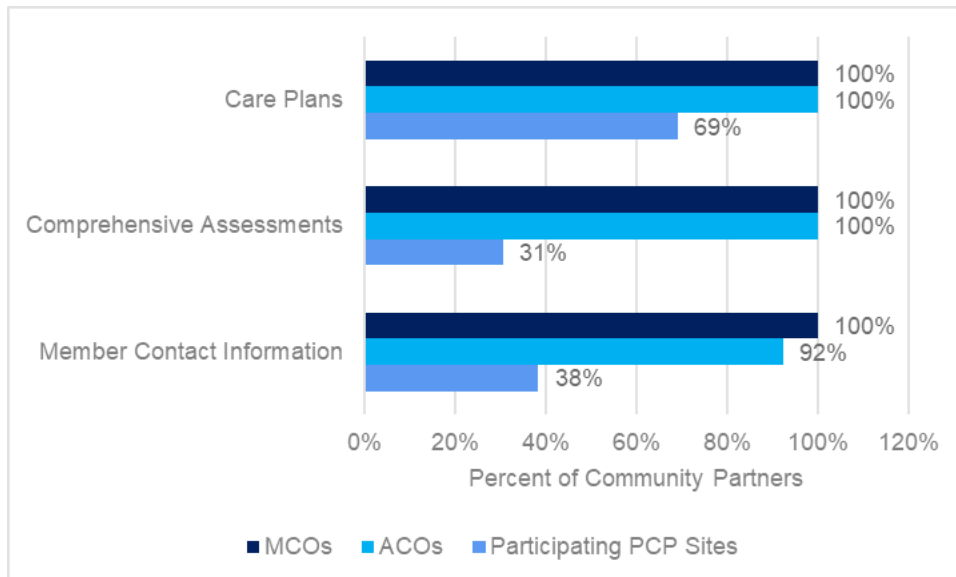
Number of CPs Reporting, N =26
Figure displays "Most" or "All or Nearly All" *responses from BP2 APR Implementation Progress Supplement Q1a, Q1b, Q1c.*
Statistical significance testing was not done due to small sample size.

Data Analytics

CPs track and evaluate progress on quality benchmarks in order to receive one hundred percent of quality withhold dollars. CPs used DSRIP infrastructure dollars and Technical Assistance funds to improve their analytic capacity. Most CPs developed at least one dashboard, overseen by a multidisciplinary team, to oversee documentation and performance on key quality metrics. Most CPs use the dashboard(s) to create sample reports for performance management. Many CPs used a vendor other than their EHR vendor to design and build dashboards. Close to a third have used or are currently **using TA funds to support data analytics projects.**

The dashboards pull data from a variety of sources. Most CPs built dashboards using data from their EHR. Some CPs used DSRIP funding to create centralized data warehouses to combine information from their EHR, Health-related social needs screenings, and member claims data. CPs then use these repositories to feed their dashboards.

Seven CPs lack a real-time dashboard to oversee documentation and performance on key quality metrics. This gap in reporting capability leaves CPs dependent on reports produced centrally using data from their EHR/care management platform. A few CPs report exporting data from their EHR/care

management platform into a series of spreadsheets and then viewing it in the aggregate to measure progress on established benchmarks. This type of manual data collection leaves CPs unable to track changes in performance metrics on a frequent basis.

Most **CPs track member engagement performance metrics** such as the number of comprehensive assessments received, care plans signed and time from assignment to engagement. Many CPs combine claims data with EHR/care management platform data to measure progress on CP quality measures. Some CPs track population health measures such as member utilization and TCOC. Some CPs established care team goals and are tracking staff productivity.

All CPs report progress on quality metrics to program leadership. Many CPs run data reports or refresh dashboards at least weekly, and in some cases daily. In a majority of CPs, supervisory staff or care coordinators have regular access to data and use it to inform daily operations. In this group, some CPs have managers use quality measure data to set care team goals or priorities. In fewer cases, staff discuss progress on care team goals at routine care team meetings.

5. CARE MODEL

Characteristics of CPs considered On track:

- ✓ **Outreach and engagement strategies**
    - o ensures staff are providing services that are tailored to and reflective of the population racially, ethnically and linguistically;
    - o uses Peer Support and/or Community Health Workers throughout the provision of CP supports and activities;
    - o has a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations.
- ✓ **Person-centered care model**
    - o ensures goals are documented in the care plan so that the team is engaged in supporting the enrollee towards achieving goals;
    - o uses person-centered modalities so that care coordinators can assist enrollees in setting health and wellness goals.
- ✓ **Managing transitions of care**
    - o manages transitions of care with established processes including routine warm handoffs between transitions of care teams and CP care team.
- ✓ **Improving members' health and wellness**
    - o standardizes processes for connecting members with community resources and social services.
- ✓ **Continuous quality improvement**
    - o has a structure for enabling continuous quality improvement in quality of care and member experience.

Findings

For the Care Model focus area, the IA found that five CPs are On track, eighteen are On track with limited recommendations, and four demonstrate an Opportunity to Improve.

Outreach and engagement strategies:

Despite widespread progress, the majority of CPs experienced some challenges in outreach and engagement of members. Although all CPs appear to be performing in-person outreach attempts, BH CPs described employing multiple specific strategies for community-based outreach, while LTSS CPs typically did not. Differences in the populations served may underly this observed difference. The two most frequently identified gaps related to community outreach strategies for members who are not easily

reached telephonically, and the use of peer supports and/or CHWs throughout the provision of CP support. A gap noted for about one-quarter of CPs was the use of peer supports and/or CHWs throughout the provision of CP support.

Most CPs have implemented strategies to enable staff to provide services that are tailored to and reflective of the member population racially, ethnically, and linguistically. One common practice among CPs is hiring bi- and multi-lingual staff whose language capabilities match the diversity of the CP's member populations. A few CPs leveraged access to ACO partners' multi-lingual staff to facilitate communication with assigned CP members in their preferred languages. Most CPs also contracted with interpretation services to support members with any language needs not met by CP or agency staff. The majority of CPs contracted with a combination of in-person, phone, and web-based interpretation services to give care coordinators access to translation services when working in the community with assigned members.

To further tailor services to the CPs' member populations, many CPs hired staff with a variety of work and lived experience. CPs made it a priority to hire staff with experience in medicine, mental health, addiction, the legal system, the LGTBQ community, and homelessness to reflect the individual CP's member population. Additionally, a few CPs make cultural competency a hiring and training priority to prepare staff to provide services that are appropriately tailored to the member population.

The IA found that LTSS CPs were often, but not universally using Peer Supports/CHWs throughout the provision of services. Most BH CPs employ CHWs and/or peer supports to facilitate the delivery of CP supports and activities. These staff are often responsible for accompanying members to appointments, conducting home visits, performing community outreach with assigned members, and assisting with inpatient rounds. In addition to CHWs and Peer Supports, a few CPs employ care coordinators who are Recovery Support Navigator/Recovery Coach trained to assist members with substance use disorder or are Housing Specialists to support members experiencing homelessness.

Most CPs use PCP and ACO/MCO records, ENS/ADT notifications, and claims data to identify updated member contact information to properly perform outreach and engagement activities. Multiple CPs have difficulty conducting outreach and engaging assigned members telephonically but have not implemented a community outreach strategy to contact members who are not easily reached by phone or who are mistrustful of the healthcare system to mitigate this challenge. Across the cohort, many potential members will not return phone calls and often opt out of participating in the CP program when contacted by CP staff.

Among the CPs that did implement a **community outreach strategy**, most hired engagement specialists outreach team staff to lead the CP's outreach and engagement efforts. To promote culturally competent outreach that is effective for the CP's member population, some CPs' staff attended specialized community outreach trainings. These trainings give staff the opportunity to practice their outreach skills and learn community canvassing strategies.

The majority of CPs have staff go to members' homes, shelters, and other sites where individuals experiencing homelessness sleep to locate assigned members. Some CPs also visit food pantries, congregate meal sites, treatment centers, APs' facilities and programs, and EDs to find and engage assigned members. A few CPs embedded staff within PCP and ACO offices to conduct outreach with assigned members in the waiting room, which all but one PCP location allows.

To incentivize continued engagement with the CP after the initial outreach phase, a few CPs implemented a member cell phone program that issues engaged CP members cell phones for members who remain in contact with their assigned care coordinator.[30] Additionally, some CPs provide members with small gift card incentives for continued engagement and for achievement of engagement milestones, such as

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[30] CPs should first utilize Lifeline program for members as appropriate.

completing the comprehensive assessment and attending care plan meetings. A few CPs also implemented staffing on nights and weekends for members who are not reachable during standard business hours.

Person-centered care model:

All CP care coordination staff document established goals in a member's individual care plan. Most CPs include clear action steps and a method for tracking progress for each of the member's established goals in the care plan. Most CPs use members' needs, preferences, and beliefs to design specific goals and action steps in the care plan. Goals are typically derived from information available from the member's comprehensive assessment and information gleaned from conversation with the member. A few CPs engage the member's other service providers and natural supports such as family members and caregivers in the care planning process and look to these individuals to help identify appropriate goals for the member. To engage members' entire care team to help them meet their established goals, CPs include health and wellness goals in the care plan. Some CPs **convene regular care team meetings with all of a member's service providers** to discuss the member's progress and highlight any gaps in care. All CPs review and update the care plan at established points throughout the year or more frequently in response to a change in the member's condition.

In addition to identifying and documenting member goals related to health and wellness, CPs reported on the value of required contingency plans or crisis plans. BH CPs indicate that crisis plans are especially useful for members with a history of high service utilization and complex behavioral health needs. Other CP's care planning processes include recording members' HRSN and documenting any necessary referrals in the care plan. A few CPs also implemented internal care plan review procedures to produce care plans that meet the CP's standards and are ready for PCP review and approval.

Most CPs utilize motivational interviewing to empower members to identify goals and determine the action steps necessary to achieve these goals. Many CP's implemented other person-centered modalities to facilitate the care plan development process. Additional strategies include the 5-stages of change model, de-escalation techniques, trauma-informed care principles, the peer support health and resiliency framework, option counseling, wraparound care, shared decision making, and brief negotiated interview.

Managing transitions of care:

Nearly all CPs explicitly described their **standard processes to manage transitions of care**. Most CP's are made aware of an assigned member's presentation at an inpatient facility or ED through ENS/ADT notifications. Many CPs rely on notifications delivered through the CP's care management platform or notifications delivered via shared EHR. Some CPs receive notifications by email. CPs tasked a variety of staff members with the responsibility for transitions of care including care coordinators, care managers, nurse/clinical care managers, intake coordinators, and transitions of care nurses, managers, coordinators, and coaches. A few CPs have **dedicated teams to manage member's transitions of care while others have embedded staff within inpatient facilities** to facilitate transitions of care and warm handoffs from the inpatient facility to the CP.

Most CPs begin the transition of care process by reaching out to the inpatient facility upon notification of a member's Admission and contacting the member either by phone or in-person. Typically, CP staff maintain contact with the member and the member's inpatient care team and engage in Discharge planning as much as possible. Upon Discharge, most CP staff make follow-up appointments for the member, identify necessary referrals, and conduct required post-Discharge CP follow-up appointments. In accordance with the CP contract, some BH CPs have reported clinical care staff perform medication reconciliation for members as part of the Discharge process. A few CPs established a process for expediently scheduling follow-up appointments for members at co-located outpatient clinics and treatment centers. These CPs indicate that having this process in place helps members adhere to their Discharge plans as they are not impeded by long wait times for appointments.

Most CPs focused on **building relationships with inpatient facility staff** to improve transitions of care efforts. CPs indicate that these relationships lead to more timely communication about member presentation from the inpatient facility and increased CP engagement throughout the transitions of care and Discharge processes. Many CPs also participate in monthly or bi-weekly meetings with ACO/MCO care teams to discuss transitions of care processes, including care for members experiencing homelessness and members with a history of high service utilization. Many CPs also take responsibility for communicating the member's status with care team partners. With consent from the member, CP staff discuss the member's condition and Discharge plan with appropriate programs and agency providers such as, the Department of Mental Health, to ensure that all care team members can appropriately engage with the member throughout the transitions of care and Discharge processes.

Improving Members' Health and Wellness:

While all CPs screen members for health-related needs and connect members to community resources and social services, the processes for doing so are often not automated or standardized. The **lack of a standardized process to connect members to community resources and social services** was a commonly identified gap in the CCCM focus area.

The CPs that established a standardized process to connect members to community resources and social services developed or subscribe to a referral resource that helps staff connect members to providers or services intended to help members achieve their health and wellness goals. Many of these CPs maintain a resource directory on the CP's intranet, file sharing system, or within the care management platform where it is accessible to all care coordination staff. Other CPs subscribe to a national database that compiles community resources. The CPs tailored this national database to align with their specific ACO partners and geographic area. A few CPs rely on care coordinators to maintain and disseminate information about available community resources. Care coordinators identify these resources and share information about them during staff meetings for other care coordinators to use.

In addition to creating member referral resources, a few CPs created a dedicated role responsible for developing connections to providers and community agencies. These staff cultivate positive relationships with providers, familiarizing them with the CP, their services and the referral process. Some CPs arranged for members to receive free or reduced cost access to local community-based resources including gyms, farmers markets, YMCAs, recreation programs, and recovery programs. Other CPs refer members to wellness and disease management programs available through their CEs, APs, ACO, and PCP partners.

In addition to making referrals to community resources, nearly all CPs provide health education or coaching for enrollees and in-house health and wellness programs. A few CPs maintain a dedicated health and wellness committee. Care coordinators are most often tasked with providing this education though some CPs employ wellness coaches to oversee the CP's health and wellness education programming. CPs primarily focus health education and coaching sessions on proper nutrition, weight management, exercise, stress management, fall prevention, chronic disease management, and depression management. Most CPs also implemented educational programs aimed at reducing high-risk behaviors such as smoking, inadequate nutrition, and infrequent exercise. Some CPs developed walking groups where members go for a walk with a CP staff member while engaging in conversations about wellness and health related information.

Continuous Quality Improvement:

Most CPs implemented a strategy for continuous improvement in quality of care and/or member experience. Some CPs leveraged their CABs to gain information about member experience and identify opportunities for improvement. A few of these CPs expanded the member feedback process by implementing a survey of the entire CP member population. CPs whose member population is widely affected by housing instability implemented **housing dashboards to monitor members' housing status**

and hired housing specialists who can support this population's journey through the housing continuum.

Other CPs engaged in Technical Assistance projects to improve quality of care and the provision of CP supports and services through data analytics. CPs implemented analytics projects to assess quality of care in relation to TCOC, to combine EHR and claims data to better monitor interventions designed to address health outcomes, and to analyze member utilization and cost patterns for improved efficiency in care coordination activities. A few CPs have taken on similar data analytics projects without the support of a Technical Assistance vendor. Some CPs implemented data driven plan, do, study, act (PDSA) cycles, quality management plans, and other quality improvement science methods to advance continuous quality improvement.

To evaluate their own performance and identify areas for improvement, a few CPs completed comprehensive **CP program assessments comparing their practices to nationally accredited models**. Other CPs conducted strategic planning sessions to evaluate programmatic, financial, and community factors impacting the CP program while others implemented risk management committees or to review critical incident reports and develop strategies to mitigate risk for members.

CPs indicate that an engaged and empowered workforce leads to better quality of care for CP members, as staff are less prone to burnout and the effects of staff turnover on members are mitigated. To promote continuous improvement in the workforce, a few CPs implemented a staff satisfaction survey to determine how to better support and retain staff. Additionally, some CPs created channels for staff members to provide input on CP operations and contribute their opinions in the development of policies and procedures to improve care.

H. SWI REVIEW

INTRODUCTION

MassHealth began the Statewide Investments (SWI) portfolio of programs to assist ACOs and CPs with various care transformation initiatives designed to fulfill the goals of DSRIP. The SWI program is composed of eight separate funding areas that can be broadly defined through three categories of desired outcomes: building and training the primary care, behavioral health, and frontline/peer workforces, building capacity for ACOs, CPs and providers, and addressing statewide gaps in care delivery.

This section of the Midpoint Assessment (MPA) reviews the actions taken by MassHealth, the vendors supporting the SWI program and the ACOs and CPs themselves during the first two years of the DSRIP demonstration. Additional insights into what changes are expected within the SWI program during latter years of the demonstration have also been included. For a detailed description of SWI implementation, see Appendix E.
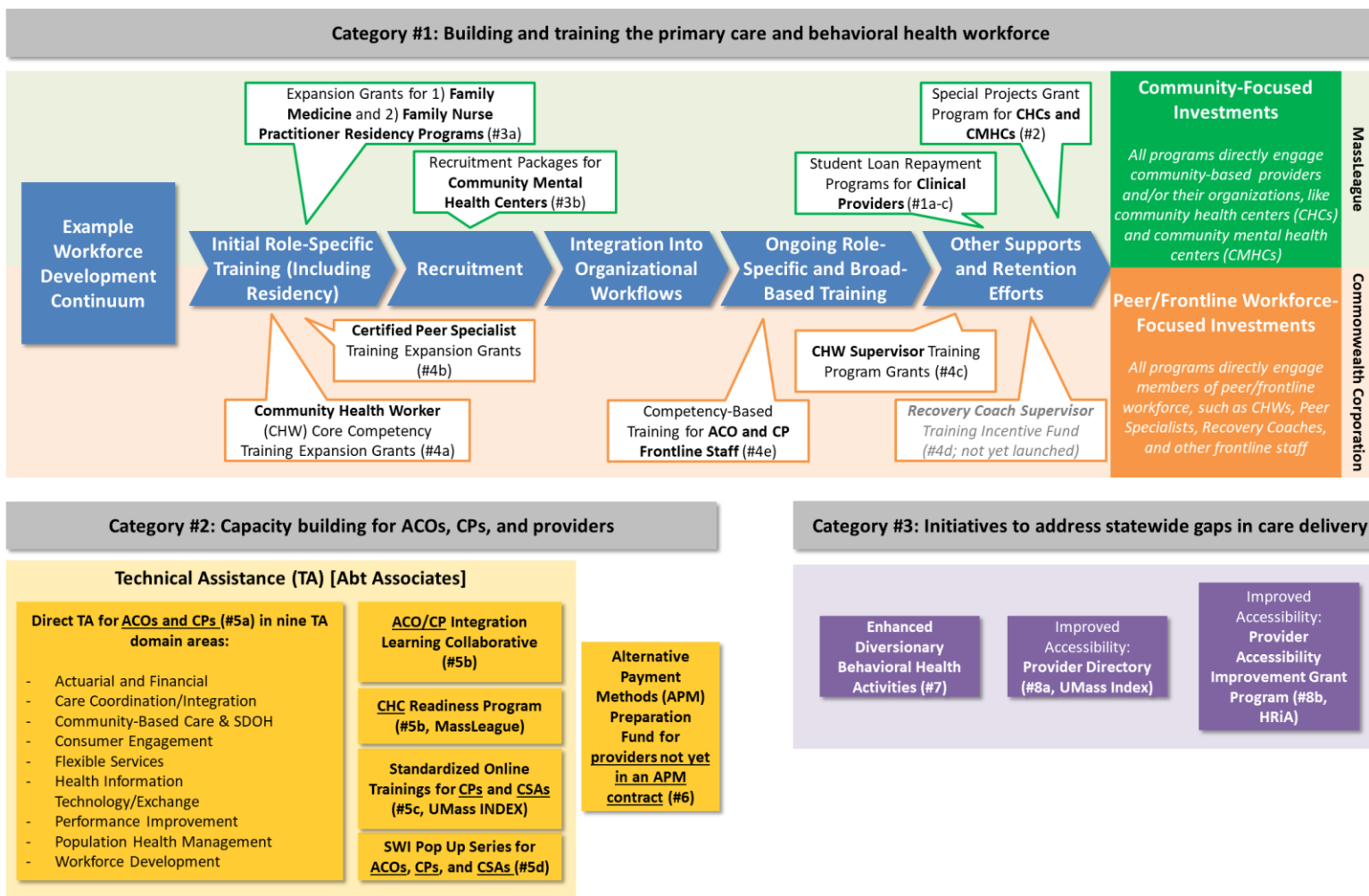
FIGURE 26. SUMMARY OF STATEWIDE INVESTMENTS

1. MANAGEMENT AND OPERATIONALIZATION OF STATEWIDE INVESTMENTS

The Statewide Investment Team, consisting of a Deputy Director and two Program Managers, provides program management and oversight of the entire SWI program for MassHealth. This core team is supplemented as needed by additional subject matter experts from across MassHealth and other agencies inside of EOHHS. A set of support vendors were also selected to fulfill most of the SWI's operational tasks including procurements (application release, review processes, etc.), payment processing, co-developing program content, and coordinating a Technical Assistance program for participating ACOs and CPs (Table 6). MassHealth actively oversees, manages, and collaborates with these vendors. Vendors have regularly scheduled meetings with MassHealth presenting regular reports and updates on specific investment operations. As part of their work, some vendors also manage subcontractors who support specific aspects of certain investments. Through this constellation of vendors, MassHealth has been able to manage a significant number of investments with relatively few dedicated staff.

TABLE 6. SWI VENDORS

I. Building and Training the Primary Care and Behavioral Health Workforce	
Investment Name	**Key Vendors**
SWI 1 Student Loan Repayment Program **Student Loan Repayment Program Behavioral Health Workforce Development Program Community Partner Recruitment Incentive Program**	Massachusetts League of Community Health Centers (MassLeague); a non-profit organization that serves as an information source on community-based health care and provides a wide range of Technical Assistance to health centers and communities. The MassLeague executes a range of investments through the management of application and review processes, disbursing funds, and providing ongoing oversight of award recipients to ensure loan condition compliance. The Association for Behavioral Healthcare (ABH) also plays an explicit role in the design, management, and ongoing improvement of this suite of programs by providing dedicated subject matter expertise specific to community-based behavioral health provider organizations. Heath Management Associates (HMA) is subcontractor to the MassLeague and provides insight on the Learning Days component of this investment.
SWI 2 Primary Care/ Behavioral Health Special Projects Program	MassLeague and ABH
SWI 3 Investment in Community-based Training and Recruitment a. **Family Medicine and Nurse Practitioner Residency Training** b. **Community Mental Health Center Behavioral Health Recruitment Fund**	MassLeague, HMA and ABH (for CMHC BH Recruitment Fund, only)

Public Consulting Group, Inc.

SWI 4 Workforce Development Grant Program
   a. **Community Health Worker Training Capacity Expansion Grants (SWI 4a)**
   b. **Peer Specialist Training Capacity Expansion Grant (SWI 4b)**
   c. **Community Health Worker Supervisors Training Program Grant (SWI 4c)**
   d. **Recovery Coach Supervisor Training Incentive Fund (SWI 4d)**
   e. **Competency-Based Training for ACOs and CPs (SWI 4e)**
	Commonwealth Corporation; a quasi-public workforce development agency that supports the Workforce Development investments in SWI 4a - e.
	These investments were implemented with the Commonwealth Corporation through an Interdepartmental Service Agreement (ISA) with the Executive Office of Labor and Workforce Development (EOLWD). The Commonwealth Corporation is responsible for creating documentation, managing the application and review processes, and serving as a point of contact between program awardees and MassHealth.

II.   Capacity Building for ACOs, CPs, and Providers

Technical Assistance (SWI 5) **Direct Technical Assistance (SWI 5a)**	Abt Associates; a consulting firm supporting the Technical Assistance (TA) Program. Direct TA (SWI 5a): Abt manages the contracts with the TA vendors and as such it is responsible for invoicing, regular reporting, compliance, and other vendor management issues between the ACOs, CPs, and vendors.
Learning Collaboratives (SWI 5b)	Abt oversees several subcontractors developing content for learning collaboratives. Center for Health Care Strategies (CHCS), a non-profit policy center, is a collaborator on the other learning collaborative. The MassLeague is directly contracted with MassHealth on one of the learning collaboratives.
Statewide Investment Pop-ups (SWI 5c)	Abt collaborates with MassHealth on all Statewide Investment Pop-ups learning and networking events
Standardized Trainings for CPs and CSAs (SWI 5d)	University of Massachusetts Medical School (UMMS)
Alternative Payment Preparation Fund (SWI 6)	N/A

III.   Initiatives to Address Statewide Gaps in Care Delivery

Enhanced Diversionary Behavioral Health Activities (SWI 7)	Massachusetts Health and Hospital Association through their work with Collective EDIE
Provider Directory (SWI 8a)	University of Massachusetts Index, a program of The Eunice Kennedy Shriver Center at the University of Massachusetts Medical School
Provider Accessibility Improvement Grant Program (SWI 8b)	Health Resources in Action (HRiA) is the grant manager responsible for developing the materials for this investment, managing the application and review process, and disbursing grants.

2. BUILDING AND TRAINING THE PRIMARY CARE AND BEHAVIORAL HEALTH WORKFORCE

Student Loan Repayment Program (SWI 1a) and Behavioral Health Workforce Development Program (SWI 1b)

Overview

The Student Loan Repayment Program (SLRP) and Behavioral Health Workforce Development Program (BHWDP) aims to reduce the shortage of primary care providers and licensed behavioral health professionals in community-based primary care and behavioral health settings. The program repays a portion of student loan obligations for providers in exchange for a four-year commitment to practice in a community setting. The Student Loan Repayment Program (SLRP) and the Behavioral Health Workforce Development Program (BHWDP) are nearly identical funding programs, with the exception of their eligibility criteria and number of application cycles. Both programs are managed by the MassLeague.

The SLRP is open to physicians, psychiatrists, psychologists, nurse practitioners, advanced practice registered nurses, and a wide range of licensed behavioral providers practicing in community health centers and community-based behavioral healthcare organizations. Eligibility for the BHWDP is limited to licensed behavioral health providers and masters-prepared unlicensed behavioral health providers practicing in community-based behavioral healthcare organizations.

A total of four application cycles are expected for the Student Loan Repayment Program, one for each of the first four years of the waiver. The BHWDP was a one-time program implemented in the first DSRIP year.

Management and oversight of the program

The MassLeague developed and oversaw the application process for both programs. This included developing the program's application, recruiting applicants and reviewing and managing the scoring and evaluation of applications. MassLeague oversees the distribution of loan funds to participants and performs oversight over the term of each loan's repayment. This includes maintaining contact with recipients to ensure they fulfil loan conditions including maintaining employment with a qualified organization. The MassLeague also prepares most of the two program's communications materials including notification letters, and informational webinars. All external communications materials are ultimately approved by MassHealth.

MassHealth has participated directly in the final review process related to these programs along with representatives from the MassLeague and the Association for Behavioral Healthcare (ABH). All award recommendations are reviewed and approved by the Assistant Secretary for MassHealth and the Secretary for EOHHS prior to finalizing award decisions.

The Association for Behavioral Healthcare also serves in an advisory role to the MassLeague and MassHealth. Health Management Associates (HMA) has partnered as the MAs League's subcontractor to support the program's "Learning Days", including the curriculum, which are provided to awardees throughout the Demonstration period.

MassHealth and the MassLeague maintain a regular touch-point to review and coordinate ongoing business across all work streams administered by the MassLeague.

Observations and Recommendations

The IA notes that demand for MD, PHD, APRN, NP and PA student loan repayment seemed to be lower than anticipated while demand for BH providers appears higher than anticipated. MassHealth compensated for this by reallocating awards to areas where demand was higher.

In year two, the number of applications declined. Some potential applicants expressed a concern over their ability to meet the 4-year commitment due to issues like paternal leave, moving, or reductions in clinical hours due to promotion. Other feedback noted that the application process was long and difficult. One hypothesis is that as this program is for early career providers, it may be that the market of early career providers working in community-based organizations has been saturated as most of these individuals have applied.

The IA recommends MassHealth to consider the following recommendations:

- Continuing to streamline the application process to reduce barriers for applicants.
- Increasing outreach to potentially interested providers to confirm that the message is reaching the target audience.
- Considering modifying the 4-year commitment to better align with the concerns of early career providers.

Community Partner Recruitment Incentive Program (SWI 1c)

Overview

The Community Partner (CP) Recruitment Incentive Program aims to assist Behavioral Health and Long-Term Services and Supports CPs in recruiting and retaining Care Coordinators (CC) and Registered Nurses (RN)/Licensed Practical Nurses (LPN) in the first year of the MassHealth CP Program. The program provided an allocation of student loan repayment slots to CPs that they can offer as incentives to prospective new hires in exchange for an eighteen-month commitment from CCs and a four-year commitment from RNs/LPNs.

This was a one-time investment for year 1 only.

Management and oversight of the program

This investment is also managed by the MassLeague. Since the CP Recruitment Incentive Program was explicitly designed to address an identified CP program need, the MassHealth CP team (in addition to the SWI team) plays an active role in all design and decision making related to this program. A designee of the MassHealth CP team participated in all meetings with the MassLeague that focused on the design and launch of this program. Similarly, the MassHealth CP team provides guidance on all questions and decision points that emerge over the course of its implementation. MassHealth reviews and approves all written material produced by the MassLeague for this work stream. MassHealth provides sign-off on all decisions related to this program prior to communication with CPs or student loan repayment recipients.

Observations and Recommendations

While some CPs were successful in recruiting CC and RN/LPNs who were able to access these funds, others were not. Ultimately it is not clear how effective offers of student loan repayment were as a recruitment tool.

The IA has no recommendations for this investment.

Primary Care/Behavioral Health Special Projects Program (SWI 2)

Overview

The Primary Care/Behavioral Health Special Projects Program aims to engage and retain primary care and behavioral health providers in community settings across Massachusetts. The program also aims to

support innovative on-the-ground projects that advance the ability of community-based primary care and behavioral health provider organizations to succeed under the new Accountable Care Organization structure. This program awards one-year grants to community-based organizations to support provider-led projects related to Accountable Care Organization implementation. The program can grant up to 25 awards of $40,000 each per year.

Providers eligible to lead projects include family physicians, general internists, pediatricians, psychologists, psychiatrists, advanced practice registered nurses (APRNs), nurse practitioners (NPs), physician's assistants (PAs), licensed certified social workers (LCSWs), licensed independent clinical social workers (LICSWs), licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), and licensed alcohol and drug counselors I (LADCs). Providers nominated to lead projects are required to have a start date at an eligible organization within six months of the application due date, or, for those who are currently employed at the time of application, have been working in an eligible organization for five years or less.

Management and oversight of the program

MassHealth is working with the Massachusetts League of Community Health Centers to administer this program. MassHealth and the MassLeague have a standing weekly 1-hour meeting to review and coordinate ongoing business across all work streams administered by the MassLeague on behalf of MassHealth.

MassHealth participates directly in final review committee discussion and decision making related to this program along with representatives from the MassLeague and the Association for Behavioral Healthcare. All award recommendations are reviewed and approved by the Assistant Secretary for MassHealth and the Secretary for EOHHS prior to finalizing award decisions.

Observations and Recommendations

The IA notes that this program has been able to distribute projects across provider types assisting with the goal of engaging and retaining many different types of providers. The majority of awards went to non-physician positions with 60% of awards going to APNs, LICSWs, LMHCs, NPs and Psychologists, and 40% going to MDs and Psychiatrists.

The projects awarded over the two years have focused on areas as diverse as diabetic education, obesity, behavioral health gaps in care, SUD, social determinants of health, smoking cessation, health equity. This program appears to be popular among the provider community and offers ways for organizations to work on projects important to their organization and the community it serves.

The IA recommends MassHealth to consider the following recommendation:

- Continuing to work to publicize the program so that more organizations that have not already applied will do so.

Investments in Community-Based Training and Recruitment: Family Medicine and Nurse Practitioner Residency Training (SWI 3a)

Overview

The Family Medicine and Nurse Practitioner Residency Training aims to increase the number of primary care physicians and nurse practitioners trained in community health centers (CHC). The program provides funding to increase the number of available primary care residency training slots in CHCs. The broader goal of this investment is expanding the pool of providers who are committed to serving underserved populations and well prepared to care for members in community settings.

Management and oversight of the program

Public Consulting Group, Inc.

MassHealth is working with the Massachusetts League of Community Health Centers (MassLeague) to administer this program. MassHealth and the MassLeague have a standing weekly 1 - hour meeting to review and coordinate ongoing business across all work streams administered by the MassLeague on behalf of MassHealth. For these two programs, the MassLeague contracts with Health Management Associates (HMA) for subject matter expertise and to complete deliverables associated with the funding stream.

MassHealth reviews and approves all written material produced by the MassLeague and/or HMA for these work streams prior to dissemination. MassHealth participates directly in final review committee discussion and decision making related to this program along with representatives from the MassLeague and HMA and any subject matter experts who participate in the review. All award recommendations are reviewed and approved by the Assistant Secretary for MassHealth and the Secretary for EOHHS prior to finalizing award decisions.

Observations and Recommendations

The IA notes this investment has successfully expanded the training opportunities for both family physicians and family nurse practitioners. In particular an increase in Family Nurse Practitioner Residency Programs is a direct result of this investment. Prior to this investment, there was only one CHC that offered Family Nurse Practitioner (FNP) residency training opportunities in Massachusetts;; there are now FNP residency training opportunities at six CHCs for a total of new 12 residency training slots in the first year of funding.

The IA has no recommendations for this investment.

Community Mental Health Center Behavioral Health Recruitment Fund (SWI 3b)

Overview

The Community Mental Health Center Behavioral Health Recruitment Fund aims to increase the number of psychiatrists and nurse practitioners with prescribing privileges at community mental health centers (CMHC) by reducing obstacles to recruitment in these settings. The program makes available recruitment packages of student loan repayment and provider-led special project funding that CMHCs can offer as recruitment incentives to prospective new hires.

The recruitment packages for psychiatrists total $150,000 over two years; up to $50,000 per recruited psychiatrist supports student loan repayment and up to $100,000 per recruited psychiatrist to lead special projects related to accountable care. The recruitment package for NPs total $110,000 over two years; up to $30,000 per recruited NP to support student loan repayment and up to $80,000 per recruited NP to lead special projects related to accountable care. Providers must commit to serve for four years at a CMHC.

Management and oversight of the program

MassHealth is working with the Massachusetts League of Community Health Centers (MassLeague) to administer this program.

MassLeague/MassHealth responsibilities regarding oversight of program awardees include:

- Ensuring that new hires are eligible for student loan repayment.
- Documenting that new hires remain at the CMHC for each of the four years of obligated service associated with student loan repayment.
- Review and approve proposals for special projects led by the new hires.
- Review and approve mid-year and annual reports on new hire-led special projects

- Review mid-year and final reports from CMHCs on recruitment efforts.

CMHCs must describe up to seven potential special projects in their program applications. CMHCs that are awarded a recruitment package have up to six months after bringing on board a new provider to submit a detailed proposal for a special project that addresses a critical need at the organization and is consistent with the career goals and interests of the new provider.

Observations and Recommendations

Statewide, there is a relatively limited pool of psychiatrists and NPs with prescribing privileges. Recruiting them to work at community health centers can be challenging as the work is perceived to be hard and the pay is perceived to be relatively low. The IA notes, over the two funding cycles, as of December 31, 2019, 6 providers were recruited through this program out of a potential 22 slots. These initial results show a slow uptake, however, CHC's have until June 30, 2020 to fill Year 1 allocation.

The IA has no recommendations for this investment.

Workforce Development Grant Program (SWI 4)

Overview

These investments engage members of the peer/frontline workforce like CHWs, peer specialists and recovery coaches. MassHealth administers these programs (SWI 4A – 4E) with the Commonwealth Corporation through an interdepartmental Service Agreement (ISA) with the Executive Office of Labor and Workforce Development (EOLWD).

Management and oversight of the programs

MassHealth has a standing weekly 1-hour meeting with representatives from the Commonwealth Corporation to coordinate all of the workstreams administered by the Commonwealth Corporation. Ad hoc meetings are also scheduled as required. MassHealth reviews and approves all written material produced by the Commonwealth Corporation for these work streams prior to dissemination in accordance with the terms of its contract with EOLWD.

MassHealth participates directly in final review committee discussion and decision making related to this program along with representatives from the Commonwealth Corporation and relevant subject matter experts, including but not limited to representatives from the Massachusetts Department of Public Health's Office of Community Health Workers.

The EOLWD reviews the scope of work and budget for this engagement on an annual basis.

Community Health Worker Training Capacity Expansion Grants (SWI 4a)

Overview

The Community Health Worker Training Capacity Expansion Grants aim to increase the number of well-prepared CHWs employed by ACOs and CPs. This program was designed in part to address the backlog of training opportunities reported at the start of the waiver period. This program awards one-year grants to CHW core competency training programs to increase the number of training slots available for CHWs employed by provider entities in ACOs and CPs. MassHealth is working with Commonwealth Corporation and the Executive Office of Labor and Workforce Development to administer this program.

The applications for this program were released on July 10, 2018 with a deadline of August 30, 2018. Ten applications were received and 6 were awarded. The amount awarded per training cycle is $40,000 with a total amount awarded of $320,000 for 200 CHW core competency training slots in calendar year 2019.

Observations and Recommendations

Overall, inclusive of all training cohorts (DSRIP- and non-DSRIP-funded), the CHW core competency training programs that received DSRIP grants have so far enrolled a total of 274 CHWs currently employed at an ACO or CP in 2019 and approximately 490 total CHWs across all 2019 training cohorts (inclusive of both training cohorts funded by DSRIP and cohorts funded by other sources). Overall CHWs currently employed at an ACO or CP utilized 56% of total available training capacity in 2019. Waitlist data provided by MassHealth indicates continued demand for these trainings.

Based on the best available data, 75% of the ACOs, 39% of the BH CPs and 44% of the LTSS CPs have utilized training opportunities.

The IA recommends MassHealth to consider the following recommendation:

- Working with ACOs and CPs to encourage continued enrollment in these trainings for CHWs in all ACOs and CPs.

Peer Specialist Training Capacity Expansion Grant (SWI 4b)

Overview

The Peer Specialist Training Capacity Expansion Grant aims to increase the number of trained Peer Specialists employed by ACOs and CPs. This program awarded a one-year $240,000 grant to the Transformation Center, the sole Peer Specialist training program in Massachusetts for individuals with lived experience with serious and persistent mental illness, to increase the number of training slots available for Peer Specialists employed by provider entities in ACOs and CPs. The training grant funded an additional 140 Peer Specialist training slots.

Observations and Recommendations

As of November 2019, 7 of the 8 training CPS training cohorts (both DSRIP- and non-DSRIP-funded) planned for calendar year 2019 had been launched. Approximately 157 of the 227 individuals enrolled in these training cohorts were currently employed at an ACO or CP.

The IA has no recommendations for this investment.

Community Health Worker Supervisors Training Program Grant (SWI 4c)

Overview

The Community Health Worker Supervisors Training Program aims to strengthen the CHW workforce and improve the effectiveness and retention of CHWs in MassHealth ACOs and CPs by expanding capacity and access to training for supervisors of CHWs. The program awarded a grant to the Center for Health Impact, a training program with expertise in training CHWs, to design a new or modify an existing curriculum and implement a training program for CHW supervisors employed by entities engaged in ACOs and CPs with approved workforce development DSRIP plans. MassHealth approved the CHW supervisor training curriculum developed by CHI in September 2019. The first training cohort launched in December 2019 with 38 individuals approved for training and 23 enrolled representing 8 ACOs and 6 CPs. MassHealth decided to fund the grant again with Year 2 money and secured an additional 60-75 training spots and plans to make the training curriculum publicly available.

Observations and Recommendations

The first training cohort launched at the end of the time period covered by this report. As such the limited enrollment data is encouraging for continued utilization of these training opportunities.

The IA recommends MassHealth to consider the following recommendation:

- Continuing to work with ACOs and CPs to ensure that all training spots are utilized and take steps to make the training curriculum publicly available.

Recovery Coach Supervisor Training Incentive Fund (SWI 4d)

Overview

The Recovery Coach Supervisor Training Incentive Fund was designed to increase the number of certified recovery coach supervisors employed by ACOs and CPs by covering the cost of salary replacement and training fees so that recovery coaches can complete recovery coach supervisor training programs. However, this investment was put on hold because the CARE Act established a commission to review and make recommendations regarding the standards governing the credentialing of Recovery Coaches in Massachusetts and the recommendations had not been approved. Rather than fund trainings when the standard was not finalized, MassHealth moved this funding to another SWI focused on provider facing trainings.

Observations and Recommendations

The IA notes that this investment has been repurposed into other trainings. The IA recommends MassHealth to consider the following recommendation:

- Working with ACOs and CPs to identify the demand and utilization of recovery coaches and look for other ways that they may need to be supported.

Competency-Based Training for ACOs And CPs (SWI 4e)

The Competency-Based Training Program aims to build the competence and confidence of the frontline healthcare workforce to improve their capacity to function at the top of their roles in team-based care models in MassHealth ACOs and CPs. It also aims to equip individual program participants with portable and stackable credentials that can help advance their careers and pursue higher education. The program engaged College for America (CfA) at Southern New Hampshire University (SNHU) to develop and implement the competency-based training program. The program will then award ACOs and CPs access to training and funding to administer a one-on-one coaching component via a competitive process.

Observations and Recommendations

The IA notes that demand for ACO specific training was lower than expected. The IA recommends MassHealth to consider the following recommendation:

- Working with ACOs and CPs to increase enrollment in this training program.

3. CAPACITY BUILDING FOR ACOS, CPS, AND PROVIDERS

These investments seek to provide support directly to ACOs, CPs and providers to facilitate their ability to participate in the MassHealth DSRIP program.

Technical Assistance SWI 5

MassHealth procured Abt Associates to manage the majority of the Technical Assistance Program (SWI 5). A Request for Quotes (RFQ) was released July 31, 2017 with a deadline of September 6, 2017. A contract was executed with Abt Associates December 4, 2017. As part of this contract Abt developed the TA Marketplace website https://www.ma-dsrip-ta.com/. Abt also hired and managed a group of subcontractors. Parts of this investment is also supported by the MassLeague (SWI 5b) and UMass Medical School (SWI 5c)

Direct Technical Assistance Support (SWI5a)

Overview

The Technical Assistance (TA) Program supports ACOs and CPs in their efforts to reduce total cost of care and improve MassHealth member health outcomes and experience. Each ACO and CP receives an allocation of funding that can be used to redeem services from a catalog of TA vendors to support discrete, time-limited TA projects.

Management and oversight of the program

MassHealth is working with Abt Associates to administer this program. Abt manages the contracts with the TA vendors and as such it is responsible for invoicing, regular reporting, compliance and other vendor management issues between the 17 ACOs, 27 CPs and 47 vendors.

Observations and Recommendations

ACOs and CPs varied as to their uptake of Technical Assistance. ACOs often had existing relationships and experience with TA vendors while many CPs were less familiar with TA vendors and their offerings. As of December 31, 2019, of the $9.2 million that had been spent in the direct Technical Assistance program, $6.1M was by ACOs and $3.1M by CPs. This represents 65% of ACO's TA cards and 56% of CP's TA cards across both Year One and Year Two TA Cards. Overall ACO and CP feedback on the program has been positive as most are satisfied with their TA projects, The IA notes vendors applied for this program at the beginning for the DSRIP initiative at a time when the specific TA needs among ACOs and CPs had not yet been well-defined. Thus far of the 47 vendors who were accepted into the program, only 27 have had projects with ACOs or CPs.

The IA recommends MassHealth to consider the following recommendation:

- Re-opening the procurement to allow new vendors to bid and to allow vendors on the procurement to bid on other categories than those they are approved.
- Allowing vendors to develop different types of marketing materials that ACOs and CPs could access that illustrate potential TA projects and their potential benefits.

Learning Collaboratives (SWI 5b)

Overview

The TA Program also hosts shared learning forums aimed at advancing ACO and CP efforts to reduce total costs of care and improve MassHealth member health outcomes and experience. These activities include:

- a learning collaborative focused on supporting ACO and CP integration;
- learning communities that provide access to professional development, mentoring, and peer support for CHWs and Peer Specialists,
- a series of mini conferences (i.e. SWI "Pop-Ups") that explore numerous topics related to accountable care.

MassHealth is working with Abt Associates to administer these programs.

MassHealth is also administering a learning collaborative to help community health centers transition to value-based payment with dedicated TA from TA vendors. MassHealth is working with the Massachusetts League of Community Health Centers to administer this program.

ACO/CP Integration Learning Collaborative (SWI 5b)

Observations and Recommendations

MassHealth and CHCS have worked over 2019 to design the Learning Collaborative. MassHealth anticipates launching a webinar in the Spring of 2020 and anticipates it being ongoing for the next 9-12 months. The learning collaborative implementation was delayed with the initial implementation dates planned for late summer/fall of 2019. While there were a number of factors that contributed to the delay, in particular, a change in MassHealth's care planning policy occurred during the development of this project and the implementation of this learning collaborative was impacted by that change in policy.

The IA recommends MassHealth to consider the following recommendation:

- Working to roll this program out in the next calendar year so that participants can benefit from the learning collaborative.

Community Health Worker and Peer Specialist Learning Communities (SWI 5b)

Observations and Recommendations

Health Resources in Action (HRiA) in partnership with the Massachusetts Association for Community Health Workers (MACHW), The Transformation Center, and the Harvard Medical School (HMS) Center for Primary Care (CPC) worked to build a set of high-level ideas for what learning communities could look like. MassHealth reports that learnings from this project including, how peer specialists and CHWs would be successful in the Value Based Payment environment were generated and will be incorporated into the next round of investments in the CHW space. However, based on the difficulties in translating these findings into specific projects and leadership changes at one of the participating agencies resulting in priority changes, MassHealth made the decision with Abt Associates to not fund the implementation of the learning community.

The IA has no recommendations for this investment.

Community Health Center (CHC) Readiness Program (SWI 5b)

Overview

The Community Health Center (CHC) Readiness Program aims to bring CHCs in Massachusetts to a level playing field in regard to the knowledge base and core competencies essential to their meaningful participation in value-based payment and accountable care. This investment is planned to run for all five years of the DSRIP program.

Observations and Recommendations

MassLeague developed content and curriculum for the year one topic, Taking Team-Based Care to the Next Level: Success in the Era of Accountability and there were 14 teams working on team-based care, with 12 health centers participating. For the second collaborative, as of December 2019, work was being done to define the topic and specific content, but the plan is to focus on a financial theme.

The IA has no recommendations for this investment.

Statewide Investment Pop Ups (SWI 5c)

Overview

Statewide Investments Pop Ups are a series of mini-conferences that enable ACO/CP leaders, staff members, and clinical providers to make time-limited deep dives into an array of relevant topics.

Observations and Recommendations

These events, and one planned for 2020 focus on member engagement, and were held in the Roxbury Innovation Center in Boston. They brought together individuals to learn about lessons learned in other states.

The IA recommends MassHealth to consider the following recommendation:

- Adding future events outside the greater Boston area so that it is easier for participants from other parts of the state to attend.
- Consider adding virtual events as a way to provide access to individuals from all parts of the state.

Standardized Trainings for CPs and CSAs (SWI 5d)

Overview

This investment provides access to a series of online trainings, some contractually required and others optional, to CPs, CSAs, and their staff members that are required and relevant to their care coordination goals.

Observations and Recommendations

Care Coordinators in CPs must complete the trainings listed below per the MassHealth contract with CPs. CPs may use their own training materials or use MassHealth standardized trainings.

- Cultural competency
- Accessibility and accommodations
- Independent Living and Recovery principles
- Motivational interviewing
- Conflicts of interests
- Health and Wellness principles
- Person-centered planning processes
- MassHealth State Plan LTSS and eligibility criteria
- Trauma informed care

Some trainings have the option to request a certificate of completion that can be shared with employers and supervisors. As of October 2019, nearly three thousand certificates had been requested, in the following modules:

Topic	Certificates
Motivational Interviewing	234
Disability Etiquette	72
Intro to LTSS Training	231
Principles of Person-Centered Planning	361
Independent Living and Recovery Principles	258
Putting Person Centered Planning Principles into Action Training	276
Community Partners 101 Training	317
Best Practices in Care Planning Training	1185
Total	**2934**

The IA has no recommendations for this investment.

Alternative Payment Methods Preparation Fund (SWI 6)

Overview

In the first year of DSRIP, the Alterative Payment Methods (APM) Preparation Fund supports providers that were not yet ready to participate in an APM but that wanted to prepare themselves to participate. Each year MassHealth will review this investment and allocate it to where it is most needed.

Observations and Recommendations

The IA notes that this investment was successful in assisting providers join ACOs. MassHealth decided to not invest more in direct APM support for medical practices as they felt that there was sufficient investment being made in the medical side of the delivery system and that there was sufficient provider capacity available in the ACOs. In DSRIP Years 2 and 3, SWI 6 will be combined with SWI 7 to provide grants to community-based behavioral health provider organizations via a grant program entitled the Behavioral Health Innovation Fund. The Behavioral Health Innovation Fund launch was delayed in order to better align with the Behavioral Health Redesign Initiative. As this fund did not launch in Year 2 the funds were rolled over into Year 3. The IA has no recommendations for this investment.

4. INITIATIVES TO ADDRESS STATEWIDE GAPS IN CARE DELIVERY

Enhanced Diversionary Behavioral Health Activities (SWI 7)

Overview

The Enhanced Diversionary Behavioral Health Activities investment supports the implementation of strategies to ensure members with behavioral health needs receive care in the most appropriate, least restrictive settings. In year one, MassHealth invested in an initiative to reduce ED boarding with the Massachusetts Health and Hospital Association (MHA). This contract runs through the DSRIP program period, until June 30, 2022. The design for SWI 7 is revisited each year to confirm that use of this investment stream is optimally aligned with statewide strategies for ensuring that members with behavioral health needs receive care in the most appropriate, least restrictive settings.

Observations and Recommendations

In DSRIP Years 2 and 3, SWI 7 will be combined with SWI 6 to provide grants to community-based behavioral health provider organizations via a grant program entitled the Behavioral Health Innovation Fund. The Behavioral Health Innovation Fund launch was delayed in order to better align with the Behavioral Health Redesign Initiative. As this fund did not launch in Year 2 the funds were rolled over into Year 3. The IA has no recommendations for this investment.

Improved Accessibility for People with Disabilities or for whom English is Not a Primary Language (SWI 8)

Provider Directory (SWI 8a)

Overview

SWI 8A is funding the development of a member-facing web directory that details the accessibility features and equipment available through MassHealth providers.

Observations and Recommendations

MassHealth appears to be conducting adequate oversight of this project and the UMass Index team appears to be well positioned to successfully launch and ensure provider information is kept up dated through regular outreach to MassHealth providers. The IA has no recommendations for this investment.

Provider Access Improvement Grant Program (PAIGP) (SWI 8b)

Overview

This investment assists MassHealth providers in purchasing accessible medical diagnostic equipment, communication devices and other resources to increase member access to these specialty services. The program supports providers in the acquisition of equipment and resources that meet the needs of members with disabilities or for whom English is not a primary language. These activities began in year two of the Demonstration.

Observations and Recommendations

MassHealth and HRiA have made program updates based on the results from the program's first cycle and appear to be effectively managing the program in a way which will encourage applicants from a broader swath of appropriate providers in future years. The IA has no recommendations for this investment.

SUMMARY

The Statewide Investments Program is a unique feature of the MassHealth DSRIP program. Interest in the program was strong. Medical and behavioral health providers in particular, actively sought out student loan repayment opportunities targeted to early career professionals working in community-based settings. Workforce training opportunities for CHWs showed high levels of interest and attendance. New residency training opportunities for MDs and NPs were created. Technical Assistance to ACOs and CPs was slower to launch than anticipated. MassHealth continues to modify the program to ensure that ACOs and CPs are able to access direct Technical Assistance and that the learning collaborative launches. In year 2, several investments were combined into the Behavioral Health Innovation Fund, and this program launch was delayed to better align with the MassHealth Behavioral Health Redesign Initiative. The IA notes that where MassHealth has met with delays or found demand for the program to be lower than initially anticipated it continues to modify the program to attempt to increase applications, overcome obstacles and invest in areas that continue to show need.

I. MITIGATION STRATEGIES FOR MID-COURSE CORRECTION

INTRODUCTION

This section discusses widespread or systemic challenges that inhibit progress towards DSRIP goals. The IA derived these challenges from the MPA findings in conjunction with concerns listed by ACOs and CPs when they were asked to identify challenges in the year two annual reports. The IA acknowledges MassHealth's existing initiatives that address these barriers while recommending additional mitigation opportunities for MassHealth's consideration as part of ongoing policy decisions for the remainder of DSRIP.

1. INTERFACE OF ACOS AND CPS

The success of the CP program depends on collaboration between ACOs and CPs. Both ACOs and CPs have devoted substantial resources to establishing systems for communication and data sharing. Despite the progress achieved by ACOs and CPs, opportunities to improve efficient and effective communication persist. ACOs report **a lack of standardization of the scope of responsibilities** between ACOs and CPs, resulting in confusion about which organization should provide care coordination and care management for members referred for CP services. CPs also describe a **lack of standardized communication methods**, noting that ACOs differ in their requirements for the format and route of sharing data and care plans. CPs have implemented workarounds, often tasking one of their staff to cope with the variation among ACOs. CPs also report difficulty in getting timely and accurate member information, limiting their ability to contact members promptly after referral. Obtaining PCP sign-off on care plans has been an additional challenge for CPs. Intervention by ACO or MCO staff to help CPs obtain outstanding PCP sign-off has helped address this challenge, but CPs report that they do not always receive this support, particularly from MCOs and Model B ACOs.

Full standardization of the ACO/CP interface may be neither realistic nor desirable, due to the variations among entities in organizational structures and established operational practices. Still, MassHealth can mitigate these challenges by providing tools and trainings that direct ACOs and CPs to pursue preferred relationships and focus on performance which will help standardize roles and responsibilities in these relationships. MassHealth should consider updating phase 3 of the PCDI[31] provider training as a venue to address concerns about overlapping roles and best practices for shared functions, such as care plan sign-off. MassHealth could further improve communication between entities and the overall efficiency of the program by promoting increased standardization of the method and format by which ACOs/MCOs submit referral files to CPs. MassHealth reports plans to launch an interactive portal which will help ACOs and CPs achieve a standardized format for file exchange. MassHealth could also require that ACOs/MCOs send CPs a prospective list of members' redetermination dates for those who have lost eligibility to improve CPs' ability to bill for these members in the future.

Several ACO and CP participants took advantage of DSRIP TA funding (SWI 5) to improve coordination between ACO and CP partners. Projects included gathering data and stakeholder perspectives, reviewing current processes, and identifying new strategies and processes. Similarly, the ACO/CP Integration Learning Collaborative funded by SWI 5b brings together ACO and CP staff from across the system to share experience and expertise. The IA recommends that MassHealth continue to support these projects and leverage the insights of collaborative participants to inform program decisions.

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[31] Payment and Care Delivery Innovation. https://www.mass.gov/info-details/masshealth-pcdi-provider-training

2. RECRUITING QUALIFIED STAFF

Shortages of clinical and care coordination staff continue to challenge system transformation. Both ACOs and CPs report **difficulty in hiring CCCM staff and BH clinicians**. Rural areas are particularly affected. **Competition among organizations** – ACOs, participating health systems, participating provider organizations, and CPs - for a limited pool of qualified staff was a cross-cutting theme. ACOs and CPs reported needing to pursue varied and aggressive recruiting strategies to attract professionals with necessary skills, such as bilingual CCCM staff. ACOs cited the shortage of BH providers as one obstacle to better integration of BH into primary care.

Mitigation opportunities for the state include addressing the shortages through training, professional development, and incentives. The SWI component of DSRIP includes several such initiatives, including Student Loan Repayment, and grants to support training. The Student Loan Repayment Program (SWI 1a) which targeted both physical and behavioral health providers, and the Behavioral Health Workforce Development Program (SWI 1b)[32] which directly targeted BH providers, addressed the clinician shortage by offering partial repayment of student loan obligations for providers who commit to four years of service at specific facilities, such as CPs and community mental health centers. The IA found that demand for the program among behavioral health practitioners was strong and recommends that the state continue to build on these initiatives. More individuals could participate in loan repayment if the four year commitment allowed for more flexibility regarding family commitments and non-clinical work. MassHealth could consider modifying program requirements and helping organizations, particularly community mental health centers, recruit eligible professionals. CHW training was also in high demand and represents an opportunity to grow the supply of these critical professionals. MassHealth should continue to encourage ACOs and CPs to have their employees take advantage of training opportunities to develop the capabilities of their workforce.

An additional opportunity to combat workforce shortages is presented by the recent pandemic-driven expansion of telemedicine. MassHealth approved $1 million in emergency Technical Assistance funding at the outset of the pandemic to help community health centers (CHC)s make a rapid shift to telemedicine, and plans to introduce a new telemedicine TA Domain to the SWI Program, launching in the fall of 2020. If MassHealth, working in concert with applicable federal and state agencies, permanently removed payment and policy barriers, ACOs and CPs could continue to use telemedicine to deploy their workforce more efficiently. telemedicine could help to alleviate regional shortages, allowing providers anywhere in the state to serve rural areas.

3. MEMBER ENGAGEMENT

The shift to value-based care holds ACOs and CPs accountable for engaging members in appropriate care, including members with a history of fragmented care, disengagement from regular care, or distrust of health care institutions. Both ACOs and CPs report difficulty in engaging some members for primary care, care planning, and services generally. This can begin with an **inability to contact members** telephonically, especially among members experiencing housing instability. Once contacted, some members, frequently individuals with BH conditions, are **disinclined to participate** in care planning or services. Other members experience language or cultural barriers or miss appointments due to transportation problems. ACOs and CPs universally report that they are devoting resources and staff to engaging these populations, but that it is an ongoing challenge.

In addition to the challenges inherent in engaging some populations, CPs report that their outreach efforts are often inhibited by incorrect or outdated contact information for members. CPs noted that some members experiencing housing instability have multiple places where they repeatedly stay, and having access to previous addresses, not only the one most recently provided by the member, helped CPs

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[32] This program was only offered in year 1.

locate these members. The IA recommends that MassHealth standardize the practice of providing access to multiple relatively recent addresses when applicable.

The state has long invested in programs directed at engaging hard-to-reach populations through community-based outreach, home visits, and 1:1 relationship building. Several ACOs anchored by community hospitals have built on the practices developed[33] during the pre-DSRIP Community Hospital Acceleration, Revitalization, and Transformation Investment Program.[34] During DSRIP, several ACOs and CPs are leveraging TA projects funded by SWI 5 to strengthen their member engagement approach. Some projects are gathering member perspectives through focus groups and interviews while others focus on communication strategies or more effective use of data. The IA recommends that MassHealth play an active role in dissemination of best practices for member engagement and review payment methods to ensure that member outreach activities can be appropriately resourced.

4. EVENT NOTIFICATION

Care teams at ACOs and CPs depend on ENS/ADT systems to alert them when a member is Admitted, Discharged or transferred; these alerts are crucial for timely connection with members during transitions of care. Some entities subscribe to multiple ENS/ADT feeds in order to capture more of the providers in their area and receive alerts for more of their members. Some large hospital systems are not participating in widely available ENS/ADT services, which negatively impacts ACOs and CPs in the region by preventing timely outreach by CCCM staff. CPs note that the problem can be particularly acute when engaging members with BH conditions during transitions of care, as some SUD providers do not participate in ENS alerts and do not confirm or deny member admission. Organizations that have connected to Mass HIway[35] and have integrated alerts into their care management platform report that the system is helpful but is **limited by a lack of universal participation**. The IA recommends that MassHealth incentivize or require statewide participation in Mass HIway notifications.

5. PAYMENT MODELS

DSRIP intends to prepare ACOs and CPs to deliver integrated, person-centered care in the context of risk contracts. The MPA did not include an assessment of the DSRIP payment model itself, but some ACOs and CPs commented on the DSRIP payment model in progress reports. Participating entities expressed concerns about the sustainability of the progress they have made due to the financial implications of current contracts. Some ACOs **experienced substantial financial losses and cited increases in the cost of care** as a challenge to sustaining value-based care. Provider price variation continues to drive high costs in Massachusetts, and ACOs often need to contract with out-of-network providers at high prices.[36] Sustainability depends on the availability of specific contract terms that enable ACOs to achieve savings. Some ACOs, particularly those relying primarily on public payers, suggest revisions to the allocation and methodology for funding. The IA recommends that MassHealth engage ACO leaders, including those focused on enhancing safety net care, and use their feedback on payment models and ongoing review of financial performance to further align the implementation of risk contracting.

CPs have also voiced concerns about payment methodology. They feel that they have less leverage in contract negotiations than their ACO partners. CPs report that current payment models do not adequately account for the **initial outreach work** needed to engage newly referred members, which routinely exceeds 3 months. CPs point to a need both for more reliable contact information, and for payment models that factor in realistic time periods for initial outreach. The IA recommends that MassHealth

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[33] The Chart Playbook: A Guide to Building Capacity, Engaging Patients, and Transforming Care In Community Hospital Settings. https://www.mass.gov/doc/chart-playbook/download

[34] Community Hospital Acceleration, Revitalization, & Transformation (CHART) Investment Program funded by the Health Policy Commission. https://www.mass.gov/service-details/chart

[35] Mass HIway is the state-sponsored, statewide, health information exchange.

[36] DiCenzo D., and Freedman, J., 2019. *Re-examining the Health Care Cost Drivers and Trends in the Commonwealth. A review of state reports (2008–2018).* Retrieved from https://9a2.583.myftpupload.com/wp-content/uploads/2019/05/freedman-report-2018-final.pdf

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convene representatives from ACOs and CPs to explore options for financing the outreach and engagement process.

J. ADVANCEMENT OF BEST PRACTICES

1. ACO PROMISING PRACTICES

Promising practices are gleaned from ACO descriptions of practices that they find useful and that the IA found to be associated with robust progress. This section highlights some themes and directional choices that emerged throughout the IA's review of ACO activities and offers a "menu" of specific activities or strategies relevant to each focus area for consideration by other ACOs. Not all practices will be appropriate for all ACOs. The IA recommends that ACOs review this menu in light of their own needs and goals. The menu is organized into the six focus areas discussed in the MPA.

ACO Themes

Nearly all ACOs oriented their governing structures in a way which sets high level goals for care transformation and performance improvement at the ACO level, while decentralizing decision making to provider groups about how to achieve those goals. ACO leadership should reinforce this decentralized approach by providing educational opportunities and significant support for the practice of continuous quality improvement at the provider level. The ACOs that stood out for their strong progress across focus areas highlighted the importance of **creating a culture of continuous improvement**. With ACOs pursuing novel structures for CCCM, a process to collect feedback from frontline staff and the ability to rapidly test alterations to clinical and non-clinical care protocols in a structured way will support ACO evolution throughout the remainder of the demonstration program. The IA recommends that ACOs reinforce the importance of QI efforts by protecting time for providers at all levels and by making funds available to providers to identify, implement and test performance improvement initiatives.

Including HRSN data as a component of risk stratification is emerging as a practice that enables more accurate identification of members who are high need or at high-risk for unnecessary or avoidable care. The use of HRSN data also increases the importance of multi-disciplinary care teams as a basis for providing person-centered care. By aggressively collecting HRSN data and incorporating it into risk scoring tools and member needs assessments, ACOs are heightening awareness of key drivers of avoidable care; housing instability, food instability and other socially-related risk factors that otherwise complicate or reduce the effectiveness of preventive and chronic illness care. As ACOs continue to scale up HRSN data collection efforts, multi-disciplinary teams at the core of CCCM programs are well positioned to assist MassHealth members seek appropriate care and reduce reliance on avoidable use.

ACOs use varied approaches to integrate care practices with Community Partners (CPs). ACOs that emphasized **meaningful collaborative engagement with CPs** from the start of the program had the greatest levels of success developing functional relationships and executing effective handoffs and care planning. Meaningful integration of ACOs and CPs results when ACOs embed CP representatives in key decision-making operational authorities at all levels, including executive, quality and care integration committees. Technological integration enhances decision-making and operational integration between ACOs and CPs. Giving CPs adequate access to patient data systems and enabling bi-directional exchange of data appear to be critical components of effective partnerships. Removing barriers to data sharing increases trust between the entities and provides transparency in the services each entity provides to members and helps manage performance. During the initial months of the CP program, ACOs were skeptical of CPs' assessments of enrollees' needs. ACOs had not fully recognized and integrated CP enrollment status into member records and care planning. The robust efforts that both ACOs and CPs have taken to meaningfully integrate operations and underlying technology appear to have built more effective relationships with increasing levels of trust. The IA recommends that ACOs prioritize ongoing

collaboration and troubleshooting with CPs and leverage TA funds where appropriate to build mutually beneficial cooperative systems.

ACO Focus Areas: Highlights and Menu of Promising Practices

Organizational Structure and Engagement

ACOs making strong progress developed an approach to performance improvement that is **centrally supported but independently managed.** This approach is largely characterized by ACOs assuming the responsibilities of integrating data, producing uniform and as-needed performance reports and facilitating the spread of leading practices across a federated system of provider groups. These discretely defined provider groups, which are often risk-bearing entities, then initiate care transformation and performance improvement efforts using a common set of performance metrics that are complemented by support from ACO-staffed quality improvement or population health management personnel. The ACOs support most often manifests through regularly occurring meetings where ACO staff share evidence based best practices, leading practices from sites across the ACO network and in-depth reviews of performance reports.

Some ACOs nurture a culture of continuous improvement by providing ongoing QI training for relevant staff at all levels and by **protecting clinical staff time from clinical services** so they can focus on population health management initiatives. One ACO protects up to four hours each week for providers to engage in these initiatives. Some ACOs also created independent funding sources that providers can use to initiate their own QI initiatives.

The IA recommends ACOs consider the following menu of promising practices for this focus area.

- ✓ *Established governance structures*
    - o *Engaging Community Partners (CPs) in ACO governance by developing a subcommittee with ACO and CP representatives focused on increasing CP integration and collaboration.*
    - o *Creating a centralized PFAC to synthesize information from practice site specific PFACs and disseminate promising practices to other provider groups and practice sites within the ACO's network.*
    - o *Seeking feedback from consumer representatives or PFACs related to member experience prior to adoption of new care protocols or other changes.*
    - o *Including a patient representative in each of an ACO's subcommittees in addition to having a patient representative on the governing board.*
- ✓ *Provider engagement in delivery system change*
    - o *Protecting dedicated provider time for population health level activities or individual quality improvement projects.*
    - o *Engaging frontline providers in continuous feedback loops to identify areas where patient experience could be improved.*
    - o *Hosting regular meetings between providers or provider groups and senior management to collect provider feedback on care management operations and quality improvement initiatives.*
    - o *Developing provider-accessible performance dashboards with practice-site level data.*
    - o *Employing individuals in roles dedicated to QI, who assist providers and practice sites to review quality measures and identify pathways to improve care processes and provider performance.*

Integration of Systems and Processes

ACOs are increasing the accessibility of behavioral health care services for their enrollees. ACOs demonstrating effective integration of BH services typically **embed BH personnel in their primary care**

practice sites or leverage central ACO staff to augment practice site personnel. Increased accessibility of BH care helps care management programs engage members and connect them to services in a timely manner. Some ACOs improved the integration of BH services by **offering SUD education and anti-stigma training** for their PCPs. Similarly, the establishment of ongoing case conferences for ACO care management teams help staff collaborate, with the guidance of managers, to improve the quality of care in real time and for future processes.

An investment in robust training has helped staff achieve ACO goals. ACOs can leverage DSRIP SWI to provide training for CHWs and invest in CHW supervisor training to ensure CHW program approaches are coordinated, consistent and perform at desired levels.

The IA recommends ACOs consider the following menu of promising practices for this focus area.

- ✓ *Administrative coordination among ACO member organizations and with CPs*
    - o *Establishing weekly meetings to discuss newly engaged members.*
    - o *Establishing monthly meetings with practices sites and CPs to discuss member care plans.*
    - o *Creating a case review process including care coordination, service gaps and service duplication.*
    - o *Sharing member risk stratification reports including results of predictive modeling.*
- ✓ *Clinical Integration among ACO member organizations and with CPs*
    - o *Designating a practice site champion responsible for integrating Care Coordination and Care Management (CCCM) and clinical care plans.*
    - o *Embedding CCCM staff at practice sites to participate in shared model for case management.*
    - o *Providing resiliency training to CCCM staff to improve team cohesion and offer emotional support.*
    - o *Developing a centralized care management office to support member care teams in conducting needs assessment, follow-up, disease management and transitions of care.*
    - o *Following members for at least 30 days post-Discharge from the hospital.*
    - o *Providing laptops or other devices that enable EHR access by off-site providers during visits with members.*
    - o *Holding monthly meetings of CCCM teams to share best practices, develop solutions to recent challenges and provide collegial support.*
- ✓ *Joint management of performance and quality*
    - o *Developing practice site specific quality scorecards and reviewing them at monthly or quarterly meetings.*
    - o *Having the Joint Operating Committee (JOC) review scorecards of clinical, quality, and financial measures.*
    - o *Sharing individual performance reports containing benchmarks or practice wide comparisons with providers.*
- ✓ *ACO/MCO coordination* (at Accountable Care Partnership Plans)
    - o *Reviewing performance and quality outcomes at regular governance meetings.*
    - o *Developing coordinated goals related to operations, budget decisions and clinical quality outcomes*

Workforce Development

Dynamic shifts to the population served can lead to unpredictable staffing shortages or surpluses. Some ACOs **contract with a local social services agency** capable of providing the ACO with short term CHWs. This enables ACOs to adjust staff size on an as-needed basis and supports recruitment of CHWs directly from the community the program serves. CHWs who come from the same communities as the population served have heightened sensitivities to local conditions particularly related to HRSN.

ACOs report that role-specific trainings for personnel improves performance across primary job functions and contributes to career advancement and retention within the ACO and its member entities. Role specific training through higher education assistance and targeted professional development efforts particularly helps the ACO re-deploy non-clinical staff to clinical roles. The use of **resiliency trainings and peer-to-peer support structures** are important activities that improve staff retention. Particularly among interdisciplinary teams, ACOs should dedicate time for staff to discuss personal job-stress issues and focus on effective approaches to team building.

Some ACOs **developed new staff cohorts** by setting common start dates. Particularly among CCCM staff, this cohort structure reduces the strain on new staff members by fostering shared learning across teams. Some ACOs further help on-board new staff through the implementation of mentorship programs, where the ACO pairs new staff with longer tenured staff. The mentoring structure shortens onboarding time and clarifies new team members' roles and responsibilities.

The IA recommends ACOs consider the following menu of promising practices for this focus area.

- ✓ *Promoting diversity in the workplace*
  - o *Compensating staff with bilingual capabilities at a higher rate.*
  - o *Establishing a Diversity and Inclusion Committee to assist HR with recruiting diverse candidates.*
  - o *Advertising in publications tailored to non-English speaking populations.*
  - o *Attending minority focused career fairs.*
  - o *Recruiting from diversity-driven college career organizations.*
  - o *Tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives.*
  - o *Implementing an employee referral incentive program to leverage existing bilingual and people of color (POC) staff's professional networks for recruiting.*
  - o *Advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers.*
  - o *Recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.*
- ✓ *Recruitment and retention*
  - o *Contracting with a local social services agency capable of providing the ACO with short term CHWs, enabling the ACO to rapidly increase staff on an as-needed basis.*
  - o *Onboarding cohorts of new CCCM staff with common start dates, enabling shared learning.*
  - o *Implementing mentorship programs that pair newly onboarded staff with senior members to expedite training, especially amongst CCCM teams with complex labor divisions.*
  - o *Providing opportunities for a staff voice in governance through regularly scheduled leadership town halls at individual practice sites.*
  - o *Recruiting staff from professional associations, such as the Case Management Society of America, and from targeted colleges and universities.*
  - o *Offering staff tuition reimbursement for advanced degrees and programs.*
  - o *Using employee referral bonuses to boost recruitment.*
- ✓ *Training*
  - o *Offering staff reimbursement for training from third-party vendors.*
  - o *Tracking staff engagement with training modules and proactively identifying staff who have not completed required trainings.*
  - o *Providing additional training opportunities through on-line training programs from third- party vendors.*
  - o *Offering Medical Interpreter Training to eligible staff.*
  - o *Sponsoring staff visits to out of state health systems to learn best practices and bring these back to the team through peer-to-peer trainings.*

- ✓ *Teams and staff roles designed to support person-centered care delivery and population health*
  - o *Protecting provider time for pre-visit planning.*
  - o *Pairing RN care managers or social workers with CHWs to provide care coordination.*
  - o *Including pharmacists/pharmacy technicians and dieticians on care teams.*
  - o *Developing trainings and protocols for staff providing home visits.*
  - o *Developing trainings and protocols for staff using telemedicine.*
  - o *Leveraging CHWs who specialize in overcoming barriers to engagement, including issues of distrust of the medical community, to build relationships with hard-to-engage members.*

Health Information Technology and Exchange

ACOs are working towards network-wide EHR interoperability. While it is often cost prohibitive to transition to a universal EHR, ACOs have made strong progress by **employing multiple workaround solutions** that enable privacy compliant real-time exchange of member information and support care coordination. Bi-directional, real-time data exchange with both affiliated and non-affiliated providers optimizes member care. ACOs have also expanded the use of patient and provider portals, data exchanges and other information conduits. Timely event notification and ADT reporting improves member support by minimizing service duplication as they transition between levels of care. The IA recommends that ACOs **expand their participation in Mass HIway[37] and other available avenues for data exchange across institutional boundaries**.

Increasingly, ACOs are including HRSN information in automated risk stratification systems. This enables CCCM teams and providers to proactively identify and manage high-risk and high need members who require additional clinical or community-based services. **Combining the inclusion of HRSN data in risk stratification with automated referrals**, ACOs can engage members in a timely manner and reduce unnecessary inpatient Admissions or ED visits.

The IA recommends ACOs consider the following menu of promising practices for this focus area.

- ✓ *Infrastructure for care coordination and population health*
  - o *Leveraging EHR integrated care management and population health platforms.*
  - o *Automating risk stratification to identify high-risk, high need members.*
  - o *Developing HIT training for all providers as part of an on-boarding plan.*
  - o *Incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress.*
  - o *Conducting ongoing review and evaluation of risk stratification algorithms to improve algorithms and refine the ACO's approach to identifying members at risk who could benefit from PHM programs.*
- ✓ *Systems for collaboration across organizations*
  - o *Establishing EHR portals that allow members to engage with their chart and their care teams.*
  - o *Providing EHR access through a web portal for affiliated providers, CPs or other entities whose EHR platforms are not integrated with the ACOs EHR.*
  - o *Developing methods to aggregate data from practice sites across the ACO; particularly if sites use different EHRs.*
  - o *Pushing ADT feeds to care managers in real time to mitigate avoidable ED visits and/or Admissions.*
  - o *Developing continuously refreshing dashboards to share real-time program eligibility and performance data.*

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[37] Mass HIway is the state-sponsored, statewide, health information exchange.

Care Coordination and Management

Standout ACOs are **leveraging each contact point with high-risk members** as an opportunity to screen for real-time needs. ACO staff create an EHR flag to identify high-risk members and automatically connect these members with an RN whenever those members call or visit a practice site.

ACOs continue to work toward reducing unnecessary ED visits. ED overuse is itself a cost driver, and more broadly, frequent ED visits often signal unmanaged chronic conditions, undiagnosed BH conditions, or unmet social needs. ACOs have made strong progress in this area **by locating care management staff, BH providers, and social workers in EDs**, recognizing that the ED provides an opportunity to connect with members who are not engaged in primary care. Many ACOs use automatic ENS/ADT notifications to alert ED based staff to the presence of members in the ED. Staff use a **root-cause approach to identify underlying problems and needs**, perform a whole-person assessment, and connect the member with longer term care and supports.

Integration of Behavioral Health and primary care is a key goal of MassHealth's delivery system reform, and an area of opportunity for further progress by ACOs. Standout ACOs have developed **a comprehensive approach to BHI** based on analyzing and responding to the needs of their member population, dedicating staff with BH expertise, and leveraging their facilities efficiently, in some cases investing in new or remodeled facilities. Their BHI strategies include co-location at primary care sites, reverse integration into BH facilities, and use of telehealth to provide BH services.

The IA recommends ACOs consider the following menu of promising practices for this focus area.

- ✓ *Full continuum collaboration*
    - o *Establishing a systematic documentation process to track members receiving care coordination from CPs.*
    - o *Matching members based on their needs to interdisciplinary care coordination teams that include representatives from primary care, nursing, social work, pharmacy, community health workers and behavioral health.*
    - o *Expanding BH integration through multiple strategies, including embedding staff in primary care sites, reverse integration of physical health care at BH sites, and telehealth.*
    - o *Increasing two-way sharing of information between ACOs and CPs.*
    - o *Leveraging EHR-integrated tools to flag members requiring a higher level of care coordination.*
    - o *Coordinating with government agencies and community organizations to enhance care coordination and avoid duplication for members receiving other services.*
    - o *Supporting families of pediatric members by offering to have care managers work with school-based personnel to address health or disability related needs identified in the Individualized Education Program.*
- ✓ *Member outreach and engagement*
    - o *Developing a high-intensity program for extremely high-need, high-risk members with strategically low case load.*
    - o *Establishing trust between members and CCCM staff by building and maintaining a 1:1 consistent relationship.*
    - o *Creating a mobile phone lending program for hard-to-reach members, particularly those experiencing housing instability.[38]*
    - o *Embedding CCCM staff in EDs.*
    - o *Creating a "Navigation Center" to manage referrals outside the ACO, handle appointment scheduling, and coordinate testing, follow-up, and documentation transfers.*

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[38] ACOs should first utilize Lifeline program for members as appropriate

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- o *Developing an assistance fund to support transportation vouchers[39] and low-cost cell phones.[40]*
- ✓ **Connection with navigation and care management services**
  - o *Utilizing EHR-based documentation transfer during warm handoffs.*
  - o *Establishing daily or weekly care management huddles that connect PCPs and CCCM teams and streamline care transitions.*
- ✓ **Referrals and follow-up**
  - o *Utilizing EHR messaging tools to better describe the purpose of specialty consults and a plan for follow-up communication.*
  - o *Automating referral tracking and management, using flags to prompt referrals, linked directories to suggest appropriate providers and services, notifications to care managers when referral results are available, and databases allowing care teams to easily identify follow-up needs.*

Population Health Management

All ACOs conduct screening for HRSNs, though not all have fully integrated HRSN into their performance strategy. ACOs that stood out for their progress in population health are characterized by their sophisticated strategies for using screening results and addressing HRSN through multiple avenues. ACOs seeking to better address HRSN can **build partnerships with community-based organizations** (CBO) such as food pantries, meal delivery services, transitional housing, and emergency shelters. Historically, clinicians have often complained that when they refer a patient to social services, they have no way to confirm that service was received and may learn much later that the patient was not successfully connected to services. Some ACOs target this problem through **automated tracking of referrals to services in EHRs**. This tracking aids care management, and also enables the ACO to easily identify the CPs and CBOs that serve a sizable number of ACO members. ACOs should consider establishing **regular meetings and data sharing with CPs or CBOs** that regularly serve their population. Some ACOs established better relationships with CBOs by engaging with local public health boards and agencies that have established relationships with CBOs to serve as a bridge, such as the Boston Public Health Commission, Alliance for Community Health Integration (ACHI), and Berkshire Public Health Alliance. ACOs can also collaborate with these agencies to create a resource directory of services in the community. The IA recommends that ACOs **incorporate health equity measures**, such as the Boston Health Equity Measure Set, into their performance goals to better align the HRSN component of their population health strategy.

The IA recommends ACOs consider the following menu of promising practices for this focus area.

- ✓ **Integration of health-related social needs**
  - o *Implementing universal HRSN screening in all primary care sites and behavioral health outpatient sites.*
  - o *Using screening tools designed to identify members with high BH and LTSS needs.[41]*
  - o *Using root-cause analysis to identify underlying HRSNs or unmet BH needs that may be driving frequent ED utilization or readmissions.*
  - o *Partnering with local fresh produce vendors, mobile grocery markets, and food banks to provide members with access to healthy meals.*
  - o *Providing a meal delivery service, including medically tailored meals, for members who are not able to shop for or prepare meals.*
  - o *Organizing a cross-functional committee to understand and address the impact of homelessness on members' health care needs and utilization.*

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[39] ACOs should utilize the MassHealth transportation program (PT-1) for member needs first as appropriate.
[40] ACOs should first utilize Lifeline program for members as appropriate.
[41] Screening for BH and LTSS needs is included as a component of ACOs' HRSN strategy because unmet social needs frequently co-occur with BH and LTSS needs, and some cases these needs are addressed by overlapping services.

- o *Enabling members and CCCM field staff to document HRSN screenings in the EHR using tablet devices with a secure web-based electronic platform.*
- o *Automating referrals to community agencies in the EHR/care management platform.*
- ✓ ***Population health analysis***
  - o *Developing and utilizing condition-specific dashboard reports for performance monitoring that include ED and hospital utilization and total medical expense.*
  - o *Developing key performance indicator (KPI) dashboards, viewable by providers, that track financial and operational metrics and provide insights into patient demographics and how the population utilizes services.*
  - o *Developing a registry or roster that includes cost and utilization information from primary care and specialty services for primary care teams and ACO leadership to better serve MassHealth ACO members.*
  - o *Implementing single sign-on and query capability into the online Prescription Monitoring Program, so that providers can quickly access and monitor past opioid prescriptions to promote safe opioid prescribing.*
- ✓ ***Program development informed by population health analysis***
  - o *Engaging top level ACO leadership in design and oversight of PHM strategy.*
  - o *Developing methods to assess members' impactability as well as their risk, so that programs can be tailored for and targeted to the members most likely to benefit.*
  - o *Developing services that increase access to real-time BH care, such as an SUD urgent care center.*
  - o *Developing programs that address BH needs and housing instability concurrently.*
  - o *Offering SUD programs tailored to subgroups such as pregnant members, LGBT members, and members involved with the criminal justice system allowing the care team to specialize in helping these vulnerable populations.*
  - o *Providing education at practice sites or community locations such as:*
    - ▪ *Medication workshops that cover over-the-counter and prescription medication side effects, how to take medications, knowing what a medication is for, and identifying concerns to share with the doctor.*
    - ▪ *Expectant parenting classes that cover preparation for childbirth, breastfeeding, siblings, newborn care, and child safety.*
    - ▪ *Cooking classes that offer recipes for healthy and cost-effective meals.*
  - o *Offering items that support family health such as:*
    - ▪ *Free diapers for members who have delivered a baby as an incentive to keep a postpartum appointment within 1-12 weeks after delivery.*
    - ▪ *Car seats, booster seats, and bike helmets.*
    - ▪ *Dental kits.*

2. CP PROMISING PRACTICES

<u>Promising practices</u> are gleaned from CP descriptions of practices that they find useful and that the IA found to be associated with robust progress. This section highlights some themes and directional choices that emerged throughout the IA's review of CP activities and offers a "menu" of specific activities or strategies relevant to each focus area for consideration by other CPs. Not all practices will be appropriate for all CPs. The IA recommends that CPs review this menu in light of their own needs and goals. The menu is organized into the five focus areas discussed in the MPA.

CP Themes

CPs that stood out for progress across focus areas were notable for their attitude towards integration with ACOs and other organizations. These CPs established multiple mechanisms to engage ACOs, MCOs, and PCPs. They formed **separate administrative teams to manage member contact information** and worked to establish local contacts at PCPs. They scheduled regular care review meetings and case

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conferences and leveraged these meetings to obtain care plan sign-off. Rather than relying on the ACO/MCO leadership to obtain care plan sign-off from PCPs, these CPs created systematic routes for **direct communication with PCPs**, such as weekly updates on outstanding care plans. They developed creative solutions to improve inaccurate member contact information or mitigate delays caused by requirements that members be seen prior to care plan sign-off. These CPs typically employed technology and automation to support communication but did not rely exclusively on HIT. No single strategy stood out as the best approach to managing the interface with other organizations, but rather the **combination of innovative strategies** enabled these CPs to progress effectively.

Effective CPs similarly employed multiple complementary strategies that leverage primary care for member engagement. HIT played an important role in member engagement but was used in combination with staff efforts. Some of these CPs gained access to EHR systems that document the date of a newly referred member's last PCP visit. If the visit was more than one year prior, the CP proactively schedules an appointment on behalf of the member to avoid delays in care plan sign-off. Some CPs also leverage their access to members' schedules to deploy staff to meet members in the waiting room of their appointments to perform outreach and engagement activities without the need for additional visits. A few innovative CPs negotiated fast track primary care appointment scheduling with practice sites to ensure their members receive timely care and their staff can obtain PCP sign-off on members' care plans. One CP collaborated with interdisciplinary staff, such as CE and AP program managers, clinical care managers, nurses, and care coordinators to develop a PCP engagement and care plan sign-off promising practices toolkit.

Multiple complementary member-facing strategies were also key to effective engagement. The populations served by CPs include members with barriers to accessing care including housing instability, lack of transportation, and distrust of health care institutions. CPs deployed **home visits, community-based outreach, and trust-building strategies**. They actively worked to overcome transportation, literacy, and language barriers though a variety of approaches (discussed in detail below, see CCCM focus area.) These CPs found that their persistence and creativity enabled efficient progress towards their DSRIP goals.

CP Focus Areas: Highlights and Menu of Promising Practices

Organizational Structure and Engagement

Some standout CPs developed a process to **funnel feedback from grass roots level staff to the executive level** which informs effective organizational and operational changes. Some Executive Boards, or more commonly their Quality Management Committees (QMC), use member experience recommendations from the Consumer Advisory Board (CAB) and front-line staff feedback about barriers to and facilitators of success to drive quality initiatives or adjust workflows. To further connect to key stakeholders and increase accountable governing, some Executive Boards conduct monthly meetings and regular site-visits with partners in addition to weekly conferences with frontline staff to discuss interdisciplinary collaboration. Open channels of communication, consistent feedback loops with grass roots stakeholders and regularly occurring meetings has helped CP networks function as unified entities and provide consistent service with an engaged staff.

Meaningfully engaging members in CABs requires sensitive planning and adaptability. Some CPs limit the amount of CP staff who attend CAB meetings so as not to overwhelm their membership. Some CPs also increased CAB membership by adapting meeting schedules, so they do not conflict with member needs, such as the need to queue at homeless shelters in the afternoon. Additionally, some CPs hold meetings in centrally located community spaces or make resources available to members who prefer to participate by phone from an off-site location. Repeated reminders of upcoming meetings using multiple mediums like the phone and written letters or community space announcements may also help improve member attendance. Most CPs issue incentives to members who participate such as providing a meal

during the meeting and a relevant gift card after the meeting. Some CPs further engage CAB members by **presenting performance data related to activities generated by CAB input** from prior meetings.

QMCs enhance the effectiveness of CPs by establishing a structure to share best practices related to key quality measures to all staff. To accomplish this, the CP must have a data monitoring plan that integrates data from multiple sources to underwrite quality dashboards or regularly issued reports. Some CPs' QMCs make this data more actionable by **adopting a structured quality methodology** such as Six Sigma Lean or PDSA. Some CPs assign management or executive level staff to provide oversight of performance data analysis, to identify performance gaps and to translate these gaps into quality improvement initiatives by engaging appropriate staff.

The IA recommends CPs consider the following menu of promising practices for this focus area.

- ✓ *Executive Board*
  - o *Holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs).*
  - o *Conducting one-on-one quarterly site visits with APs and CEs.*
  - o *Holding weekly conferences with frontline staff to encourage interdisciplinary collaboration.*
  - o *Identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the ACO's Joint Operating Committee.*
  - o *Establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives.*
  - o *Staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent services to members.*
- ✓ *Consumer Advisory Board*
  - o *Seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups.*
  - o *Adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon.*
  - o *Hosting meetings in centrally located community spaces that are easy to get to and familiar to members.*
  - o *Adapting in-person participation requirements to allow participation by phone and providing quiet space and phone access at locations convenient for members.*
  - o *Limiting CP staff presence at CAB meetings to a small number of consistent individuals, so that members are the majority in attendance and become familiar with the staff.*
  - o *Sending reminders to members in multiple formats prior to each meeting to increase attendance, including reminder letters and phone calls.*
  - o *Incentivizing participation by paying members for their time, most often through relevant and useful gift cards.*
  - o *Incentivizing participation by providing food at meetings.*
  - o *Presenting performance data and updates to CAB members to show how their input is driving changes in the organization.*
- ✓ *Quality Management Committee*
  - o *Establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures.*
  - o *Scheduling regular presentations about best practices related to quality metrics.*
  - o *Adopting a purposeful organizational quality improvement strategy such as Lean Six Sigma or PDSA cycles.*

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o *Integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data.*

o *Ensuring that management or executive level staff roles explicitly include oversight of performance data analysis, identification of performance gaps, and reporting gaps as potential quality improvement initiatives through the appropriate channels.*

Integration of Systems and Processes

CPs strive to perform outreach to engage a new member as soon as they receive the referral information. Some CPs adopted **automated systems, immediately inputting new ACO member information in their platform and reconciling those new members with existing eligibility lists**. Some CPs achieved even more efficiency by offering partners access to their full member records that can be viewed in real-time.

Additional staff engagement can lead to higher member and PCP engagement and ultimately increase CP success. Some CPs hire a **dedicated community liaison** to build relationships with PCPs and educate them about the benefits provided by the CP program. Some CPs also embed care coordinator staff at practices that require a PCP see a patient before signing off on their care plan.

CPs found that collaboration across systems is key to success. Some CPs attend **regularly occurring case conferences with PCPs** to review member cases and obtain PCP sign-off on care plans. Additionally, CPs collaborate with state agencies to improve management of mutual members. Some CPs developed an FAQ document to explain how two organizations may effectively work together to provide the best care for members. Other CPs schedule joint visits with the PCP, an ACO/MCO clinical care team representative and the CP care coordinator to present a unified team to the member and establish distinct support roles that identify who the member can contact to address different needs. Some CPs established a process that allows them to meet with members prior to their clinical appointments at PCP sites. Some CPs improved outreach with homeless members, and their ability to connect these members to care coordination services, by embedding staff at local EDs.

The ability to collect and review data regularly supports the CPs' goal of providing members with high quality care. Many CPs monitor process metrics associated with member outreach and engagement to improve operations. These measures provide insights on the number of interactions staff have with members, how many interactions typically lead to member engagement, and the types of actions most conducted by CP staff. Some CPs also track member status by sending weekly updates to all ACO partners listing members who recently signed a participation form, members who have a comprehensive assessment outstanding and members who have unsigned care plans that are due or overdue. Some CPs use **dashboards with real-time data** combined from MassHealth, ACO and MCO partners, and the EHR to track members' affiliations and enrollment status, thus helping staff target members for engagement. Some CPs further leverage technology to improve coordination of services by maintaining a dedicated web portal to share information with CP care teams across member organizations. This shared information includes contact information of primary care practices; both the LTSS and BH provider networks and local social services providers; training materials; and policies and procedures.

All of these processes require data cleaning to reconcile data from different sources and dates. CPs find it helpful to develop a regular report that compares ACO member information in the Eligibility Verification System (EVS) to information contained in the CP's EHR to flag changes in members' ACO assignment keep the records in the EHR up to date. In addition to member demographic information, it is important to have clinical staff perform comprehensive care plan reviews to improve the quality and thoroughness of plans prior to submission to PCPs for sign-off. The IA recommends that CPs systematize their tracking so that unsigned **care plans automatically generate a reminder list** which is shared with ACO and MCO key contacts.

The IA recommends CPs consider the following menu of promising practices for this focus area.

✓ *Joint Approach to Member Engagement*
- *Adopting systems, preferably automated, that process new ACO member files instantaneously, inputting member information in the applicable platform and reconciling those members with existing eligibility lists, enabling the CP to engage with the new member list without delay.*
- *Redesigning workflows and automated notifications so that receipt of a comprehensive assessment from an ACO/MCO partner generates a new outreach attempt.*
- *Establishing on-demand access to full member records through partners' EHRs.*
- *Tracking members' upcoming appointments through partners' EHRs to enable staff to connect with members in the waiting room prior to their appointment.*
- *Negotiating fast track primary care appointments with practice sites to ensure that members receive timely care and to enable PCPs to engage with and sign-off on the member's care plan.*
- *Collaborating with interdisciplinary staff, such as CE and AP program managers, clinical care managers, nurses, and care coordinators to develop a promising practices toolkit for PCP engagement and care plan sign-off.*
- *Hiring a dedicated community liaison to build relationships with PCPs and educate them about the benefits provided by the CP program.*
- *Embedding care coordination staff at PCP practices, particularly those that require an in-person visit as a prerequisite for care plan sign-off.*
- *Determining the date of the member's last PCP visit within a month of that member's assignment, and proactively scheduling an appointment on behalf of any member who has not had a PCP visit in the prior 12 months.*
- *Developing a single point of contact for ACO/MCO partner referrals to review prospective members, research previous treatment history, and to strategize on how to accommodate new members with current CP care team capacity.*
- *Identifying a lead member organization or CP care team to align with each ACO/MCO partner to promote and facilitate relationship building between CP care teams and ACO/MCO clinical staff.*
- *Implementing a real-time communication tool such as secure texting to communicate with ACO practices about shared members.*

✓ **Integration with ACOs and MCOs**
- *Attending regularly occurring case conferences with PCPs to review member cases and obtain PCP sign-off on care plans.*
- *Collaborating with state agencies to improve management of mutual members. For example, creating an FAQ document to explain how the two organizations may effectively work together to provide the best care for members or conducting complex case conferences.*
- *Scheduling joint visits with the PCP, ACO/MCO clinical care team representative, and the CP care coordinator to present a unified team to the member and establish distinct support roles and who the member can contact in to address various needs.*
- *Collaborating with PCP practice sites so that CP care coordinators are invited to meet with members onsite prior to their clinical appointments.*

✓ **Joint Management of Performance and Quality**
- *Monitoring process metrics associated with member outreach and engagement such as the number of interactions staff have with members, how many interactions typically lead to member engagement, and the types of actions most conducted by CP staff.*
- *Sending weekly updates to all ACO partners listing members who recently signed a participation form, members who have a comprehensive assessment outstanding, and members who have unsigned care plans that are due or overdue.*

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- *Having clinical staff perform comprehensive care plan reviews to improve the quality and thoroughness of those plans prior to submission to PCPs for sign-off.*
- *Developing dashboards that combine data from MassHealth, ACO and MCO partners, and the EHR to track members' affiliations and enrollment status, thus helping staff target members for engagement.*
- *Generating a reminder list of unsigned care plans for ACO and MCO key contacts.*
- *Maintaining a dedicated web portal to share information with CP care teams across member organizations. Shared information includes contact information of primary care practices; both the LTSS and BH provider networks and local social services providers; training materials; and policies and procedures.*
- *Developing a daily report that compares ACO member information in the Eligibility Verification System (EVS) to information contained in the CP's EHR to identify members' ACO assignment changes and keep the members' records in the EHR up to date.*
- *Embedding staff at local Emergency Departments to improve outreach to members not engaged in regular care, particularly members experiencing homelessness, and connect them to care coordination services.*

Workforce Development

Diversity in the workplace is a priority for **On track** CPs. CPs found that **building a team that reflects the demographics and spoken languages of their local community** aids in overall success. CPs pursued a diverse workforce by advertising in publications tailored to non-English speaking populations and implementing an employee referral incentive program to leverage the recruitment opportunity in existing bilingual and diverse staff's professional networks. Additionally, some CPs compensate staff with bilingual capabilities at a higher rate.

To appropriately hire staff that reflect the population served, some CPs track the demographic, cultural, and epidemiological profile of their service population. The formation of a Diversity and Inclusion Committee to assist HR recruit diverse candidates has also helped CPs achieve their diversity objectives. Some CPs send recruitment staff to Puerto Rico to hire qualified staff who reflect that subset of their service population while covering some relocation expenses. CPs also recruit diverse staff by attending minority focused career fairs and recruiting from diversity driven college career organizations. Some CPs also advertise positions with local professional and civic associations affiliated with the target hiring demographic to reach candidates with appropriate professional backgrounds such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, and the National Association of Puerto Rican and Hispanic Social Workers.

To improve overall recruitment some CPs implemented a management training program to incentivize lower level staff with a path to promotion. CPs also participate in **SWI loan assistance** for qualified professional staff. Some CPs implement an internship program in partnership with higher education institutions to create a pool of eligible applicants that the CP can hire after graduation. CPs can also assess applicants based on skill sets rather than credentials, then offering onsite training to close any gaps.

Retaining staff is known to be more effective than experiencing high turnover. Conducting staff satisfaction surveys enable CP to assess their strengths and opportunities for improvement related to workforce development and retention. Some CPs leverage their QMCs to monitor and implement improvement initiatives related to staff retention. Some CPs establish structures for peer mentoring, flexible work hours and work from home options to improve the experience of care coordinator staff. Some CPs support staff through the establishment of office hours that allow care coordinators to network and receive support from experienced staff and communicate directly with CP leadership. To improve care coordinators' work experience with an aim towards retention, CPs should strive to maintain a **balanced ratio of care coordinators to members served**, mitigating staff burn out due to

unmanageable workloads. Some CPs offer retention bonuses to staff that are separate from performance-based bonuses.

Continuous education is essential in healthcare to keep pace with clinical updates, best practices and reinforce dynamic organizational policies and procedures. Training, however, can require **a significant time commitment to an already burdened staff**. Some CPs reduce staff training burden by allowing experienced staff to test of out of basic exercises freeing up time to participate in more advanced training modules of their choice. Some CPs developed a learning management system to provide online access to on-demand training modules. Some CPs review internally produced training modules annually to confirm that they reflect the latest best practices and are effectively meeting training objectives that fill knowledge or skill gaps. CPs found that the inclusion of role-playing exercises in trainings helps reinforce key skills. In addition to organization led training, CPs support staff with paid time off to attend outside trainings that support operational and performance goals. Some CPs partner with local educational institutions to provide staff access to professional certification training programs. The IA recommends that CPs ensure staff have sufficient time protected for ongoing training.

The IA recommends CPs consider the following menu of promising practices for this focus area.

- ✓ *Promoting Diversity in the Workplace*
  - *Compensating staff with bilingual capabilities at a higher rate.*
  - *Establishing a Diversity and Inclusion Committee to assist HR with recruiting diverse candidates.*
  - *Advertising in publications tailored to non-English speaking populations.*
  - *Attending minority focused career fairs.*
  - *Recruiting from diversity-driven college career organizations.*
  - *Tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives.*
  - *Implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting.*
  - *Advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers.*
  - *Recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.*
- ✓ *Recruitment and Retention:*
  - *Implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation.*
  - *Assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps.*
  - *Conducting staff satisfaction surveys to assess the CP's strengths and opportunities for improvement related to CP workforce development and retention.*
  - *Making staff retention a priority initiative of the QMC to leverage existing quality improvement structures and engage leadership to monitor progress towards retention goals.*
  - *Implementing opportunities for peer mentoring and other supports. For example, scheduling office hours that allow care coordinators to network and receive support from experienced staff and/or have direct communication with CP leadership.*
  - *Reducing staff training burden by allowing experienced staff to test of out of basic training exercises and instead participate in more advanced training modules.*
  - *Instituting a management training program to provide lower level staff a path to promotion.*

- *Allowing flexible work hours and work from home options for care coordination staff.*
- *Striving to maintain a balanced ratio of care coordinators to members served, to avoid unmanageable workloads and staff burnout.*
- *Offering retention bonuses to staff that are separate from performance-based bonuses.*
- *Participating in SWI loan assistance for qualified professional staff.*

✓ ***Training:***
  - *Providing staff with paid time to attend outside trainings that support operational and performance goals.*
  - *Assessing the effectiveness of training modules at least annually to ensure that staff felt the module's objectives were met and that staff are getting what they need to fill knowledge or skill gaps.*
  - *Updating training modules on an annual basis to ensure they reflect the latest best practices.*
  - *Developing a learning management system that tracks staff's completion of required trainings and provides online access to additional on-demand training modules.*
  - *Including role-playing exercises in trainings to reinforce best practices of key skills.*
  - *Partnering with local educational institutions to provide staff access to professional certification training programs.*
  - *Providing new staff with opportunities to shadow experienced care coordinators in the field prior to taking on their own caseload to build tangible skills and foster relationships between team members.*
  - *Making use of online trainings designed and offered by MassHealth.*

Health Information Technology and Exchange

Some CPs enhanced the capabilities of their EHR and Care Management Platform to ameliorate the challenge of receiving a variety of file types through a variety of methods from ACO partners. Adopting enterprise exchange engine software allows CPs to **automatically retrieve partner files through the SFTP and integrate them into the EHR platform**. EIE software also allows a CP to exchange information with community organizations who do not have EHRs or who primarily share data through fax or secure email. To further leverage technology to improve integration, some CPs leverage Mass HIway[42] and also connect to a regional Health Information Exchange (HIE) provider.

To support robust performance dashboards or other strategic reporting capabilities, some CPs designed data warehouses to integrate and store **data from multiple sources in a central location**. A few CPs **update performance dashboards daily** and incorporated HEDIS metrics to support ACO/MCO partners with those performance goals. To improve the quantitative data monitoring, some CPs implemented meta-data tagging in their care management platforms which allow supervisors to monitor workflow progress.

The IA recommends CPs consider the following menu of promising practices for this focus area.

✓ ***Implementation of EHR and Care Management Platform:***
  - *Adopting enterprise exchange software that automatically retrieves files from partner SFTPs and moves them into the CP's EHR.*
✓ ***Interoperability and data exchange:***
  - *Adopting an EIE that enables a CP to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email.*
  - *Connecting with regional Health Information Exchanges.*
✓ ***Data analytics:***

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[42] Mass HIway is the state-sponsored, statewide, health information exchange.

- *Designing a data warehouse to store documentation and performance data from multiple sources in a central location that can underwrite a performance dashboard.*
- *Incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress.*
- *Updating dashboards daily for use by supervisors, management, and the QMC.*
- *Incorporating HEDIS metrics into dashboards to support integration with ACO/MCO partners.*

Care Model

CPs developed a wide range of strategies to engage and support members through the continuum of care. Some CPs **expanded staff coverage** outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities. Some CPs found that setting small initial goals that members can achieve in a short time helps to build member confidence and supports longer-term engagement. CPs find that it is important to address a member's most pressing social needs, such as homelessness, before tackling other wellness goals **to build trust and provide person centered support**. Care coordinators subsequently focus on creating a care plan which will identify intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs. CPs reinforce members' engagement by offering gift cards for steps such as signing the participation form and completing a person-centered treatment plan. Some CPs created a position responsible for initial contact of all referrals, including difficult to reach members and community engagement. This dedicated initial outreach resource reduces outreach burden on care coordinators who can focus more on member engagement and billable activities. CPs have also found success by **assigning special populations to designated care coordinators** who can become skilled at addressing the needs of and tailoring services for those populations including pediatric, LGBTQ, and populations experiencing homelessness among others.

In addition to engaging members, CPs are working to engage PCPs, hospitals, and other sites where members receive care. Some CPs found it helpful to assign an RN to make the initial call to a hospital or ED where a member was admitted, leveraging this staff member's clinical experience to get a better response from hospital staff. Establishing a **key point of contact at hospital units** also improves coordination of member transitions and helps the CP gather details about the member's Discharge.

The IA recommends CPs consider the following menu of promising practices for this focus area.

- ✓ *Outreach and engagement strategies:*
  - *Acknowledging and/or celebrating members' engagement milestones such as signing the participation form and completing a person-centered treatment plan.*
  - *Creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement.*
  - *Providing free transportation options for members to engage with services.[43]*
  - *Assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, and homeless members, so that they can become skilled at addressing the needs of and tailoring services for those populations.*
  - *Expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.*
- ✓ *Person-centered care model:*
  - *Addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals.*
  - *Setting small initial goals that a member is likely to achieve to build member confidence in the engagement.*

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[43] CPs should utilize the MassHealth transportation program (PT-1) for member needs first as appropriate.

- *Developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs.*
- *Allowing members to attend care planning meetings by phone or teleconference.*

✓ ***Managing transitions of care:***
- *Assigning an RN to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response.*
- *Establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's Discharge.*
- *Meeting an enrollee in person once care coordinators receive alerts that they were admitted.*
- *Visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member Discharges.[44]*
- *Establishing a multidisciplinary Care Transitions team to review Discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations.*
- *Having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's Discharge plan.*

✓ ***Improving Members' Health and Wellness:***
- *Allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform.*
- *Negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms.*
- *Contracting with national databases for community resources to develop a library of available supports.*

✓ ***Continuous Quality Improvement:***
- *Providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care.*
- *Administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey.*
- *Scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff.*
- *Creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.*

3. POLICY OPPORTUNITIES FOR INTEGRATION OF HEALTH-RELATED SOCIAL NEEDS

In response to abundant evidence linking unmet social needs to poor outcomes and higher health care costs, Massachusetts introduced sweeping reforms that allow health care providers to better address HRSNs. MassHealth engagement is critical to define the role of the healthcare system in addressing HRSN/SDoH. By requiring HRSN screening of MassHealth members, MassHealth promoted widespread documentation of member needs and established a foundation for integration of HRSN into the health care system. In this section the IA briefly describes policy opportunities that MassHealth is leading or participating in, with recommendations about how to leverage these initiatives to achieve DSRIP goals.

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[44] Where members have authorized sharing of SUD treatment records.

MassHealth ACO Flexible Services Program

DSRIP targets HRSN through the Flexible Services Program. Under the authority of the DSRIP 1115 waiver, MassHealth established the program to pay, through ACOs, for certain health-related nutrition and housing supports for qualifying members enrolled in an ACO. ACOs either provided these supports directly to members or by connecting members to qualified community-based organizations.[45] ACOs have welcomed the opportunity to address HRSNs as part of their population health strategy.[46] During years 1 and 2 of DSRIP, all MassHealth ACOs developed a plan for implementation of Flexible Services, detailing the particular services they plan to provide and individuals they plan to serve. MassHealth approved the plans and ACOs began providing services in January 2020.

A critical aspect of Flexible Services is the need for **participation of community-based organizations** on a large scale with structure and accountability. Contracting, communication, and data exchange between ACOs and CBO partners requires ongoing attention. As the launch of Flexible Services approached, CBOs expressed confusion about how to engage with ACOs, noting the lack of a centralized entry point or contact person with knowledge and authority whom CBOs can engage.[47] In addition, CBO leaders repeatedly described a "sense of missing or incomplete information regarding the Medicaid redesign, creating an environment in which it was challenging to report either strategies or concerns with confidence."[48] ACOs recognized the value of CBOs' access and fluency, but noted that CBOs often lacked the administrative infrastructure needed for contracting with ACOs in a value-based care context. MassHealth can play a key role by acting as a facilitator and regulator.

The IA recommends MassHealth consider these recommendations in order to foster the success of the ACO Flexible Services Program:

- o Granting ACOs flexibility to pilot new ideas and adapt existing strategies to their various population and region.
- o Disseminating evidence and promising practices from HRSN initiatives funded by previous state programs, including the SHIFT-Care Challenge.[49]
- o Acting as a convener to bring CBOs and ACOs together to explore contract models, such as aggregate contracts, which allow small CBOs to cooperate for greater scale and efficiency.
- o Collaborating with local boards of health and leverage their knowledge of the CBO landscape.
- o Developing a toolkit for partnerships that includes contract models, data sharing agreements, and guiding principles for ACOs reviewing the expertise of CBOs and the benefits of partnering with them when considering whether to "buy" (partner with CBOs) or "build" (internally develop and build) supports.[50]
- o Considering adopting elements of the New York DSRIP model for CBO contracting. In New York's DSRIP model, the State requires providers to contract with CBOs and address at least one SDOH. The state developed a CBO Toolkit and Value Based Payments (VBP) resource library to support ACOs and CBOs in building relationships.[51]

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[45] https://www.mass.gov/doc/flexible-services-program-summary/download

[46] Sheff, Alex et al. October 2019. *Addressing Health-Related Social Needs: A report on MassHealth Accountable Care Organization and Community-Based Organization Collaboration.* Health Care for All. https://www.hcfama.org/sites/default/files/hcfa_report_on_aco-cbo_collaboration_2019_0.pdf

[47] Sheff et al, ibid.

[48] Taylor, L.A and Byhoff, E.B., 2019. *Massachusetts Community-Based Organization Perspectives on Medicaid Redesign.* Am J Prev Med 2019;57(6S1):S74−S81 retrieved From https://www.ajpmonline.org/article/S0749-3797(19)30325-3/fulltext#seccesectitle0010

[49] https://www.mass.gov/service-details/the-shift-care-challenge

[50] Sheff et al, ibid.

[51] https://www.health.ny.gov/health_care/medicaid/redesign/sdh/index.htm

The Flexible Services program represents an opportunity both to provide services to current members, and also to develop a sustainable approach to HRSNs for the future. During Flexible Services implementation, the IA recommends that MassHealth dedicate resources to reflection, evaluation, and collaborative learning to extract emerging practices and strategies from this innovative program.

Quality Measure Alignment

Incorporation of HRSNs into MassHealth requires the development of quality measures to monitor goals and milestones around screening and addressing HRSN and SDoH. The development of measures for HRSN is challenging, in part due to the difficulty of identifying outcomes that can be standardized and measured on a time scale consistent with contract terms.

In Massachusetts, the Executive Office of Health and Human Services Quality Measure Alignment Taskforce (EOHHS Quality Measure Alignment Taskforce) was convened in 2017 with the primary goal of building consensus on an **aligned measure set for voluntary adoption by private and public payers** and by providers in global budget-based risk contracts.[52] The Taskforce's focus is on aligning contractual quality measures in the Massachusetts Aligned Measure Set, which currently only requires reporting of one behavioral health measure. [53]

As a participant in the EOHHS Quality Measure Alignment Taskforce, MassHealth has the opportunity to advocate for measure development relevant to HRSN. The IA recommends that MassHealth, working with the taskforce, seeks to develop measures that align across ACOs and CBOs participating in Flexible Services.

MassUP

Another opportunity that aligns with DSRIP goals is the "Moving Massachusetts Upstream" (MassUP) initiative, a coordinated state initiative to support partnerships between health care systems and community organizations to address SDOH.[54] In this initiative, MassHealth is collaborating with other Massachusetts state agencies including the Health Policy Commission (HPC), the Department of Public Health (DPH), the Office of the Attorney General, the Executive Office of Elder Affairs, and the Executive Office of Health and Human Service.

MassUP established a state-level inter-agency policy alignment working group with representatives from each participating agency. In parallel, the MassUP investment program provides funding and Technical Assistance to partnerships between health care providers and community-based organizations who work together to address the upstream (i.e. social, economic, and environmental) causes of poor health outcomes and health inequities. Four partnerships are funded, focusing on **economic stability and mobility, and food systems and security**. MassUP presents an opportunity to use potentially braided or pooled funding to align the different programs and incentives together, as a deepened investment in social supports and a more upstream approach requires a long-term, multifaceted effort.

Telemedicine

Massachusetts has attempted for years to spread the use of telemedicine, especially to increase access to behavioral health care for vulnerable populations.[55] By providing greater access to care for people who lack transportation, are home-bound, or live in remote geographic areas, telemedicine has the potential to reduce disparities in access. telemedicine is a relevant strategy for promoting whole-person care.

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[52] https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce
[53] https://www.mass.gov/doc/quality-measurement-taskforce-meeting-32-january-22-2020/download
[54] https://www.mass.gov/info-details/moving-massachusetts-upstream-massup-investment-program

[55] https://www.mass.gov/service-details/telemedicine-pilot-program

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During the first 2 years of DSRIP, several ACOs engaged in or piloted telemedicine, but usually only focused on a small number of providers and members in a few specialized areas. The main barriers to adopting more widespread telemedicine practices have consistently been reimbursement, and provider unfamiliarity or skepticism with telemedicine. In 2020, the COVID-19 pandemic has forced temporary solutions to these barriers. As the pandemic made remote care essential, provider organizations have generated provider buy-in and logistical pathways to telemedicine implementation. Payers altered reimbursement rules. This moment in history is an **opportunity to deploy telemedicine as part of a long-term strategy to increase access to care**, particularly in underserved areas, and to reduce non-beneficial utilization of acute care. ACOs can use data analysis and provider feedback to evaluate where telemedicine is working most effectively and identify where additional practices and protocols may be useful. Ongoing incorporation of telemedicine would require:

- Sustainable reimbursement for telemedicine
- Aligned quality standards
- Training for providers
- Dissemination of protocols and best practices for providers

The IA recommends that MassHealth leverage the dramatic expansion of telemedicine occasioned by the COVID-19 pandemic as an opportunity to develop long-term solutions and policies.

K. OVERALL FINDINGS AND RECOMMENDATIONS

ACO REVIEW

The IA's review of ACO progress found that the majority of ACOs are **On track with no recommendations** or **On track with limited recommendations** for all six focus areas. Five ACOs were found to have an **Opportunity to improve** in one or more focus areas. The IA made the following observations and recommendations, by focus area:

Organizational Structure and Engagement: For the Organizational Structure and Engagement focus area, the IA found that ten ACOs were **On track with no recommendations**, and seven ACOs were **On track with limited recommendations**. All ACOs have established appropriate governance structures, which vary by ACO model. The IA recommends that ACOs should expand their efforts to engage MassHealth members in their PFACs and systematically integrate PFAC input into leadership feedback reporting structures and other substantial aspects of ACO operations. ACOs have established centralized processes to identify quality and performance management priorities but allow practice sites to have significant autonomy to pursue improvement efforts. Even with this autonomy, ACO performance management priorities, strategies and resources guide improvement efforts and increase standardization in measurement and feedback processes across the organization.

Integration of Systems and Processes: For the Integration of Systems and Processes focus area, the IA found that six ACOs are **On track with no recommendations**, and eleven are **On track with limited recommendations**. ACOs routinely share quality and utilization data with practice sites. Some ACOs distribute static reports while others create dashboards or scorecards. Administrative coordination with CPs varies; the IA recommends that ACOs integrate CPs into their reporting structures as a routine aspect of operations. All ACOs deploy some form of a team model for care management that engages member organizations or other partners, sometimes embedding teams at practices sites. ACOs vary in their progress in integration of BH care, and the IA recommends that ACOs continue working to expand the breadth of behavioral health services, including OBAT, provided across all primary care locations. Among ACPPs, ACO/MCO pairs with established institutional relationships predating DSRIP generally have shifted more functions to the ACO, though all report that transitioning complex care management to the ACO is complete or in progress.

Workforce Development: For the Workforce Development focus area, the IA found that two ACOs are **On track with no recommendations**, fifteen are **On track with limited recommendations**. Most ACOs appear to have avoided major staffing gaps, but certain positions have been consistently difficult to fill. The IA recommends that ACOs should be mindful of the impact of their hiring practices on practice sites, particularly in areas where staff shortages occur. Most ACOs offer their staff a wide variety of training opportunities from onboarding to role-specific trainings; often trainings are jointly offered by ACOs and practices site. Most ACOs report using some mix of nurse care managers, social workers, care managers, or patient navigators and CHWs along with behavioral therapists and pharmacists. The IA recommends that ACOs expand the integration of CP members into CCCM care team structures to reduce barriers to effective patient handoffs and further improve the operational infrastructure between themselves and CPs.

Health Information Technology and Exchange: For the HIT&E focus area, the IA found that three ACOs are **On track with no recommendations**, fourteen are **On track with limited recommendations**. Some ACOs and practices sites perform care management and population health functions within the EHR using integrated software, while at others have distinct software packages for these functions. Practice sites generally report that they find these platforms useful, and that they improve care coordination. In response to ongoing interoperability challenges, ACOs are finding effective data conduits through the use of member and provider portals, data exchanges and other information conduits that enable privacy compliant real-time exchange of member information and promote optimal care coordination. Dashboard functionality varies widely across the ACOs. Some ACOs continue to utilize a manual process of extracting and tracking data related to both care management and population health analysis. The IA recommends that ACOs expand the automation and integration of data management for both care management and population health analysis, including automated creation and tracking of referrals, and generation of registries from risk stratification. The IA also recommends that ACOs should extend timely two-way communication to CPs and non-affiliated providers.

Care Coordination and Care Management: For the Care Coordination and Care Management focus area, the IA found that twelve ACOs are **On track with limited recommendations**, and five demonstrate an **Opportunity to improve**. Most ACOs have established processes to identify members appropriate for referral for BH or LTSS services and to collaborate with CPs to exchange member information and partner on care coordination when the CP has primary care management responsibility. Survey results suggested that practice site providers regularly refer members for specialty care and receive test results after the referrals but reported more difficulty confirming that a member was seen or receiving the recommendations from the consulting clinicians. Designating individuals as a specific point of contact for CPs and state agencies, such as DMH, was found to improve communication across the continuum of care. The IA recommends that more ACOs formalize their relationships with state agencies and with CPs through regular meetings and designated points of contact.

Some care coordination strategies have been adopted broadly. Most of the ACOs use both IT solutions and manual outreach to improve accuracy of member contact information. Most of the ACOs enable staff to build 1:1 relationships with high-need members to provide care coordination. These relationships allow the care team to develop trust and a holistic perspective of the member's clinical and non-clinical needs. ACOs typically communicate with recently Discharged members and their physicians within 72 hours post-Discharge. Embedding staff in or near EDs is a common strategy. Medication reconciliation is also widely deployed. Referrals for HRSNs and BH needs are common, though the processes for making and tracking referrals are sometimes cumbersome. EHR-integrated and automated approaches to referrals are leveraged by some ACOs and can support follow-up processes including case conferences. The IA recommends that ACOs work towards increasing standardization of referral processes and follow-up through regular case conferences.

Population Health Management: For the Population Health Management focus area, the IA found that eight ACOs are **On track with no recommendations**, eight are **On track with limited**

recommendations and one demonstrates an **Opportunity to improve**. ACOs conduct standardized screenings for HRSN including housing, food and transportation, but vary in how systematically they screen, and how they act on the results. All ACOs provide referrals and services for members with identified HRSNs. Some ACOs have formed partnerships with and with state agencies to coordinate services. An average of 39% of practice sites across the ACO cohort indicated that "tailoring delivery of care to meet the needs of patients affected by health inequities" has gotten a little or a lot easier over the past year, which may reflect those ACOs' growing ability to identify HRSNs and refer members for appropriate services.

The IA noted a range of sophistication in strategies ACOs use for member stratification with more advanced systems using multiple data sources. The IA recommends that ACOs incorporate more data sources (for example, EHR data, Admission and Discharge data, referral data and HRSN screenings) into their algorithms and conduct ongoing empirical testing of their results against modified algorithms and actual outcomes.

All ACOs regularly generate TCOC reports. To ensure that the ACO and its practice sites are working towards the same goal, most ACOs generate and distribute TCOC data on a quarterly or monthly basis to providers either through reports, interactive scorecards or dashboards. The level of reporting varies; most report being able to drill down to the practice level and some to the provider level.

The IA recommends that ACOs review the menu of ACO promising practices for each focus area (pp 77-84) and consider adopting approaches appropriate for their needs and goals.

CP REVIEW

The IA's review of CP progress found that the majority of CPs are **On track with no recommendations** or **On track with limited recommendations** for all five focus areas. The IA made the following observations and recommendations, by focus area:

Organizational Structure and Engagement

For the Organizational Structure and Engagement focus area, the IA found that eighteen CPs are **On track with no recommendations**, and nine are On track with limited recommendations. All CPs established an executive board or leadership team that regularly meets with administrative and clinical personnel to discuss operations and program improvement strategies. CPs use CAB member insight to help inform strategic decision making in areas related to member engagement, stigma reduction, and strategies for disseminating information to the member population at large.

Though some CPs successfully recruited MassHealth members for their CAB, the majority experienced inconsistent or low member participation rates; several have engaged TA to improve CAB participation. The IA recommends that CPs build on these efforts and revisit the incentives and compensation that they offer for CAB participation in order to receive a range of perspectives needed for a meaningful consumer voice. All CPs maintain a QMC that meets at least quarterly to review performance on quality initiatives and identify opportunities for new initiatives. The majority of QMCs report their results and activities directly to the CP's governing body.

Integration of Systems and Processes

For the Integration of Systems and Processes focus area, the IA found that fourteen CPs are **On track with no recommendations**, twelve are **On track with limited recommendations**, and one demonstrates an **Opportunity to improve**. All CPs established Documented Processes to exchange member information with ACO/MCO partners. Nearly all CPs exchange care plans, member contact information, and other member files through SFTP and/or secure email. Many CPs also have processes to exchange member files through a secure file sharing app. The administrative effort required to exchange member information with ACO/MCO partners is substantial, and some CPs divide

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administrative and clinical tasks to save time and enable clinical staff to focus on member-facing activities. The majority of CPs have a dedicated staff member or team of staff to review ACO/MCO spreadsheets for missing data points, respond to ACO/MCO referral requests, and confirm member contact information with ACO/MCO and PCP partners. The IA recommends that CPs work with ACOs and adopt systems to increase interoperability of member data exchange to reduce administrative burden and improve coordination efforts.

Partner engagement is a focus across the CP cohort. Most CPs established internal points of contact to develop relationships with PCP and ACO/MCO staff in order to facilitate care plan approval and sign-off. Most CPs attend routine case review meetings and integrated care planning meetings to share clinical information, identify high-risk members, and facilitate care plan sign-off. A few CPs have staff that are embedded at ACO/MCO health centers and primary care practices. Staff at these sites work alongside ACO/MCO care teams and have monthly or even daily meetings to strategize on behalf of members, discuss mutual expectations and refine workflows. The IA recommends that CPs strive to embed staff at practice sites, EDs or other locations with embedded ACO care coordination staff to improve care coordination.

Some CPs struggled to engage PCPs in care plan review due to PCPs lacking awareness about the CP program. CPs would like their ACO/MCO partners to more actively increase PCP awareness of the CP program to facilitate the care plan review process.

In response to member transitions, integrated ENS/ADT notifications that are pushed directly into CP EHRs assist CP care coordinators review member admissions in real-time or within the day. Some CPs assign staff to work directly with ACO transition of care teams, ACO nurses, social workers, and/or CHWs located in EDs and inpatient units to assist with Discharge planning and follow-up.

Workforce Development

For the Workforce Development focus area, the IA found that eighteen CPs are **On track with no recommendations**, and nine are **On track with limited recommendations**. Most CPs do not have persistent vacancies in planned staff roles. Some CPs struggled to achieve workplace diversity and experienced challenges recruiting non-care coordination staff and masters-level care coordination staff. Multiple CPs expressed that competition with other CPs and ACOs presented significant barriers to recruiting a diverse pool of candidates. However, all CPs adapted to hiring challenges throughout the course of the demonstration to the extent that they have not experienced long-term vacancies. Nearly all CPs used DSRIP Statewide Investment (SWI) funds to further support recruitment and retention efforts. Many CPs reported SWI-supported student loan repayment programs and additional certification opportunities for staff were beneficial for recruitment and retention. The IA recommends that all CPs continue or begin to use DSRIP SWI to improve recruitment and retention of qualified staff. CPs also employed a broad range of strategies for recruitment, including partnerships with local universities.

All CPs hold regular trainings focused on best practices and recent advancements in the field, with the majority of CPs holding trainings on a monthly basis. Most CPs track training compliance through reporting logs. In addition to in-house trainings, many CPs use partner organizations and MassHealth training forums to expand available training. Some staff participate in joint learning events with ACO/MCO partners, attend CHW training, access trainings offered through educational institutions, and attend external conferences and trainings.

Health Information Technology and Exchange

For the Health Information Technology and Exchange focus area, the IA found that one CP is On **track with no recommendations**, and twenty-six are **On track with limited recommendations**. Nearly all CPs are using an integrated EHR care management platform provided by a single vendor. This platform can produce and transmit consolidated clinical document architecture (CCDA) files, query EOHHS

eligibility data, and submit structured outcomes reports to EOHHS, other state agencies, and ACO/MCO partners. Nearly all CPs integrated ENS/ADT notifications from area providers into their care management platform and use the notifications daily. Among the CPs with integrated ENS/ADT notifications, most have contracted with one or more vendors to push event data for members into the CP's care management platform, allowing care coordination staff to act on information in real time. Nearly half of CPs gained access, typically read-only, to ACO/MCO partner EHRs to access information on shared members. Nearly all CPs reported that they can share and/or receive member contact information electronically with the majority of their ACO and MCO partners. Most CPs reported they can share and/or receive member care plans electronically with the majority of PCP partners but reported difficulties with sharing and/or receiving comprehensive assessments and member contact information with PCPs. The IA finds that a combination of file exchange methods helps CPs achieve full interoperability with all ACO/MCO and PCP partners and recommends that CPs continue using multiple complementary methods as needed.

Most CPs developed at least one dashboard, overseen by a multidisciplinary team, to oversee documentation and performance on key quality metrics. Most CPs monitor member engagement metrics such as the number of comprehensive assessments received, care plans signed and time from assignment to engagement. Many CPs combine claims data with EHR/care management platform data to measure progress towards CP quality benchmarks. Some CPs track population health measures such as member utilization and TCOC.

Care Coordination and Care Management[56]

For the Care Model focus area, the IA found that five CPs are **On track with no recommendations**, eighteen are **On track with limited recommendations**, and four demonstrate an **Opportunity to improve**. Despite widespread progress, the majority of CPs experienced some challenges in outreach and engagement of members. Most CPs have implemented strategies to ensure that staff are providing services that are tailored to and reflective of the member population racially, ethnically, and linguistically. The IA found that all BH CPs, and many LTSS CPs, were using Peer Supports/CHWs throughout the provision of services. The majority of CPs have staff go to members' homes, shelters, and other sites where individuals experiencing homelessness sleep to locate assigned members. Some CPs also visit food pantries, congregate meal sites, treatment centers, APs' facilities and programs, and EDs to find and engage assigned members. A few CPs embedded staff within PCP and ACO offices to conduct outreach with assigned members in the waiting room. Some CPs convene regular care team meetings with all service providers to discuss the member's progress and highlight any gaps in care. All CPs review and update the care plan at established points throughout the year or more frequently in response to a change in the member's condition. Nearly all CPs provided evidence of standard processes to manage transitions of care. A few CPs have dedicated teams to manage members' transitions of care while others have embedded staff within inpatient facilities to facilitate transitions of care and warm handoffs from the inpatient facility to the CP. Most CPs focused on building relationships with inpatient facility staff to improve transitions of care efforts.

While all CPs screen members for health-related needs and connect members to community resources and social services, the processes for doing so are often not automated or standardized. The lack of a standardized process to connect members to community resources and social services was a commonly identified gap in the CM focus area. Those CPs that established a standardized process to connect members to community resources and social services all use a referral such as a resource directory on

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[56] While recognizing the distinct difference between care coordination (a more wholistic and over-arching approach to optimize the integration of both medical and non-medical) and care management (typically focused on caring for individuals or a subset of patients with a common clinical need such as diabetes or asthma), the focus area assessment combines the two with the understanding that ACO and CP efforts in these areas often overlap or integrate

the CP's intranet, or a subscription-based database of local resources. A few CPs created a dedicated role responsible for developing connections to community resource providers and state agencies.

Nearly all CPs implemented a strategy for continuous improvement in quality of care and/or member experience. Some CPs leveraged their CABs to gain information about member experience and identify opportunities for improvement. To evaluate their own performance and identify areas for improvement, a few CPs completed comprehensive CP program assessments comparing their practices to nationally accredited models. Other CPs conducted strategic planning sessions to evaluate programmatic, financial, and community factors impacting their program.

The IA recommends that CPs review the menu of CP promising practices for each focus area (pp 84-93) and consider adopting approaches appropriate for their needs and goals.

SWI REVIEW

The IA's review of the Statewide Investments found that interest in the program was strong. Medical and BH providers in particular actively sought out student loan repayment opportunities targeted to early career professionals working in community-based settings. Workforce training opportunities for CHWs showed high levels of interest and attendance. New residency training opportunities for MDs and NPs were created. Technical assistance to ACOs and CPs was slower to launch than anticipated. MassHealth continues to modify the program to ensure that ACOs and CPs are able to access direct technical assistance and that the learning collaborative launches. In 2019, several investments were combined into the Behavioral Health Innovation Fund, and this program launch was delayed to better align with the MassHealth Behavioral Health Redesign Initiative. The IA notes that where MassHealth has met with delays or found demand for the program to be lower than initially anticipated it continues to modify the program to attempt to increase applications, overcome obstacles and invest in areas that continue to show need.

OPPORTUNITIES FOR MITIGATION

The IA identified several systemic challenges affecting progress towards DSRIP goals:

- To mitigate challenges in the interface of ACOs and CPs, the IA recommends increasing standardization of roles and responsibilities.
- To mitigate challenges in recruiting qualified staff, the IA recommends continuing the workforce development SWI with adaptations to increase accessibility and leveraging the recent expansion in telemedicine.
- To mitigate challenges in member engagement, the IA recommends adoption of best practices in sharing of contact information, community based member outreach, and reviewing payment methods with an eye to appropriately resourcing outreach activities.
- To mitigate challenges in the use of event notifications, the IA recommends broader participation and integration of Mass HIway[57].
- To mitigate challenges in payment models, the IA recommends ongoing review of payment models based on ACO and CP performance and feedback from ACO and CP leadership.

OPPORTUNITIES FOR ADVANCEMENT OF PROMISING PRACTICES

The IA Identified integration of HRSNs as a critical area for MassHealth to nurture and promote the adoption of promising practices. The IA recommends that MassHealth leverage policy opportunities including the Flexible Services and SWI TA components of DSRIP, and collaborations with other state

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[57] Mass HIway is the state-sponsored, statewide, health information exchange.

agencies, to support sustainable integration of HRSN as a key aspect of health care system transformation.

L. APPENDICES

APPENDIX A: LOGIC MODEL

DSRIP Implementation Logic Model

A. INPUTS

1. DSRIP funding for ACOs **[$1065M]**
2. DSRIP funding for BH CPs, LTSS CPs, and Community Service Agencies (CSAs) **[$547M]**
3. State Operations & Implementation funding (DSRIP and other sources)
4. DSRIP Statewide Investments (SWIs) funding **[$115M]**
5. Internal ACO & CP program planning and investments

State Context, e.g.
- Baseline performance, quality, cost trends
- Baseline medical/non-medical service integration
- Baseline levels of workforce capacity
- Transformation readiness
- Baseline status and experience with alternative payment models (e.g., MSSP, BPCI, AQC)
- Payment & regulatory policy
- Safety Net System
- Local, state, & national healthcare trends

B. OUTPUTS (Delivery System Changes at the Organization and State Level)

ACO, MCO, & CP/CSA ACTIONS SUPPORTING DELIVERY SYSTEM CHANGE
(INITIAL PLANNING AND ONGOING IMPLEMENTATION)

ACO UNIQUE ACTIONS

1. ACOs established with specific governance, scope, scale, & leadership
2. ACOs engage providers (primary care and specialty) in delivery system change through financial (e.g. shared savings) and non-financial levers (e.g. data reports)
3. ACOs recruit, train, and/or re-train administrative and provider staff by leveraging SWIs and other supports; education includes better understanding and utilization of BH and LTSS services
4. ACOs develop HIT/HIE infrastructure and interoperability to support population health management (e.g. reporting, data analytics) and data exchange within and outside the ACO (e.g. CPs/CSAs; BH, LTSS, and specialty providers; social service delivery entities)
5. ACOs develop capabilities and strategies for non-CP-related population health management approaches, which includes risk stratification, needs screenings and assessments, and addressing the identified needs in the population via range of programs (e.g., disease management programs for chronic conditions, specific programs for co-occurring MH/SUD conditions)
6. ACOs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., DMH)
7. ACOs develop structures and processes for integration of health-related social needs into their PHM strategy, including management of flex services
8. ACOs develop strategies to reduce total cost of care (TCOC) (e.g. utilization management, referral management, non-CP complex care management programs, administrative cost reduction)
9. MCOs in Partnership Plans (Model A's) increasingly transition care management responsibilities to their ACO Partners

CP/CSA UNIQUE ACTIONS

10. CPs established with specific governance, scope, scale, & leadership
11. CPs engage constituent entities in delivery system change through financial and non-financial levers
12. CPs/CSAs recruit, train, and/or re-train staff by leveraging SWIs and other supports
13. CPs/CSAs develop HIT/HIE infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP (e.g. ACOs, MCOs; BH, LTSS, and specialty providers; social service delivery entities)
14. CPs/CSAs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., DMH)

ACO, MCO, & CP/CSA COMMON ACTIONS

15. ACOs, MCOs, & CPs/CSAs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)
16. ACOs, MCOs, & CPs/CSAs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)
17. ACOs, MCOs, & CPs/CSAs establish structures and processes for joint management of performance and quality, and conflict resolution

STATEWIDE INVESTMENTS ACTIONS

18. State develops and implements SWI initiatives aimed to increase amount and preparedness of community-based workforce available for ACOs & CPs/CSAs to hire and retain (e.g. expand residency and frontline extended workforce training programs)
19. ACOs & CPs/CSAs leverage DSRIP technical assistance program to identify and implement best practices
20. Entities leverage State financial support to prepare to enter APM arrangements
21. State develops and implements SWI initiatives to reduce Emergency Department boarding, and to improve accessibility for members with disabilities and for whom English is not a primary language.

C. IMPROVED CARE PROCESSES (at the Member and Provider Level) AND WORKFORCE CAPACITY

IMPROVED IDENTIFICATION OF MEMBER NEED

1. Members are identified through risk stratification for participation in Population Health Management (PHM) programs
2. Improved identification of individual members' unmet needs (including SDH, BH, and LTSS needs)

IMPROVED ACCESS

3. Improved access to with physical care services (including pharmacy) for members
4. Improved access to with BH services for members
5. Improved access to with LTSS (i.e. both ACO/MCO-Covered and Non-Covered services) for members

IMPROVED ENGAGEMENT

6. Care management is closer to the member (e.g. care managers employed by or embedded at the ACO)
7. Members meaningfully participate in PHM programs

IMPROVED COMPLETION OF CARE PROCESSES

8. Improved physical health processes (e.g., measures for wellness & prevention, chronic disease management) for members
9. Improved BH care processes for members
10. Improved LTSS care processes for members
11. Members experience improved care transitions resulting from PHM programs
12. Provider staff experience delivery system improvements related to care processes

IMPROVED CARE INTEGRATION

13. Improved integration across physical care, BH and LTSS providers for members
14. Improved management of social needs through flexible services and/or other interventions for members
15. Provider staff experience delivery system improvements related to care integration (including between staff at ACOs and CPs)

IMPROVED TOTAL COST OF CARE MANAGEMENT LEADING INDICATORS

16. More effective and efficient utilization indicating that the right care is being provided in the right setting at the right time (e.g. shifting from inpatient utilization to outpatient/community based LTSS; shifting more utilization to less-expensive community hospitals; restructuring of delivery system, such as through conversion of medical/surgical beds to psychiatric beds, or reduction in inpatient capacity and increase in outpatient capacity)

IMPROVED STATE WORKFORCE CAPACITY

17. Increased preparedness of community-based workforce available
18. Increased community-based workforce capacity though more providers recruited, or through more existing workforce retrained
19. Improved retention of community-based providers

D. IMPROVED PATIENT OUTCOMES AND MODERATED COST TRENDS

IMPROVED MEMBER OUTCOMES

1. Improved member outcomes
2. Improved member experience

MODERATED COST TRENDS

3. Moderated Medicaid cost trends for ACO-enrolled population

PROGRAM SUSTAINABILITY

4. Demonstrated sustainability of ACO models
5. Demonstrated sustainability of CP model, including Enhanced LTSS model
6. Demonstrated sustainability of flexible services model
7. Increased acceptance of value-based payment arrangements among MassHealth MCOs, ACOs, CPs, and providers, including specialists

APPENDIX B: SUMMARY TABLE OF EACH ACO FOCUS AREA RATING

Summary of Findings for ACOs by Focus Area							
ACO Full Name	Acronym	Organizational Structure	Integration	Workforce	HIT&E	Care Coordination & Care Management	Population Health Management
Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan	BMCHP BACO	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	Opportunity to Improve with recommendations	On track with limited recommendations
Mercy Health Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan	BMCHP Mercy	On track	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track
Signature Healthcare Corporation in partnership with Boston Medical Center HealthNet Plan	BMCHP Signature	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	Opportunity to Improve with recommendations	On track
Southcoast Health Network in partnership with Boston Medical Center HealthNet Plan	BMCHP Southcoast	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track	On track with limited recommendations	On track
Community Care Cooperative, Inc.	C3	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track

Summary of Findings for ACOs by Focus Area

ACO Full Name	Acronym	Organizational Structure	Integration	Workforce	HIT&E	Care Coordination & Care Management	Population Health Management
Health Collaborative of the Berkshires in partnership with Fallon Community Health Plan	FLN Berkshire	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	Opportunity to Improve with recommendations	On track with limited recommendations
Reliant Medical Group in partnership with Fallon Community Health Plan	FLN Reliant	On track with limited recommendations	On track	On track	On track	On track with limited recommendations	On track
Wellforce in partnership with Fallon Community Health Plan	FLN Wellforce	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	Opportunity to Improve with recommendations	Opportunity to Improve with recommendations
Baystate Health Care Alliance in partnership with Health New England	HNE Baystate	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	Opportunity to Improve with recommendations	On track with limited recommendations
Lahey Clinical Performance Network, LLC	Lahey	On track	On track with limited recommendations	On track with limited recommendations	On track	On track with Limited recommendations	On track with limited recommendations
Merrimack Valley ACO in partnership with AllWays Health Plan	AHP MVACO	On track	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track
Partners HealthCare Accountable Care Organization, LLC	PHACO	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track
Steward Medicaid Care Network, Inc.	SMCN	On track	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations

Summary of Findings for ACOs by Focus Area

ACO Full Name	Acronym	Organizational Structure	Integration	Workforce	HIT&E	Care Coordination & Care Management	Population Health Management
Atrius Health in partnership with Tufts Health Public Plans	THPP Atrius	On track	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track
Beth Israel Deaconess Care Organization in partnership with Tufts Health Public Plans	THPP BIDCO	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations
Cambridge Health Alliance in partnership with Tufts Health Public Plans	THPP CHA	On track	On track with limited recommendations	On track	On track with limited recommendations	On track with limited recommendations	On track
Boston Children's Accountable Care Organization in partnership with Tufts Health Public Plans	THPP BCACO	On track	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations

APPENDIX C: SUMMARY TABLE OF EACH CP FOCUS AREA RATING

Summary of Findings for CPs by Focus Area						
Community Partner Name	CP TYPE	Organizational Structure & Engagement	Integration of Systems & Processes	Workforce Development	Health Information Technology & Exchange	Care Model
Central Community Health Partnership (CCHP LTSS)	LTSS	On track with Limited Recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations
Behavioral Health Network Inc (BHN)	BH	On track	On track	On track	On track	On track
Behavioral Health Partners of Metrowest LLC (BHPMW)	BH	On track with limited recommendations	On track	On track	On track with limited recommendations	On track with limited recommendations
Boston Allied Partners (BAP)	LTSS	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations
Boston Coordinated Care Hub (BCCH)	BH	On track	On track	On track	On track with limited recommendations	On track with limited recommendations
Brien Center Community Partner Program (Brien)	BH	On track with limited recommendations	On track with limited recommendations	On track	On track with limited recommendations	On track
Care Alliance of Western MA (CAWM)	LTSS	On track	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations
Coordinated Care Network (CCN)	BH	On track	On track with limited recommendations	On track	On track with limited recommendations	On track
Clinical and Support Options, Inc. (CSO)	BH	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations
Community Care Partners, LLC (CCP)	BH	On track with limited recommendations	On track	On track	On track with limited recommendations	On track with limited recommendations
Community Counseling of Bristol County, Inc. (CCBC)	BH	On track	On track	On track	On track with limited recommendations	On track with limited recommendations
Community HealthLink, Inc. (CHL)	BH	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations
Eliot Community Human Services, Inc. (Eliot)	BH	On track	On track	On track	On track with limited recommendations	On track with limited recommendations
Family Service Association (FSA)	LTSS	On track with limited recommendations	Opportunity to Improve with recommendations	On track with limited recommendations	On track with limited recommendations	Opportunity to Improve with recommendations
Greater Lowell Behavioral Health CP (Lowell)	BH	On track	On track	On track	On track with limited recommendations	On track

			Summary of Findings for CPs by Focus Area			
Community Partner Name	**CP TYPE**	**Organizational Structure & Engagement**	**Integration of Systems & Processes**	**Workforce Development**	**Health Information Technology & Exchange**	**Care Model**
Innovative Care Partners, LLC (ICP-LTSS)	LTSS	On track	On track with limited recommendations	On track	On track with limited recommendations	On track with limited recommendations
Innovative Care Partners, LLC. (ICP-BH)	BH	On track	On track with limited recommendations	On track	On track with limited recommendations	On track with limited recommendations
Lahey Health Behavioral Services (Lahey)	BH	On track	On track	On track with limited recommendations	On track with limited recommendations	Opportunity to Improve with recommendations
LTSS Care Partners, LLC (LTSSCP)	LTSS	On track with limited recommendations	On track	On track	On track with limited recommendations	Opportunity to Improve with recommendations
Massachusetts Care Coordination Network (MCCN)	LTSS	On track	On track	On track	On track with limited recommendations	On track with limited recommendations
Merrimack Valley CP (MVCP)	LTSS	On track with limited recommendations	On track	On track	On track with limited recommendations	On track with limited recommendations
Northern Region LTSS Partnership (NRLP)	LTSS	On track	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations	On track with limited recommendations
Riverside Community Partners (Riverside)	BH	On track	On track with limited recommendations	On track	On track with limited recommendations	Opportunity to Improve with recommendations
South Shore Community Partnership (South Shore CP)	BH	On track	On track with limited recommendations	On track	On track with limited recommendations	On track with limited recommendations
Southeast Community Partnership, LLC (SCP)	BH	On track	On track with limited recommendations	On track	On track with limited recommendations	On track with limited recommendations
SSTAR Care Community Partners (SSTAR)	BH	On track	On track	On track	On track with limited recommendations	On track with limited recommendations
Central Community Health Partnership (CCHP BH)	BH	On track with limited recommendations	On track	On track with limited recommendations	On track with limited recommendations	On track

APPENDIX D: AGGREGATE PRACTICE SITE ADMINISTRATOR SURVEY RESULTS FOR ALL SURVEY QUESTIONS

The aggregate ACO-level Statewide survey results, in their entirety, are provided in this Appendix, organized by focus area. For a full description of the survey methodology, see Section D ("Methodology"), Subsection 5, "ACO Practice Site Administrator Survey Methodology."

- 353 practice sites were sampled; 225 responded (64% response rate)

- Survey questions are organized by focus area.

- Survey results were collected at the practice site level; data for each question was averaged across all ACOs, with each ACO weighted equally

- The table provides the survey question, answer choices, and percent of respondents that selected each available answer. Some questions included a list of items, each of which the respondent rated. For these questions (i.e., Q# 12), the items rated appear in the answer choices column.

- N/A indicates an answer choice that is not applicable to the survey question.

Focus Area: Organizational Structure and Engagement

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
12	In the past year, to what degree have the following practices in your clinic become more standardized, less standardized or not changed? *A lot less, a little less, no change, a little more, a lot more standardized (1-5), I Don't Know*	a. Physician compensation	1%	3%	31%	14%	14%	N/A	N/A	37%
		b. Performance management of physicians	1%	0%	23%	28%	25%	N/A	N/A	24%
		c. Care processes and team structure	0%	0%	21%	31%	38%	N/A	N/A	9%
		d. Hospital discharge planning and follow-up	0%	0%	15%	28%	48%	N/A	N/A	8%
		e. Recruiting and performance review	1%	1%	23%	24%	24%	N/A	N/A	27%
		f. Data elements in the electronic health record	0%	0%	15%	30%	42%	N/A	N/A	13%
21	To the best of your knowledge, in the past, has your practice participated in payment contract(s) together with the other clinical providers and practices that are now participating in the [ACO Name]? Select one.	a. Yes, with most of the clinical providers and practices that now compose this ACO (1) b. Yes, with some of the clinical providers and practices that now compose this ACO (2) c. No, this is our first time participating in a payment contract with the clinical providers and practices that compose this ACO (3) d. Don't know	25%	10%	16%	N/A	N/A	N/A	N/A	48%
f22	Has your practice received any financial distributions (DSRIP dollars) as part of its engagement with the MassHealth Accountable Care Organization?	Yes (1) No (2) Don't know	33%	8%	N/A	N/A	N/A	N/A	N/A	59%
23	Is a representative from your practice site engaged in ACO governance?	Yes (1) No (2) Don't know	39%	28%	N/A	N/A	N/A	N/A	N/A	33%
24	To what extent do you feel your practice has had a say in important aspects of planning and decision making within the MassHealth Accountable Care Organization that affect your practice site?	Almost never had a say (1) Rarely had a say (2) Sometimes had a say (3) Usually had a say (4) Almost always had a say (5) Don't Know/Not Applicable	19%	10%	16%	14%	14%	N/A	N/A	27%

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#	Question	Options								
25	Please indicate the extent to which you agree or disagree with the following statement: ACO leaders have communicated to this practice site a vision for the MassHealth ACO and the care it delivers.	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5) Don't know/ Not applicable	5%	8%	16%	40%	21%	N/A	N/A	11%
26	To what extent do you agree or disagree with each of the following statements? *Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know/Not Applicable*	a. The MassHealth ACO is a resource and partner in problem-solving for our practice.	2%	9%	22%	37%	20%	N/A	N/A	10%
		b. When problems arise with other clinical providers in the MassHealth ACO, we are able to work jointly to find solutions.	2%	7%	25%	31%	13%	N/A	N/A	22%
		c. All entities in this MassHealth ACO work together to solve problems when needed.	2%	6%	25%	32%	18%	N/A	N/A	17%
28	Overall, how satisfied are you with your practice's experience as part of this MassHealth ACO?	Highly dissatisfied (1) Somewhat dissatisfied (2) Neither satisfied nor dissatisfied (3) Somewhat satisfied (4) Highly satisfied (5)	5%	7%	39%	37%	12%	N/A	N/A	N/A
34	In the past year, to what extent has your practice changed its processes and approaches to caring for MassHealth members?	a. Massive change - completely redesigned their care (1) b. A lot of change (2) c. Some change (3) d. Very little change (4) e. No change (5)	0%	24%	45%	19%	12%	N/A	N/A	N/A
35	In the past year, to what extent has your practice's ability to deliver high quality care to MassHealth members gotten better, gotten worse, or stayed the same?	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	2%	11%	44%	39%	4%	N/A	N/A	N/A
37	Which of the following approaches are used to manage the performance of individual physicians who practice at your site? Select all that apply.	a. Performance measures on quality are reported and shared with physicians (1) b. Performance measures on cost are reported and shared with physicians (2) c. One-on-one review and feedback is used (3) d. Individual financial incentives are used (4) e. Individual non-financial awards or recognition is used (5)	91%	67%	73%	47%	40%	N/A	N/A	N/A
38	To the best of your knowledge, has your practice ever participated in any of the following, either directly or through participation in a physician group or other organization authorized to enter into such an agreement on behalf of the practice? Select all that apply.	a. Bundled or episode-based payments (1) b. Primary care improvement and support programs (e.g. Comprehensive Primary Care Initiative, Patient Centered Medical Home, Primary Care Payment Reform etc.) (2) c. Pay for performance programs in which part of payment is contingent on quality measure performance (3) d. Capitated contracts with commercial health plans (e.g. Blue Cross Blue Shield Alternative Quality Contract), etc.) (4) e. Medicare ACO upside-only risk bearing contracts (Medicare Shared Savings Program tracks one and two) (5) f. Medicare ACO risk bearing contracts (Pioneer ACO, Next Generation ACO, Medicare Shared Savings Program track three) (6) g. Commercial ACO contracts (7)	22%	59%	76%	48%	28%	30%	22%	N/A

Focus Area: Integration of Systems and Processes

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1b	For the care coordination and management resources used by your practice, how many of these resources are MANAGED by people at the following organizations (e.g., overseen, supervised)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	15%	50%	22%	13%	N/A	N/A	N/A	N/A
		b. The physical location and department where you work	16%	40%	31%	13%	N/A	N/A	N/A	N/A
		c. A community-based organization	34%	49%	11%	6%	N/A	N/A	N/A	N/A
		d. A different practice site, department, or location in your organization	31%	52%	13%	4%	N/A	N/A	N/A	N/A
		e. Other organization, entity, or location	44%	47%	7%	1%	N/A	N/A	N/A	N/A
1c	For the care coordination and management resources used by your practice, how many of these resources are HOUSED at the following locations (by housed we mean the place where these resources primarily provide patient services)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	28%	43%	17%	12%	N/A	N/A	N/A	N/A
		b. The physical location and department where you work	15%	35%	33%	17%	N/A	N/A	N/A	N/A
		c. A community-based organization	37%	45%	9%	9%	N/A	N/A	N/A	N/A
		d. A different practice site, department, or location in your organization	30%	48%	14%	8%	N/A	N/A	N/A	N/A
		e. Other organization, entity, or location	44%	45%	5%	6%	N/A	N/A	N/A	N/A
3	For your MassHealth members who receive care coordination and management services from more than one program or person, how often do these resources operate together efficiently?	Never (1) Rarely (2) Sometimes (3) Usually (4) Always (5) Don't Know/Not Applicable	0%	5%	28%	44%	11%	N/A	N/A	12%
8b	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5), I Don't Know*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	45%	9%	11%	10%	13%	N/A	N/A	13%
		b. counseling therapists, including clinical social workers	25%	2%	22%	15%	24%	N/A	N/A	12%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	27%	9%	19%	8%	25%	N/A	N/A	11%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	23%	6%	18%	14%	28%	N/A	N/A	11%
10	How difficult is it for your practice to obtain treatment for your MassHealth members with opioid use disorders?	Nearly impossible (1) Very difficult (2) Somewhat difficult (3) A little difficult (4) Not at all difficult (5) Don't Know/Not Applicable	6%	18%	14%	14%	24%	N/A	N/A	24%
15	If screening for the needs in the previous question is performed at a level other than the practice (e.g., by an accountable care organization), how often does your practice have access to the results?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	6%	7%	12%	23%	20%	N/A	N/A	31%
31	Currently which of the following best describes how many MassHealth members in your practice are receiving care coordination services from a MassHealth designated Community Partner?	Very few (1) More than very few, but not many (2) About half (3) A majority (4) Nearly all (5) I don't know/I'm not aware)	13%	28%	11%	10%	1%	N/A	N/A	36%
32	How frequently have clinicians, staff and/or administrators interacted with Community Partner organization staff in coordinating these patients' care?	Almost Never (1) Rarely (2) Sometimes (3) Often (4) Almost Always (5) Don't know	4%	18%	46%	14%	10%	N/A	N/A	7%

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| 33 | To the best of your knowledge, how has the existence of Community Partners impacted your ability to provide high quality care, for your MassHealth members? | Has made it harder almost all of the time (1)
Has made it harder some of the time (2)
Has made little or no change (3)
Has made it easier some of the time (4)
Has made it easier almost all of the time (5)
Don't know | 4% | 3% | 27% | 42% | 9% | N/A | N/A | 15% |

Focus Area: Workforce Development

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
27	In the past year, which of the following resources has your practice accessed as part of its involvement in this MassHealth ACO? Select all that apply.	(1) The MassHealth ACO has provided resources and/or assistance to help recruit providers and/or staff (2) The MassHealth ACO has provided resources and/or assistance to help train providers and/or staff (3) Providers and/or staff have taken part in trainings made available directly by MassHealth (4) Providers and/or staff have received training focused on behavioral health and long-term services and supports. (5) DSRIP Statewide Investments (e.g. Student Loan Repayment Program) have been provided to help in training and/or recruiting.	17%	65%	32%	43%	18%	NA	NA	NA

Focus Area: Health Information Technology and Exchange

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
13	Which of the following technologies are in use at your practice? Select all that apply.	(1) Electronic health record (2) Care management platform (3) Population health management platform (4) Other technology	100%	50%	61%	20%	N/A	N/A	N/A	N/A
13_EHR	To what extent do you agree that the Electronic Health Record improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) I Don't Know*	9%	4%	12%	34%	38%	N/A	N/A	2%
13_CMP	To what extent do you agree that the Care Management Platform improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) I Don't Know*	2%	2%	20%	37%	34%	N/A	N/A	5%
Q13_PHP	To what extent do you agree that the Population Health Platform improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) I Don't Know*	4%	3%	16%	38%	38%	N/A	N/A	1%

Focus Area: Care Coordination and Care Management

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1a	Which of the following care coordination and management resources has your practice used in the past 12 months for your MassHealth members? Select all.	Community Health Workers (1) Patient Navigators/Referral Navigators (2) Nurse Manager/Care Coordinator (3) Any other (non-nurse) Care Coordinator/Manager (4) Social Worker (5) Other title (6)	66%	53%	74%	41%	66%	14%	N/A	N/A

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#	Question	Item								
2	In the past 12 months to what extent have these coordination and management resources helped your practice's efforts to deliver high quality care to your MassHealth members?	*Not at all, A little, Somewhat, Mostly, A great deal (1-5)*	2%	7%	32%	29%	30%	N/A	N/A	N/A
4	In the past 12 months, how often was it difficult for staff in your practice site to do each of the following for your MassHealth members? *Always, Usually, Sometimes, Rarely, Never Difficult (1-5) Don't Know*	a. Learn the result of a test your practice site ordered	0%	1%	9%	45%	39%	N/A	N/A	6%
		b. Know that a patient referred by your practice site was seen by the consulting clinician	1%	9%	34%	31%	16%	N/A	N/A	9%
		c. Learn what the consulting clinician recommends for your practice site's patient	0%	9%	36%	28%	20%	N/A	N/A	6%
		d. Transmit relevant information about a patient who your practice site refers to a consulting clinician	1%	5%	29%	34%	26%	N/A	N/A	6%
		e. Reach the consulting clinician caring for a patient when your staff need to	1%	7%	31%	36%	16%	N/A	N/A	9%
5	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for each of the following? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Arranging eye care from an ophthalmologist or optometrist	1%	0%	0%	11%	41%	39%	N/A	7%
		b. Confirming that a diabetic eye exam was performed	3%	1%	4%	11%	40%	30%	N/A	11%
		c. Ensuring that [Practice Name] receives the ophthalmologist or optometrist consult note	4%	1%	3%	15%	44%	26%	N/A	7%
6	For your complex high-need MassHealth patients, how often is any type of care coordination or management resource involved in helping the patient adhere to the care plan? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Any type of care coordinator/manager	4%	8%	32%	33%	23%	N/A	N/A	N/A
		b. Any type of non-clinician (e.g., community health worker)	6%	9%	44%	24%	18%	N/A	N/A	N/A
		c. Targeted interventions for patients who have been risk stratified into a high need sub-group	8%	9%	33%	33%	18%	N/A	N/A	N/A
		d. Home visits	17%	18%	38%	14%	14%	N/A	N/A	N/A
7	For complex, high-need MassHealth members, how often does your practice use each of the following resources to help the patient adhere to the care plan? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Referral to community-based services for health-related social needs	3%	3%	32%	43%	19%	N/A	N/A	N/A
		b. Communication with the patient within 72 hours of discharge	2%	3%	14%	28%	53%	N/A	N/A	N/A
		c. Home visit after discharge	23%	19%	37%	15%	7%	N/A	N/A	N/A
		d. Discharge summaries sent to primary care clinician within 72 hours of discharge	4%	5%	21%	38%	33%	N/A	N/A	N/A
		e. Standardized process to reconcile multiple medications	3%	3%	15%	35%	43%	N/A	N/A	N/A
8a	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? *Almost Never, Rarely, Sometimes, Usually, Almost Always within the practice site (1-5), Don't Know/Not Applicable*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	2%	3%	18%	25%	45%	N/A	N/A	7%
		b. counseling therapists, including clinical social workers	0%	1%	13%	27%	53%	N/A	N/A	6%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	3%	5%	18%	24%	43%	N/A	N/A	7%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	3%	5%	21%	20%	44%	N/A	N/A	7%
9	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for MassHealth members obtaining the following behavioral health services? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Scheduling the appropriate behavioral health services	3%	2%	2%	13%	35%	35%	N/A	9%
		b. Confirming that behavioral health services were received	5%	3%	10%	19%	33%	21%	N/A	9%
		c. Ensuring that your practice site receives the prescribing clinician, counseling therapist, or any type of care coordinator/manager's consult note, as appropriate	6%	4%	12%	18%	31%	19%	N/A	9%

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Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
		d. Establishing when a prescribing clinician, counseling therapist, or any type of care coordinator/manager will share responsibility for co-managing the patient's care	7%	4%	9%	19%	28%	20%	N/A	12%
11	To what extent do you agree or disagree that providers follow a clear, established process for the following activities? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Screening for service needs at home that are important for the patient's health?	7%	2%	4%	13%	31%	23%	N/A	20%
		b. Choosing among LTSS providers?	6%	2%	6%	20%	29%	10%	N/A	26%
		c. Referring patients to specific LTSS providers with which your office has a relationship?	5%	2%	5%	19%	33%	13%	N/A	23%
		d. Confirming that the recommended LTSS have been provided?	8%	2%	6%	23%	24%	14%	N/A	23%
		e. Establishing relationships with LTSS providers who serve your patients?	7%	1%	9%	20%	25%	13%	N/A	24%
		f. Getting updates about a patient's condition from the LTSS providers?	7%	1%	7%	23%	24%	13%	N/A	24%
17	When MassHealth members receive referrals to social services organizations, how often is your practice aware that those patients have received support from those organizations?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	4%	19%	37%	17%	8%	N/A	N/A	15%
18	Does your practice regularly provide any of the following? Select all that apply.	Scheduling to enable same day appointments (1) Appointments on weekdays before 8 am or after 5 pm (2) Appointments on weekends (3) Home visits carried out by practice staff or a clinician (4) Clinical pharmacy services provided after discharge at the practice site (5) Care that is provided in part or in whole by phone or electronic media (e.g., patient portal, e-mail, telemedicine technology) (6)	96%	61%	43%	29%	36%	64%	N/A	N/A

Focus Area: Population Health Management

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
14	For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP)	a. tobacco use	97%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		b. opioid use	80%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		c. substance use	92%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		d. polypharmacy	44%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		e. depression	98%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		f. low health literacy	36%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		g. food security or SNAP eligibility	57%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		h. housing instability	72%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		i. utility needs	54%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		j. interpersonal violence	75%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		k. transportation needs	69%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		l. need for financial assistance with medical bills	52%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		m. Medicaid eligibility	62%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		n. none of the above	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
16	How often are MassHealth members referred from your practice to social services organizations to address health-related social needs (e.g., housing, food security)?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	2%	7%	39%	19%	21%	N/A	N/A	12%
19	What is the main source of information that your practice uses to identify which of your MassHealth members are complex, high need patients? Select one.	a. We perform an ad hoc review of information from our own practice's system(s) (e.g., EHR) when we think it is relevant (1) b. We regularly apply systematic risk stratification algorithms in our practice using our patient data (2) c. We receive risk stratification information from a managed care organization or accountable care organization (3) d. We do not have a way of knowing which patients are complex/high need (4) e. Don't know	15%	18%	44%	1%	21%	N/A	N/A	N/A
29	Please select the option below that best describes the change in the past year in your practice site's ability to tailor delivery of care to meet the needs of patients affected by health inequities (e.g., by using culturally and linguistically appropriate services):	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	3%	9%	49%	34%	5%	N/A	N/A	N/A
30	How often does your practice site use site-specific data to identify health inequities within its served population? For example, data might include EHR charts or ACO reports.	Annually (1) Bi-annually (2) Quarterly (3) Monthly (4) On an ad hoc basis (5) We do not have access to this type of data. (6) We have access to this type of data but do no analyze it for health inequities. (7)	4%	2%	14%	30%	25%	19%	7%	N/A

General Questions

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
20	Our records show that your practice is participating in the [ACO name] for some or all of its MassHealth Medicaid patients. Is that correct?	Yes (1) I am not aware of this (2)	96%	4%	N/A	N/A	N/A	N/A	N/A	N/A
20_O	Were you able to find a colleague who can help you answer questions about [ACO Name]?	Yes (1) No (2)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
20a	Currently, which of the following best describes how many of your practice's patients are covered by [ACO Name]?	Very few (1) A minority (2) About half (3) A clear majority (4) Nearly all (5)	3%	37%	35%	20%	5%	N/A	N/A	N/A
36	Who owns your practice? (select one)	a. Independently owned (1) b. A larger physician group (2) c. A hospital (3) d. A healthcare system (may include a hospital) (4) e. Other (please specify) (5)	28%	8%	8%	45%	10%	N/A	N/A	N/A
39	Which of the following best describes your practice site?	Adult (1) Pediatric (2) Both (3)	34%	16%	50%	N/A	N/A	N/A	N/A	N/A
40	Currently which of the following best describes how many of your practice's patients are covered by any contracts with cost of care accountability?	Very few (1) A minority (2) About half (3) A majority (4) Nearly all (5)	10%	30%	35%	24%	2%	N/A	N/A	N/A

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41	To what extent do providers and staff at your practice site seem to agree that "total cost of care" contracts will become a major and sustained model of payment at your practice in the near-term (i.e., within five years)?	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5)	1%	4%	65%	25%	5%	N/A	N/A	N/A
42	What is your professional discipline? (select one)	a. Primary care physician (1) b. Physician assistant/nurse practitioner (2) c. Registered nurse/nurse case manager/ LVN/LPN (3) d. Professional administrator (e.g., practice manager) (4) e. Other-please specify: (5)	7%	1%	18%	66%	8%	N/A	N/A	N/A
43	How long have you worked at this practice site? (select one)	a. Less than 6 months (1) b. 6-12 months (2) c. 1-2 years (3) d. 3-5 years (4) e. More than 5 years (5)	6%	9%	15%	16%	54%	N/A	N/A	N/A
44	Did you ask a colleague for help in answering questions on the survey?	Yes (1) No (2)	30%	70%	N/A	N/A	N/A	N/A	N/A	N/A

APPENDIX E: SWI IMPLEMENTATION

Student Loan Repayment Program (SWI 1a) And Behavioral Health Workforce Development Program (SWI 1b)

Year 1:
Application Review Process

Applications for both the SLRP and the BHWDP opened on March 15, 2018 with applications due on Thursday, April 6, 2018. The deadline was ultimately extended to April 17, 2018. An informational webinar was held for interested applicants and organizations one week after the release of the applications.

A total of 293 applications were received, 224 of which were found to be eligible for consideration. Incomplete applications were not considered for funding typically based on missing information (such as the candidate's application, the employer's application, or two required references).

The SLRP was open to the following categories of providers:

☐ Family Physicians, General Internists, Pediatricians, Psychiatrists, (MDs) and/or Psychologists (PhDs)

☐ Nurse Practitioners (NPs), Physician Assistants (PAs), Advanced Practice Registered Nurses (APRNs), and/or Psychiatric Care Nurse Specialists (PCNAs)

☐ Licensed Independent Clinical Social Workers (LICSWs), Licensed Certified Social Workers (LCSWs), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), and/or Licensed Alcohol and Drug Counselors I (LADC1s)

☐ Master's-prepared Unlicensed and Licensed Behavioral Health Providers.

Independent reviewers were recruited from local foundations, health care and behavioral health organizations, state agencies, as well as staff from MassLeague to evaluate applications. Each application was reviewed by two reviewers, following initial rounds of scoring applications were ranked by score. Leadership from MassHealth, ABH, and the MassLeague then conducted several meetings to review the scoring results and make recommendations for award recipients.

To distribute awards equitably the following criteria were considered when making funding decisions:

- the type of organization (e.g. provider entity designation);
- number of awards per organization;
- provider specialty (primary care versus behavioral health), and
- geographic region.

To promote fair and equitable distribution of awards across multiple organizations, a policy was developed that limited a single organization to no more than 20% of the available awards within a given provider category.

Licensed masters-prepared behavioral health providers at community-based behavioral health organizations were eligible to be funded by both the SLRP and the BHWDP. They were considered first for the BHWDP, and again after all BHWDP awards for licensed BH provider had been filled, remaining applications were considered as part of the SLRP; Licensed BH provider category review. A total of 15 BHWDP awards were ultimately reserved for masters-prepared unlicensed BH providers.

Funding Pools Summaries:

SLRP

☐ **MD, PHD:** A total of 29 applications were received for the 30 available awards. Of these applicants 22 were recommended for funding based on scoring and award criteria. As only 22 funding allotments were awarded, the remaining eight were transferred to the SLRP's Licensed Behavioral Health Provider and BHWDP categories. These categories were selected for the additional awards because they received a high number of applications indicating a greater need for student loan repayment in community-based behavioral health settings.

☐ **NP, PA, APRN, PCNS**: A total of 24 applications were received for 20 available awards. Of these 24 applications, 18 were recommended for funding based on scoring and award criteria. The two awards that were not filled were transferred to the SLRP's Licensed Behavioral Health Provider and BHWDP categories. These categories were selected for additional awards due to a high number of applications and a recognized need for student loan repayment in community-based behavioral health settings.

☐ **Licensed BH Specialists** A total of 64 applications were received for the initial 20 available funding opportunities. However, the fund ultimately added seven additional opportunities due to the vacancies created in the MD, PhD and APRN, NP, PCNS, PA categories. As such 27 applications were recommended for funding, and an additional 14 were placed on a waitlist for future funding opportunities. Consideration was given to promote equitable distribution across a number of variables including applicants':

- location;
- organization-type (CHC v. community-based behavioral health organization), and
- provider type (LICSW, LCSW, LMHT, and LMFT).

BHWDP

☐ **Master's Prepared Unlicensed and Licensed BH Specialists**: A total of 107 applications were received for 35 available awards. Of the 107 applications, 43 were recommended for funding, and 23 were placed on a waitlist. An additional eight slots above the initial 35 were added due to vacancies created in the SLRP - MD, PhD and SLRP - APRN, NP, PCNS, PA categories. Fifteen slots were reserved for masters-prepared unlicensed providers. Consideration was given to promote equitable distribution across geographies and provider types (LICSW, LCSW, LMHT, and LMFT).

☐ Of the 110 awardees across both the BHWDP and the SLRP, 15 applicants declined the offer of the program.

o SLRP:

☐ MD, PhD: Two awardees declined the offer. As the only individuals on the waitlist were from an entity that had already met the award threshold, these slots were reassigned to the SLRP Licensed BH and BHWDP

- ☐ APRN, NP, PA: Six awardees declined the program, only one of the six awards could be filled from the waitlist as others were applying from entities which had already met award level thresholds. Licensed BH Providers: Four declined the program, these were filled by individuals on the waitlist.

o BHWDP:

☐ Licensed/Unlicensed BH Providers: Three declined, all filled by applicants from this category

Based on the two remaining awards from MD, PhD ($100,000) and five from APRN, NP, PA ($150,000) that could not be assigned within their categories, as well as changes in a candidate's status from full to part time ($60,000), there was a total of $310,000 available funds that could be used to fund student loan repayment for waitlist applicants in the Licensed BH Providers and BHWDP categories.

Year 2

In the program's second year, an online application tool along with training materials for its use was introduced for the SLRP. Applications for the second year opened on February 19, 2019 with applications due April 12, 2019. The MassLeague received 96 applications for the SLRP, of which 12 were considered incomplete or ineligible (primary reasons: working fewer than 20 clinical hours per week or not being considered early career providers or not having worked at an eligible organization for five or more years), leaving a total of 84 eligible applications all of which were recommended for funding.

Program/Eligible Provider	Year 1			Year 2		
	Awards Available	Complete Applications Reviewed	Awards Recommended	Awards Available	Complete Applications Reviewed	Awards Recommended
SLRP - MD, PhD	30	29	22	25	7	7
SLRP - APRN, NP, PCNS, PA	20	24	18	25	15	15
SLRP - Licensed BH	20	64	27	40	62	62
BHWDP - Masters-prepared unlicensed and Licensed BH	35	107	43			
Total	105	224	110	90	84	84

FUNDING

	Year One Funding	Year One Reallocation	Year Two Funding	Year Two Reallocated Funding
SLRP - MD, PhD	$750,000	$550,000	$625,000	$170,000
SLRP - APRN, NP, PA	$300,000	$270,000	$375,000	$220,000
SLRP - Licensed BH Providers	$300,000	$405,000	$600,000	$906,085
BHWDP - Un/Licensed BH Prov.	$525,000	$645,000		
Total	$1,875,000	$1,870,000	$1,600,000	$1,296,085

Funding Table Notes:
1. The $5,000 DSRIP year one program funds remaining were carried forward and added to the student loan repayment funds available in DSRIP year two.
2. The $303,915 in SLRP funding not awarded in DSRIP year two will be reconciled and reallocated to support DSRIP year three program activities.
3. MassHealth intends to continue to fund this investment in years 3 and 4 of the DSRIP program.

Learning Days

Quarterly learning days were offered during the first two years of the program. Learning days were designed to address the needs of early career providers. The MassLeague contracted with Health

Management Associates (HMA) to develop the curriculum for each learning day ultimately focusing on the following topical areas:

- Provider wellness and vitality
- Leadership and quality improvement
- Integrated models and population health
- Care for diverse populations/health equity/relationship centered care

Overall attendance of Learning Days sessions is 94% of eligible attendees. Feedback from sessions indicated attendees found the content valuable.

Over the first two years of this investment, six providers have left the program. The reasons cited for their departures included: wanting to change where they were employed and moving to an organization that is not DSRIP eligible, moving out of state or being terminated.

Community Partner Recruitment Incentive Program (SWI 1c)

The application for this program was released on March 29, 2018 with responses due April 17, 2018. The applications process was non-competitive; CPs had to complete a brief application in order to access their recruitment incentives. Each BH CP was allotted two CC incentives and one RN/LPN incentive, though it could choose to replace the RN/LPN incentive with two additional CC incentives. Each LTSS CP was allotted three CC incentives.

The slots made available to CPs and the number filled are listed in the table below.

Community Partners and Number of Student Loan Repayment Recruitment Incentives:

Community Partner	Number of Recruitment Incentives Requested	Number of Positions Filled
Behavioral Health Network	3 slots (1 RN/LPN, 2 CC)	3 (1 RN/LPN, 2 CC)
Behavioral Health Partners of Metrowest	3 slots (1 RN/LPN, 2 CC)	2 (1 RN/LPN, 1 CC)
Boston Healthcare for the Homeless Program, Inc.	4 slots (4 CC)	4 (4 CC)
The Bridge of Central Massachusetts	3 slots (1 RN/LPN, 2 CC)	2 (1 RN/LPN, 1 CC)
The Brien Center for Mental Health and Substance Abuse Services	3 slots (1 RN/LPN, 2 CC)	3 (1 RN/LPN, 2 CC)
Clinical Support Options	4 slots (4 CC)	1 (1 CC)
Community Care Partners	3 slots (1 RN/LPN 2 CC)	1 (1 CC)
Community Counseling of Bristol County	4 slots (4 CC)	4 (filled 2 CC slots, and used the 2 other CC slots to recruit 2 RN/LPNs)
Community Healthlink,	3 slots (1 RN/LPN, 2 CC)	0
Eliot Community Human Services,	3 slots (1 RN/LPN, 2 CC)	0
High Point Treatment Center	4 slots (4 CC)	4 (4 CC)
Innovative Care Partners	3 slots (1 RN/LPN, 2 CC)	0
Lowell Community Health Center	3 slots (1 RN/LPN, 2 CC)	0
Northeast Behavioral Health Corporation	3 slots (1 RN/LPN, 2 CC)	0
Riverside Community Care	3 slots (1 RN/LPN, 2 CC)	3 (1 RN/LPN, 2 CC)
Southeast Community Partnership	4 slots (4 CC)	3 (3 CC)

South Shore Mental Health Center	4 slots (4 CC)	4 (4 CC)
Stanley Street Treatment and Resources	3 slots (1 RN/LPN, 2 CC)	0
LTSS Community Partners and Number of Student Loan Repayment Slots:		
Alternatives Unlimited,	3 slots (3 CC)	0
Boston Medical Center	3 slots (3 CC)	0
Elder Services of the Merrimack Valley	3 slots (3 CC)	1 (CC)
Family Service Association,	3 slots (3 CC)	2 (CC)
Greater Lynn Senior Services	3 slots (3 CC)	1 (CC)
Innovative Care Partners	3 slots (3 CC)	0
LTSS Care Partners	3 slots (3 CC)	3 (CC)
Seven Hills Family Services	3 slots (3 CC)	2 (CC)

This investment was designed to address concerns that CPs had about their ability to recruit sufficient numbers of care coordinators and RN/LPNs during the lead up to the CP program launch. CPs requested and were granted additional time to fill these slots. Not all CPs were able to fill their entire allocation, 20 out of 27 CPs ultimately accessed the recruitment slots available to them. In total 51% of the available slots were filled. As of August 2019, two care coordinators that had been recruited had left their CP.

This program will ultimately fund 41 Care Coordinators and 8 RN/LPNs (2 have received the lower CP amount) distributing $412,500 in year 1 and $90,000 in year 2 for a total of $502,500. The initial distribution was expected to be $907,500 resulting in $405,000 being reallocated into different community and workforce focused investments.

Primary Care/ Behavioral Health Special Projects Program (SWI 2)

Year 1

The year 1 application was released on March 27, 2018 with a due date of April 30, 2018. Reviews were completed on June 4, 2018 and awards were made on September 7, 2018.

Each application was reviewed and scored by three separate reviewers who were recruited from diverse backgrounds including foundations, health care, behavioral health care organizations and state agencies. Criteria included how well the proposal met the needs of the organization, the individual and the community served as well as, the quality of the proposal.

In year 1, 25 applications were received and 23 were awarded resulting in $920,000 being distributed to awardees.

In order for MassHealth to monitor and evaluate the programs, awardees are required to submit mid-year and final reports documenting their progress and milestones that they met.

Mid-year reports for the year one award cycle recipients were due on March 31, 2019. All award recipients submitted mid-year reports, and all award recipients reported making good progress on their projects. Final reports for the year one award cycle recipients were due on September 30, 2019. All award recipients submitted final reports.

While not obligatory, all award recipients also have the option of engaging in a monthly check in/coaching call with the MassLeague's Manager of Primary Care Workforce Initiatives or Manager of BH Workforce Initiatives. Most award recipients have engaged in these calls.

Year 2

An application for the second cycle of SWI 2 was released on February 19, 2019 with a due date of April 5, 2019. Reviews were completed on June 13, 2019 and awards were made on October 16, 2019. For this cycle, 25 applications were received and 20 of these were deemed complete and eligible and were scored by a panel of reviewers. The MassHealth SWI team, the MassLeague and ABH conducted a one-and-a-half-hour meeting to review the scoring results and make recommendations for special project awards. After the review it was decided to make awards to all 20 eligible applicants. These 20 applications represent $748,865 of the $800,000 allocated funding.

For the second cycle of SWI 2, the mid-year reports are due April 30, 2020 and the final reports are due December 15, 2020.

The table below list the organizations received funding in years 1 & 2.

Organization	Year 1	Year 2
Advocates, Inc.	Y	Y
Bay Cove Human Services	Y	Y
Boston Health Care for the Homeless Program	Y	N
Bowdoin Street Health Center, Dorchester	Y	N
Brockton Neighborhood Health Center	Y	N
Brookline Community Mental Health Center	Y	N
Cambridge Health Alliance	N	Y (2 programs)
Center for Human Development	Y	N
Charles River Community Health	Y	Y (2 programs)
Community Health Center of Cape Cod	Y	N
Community Health Center of Franklin County	Y	N
Dimock Community Health Center	Y	Y
Edward M Kennedy Community Health Center	Y	N
Family Health Center of Worcester	Y	N
Family Service Association	N	Y
Fenway Community Health Center	Y	N
Greater Lawrence Family Health Center	Y	Y
Harbor Community Health Center	Y	N
Harvard Street Neighborhood Health Center	Y	N
Hilltown Community Health Center	Y	N
Justice Resource Institute (JRI)	N	Y
Lowell Community Health Center	N	Y (2 programs)

Public Consulting Group, Inc.

Lynn Community Health Center	Y	N
Manet Community Health Center	Y	N
MGH Community Health Associates Health Centers	N	Y
North Suffolk Mental Health Association, Inc. (Freedom Trail Clinic)	N	Y
Priority Professional LLC	Y	N
ServiceNet	N	Y
South End Community Health Center	Y	Y (2 programs)
Southern Jamaica Plain Health Center	N	Y
Stanley Street Treatment and Resources (SSTAR)	Y	N
Vinfen	N	Y

While MGH Community Health Associates Health Centers had been awarded a grant in year 2 on behalf of MGH Chelsea Health Center, it found that it was unable to implement the project and returned the funds to MassHealth. Total project funding was $14,560.

The MassLeague reports that, during monthly check-ins, special projects leaders have noted their appreciation of both the funding and the support the MassLeague provides throughout their project.

A few examples of written feedback include:

- "This (award) has allowed the program to be significantly enhanced." South End Community Health Center: Family Medicine-Psychiatry Combined Residency.
- "We are grateful for the assistance of this program and feel confident that it will be a sustainable service we are able to offer our patients at BHNC." Brockton Neighborhood Health Center: Centering Pregnancy at BNHC.

It is expected that the Special Projects Program will be offered in each of the remaining years of the DSRIP program. The third application cycle is expected to be launched in February 2020. Eligible organizations are able to request funding for new projects that build on the accomplishments of projects funded in an earlier application cycle. Since a key aim of this program is provider retention, applications for projects that build on previously funded work must identify a new lead provider. They must also outline a scope of work that is distinct from the earlier project, even if both projects seek to advance similar goals.

Investments In Community-Based Training And Recruitment: Family Medicine and Nurse Practitioner Residency Training (SWI 3a)

Two separate procurements were released for this funding stream in DSRIP Year Two.

Family Medicine Residency Programs

The first procurement targeted Family Medicine Residency Programs with residency training opportunities in CHCs. Applications were released on July 23, 2018 and were due on September 10, 2018. Award decisions were announced on November 30, 2018. The first funds to Family Medicine Residency Program awardees were disbursed in April 2019.

CHCs and Accreditation Council for Graduate Medical Education (ACGME)-accredited Family Medicine residency programs were eligible to be the lead organization for this program. CHCs must serve as the Family Medicine Practice (FMP) sites for all FM residency positions supported by program funding.

Regardless of the number of slots funded by this program, CHCs are required to have at least two residents at the FMP site to qualify for this program. The program funds $170,000 per year per resident for three or four years depending on the length of the residency. Two applications were received and reviewed. A Review Committee consisting of five members with relevant experience was developed to review the applications. Each member of the review committee reviewed the applications and scored them. Both applications were highly regarded by the reviewers. After discussion with MassHealth and the MassLeague, it was decided to fund the Lawrence Family Medicine Residency Program for two additional resident positions for a four-year curriculum; and Boston Medical Center Academic Family Medicine Residency Program to support two residents in a SUD track at a CHC for a three-year curriculum.

The Lawrence program was cited for its long (20 year) commitment to the residency program, its community focus and success of retaining graduates in primary care positions and underserved settings. The BMC program was noted for creating a new curriculum track for addressing substance use disorder.

The Lawrence Family Medicine Residency Program was funded $340,000 each year for four years for a total of $1,360,000. The BMC Academic Family Medicine Residency Program is funded $340,000 each year for three years or $1,020,000.

Family Nurse Practitioner Residency Programs

The second procurement targeted Family Nurse Practitioner Residency Programs in CHCs. Applications were released on August 24, 2018 and were due on September 28, 2018. Award decisions were announced on February 12, 2019. However, the MassLeague discovered that an application that had been submitted on time to this program was not included in the initial review after award decisions were announced. The review committee was reconvened, and this application was ultimately recommended for funding. This award decision was announced on May 22, 2019.

This program is limited to CHCs that are part of a MassHealth ACO. Unlike the Family Medicine Residency program, applicants did not have to have a residency program in place to apply, however they were required to show a commitment to investing in training. Applicants are required to have at least two residents at the same site, regardless of the number of applicants they request or are awarded. This program only offers one year of funding; however, a preference was stated for two-year programs.

Six applications were for programs that would support the development of new FNP residency programs with two to three positions each. One application was for an existing FNP program to expand its program with two additional positions.

A group of five reviewers with relevant experience was convened and reviewed and scored the applications. After detailed review, awards were made to the five highest scoring programs.

Applicant	Number of Requested Positions	Number of Positions Awarded	Total Funding
Baystate High Street Health Center	2	2	$210,000
Community Health Connections, Inc.	2	2	$210,000
Family Health Center of Worcester	4	4	$420,000
Harbor Health Services, Inc.	3	2	$210,000
North Shore Community Health	2	2	$210,000
Total	**13**	**12**	**$1,260,000**

The first funds to Family Nurse Practitioner Residency Program awardees were disbursed in March 2019. The second funds were disbursed in June 2019. Funds committed to FNP residency training via this program total $1,260,000 for the twelve one- year FNP residency slots.

These two programs support approximately 17 new CHC-based residency training positions in Massachusetts that began in July/August 2019.

Award recipients must submit mid-year and annual reports for all years of the residency slots funded by this program. The first mid-year reports are due on January 15, 2020 for both the Family Medicine Residency and Family Nurse Practitioner Residency Program awardees. Award recipients must also submit quarterly expenditure reports.

FNP Residency Program awardees are also expected to administer satisfaction surveys to all residents upon completion of their residency training experience.

In August 2019 MassHealth released applications for a second round of funding for both the Family Medicine Residency Program and the Nurse Practitioner Residency Program with applications due on September 27, 2019. These programs are scheduled to begin in July/August 2020.

Community Mental Health Center Behavioral Health Recruitment Fund (SWI 3b)

This program has two application and funding rounds.

Year 1

Round 1 applications were released on June 4, 2018 and due August 15, 2018, awards were made on December 17, 2018.

A total of 14 organizations applied for 29 recruitment packages. Applicants requested 12 psychiatrist positions and 17 NP positions in total. While most applicants applied for one or two positions, some organizations applied for three or more positions. Applications were reviewed for quality and the award decisions were based on both quality and criteria established to promote an equitable distribution. To make awards to the largest number of organizations, MassHealth decided to recommend no more than one psychiatrist or nurse practitioner spot per organization. Applicants that requested one provider were awarded the provider type they requested, those that asked for both a psychiatrist and a nurse practitioner were awarded a psychiatrist package but given the option to change it for a nurse practitioner package. A total of 12 positions were recommended for funding, seven psychiatrist packages and five nurse practitioner packages. Ten of the organizations are from MassHealth CPs or CSAs, the other two contract with ACOs to provide in-home therapy and serve significant numbers of MassHealth members.

Provider Allocation	Year 1 Program Funding
(7) Psychiatrists ($25,000 student loan & $50,000 special project per year)	$525,000
(5) Nurse Practitioners ($15,000 student loan & $40,000 special project per year)	$275,000
Total	$800,000

 As of December 31, 2019, five CMHCs had successfully hired new providers. Another two CMHCs reported being in the process of hiring new providers that were recruited via support from this program.

As of December 31, 2019, three CHCs had submitted detailed special project proposals (2 were approved, 1 was under review) and one is in development. The end date for recruitment activities for first award cycle awardees has been extended to June 30, 2020

Year 2

Applications for the SWI 3b second cycle were released March 4, 2019 and due April 18, 2019, awards were made on August 19, 2019.

Applications for a total of 29 recruitment packages (14 psychiatrist positions, 15 NP positions) were submitted by nine organizations. Upon review, two of the applications were found to be incomplete. As such seven applications were reviewed requesting 17 recruitment packages. (6 psychiatrist and 11 NP). All of the applications scored above the evaluation threshold. Because of this each organization was allocated at least one psychiatrist or NP, and three organizations were awarded more than one based on additional criteria. Those that requested a psychiatrist or a psychiatrist and a NP position were awarded a psychiatrist position.

A total of ten recruitment packages for the seven organizations were recommended for funding, six psychiatrist, four NP.

Provider Allocation	Year 2 Program Funding
(6) Psychiatrists ($25,000 student loan & $50,000 special project per year)	$450,000
(4) Nurse Practitioners ($15,000 student loan & $40,000 special project per year)	$220,000
Total	$670,000

As of December 31, 2019, two CMHCs awarded during the second award cycle had successfully hired new providers via support from this program.

Community Health Worker Training Capacity Expansion Grants (SWI 4a)

The Commonwealth Corporation received ten proposals for this investment. A review team was assembled consisting of staff from the Commonwealth Corporation, Massachusetts Department of Public Health, MassHealth and an external consultant with relevant experience. Each proposal was reviewed and scored by three members of the review team. After scoring the review team, along with additional Commonwealth Corporation staff and representatives from the Massachusetts Department of Public Health and MassHealth met to discuss the proposals and make recommendations. In addition to meeting scoring criteria, consideration was given to the geographic need, to assure that training was available across the state.

The following entities were awarded grants:

- Lowell Community Health Center (One Cohort, $40,000, 25 trainees)
- Justice Resource Institute (Two Cohorts, $80,000, 50 trainees)
- Holyoke Community College (One Cohort, $40,000, 25 trainees)
- Boston Public Health Commission (One Cohort, $40,000, 25 trainees)
- Center for Health Impact (Two Cohorts, $80,000, 50 trainees)
- Cambridge Public Health Commission/Cambridge HealthAlliance (One Cohort, $40,000, 25 trainees)

The funded bidders will receive $320,000 in aggregate, and train eight additional cohorts distributed across the state's regions as follows:

- Two cohorts in Greater Boston
- One cohort in Northeast
- One cohort in Southeast
- Two cohorts in Central
- One cohort in Western

One training program returned the funds for one training cohort, so only 175 training slots were funded in calendar year 2019. These funds are planned to be rebid in future years.

The trainings that are conducted by the organizations that received DSRIP awards are not strictly limited to individuals employed by ACOs or CPs. MassHealth reviews the individual applicants to DSRIP-funded CHW core competency training cohorts and confirms they are employed by an ACO or CP prior to their enrollment to ensure that the majority of DSRIP-funded training slots are filled by CHWs in ACOs and CPs. However, this approach enables enrollment in these programs to continue as they would without DSRIP funding and acknowledges that individuals not currently employed at an ACO or CP may become so in the future.

Overall, 248 individual CHWs applied to the CHW core competency training program cohorts implemented via DSRIP grants in calendar year 2019. Approximately185 individuals were accepted to DSRIP-supported cohorts, of them 143 were CHWs currently employed at an ACO or CP or 77% of the capacity.

Overall, inclusive of all training cohorts (DSRIP- and non-DSRIP-funded), the CHW core competency training programs that received DSRIP grants have so far enrolled a total of 274 CHWs currently employed at an ACO or CP in 2019 and approximately 490 total CHW in calendar year 2019, or 56% of capacity. Waitlist data provided by MassHealth indicates continued demand for these trainings.[58]

While some ACOs have created CHW programs at the ACO level, individual CHW are sometimes hired by individual provider organizations that may participate in both an ACOs and CPs. Based on the best available data, 75% of the ACOs, 39% of the CPs and 44% of the LTSS CPs have utilized training opportunities.

Peer Specialist Training Capacity Expansion Grant (SWI 4b)

As of November 2019, 7 of the 8 training CPS training cohorts (both DSRIP- and non-DSRIP-funded) planned for calendar year 2019 had been launched. Approximately 157 of the 227 individuals enrolled in these training cohorts were currently employed at an ACO or CP.

Community Health Worker Supervisors Training Program Grant (SWI 4c)

Applications were released on July 10, 2018 and were due August 21, 2018. Three proposals were received and reviewed and scored by two review team members, one from the Commonwealth Corporation, the other from the Massachusetts Department of Public Health. One grant of $85,000 was awarded to the highest scoring organization, the Center for Health Impact (CHI). MassHealth approved the CHW supervisor training curriculum developed by CHI in September 2019. The first training cohort launched in December 2019 with 38 individuals approved for training and 23 enrolled representing 8 ACOs and 6 CPs. MassHealth decided to fund the grant again with Year 2 money and secured an additional 75-90 training spots and plans to make the training curriculum publicly available.

Recovery Coach Supervisor Training Incentive Fund (SWI 4d)

The Recovery Coach Supervisor Training Incentive Fund was designed to increase the number of certified recovery coach supervisors employed by ACOs and CPs by covering the cost of salary replacement and training fees so that recovery coaches can complete recovery coach supervisor training programs. However, this program was put on hold pending recommendations put forth by the CARE Act which established a nine-person commission chaired by the Secretary of Health and Human Services to

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58 According to MassHealth, numbers on CHW enrollments are drawn from data on applications and enrollments provided by training program awardees for cohorts funded by DSRIP grants, as well as for cohorts funded by other sources. Please note that data on CHWs associated with ACOs and CPs has been "scrubbed" and scrutinized; by contrast, data on CHWs not affiliated with an ACO or CP has been counted but not closely reviewed. For this reason, the total number of individual CHWs enrolled is presented as an estimate only.

review and make recommendations regarding the standards that should govern the credentialing of Recovery Coaches in Massachusetts. The CARE Act released recommendations in August 2019, as of December 31, 2019 these recommendations were still waiting approval. Since this funding was not used it was repurposed into other provider facing trainings.

Competency-Based Training For ACOs And CPs (SWI 4e)

Commonwealth Corporation released a Request for Qualifications (RFQ) for nonprofit higher education entities to provide online competency-based training for members of the frontline workforce in ACOs and CPs on December 13, 2018 with a deadline of January 24, 2019. The contract, which supports training for up to 230 individuals, was awarded to College for America (CfA) at Southern New Hampshire University (SNHU) to provide their established Healthcare Management Fundamentals Certificate Program.

Applications for ACOs and CPs to access the training available through the Competency-Based Training Program were released on October 18, 2019, with a deadline of November 15, 2019. All CPs were given 2 positions each to which they could "opt in" by responding to a few brief questions; they could apply for more if they wished to do so. ACOs did not automatically get training positions; they had to apply for them.

This program has two components, a SNHU Certificate in Healthcare Management Fundamentals online competency-based training program and one-on-one coaching. The program application was rolled out to CPs and ACOs to access on behalf of their frontline workers. CPs had access one to-one coaches via the Commonwealth Corporation. There were two tracks that ACOs could have received this training: one-to-one coaches accessed via Commonwealth Corporation (each ACO could receive up to 10 slots) or ACOs could have received grants to hire/support an in-house one-to-one coach for workers participating in the program (ACOs could receive up to 30 slots.) None of the ACOs applied for the grants to hire/support an in-house one-to-one coach.

There were approximately 110 slots available for the first cohort and 60 slots were filled by individuals from ACOs and CPs. The remaining 50 slots will be released on a rolling basis. MassHealth also reports that participants had favorable feedback.

Technical Assistance SWI 5

MassHealth procured Abt Associates to manage the majority of the Technical Assistance Program (SWI 5). A Request for Quotes (RFQ) was released July 31, 2017 with a deadline of September 6, 2017. A contract was executed with Abt Associates December 4, 2017. As part of this contract, Abt developed the TA Marketplace website https://www.ma-dsrip-ta.com/. Abt also hired and managed a group of subcontractors. Parts of this investment is also supported by the MassLeague (SWI 5b) and UMass Medical School (SWI 5c)

Direct Technical Assistance Support (SWI5a)

A Request for Proposals (RFP) for direct TA vendors was released February 26, 2018 with a deadline of April 9, 2018. A total of 47 organizations were procured through the Request for Proposals: *Participate and Provide Services through the MassHealth TA Program*. The vendors are approved to provide TA within their respective Domain per the request of ACOs and CPs for all years of the TA Program. Once vendors have been accepted into the program, they remain for the five years of the demonstration. TA is implemented through a contract between Abt and the vendor to provide the services identified in the MassHealth approved scope for each project.

The types of Technical Assistance were divided into nine domains that are listed below. A list of contracted vendors by domain is available at the TA marketplace website[59].

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[59] https://www.ma-dsrip-ta.com/vendor-catalog/

- Domain 1: Actuarial and Financial
- Domain 2: Care Coordination/Integration
- Domain 3: Community-Based Care and Social Determinants of Health
- Domain 4: Consumer Engagement
- Domain 5: Flexible Services
- Domain 6: Health Information Exchange/Health Information Technology
- Domain 7: Performance Improvement
- Domain 8: Population Health Management
- Domain 9: Workforce

ACOs and CPs were awarded TA cards, with allocated dollars that can be spent on projects with vendors in the TA Catalog. These projects must be goal-oriented and time-limited.

To initiate the TA process, an ACO or CP must develop an application with a project description. It can pick up to three TA vendors in order of preference within the competency area the TA project advances to work with. MassHealth/Abt Associates must approve the project and then formal negotiations begin with the TA vendor. The TA Scope of Work and budget must be approved in writing by MassHealth and Abt.

Work on the project begins after there is a fully executed task order signed by Abt and the TA vendor. ACOs and CPs must submit semi-annual reports and TA Vendors must submit quarterly reports via the TA Marketplace to document progress on TA projects.

All Year One and Year Two TA cards were to be spent and work complete by December 31, 2019. However, in August 2019, the end date for Year 2 ACO TA Cards and for Year 1 and Year 2 CP TA Cards was extended to June 30, 2020. The extension takes into account the significant overlap in the Year 1 and Year 2 TA Card time period, which essentially resulted in two years of TA Card funding to be spent within a twelve-month period. It also addresses the slower uptake of TA observed among CPs, which had more obstacles to overcome in order to access the TA resources available to them. These obstacles were reported to be less familiarity with the TA vendors in the TA Catalog, less experience working with consultants, and less bandwidth as these new organizations to take on new projects.

As of December 31, 2019:

- 16 ACOs had submitted 69 TA applications. 61 of these had been approved.
- 26 CPs had submitted 79 TA applications. This resulted in 30 approved projects. The difference between the number of applications and the number of approved projects is related to a number of times a TA vendor is providing group TA to a number of CP organizations.

As of December 31, 2019, $9.2 million had been spent $6.1M by ACOs and $3.1M by CPs on direct Technical Assistance. This represents 65% of ACO's TA cards and 56% of CP's TA cards across both Year One and Year Two TA Cards.

In order to facilitate the uptake of Technical Assistance, MassHealth worked to create group TA projects where vendors could provide TA services to more than one CP at a time. Going forward MassHealth is looking for ways to make the "shopping" easier for ACOs and CPs by potentially offering off-the-shelf TA packages for ACOs and CPs so that they can: 1) compare project offerings rather than only seeing information about vendor's experience and expertise, and 2) spend less time negotiating project scopes of work and budgets with TA Vendors.

ACOs had the highest percent of projects in the Care Coordination and Integration domain followed by Population Health Management and Community-Based Care and Social Determinants of Health. Investments in these areas show a weighting towards engaging providers and engaging members.

CPs had the highest percentage of projects in Population Health Management, Health Information Exchange/Health Information Technology. This could be because these areas are newer for CPs.

	Applications		Projects	
	ACO	CP	ACO	CP

Actuarial and Financial	9%	8%	8%	10%
Care Coordination/Integration	25%	6%	26%	13%
Community-Based Care and Social Determinants of Health	13%		10%	
Consumer Engagement	7%	5%	7%	10%
Flexible Services	9%		8%	
Health Information Exchange/ Health Information Technology	10%	9%	11%	23%
Performance Improvement	4%	5%	5%	10%
Population Health Management	16%	62%	16%	23%
Workforce	7%	5%	8%	10%

Learning Collaboratives (SWI 5b)

ACO/CP Integration Learning Collaborative (SWI 5b)

An RFP for the ACO/CP Integration Learning Collaborative was released May 29, 2018 and responses were due July 27, 2018. The contract was awarded to Center for Health Care Strategies (CHCS) on October 31, 2018. MassHealth and CHCS have worked over 2019 to design the Learning Collaborative. MassHealth anticipates launching a webinar in the Spring of 2020 and anticipates it being ongoing for the next 9-12 months. As with much of the DSRIP initiative, the learning collaborative implementation was delayed with the initial implementation dates planned for late summer/fall of 2019. While there were a number of factors that contributed to the delay, in particular, a change in care planning policy occurred during the development of this project and the implementation of this learning collaborative was impacted by the change in policy.

Community Health Worker and Peer Specialist Learning Communities (SWI 5b)

An RFP for this program was released May 29, 2018 with responses due July 27, 2018. The contract was awarded to Health Resources in Action (HRiA) in partnership with the Massachusetts Association for Community Health Workers (MACHW), The Transformation Center, and the Harvard Medical School (HMS) Center for Primary Care (CPC) on October 31, 2018. This group of experts worked to build a set of high level ideas for what learning communities could look like. MassHealth reports that learnings from this project including, how peer specialists and CHWs would be successful in the Value Based Payment environment were generated and will be incorporated into the next round of investments in the CHW space. However, based on the difficulties in translating these findings into specific projects and leadership changes at one participating agency that resulted in priority changes, MassHealth made the decision with Abt Associates to not fund the implementation of the learning community.

Community Health Center (CHC) Readiness Program (SWI 5b)

In order to implement this program MassHealth contracted with the MassLeague. Health Management Associates (HMA) works as a subcontractor to the MassLeague to develop content and curriculum. The year 1 topic was Taking Team-Based Care to the Next Level: Success in the Era of Accountability and there were 14 teams working on team-based care, with 12 health centers participating. For the second collaborative, as of December 2019, work was being done to define the topic and specific content, but the plan is to focus on a financial theme.

Statewide Investment Pop Ups (SWI 5c)

Initially, Abt Associates was to procure a vendor to design and implement the SWI Pop Up series. However, MassHealth determined that Abt possessed the expertise to work directly on these events, and that direct engagement with Abt would likely be a more efficient means of standing up the SWI Pop Up series. Thus, MassHealth added a SWI Pop Up work stream to its existing contract with Abt instead of procuring an additional vendor. These events, and one planned for 2020 focus on member engagement, and were held in the Roxbury Innovation Center.

- The first SWI Pop Up event was hosted on September 13, 2019 at the Roxbury Innovation Center. It was titled "Lessons from Other States: Innovative Strategies for Finding and Engaging the Hardest to Reach MassHealth Members. The first SWI Pop Up was attended by 81 individuals, including 55 representatives from 8 ACOs and 15 CPs.
- The second SWI Pop Up was Dec. 6, 2019 at the Roxbury Innovation Center. It was titled "Lessons from Other States: Creating Care Delivery Systems that Recognize and Respond to Member Priorities and Circumstances. A total of 41 people attended, including 21 attendees from ACOs and CPs participated in this Pop Up, representing four ACOs and nine CPs. Representatives of MassHealth, Abt Associates, and key MassHealth partners also attended.

Standardized Trainings for CPs And CSAs (SWI 5d)

MassHealth executed an ISA with the University of Massachusetts to develop standardized trainings for CPs on April 18, 2018. MassHealth amended an existing contract between EOHHS Children's Behavioral Health Initiative (CBHI) and Technical Assistance Collaborative (TAC) to develop standardized trainings for CSAs on April 10, 2018. TAC subcontracted with UMass in order to produce one CSA training module and to research and curate a list of available online trainings on various topics, including family engagement, culturally competent care, and special education. Beginning January 2019 CBHI transitioned to the UMass contract to produce the remaining trainings for CSAs. These resources can be accessed at the vendor resources tab at https://www.ma-dsrip-ta.com/.

Care Coordinators in CPs must complete the trainings listed below per the MassHealth contract with CPs. CPs may use their own training materials or use MassHealth standardized trainings.

- Cultural competency
- Accessibility and accommodations;
- Independent Living and Recovery principles;
- Motivational interviewing;
- Conflicts of interests;
- Health and Wellness principles
- Person-centered planning processes
- MassHealth State Plan LTSS and eligibility criteria
- Trauma informed care

Alternative Payment Methods Preparation Fund (SWI 6)

Applications were released on March 19, 2018 with a deadline of April 27, 2018. MassHealth received 10 applications. A review committee was convened and ultimately MassHealth made awards to five organizations. Among relevant criteria the review committee considered in making its recommendations

was the number of MassHealth members served, geographic location, the demonstrated commitment from an ACO, and the project's impact on advancing integration with an ACO.

All awardees received grants of $440,000 each for a total of $2.2 million of funding disbursed. All the awardees were from central and western Massachusetts.

Central Massachusetts

- Community Health Connections, Inc.
- Harrington HealthCare System Physician Organization

Western Massachusetts
- Baystate Medical Practices
- Pediatric Physicians' Organization at Children's
- Springfield Health Services for the Homeless Health Center

Awardees undertook different projects to assist with participation in APMs. These included:

- aggregating clinical, claims, and psycho-segmentation data for population stratification, as well as integrating analytics into the clinical workflow
- structuring a complex care management team and enhancing patient scheduling
- developing a comprehensive care navigation program and establishing the foundations of a population health initiative and infrastructure
- establish a medical home model and patient safety program in each practice and expanding information technology infrastructure;
- implementing a population health strategy and improving technological infrastructure for reporting, managing total cost of care and quality, and provider coordination

The project period for grants was June 13, 2018 – December 31, 2018. While all grantees reported making progress on their projects, ultimately four of the five practices were able to join an MassHealth ACO.

The four awardees joined 3 ACOs and represented approximately 18,961 MassHealth members.

Two joined Community Care Cooperative:

- Community Health Connections, Inc. 7,300
- Springfield Health Services for the Homeless Health Center 3,561
    - One joined Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan:
- Harrington HealthCare System Physician Organization 6,000 – 7,000
    - One joined Boston Children's Accountable Care Organization in partnership with Tufts Health Public Plans:
- Pediatric Physicians' Organization at Children's 11,000

MassHealth decided to not invest more in direct APM support for medical practices as they felt that there was sufficient investment being made in the Medical side of the delivery system and that there was sufficient provider capacity available in the ACOs.

In DSRIP Years 2 and 3, SWI 6 will be combined with SWI 7 to provide grants to community-based behavioral health provider organizations via a grant program entitled the Behavioral Health Innovation Fund. BH Innovation Fund grants will be aimed at building provider capacity, (including APM-related

capacity) to participate in MassHealth's larger behavioral health restructuring initiative, which had been slated to launch 2019. The BH Innovation Fund was designed and will be managed in close partnership with MassHealth's Office of Behavioral Health. However, the launch of the BH Innovation Fund has been delayed to better align with the goals and timeline of the larger behavioral health restructuring initiative. MassHealth sought and received CMS approval to carry forward the associated DSRIP Year 2 funds to subsequent DSRIP years.

Enhanced Diversionary Behavioral Health Activities (SWI 7)

MassHealth released a Notice of Intent (NOI) to accept a best-value offer from the Massachusetts Health and Hospital Association (MHA) for implementing and managing a program to reduce emergency department boarding in the Commonwealth for below market cost. The contract was executed on June 15, 2018 and ends on June 30, 2022.

This program increased the implementation and utilization of Collective EDie in Massachusetts hospitals. Collective EDie is a technology platform that queries patient data and pushes real-time alerts based on members' prior ED visits across the state including, patient history and care guidelines as well as patient specific risk factors to the ED. By implementing this system MassHealth hopes to reduce ED boarding by getting targeted information to ED providers quicker so that members can be referred to appropriate care as soon as possible.

Per the year-end report from MHA:

- 12 hospitals were added to the Collective EDie network over the course of the grant, for a total of 54 hospitals in which the system had been implemented and 8 hospitals in which implementation was in process.
- During the same period, the number of monthly alerts nearly doubled, from 15,669 in August 2018 to 28,319 in July 2019.

MHA notes that implementation of Collective Edie has been delayed at a few hospitals that are undergoing EHR system upgrades, which typically create delays in IT projects overall.

In DSRIP Years 2 and 3, SWI 7 will be combined with SWI 6 to provide grants to community-based behavioral health provider organizations via a grant program entitled the Behavioral Health Innovation Fund. BH Innovation Fund grants will be aimed at building provider capacity, (including APM-related capacity) to participate in MassHealth's larger behavioral health restructuring initiative). The BH Innovation Fund was designed and will be managed in close partnership with MassHealth's Office of Behavioral Health. However, the launch of the BH Innovation Fund has been delayed to better align with the goals and timeline of the larger behavioral health restructuring initiative. MassHealth sought and received CMS approval to carry forward the associated DSRIP Year 2 funds to subsequent DSRIP years.

Improved Accessibility for People with Disabilities or for Whom English Is Not A Primary Language (SWI 8)

Provider Directory (SWI 8a)

MassHealth executed an ISA with the University of Massachusetts to develop the provider directory with accessibility details in May of 2018. EOHHS partnered specifically with UMass Index due to the center's work developing and supporting the website DisabilityInfo.org. UMMS Index was engaged to integrate MassHealth providers to the existing DisabilityInfo.org accessible web directory to enable users to search for providers by condition, language, disability accommodation equipment, programs, architectural features, and other applicable areas of need.

The first group of MassHealth professionals' information, programs and services data was uploaded to the sites database in December of 2019. The project anticipates including a second group of health professionals' information by the end of Spring 2020.

The project anticipates conducting final user testing following the last set of provider information being uploaded to the sites searchable database. Once the sites functionalities are confirmed, the team will reach out to MassHealth providers to encourage them to log into the site and confirm and update their accompanying information. MassHealth and the UMass Index team intend to perform regular outreach to providers to encourage their participation in keeping directory information up to date.

Provider Access Improvement Grant Program (PAIGP) (SWI 8b)

Program Implementation

EOHHS has assigned a multi-disciplinary project team with representatives from various departments to oversee this investment program. Due to procurement delays, the start of this program did not begin until the spring of 2019. Ultimately however, EOHHS engaged Health Resources in Action (HRiA) as the vendor overseeing the PAIGP.

In preparation for soliciting potential grant recipients for the first round of funding, HRiA and MassHealth pursued the following steps:

- A comprehensive education and outreach plan was developed targeting specific providers and provider associations. Outreach was then completed through social media, common professional sites (e.g. LinkedIn), HRIA's own website and through one on one contacts
- A PAIGP website and online application portal was developed and released.
- An RFP was developed and released on June 13, 2019
- An educational webinar for interested parties/potential applicants was held on June 25, 2019.
- Subject Matter Experts were recruited to assist in grant proposal reviews

A total of 15 grant applications were received during the application window. Each grant application was evaluated for completeness and appropriateness and two were found to not meet the program requirement of directly contacting with MassHealth. Eleven applications were ultimately awarded a total of $124,619.50.

This first round had a number of restrictions on applicants. The maximum amount grant applicants could seek was capped at $25,000 and applicants were required to match received funds. Applicants had to be enrolled MassHealth providers who worked in a medical setting that was not owned by a hospital or hospital system and had fewer than 30 full-time employees.

In order to draw a larger number of applications from a broader variety of providers, eligibility criteria were broadened for the second round. The term "in a medical setting" was also removed from the RFP document to encourage applications from more BH providers and services such as Early Intervention. The limitation on employee size was also removed. Applicants will be able to request funding amounts up to $75,000 and no longer have to raise matching funds.

APPENDIX F: MASSHEALTH COMMENT

MassHealth was provided with the opportunity to review the report and respond with a statement, which the IA is providing here.

MassHealth Comments on the Midpoint Assessment

MassHealth thanks the DSRIP Independent Assessor (IA), Public Consulting Group, for the thoughtful assessment it has conducted as part of MassHealth's DSRIP Midpoint Assessment (MPA), and associated mitigation strategies and policy opportunities it has identified for MassHealth. As MassHealth reviews these recommendations, it has considered the following methodological features of the MPA:

- The IA used participation plans, annual and semi-annual reports, practice site administrator survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations (ACOs), Community Partners (CPs), and the Statewide Investments Program (SWI), and MassHealth's progress implementing DSRIP

- The time period covered by the MPA is July 1, 2017 through December 31, 2019

- The MPA is a progress report on implementation of key DSRIP activities and processes, not a report of ACO, CP, or Statewide performance on cost, quality, member experience or other programmatic priorities as defined by MassHealth

Given these methodological features of the MPA, MassHealth provides the following response to the various recommendations made by the IA, as it had similarly identified many of these areas as opportunities for action. As a result, MassHealth has made significant progress on these recommendations during the time period covered by the MPA and during CY2020. This progress is documented below, organized according to the recommendation categories set by the IA:

<u>**Mitigation Strategies**</u>

- **Interface of ACOs and CPs**

  - *Update PCDI provider training to promote standardization of roles and responsibilities for all ACO and CP relationships*

    - **Progress**: Supported by DSRIP Statewide Investments funding, MassHealth launched the MassHealth Care Plan Learning Collaborative to help participating ACOs/MCOs and CPs work more effectively together on joint care planning. These efforts are anticipated to help ACO/MCO and CP partnerships better align each party's roles and responsibilities with member care.

  - *Standardize the method and format by which ACOs/MCOs submit referral files to CPs*

    - **Progress:** MassHealth provided guidance and file specifications to ACO/MCOs on assignment files and has reinforced adherence to those guidelines with ACO/MCOs. MassHealth also provided additional guidance on dates of submission of these files to CPs with the goal of assigned members being enrolled by the first of the month via the CP Program Enrollment Portal.

      While not contract requirements, ACOs/MCOs have been largely following this guidance.

- o *Sustain the ACO/CP Integration Learning Collaborative funded by SWI 5b*

  - ▪ **Progress:** The MassHealth Care Plan Learning Collaborative is ongoing through Spring 2021.

- **Recruiting of Qualified Staff**

  - o *Sustain SWI 1 Student Loan repayment*

    - ▪ **Progress:** The State intends to continue the student loan repayment program in the fourth year of DSRIP

  - o *Adapt 4-yr commitment to allow for more flexibility regarding family commitments and non-clinical work*

    - ▪ **Progress:** MassHealth is actively exploring ways to implement this suggestion for CY2021.

  - o *Support ongoing use of telehealth*

    - ▪ **Progress:**

      - MassHealth rapidly expanded telehealth flexibilities as a result of COVID, and is currently developing a long-term strategy for telehealth flexibilities to go into effect after the public health emergency has concluded. MassHealth anticipates implementing a permanent telehealth policy that maintains broad coverage.

        - o Telehealth spending has gone from almost zero to about $15M to $20M a month in the spring and summer of 2020.

        - o For physicians, telehealth spending peaked in April at 22% of total spending and has gone down to 8% in September.

        - o For the CHC category, telehealth spending peaked in April at 69% of total spending and has gone down to 39% in September.

        - o Please note that these numbers are based on fee-for-service claims only and do not include managed care encounter data.

      - As part of the DSRIP SWI TA program, MassHealth is currently finalizing a procurement for new TA vendors, which will add substantive telehealth TA expertise to the program and support ACOs and CPs in implementing their telehealth strategies

      - MassHealth and the MassLeague are currently implementing telehealth-focused TA for CHCs as part of the DSRIP SWI CHC Readiness Program and in alignment with the Telehealth Consortium, a joint initiative of Community Care Cooperative (C3) and the MassLeague that supports CHC adoption of telehealth strategies.

- **Member Engagement**

  o *Sustain and build on SWI 5 TA projects focused on member engagement*

    ▪ **Progress:**

      - MassHealth highlighted new TA projects focused on member engagement in 2020 on the DSRIP TA website to serve as example projects for other ACOs and CPs to consider pursuing

      - Many CPs have TA projects focused on improving their data analytics and workflows. This has contributed to a steady increase in engagement rates from 3% at the beginning of the program to 61% as of October 2020. It has also contributed to a steady decrease in the number of days to Care Plan Complete. In July 2019 the average number of days to Care Plan Complete was 256. In June 2020 it was 207.

      - MassHealth has implemented an SWI Pop Up series focused on member engagement, which showcases best practices and lessons learned from member engagement endeavors in other states.

      - MassHealth encouraged ACOs and CPs to use TA funds to advance member engagement and emphasized it as a MassHealth priority during a DSRIP SWI TA Program Shared Learning Event for ACOs and CPs implemented in November 2020.

  o *Play an active role in dissemination of best practices for member engagement, such as home visits*

    ▪ **Progress:**

      - MassHealth shares promising practices regarding member engagement in monthly meetings with ACOs and CPs, and during site visits, as appropriate

      - MassHealth also encourages shared learning and connections among ACOs and CPs

      - MassHealth has numerous touchpoints with ACOs and CPs (e.g., surveys) to collect information about member and staff experiences that can inform best practices for member engagement.

      - MassHealth provided flexibilities and shared learning opportunities to optimize safe continuity of care during the coronavirus pandemic. Strategies included increased usage of telehealth and identification of most vulnerable members.

      - MassHealth has implemented an SWI Pop Up series focused on member engagement

      - MassHealth hosted a DSRIP SWI TA Program Shared Learning Event for ACOs and CPs in November 2020 that served as a forum for ACOs and CPs to share best practices from TA projects focused on member engagement.

- o *Standardize the practice of providing CPs access to multiple relatively recent addresses when applicable.*

    - ▪ **Progress:** While MassHealth isn't able to provide multiple member addresses, beginning in March 2020, MassHealth began delivering a daily "834 File" to CPs. This file is an automated enrollment file in HIPAA standard transaction format that may be used to track CP enrollment, disenrollment, and changes to member information over time, such as mailing address.

- o *Review payment methods to ensure that CP member outreach activities can be appropriately resourced.*

    - ▪ **Progress:**

        - • MassHealth has regularly monitored, discussed with CPs, and made program adjustments to account for the challenges CPs have had with member engagement. In particular, MassHealth has addressed these challenges through two primary mechanisms to-date: (1) providing flexibilities on engagement timelines under certain circumstances, and (2) increasing rates of payment (along with addressing performance improvement opportunities across the board)

        - • MassHealth provided flexibilities on engagement timelines in 2018, to reflect challenges that CPs were reporting with engaging the original batch of assigned members in the program.

            - o Because CPs were still ramping up functionality, and the program launched with a large number of assigned members all at once, rates of engagement were low, and CPs reported needing additional time.

            - o Based on discussion with CMS, MassHealth modified the program requirement such that, for members assigned during the initial 4 months of the program, CPs had an additional 6 months to successfully engage the member

            - o Based on further monitoring, continued challenges faced by CPs, and further discussion with CPs and CMS, MassHealth allowed flexibilities to cohorts beyond the initial 4 months by not requiring a signed Participation Form for payment for non-outreach activities for a member in months 4 and 5 after enrollment, and extending the timeline for Care Plan Complete to the sixth month of enrollment.

        - • MassHealth increased rates of payment in the CP program in January 2020.

            - o While MassHealth believes that the program's original rates were and are appropriate under certain performance assumptions (particularly, rates of engagement and assignment), engagement rates have been lower in practice across the CP cohort, leading to financial challenges for some CPs

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- ▪ MassHealth conducted cost reporting with CPs and an internal rate review, and increased the LTSS CP PMPM from $80 to $150, and the BH CP PMPM for non-ACCS[60] members from $180 to $250

- ▪ MassHealth's view is that financial challenges experienced by CPs was partially driven by performance improvement opportunities across the board, since some CPs were and are able to achieve much higher engagement rates than their peers. Therefore, in addition to the rate increase, MassHealth has made significant efforts to ramp up its performance management efforts with CPs on this issue, and also use existing venues for dissemination of best practices

- **Event Notification**

  - o *Increase statewide participation in Mass HIway notifications*

    - ▪ **Progress**: All ACOs and CPs are contractually required to establish and implement policies and procedures to increase connection rates of participating providers to the Mass HIway

- **Payment Models**

  - o *Engage ACO leaders, including those focused on enhancing safety net care, and solicit their feedback on payment models*

    - ▪ **Progress**: Each year, MassHealth has evaluated available information on the financial performance of the ACO program, engaged ACO leaders to solicit feedback, and made appropriate adjustments. Specifically:

      - In 2018, actual medical spending exceeded capitation/benchmark by ~1.7%, but financial performance varied among ACOs, with 8 ACOs in gains (prior to risk sharing) for 2018. ACO baseline performance on total cost of care varied: for members with similar characteristics, the average cost for a member varied by up to 30%+ across ACOs.

      - In 2019, ACO medical spend per member grew on average above statewide benchmarks, primarily driven by exit of ~60K low-acuity members from the caseload, resulting in overall acuity increase. This acuity increase created financial challenges for one of MassHealth's two primary ACO models:

        - o Model A ACOs take "insurance risk" – like most prospectively-priced MCO products, in addition to trend management performance, they realize gains or losses when the acuity of the population differs from the acuity assumed in rate development. Most Model A ACOs experienced financial losses in RY19, given that capitations did not anticipate the rise in acuity driven by caseload reductions.

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[60] The PMPM for CP enrollees served by and referred from the Department of Mental Health's Adult Community Clinical Services program was set at $250 at the beginning of the program and has remained at this rate.

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- - - o Model B ACOs, which do not take insurance risk, ended the year much closer to their total cost of care target benchmark

  - Analysis in 2019 revealed this caseload shift began in 2018, and was a contributing factor to the financial performance of Model A's in 2018 as well (although to a lesser extent)

  - As a result of these findings, MassHealth convened a statewide pricing workgroup with ACO representatives and trade group representatives, which met biweekly from May to September 2020. Collaboration with the workgroup resulted in several important adjustments to the pricing model that will substantially mitigate the impact of insurance risk for Model A's starting in 2021

  - In addition to this collaborative approach to refining the pricing model, MassHealth has also identified opportunities for individual ACOs to more successfully manage trend and operating costs that are often a substantial driver of financial performance for these ACOs

    - In 2018 and in 2019, for members with similar characteristics, the average cost for a member varied by 30%+ across ACOs. Variation was driven by patterns of utilization and site of care.

    - Some ACOs experienced year-on-year spending trend well above actuarially sound trend rates baked into the pricing model.

    - Some Model A ACOs paid providers at rates significantly in excess of the MassHealth fee schedule; while improvements were seen from 2018 to 2019, further room to achieve efficiency exists.

  o *Convene representatives from ACOs and CPs to explore options for financing the outreach and engagement process*

    - **Progress**:

      - See response above with regards to actions MassHealth implemented for CP outreach efforts.

  o *Conduct ongoing review of financial performance to further align the implementation of risk contracting.*

    - **Progress**: MassHealth has implemented a standard process to regularly review ACO financial and non-financial performance, as well as to engage in targeted conversations with ACOs to identify and act on opportunities for improvement. Such engagements have resulted in significant financial savings for several ACOs in PY19 and PY20.

- **Pediatric populations**

  o *Ask ACOs to report explicitly on their approach to population health for children, youth, and families.*

    - **Progress**: MassHealth is considering this recommendation, and has been engaged with ACO stakeholders concerned with pediatric issues to help identify opportunities to enhance and improve ACOs' investment and reporting on population health for children, youth, and families, with a particular focus on

health-related social needs, care coordination for children with medical complex needs, and primary care.

Policy Opportunities: Integration of HRSN

- **MassHealth ACO Flexible Service (FS) Program**

  o *Granting ACOs flexibility to pilot new ideas and adapt existing strategies to their various population and region.*

    ▪ **Progress**: The current FS program, launched in January 2020, largely already allows for these flexibilities. Additionally, outside of Flexible Services, Accountable Care Partnership Plans have had the flexibility from the beginning of the ACO Program to use their capitated administrative rates to pilot new ideas and adapt existing strategies related to HRSNs.

  o *Disseminating evidence and promising practices from HRSN initiatives funded by previous state programs, including the SHIFT-Care Challenge.*

    ▪ **Progress**: MassHealth is considering this recommendation, and is in regular conversation with the Health Policy Commission (HPC), the sponsor of the SHIFT-Care Challenge. As part of MassUP, a partnership across Massachusetts state agencies that supports investments in social determinants of health, MassHealth and the HPC regularly identify opportunities for collaboration and information sharing

  o *Acting as a convener to bring CBOs and ACOs together to explore contract models, such as aggregate contracts, which allow small CBOs to cooperate for greater scale and efficiency.*

    ▪ **Progress**: MassHealth is considering this recommendation; additionally, certain groups of CBOs have already implemented aggregate contracts to facilitate their participation in the Flexible Services program

  o *Collaborating with local boards of health and leverage their knowledge of the CBO landscape.*

    ▪ **Progress**: MassHealth is considering this recommendation

  o *Developing a toolkit for ACO/CBO partnerships.*

    ▪ **Progress**:

      - DPH, HRiA, and MassHealth jointly implemented the Social Services Organization Flexible Services Preparation Fund Learning Community through the MA Department of Public Health and Health Resources in Action

        o This learning community brings together ACOs and SSOs to discuss various aspects of their partnerships, such as data exchange

      - ACOs are also able to leverage the DSRIP TA Marketplace for customized TA projects regarding partnering with SSOs

- o *Considering adoption of requirements for providers to contract with CBOs.*

    - **Progress**: MassHealth strongly encourages ACOs to contract with SSOs as part of the Flexible Services program; currently, all ACOs with Flexible Services programs have contracts with SSOs.

- **Quality Measure Alignment**

    - o *Working with the EOHHS Quality Measure Alignment Taskforce to develop measures that align across ACOs and CBOs participating in Flexible Services.*

        - **Progress**: MassHealth is considering this recommendation; MassHealth actively participates in the EOHHS Quality Measure Alignment Taskforce and is also actively engaged with ACOs in discussions about the measures they are using to evaluate their FS programs.

- **MassUP**

    - o *Nurturing initiatives focusing on economic stability and mobility, and food systems and security.*

        - **Progress**: MassHealth actively participates in MassUP, a partnership across Massachusetts state agencies that supports investments in social determinants of health, which has awarded funding focused in two key SDoH areas: economic stability and mobility, and food systems and security.

- **Telehealth**

    - o *Pursuing sustainable reimbursement for telemedicine*

        - **Progress**: MassHealth rapidly expanded telehealth flexibilities as a result of COVID, and is currently developing a long-term telehealth strategy to be introduced after the public health emergency has concluded.

    - o *Aligning quality standards*

        - **Progress**: MassHealth has prioritized alignment of its telehealth policy with overall MassHealth goals, including in the areas of quality, access, cost and health equity.

    - o *Offering training for providers*

        - **Progress**:

            - MassHealth is currently finalizing a procurement for new TA vendors in its DSRIP SWI TA Program which will add substantive telehealth TA expertise to the program

            - MassHealth is currently implementing telehealth-focused TA for CHCs as part of the DSRIP SWI CHC Readiness Program and in alignment with the Telehealth Consortium, a joint initiative of Community Care Cooperative and the MassLeague that supports CHC adoption of telehealth strategies.

- o *Disseminating protocols and best practices for providers*
    - ▪ **Progress**:
        - • MassHealth is currently finalizing a procurement for new TA vendors in its DSRIP SWI TA Program which will add substantive telehealth TA expertise to the program
        - • MassHealth is currently implementing telehealth-focused TA for CHCs as part of the DSRIP SWI CHC Readiness Program and in alignment with the Telehealth Consortium, a joint initiative of Community Care Cooperative and the MassLeague that supports CHC adoption of telehealth strategies.

<u>Statewide Investments (SWI) Recommendations by Investment</u>

Building and Training the Primary Care and Behavioral Health Workforce

- • **Student Loan Repayment Program (SWI 1a) and Behavioral Health Workforce Development Program (SWI 1b)**
    - o *Continuing to streamline the application process to reduce barriers for applicants*
        - ▪ **Progress**: MassHealth streamlined the Year 3 (CY2020) application process by requesting certain supporting documentation from applicants only once it has been determined that the applicant's submission is valid
    - o *Increasing outreach to potentially interested providers to ensure the message is reaching the target audience*
        - ▪ **Progress**: MassHealth increased outreach in the Year 3 (CY2020) award cycle by providing information sessions for providers within individual CHCs and community-based BH provider organizations. More than 150 applications for almost 90 awards were received in Year 3.
    - o *Considering modifying the 4-year commitment to better align with the concerns of early career providers*
        - ▪ **Progress**: MassHealth is considering this recommendation

- • **Primary Care/Behavioral Health Special Projects Program (SWI 2)**
    - o *Continuing to work to publicize the program so that more organizations that have not already applied will do so.*
        - ▪ **Progress**: MassHealth continues to publicize the Special Projects Program.

- • **Community Health Worker Training Capacity Expansion Grants (SWI 4a)**
    - o *Working with ACOs and CPs to encourage continued enrollment in these trainings for CHWs in all ACOs and CPs.*
        - ▪ **Progress**: MassHealth consistently saw CHWs from "new" ACOs and CPs (particularly CPs) in the training cohorts offered in CY2020.

- • **Community Health Worker Supervisors Training Program Grant (SWI 4c)**
    - o *Continuing to work with ACOs and CPs to ensure that all training spots are utilized and take steps to make the training curriculum publicly available.*

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- ▪ **Progress**: MassHealth filled the two training cohorts offered so far in CY2020 to capacity, and added a few additional seats to each one

- **Recovery Coach Supervisor Training Incentive Fund (SWI 4d)**

  - ○ *Working with ACOs and CPs to identify the demand and utilization of recovery coaches and look for other ways that they may need to be supported.*

    - ▪ **Progress**: MassHealth continues to maintain close contact with the Department of Public Health's Bureau of Substance Addiction Services and the MassHealth Office of Behavioral Health to support Recovery Coaches via other investment streams, including the Special Projects Program, direct TA, and SWI Pop Ups.

- **Competency-Based Training for ACOs And CPs (SWI 4e)**

  - ○ *Working with ACOs and CPs to increase enrollment in this training program.*

    - ▪ **Progress**: MassHealth recently modified the application process for the Competency-Based Training Program to directly target frontline employees in ACOs and CPs; more than 90 applications were received in less than four weeks.

Capacity Building for ACOs, CPs, and Providers

- **Direct Technical Assistance Support (SWI5a)**

  - ○ *Re-opening the procurement to allow new vendors to bid and to allow vendors on the procurement to bid on other categories than those they are approved.*

    - ▪ **Progress**: MassHealth is currently finalizing a procurement for new TA vendors in its DSRIP SWI TA Program which will add substantive telehealth TA expertise to the program, while also adding additional vendors in other TA domains

  - ○ *Allowing vendors to develop different types of marketing materials that ACOs and CPs could access that illustrate potential TA projects and their potential benefits.*

    - ▪ **Progress**:

      - MassHealth has worked with TA Vendors to create an "Off-the-Shelf" TA Project option that illustrates potential TA projects and (ideally) makes TA more accessible for many ACOs and CPs

      - ~80 TA Project Off-the-Shelf TA Projects were developed via this option. The Off-the-Shelf feature launched in October 2020

      - MassHealth also hosted the first (virtual) Shared Learning Event for ACOs and CPs specific to the TA Program in November 2020

- **ACO/CP Integration Learning Collaborative (SWI 5b)**

  - ○ *Working to roll this program out in the next calendar year so that participants can benefit from the learning collaborative.*

    - ▪ **Progress**: MassHealth launched the MassHealth Care Plan Learning Collaborative in March 2020. Immediately following the launch, MassHealth paused efforts for three months due to the COVID-19 pandemic. After adjusting the curriculum for a virtual setting, the learning collaborative restarted in July 2020, and is on track for completion by Q2 CY2021.

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- **Statewide Investment Pop Ups (SWI 5c)**

  - *Adding future events outside the greater Boston area so that it is easier for participants from other parts of the state to attend.*

    - **Progress**: Due to COVID, MassHealth has made all SWI Pop Up events virtual for the foreseeable future. The SWI Pop Up virtual event about oral health integration was widely viewed as very successful.

  - *Consider adding virtual events as a way to ensure access to individuals from all parts of the state.*

    - **Progress**: Due to COVID, MassHealth has made all SWI Pop Up events virtual for the foreseeable future.