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ACO Program Models & Strategies for Success: EBNHC & Massachusetts Medicaid ACO Program

Presentation to Best Practices 2023

March 2023

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Presentation Overview

- What's happening in Massachusetts Medicaid?
- EBNHC and the MassHealth ACO Program
- Payment innovation: Overview of MassHealth's Primary Care Sub-capitation Program
- Lessons we've learned

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About EBNHC

Major provider of care

- ~120,000 patients (across all programs and services)
- Over 400,000 visits per year
- Annual revenue of $215M+
- Over 1,500 employees

Diverse, low-income community

- 71% below 200% federal poverty level
- 70% best served in a language other than English
- Geographic isolation
- Market penetration rates*
  - East Boston: 73%
  - Chelsea: 37%
  - Revere: 29%
  - Winthrop: 27%
  - Everett: 11%

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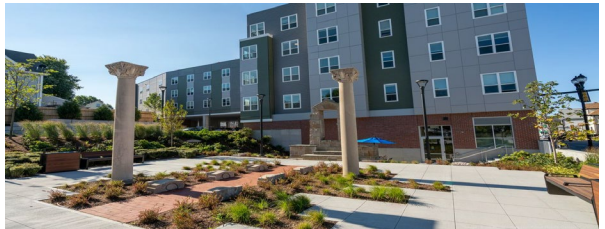
Recent Growth

- South End Community Health Center Merger
  - The first health center merger in MA history
  - All SECHC sites are now operated as locations of EBNHC
  - Increased patients served by 17%
- Winthrop Neighborhood Health
  - Newly renovated state-of-the-art outpatient facility located just over the East Boston line.
- Revere PACE (Program of All-Inclusive Care of the Elderly)
  - Growing to meet the increasing need of elderly care
- Everett Senior Care / PACE
  - Integrated senior care services co-located in newly constructed affordbale senior housing development
- Pharmacy Services
  - Within a year of opening, our pharmacy at 10 Gove Street filled more than 150,000 prescriptions for 18,000 users – three times the amount of an average retail pharmacy



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What’s happening in Massachusetts Medicaid?

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Massachusetts 1115 Waiver/DSRIP

- Medicaid 1115 Demonstration Waivers allow states to “waive” certain provisions of the Medicaid law and receive additional flexibility to design and improve their programs.

- In 2017, through the waiver proess, Massachusetts introduced major health care delivery reforms (i.e., Delivery System Reform Incentive Payment (DSRIP). This included the creation of Accountable Care Organizations (ACOs), Community Partners (CPs), the Flexible Services Program (FSP) and Statewide Investments.

- On September 28, 2022, the Centers for Medicare & Medicaid Services (CMS) approved MassHealth’s proposal to extend the 1115 Waiver through 2027. Under the extension, MassHealth will procure new ACO contracts with an increased focus on population health, network access, health equity and payments based on outcomes versus volume of services.

Source: https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2022-06/MH_Demonstration_Extenson_Jun22_FINAL_0.pdf

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About Accountable Care Organizations (ACOs)

- ACOs are a network of primary care providers who work in partnership with hospitals, specialists, LTSS providers, and state agencies to coordinate all of a member's care.
  - Are rewarded for *value* – better health outcomes and lower cost – not volume.
  - Strengthen members' relationship with their primary care provider, who engage members in their care and coordinate to help them navigate all the services they need.
  - Focus on better coordinating care and engaging members in their care to improve health outcomes and reduce preventable costs (e.g., avoidable hospitalizations).
  - Integrate all care a person needs, including behavioral health and physical health care, especially in the primary care setting, as well as long-term services and supports.
  - Develop innovative approaches to address social needs (e.g., housing, food insecurity) that impact health.
  - Are accountable for the quality, member experience and cost of care for members.

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Goals of 1115 Demonstration Waiver – ACO / Delivery System Reform Incentive Payment (DSRIP)

- The State's ACO / DSRIP goals are to:
  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 and health-related social needs; and
  3. **Sustainably support safety net providers** to ensure continued access to care for Medicaid and low-income, uninsured individuals.

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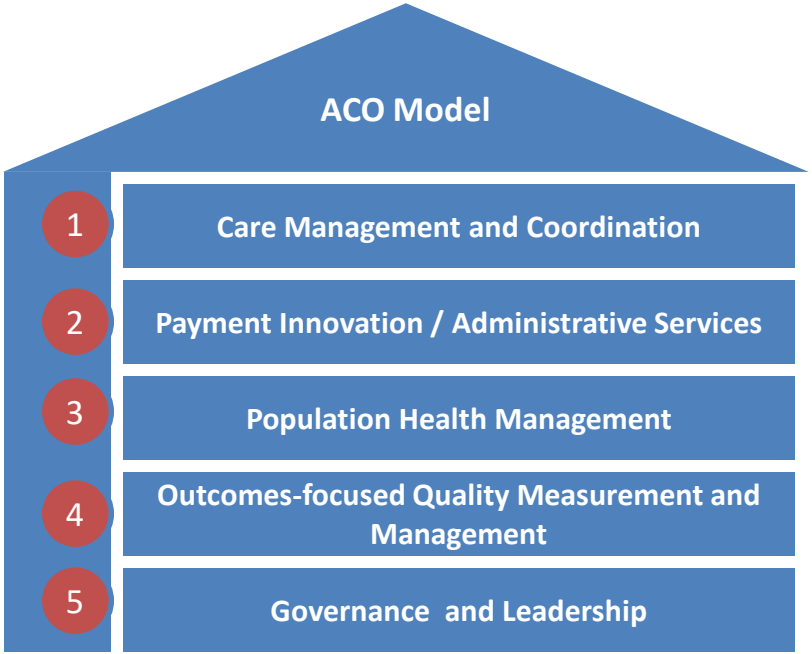
What does the extension mean for Massachusetts

- ✓ **ACOs and Value-Based Care Are Here to Stay**
- ✓ **Funding for Health-Related Social Needs**
- ✓ **New Hospital Funding**
- ✓ **Direct Investments of Workforce**

EBNHC and the MassHealth ACO Program

EBNHC perspective on the ACO Model

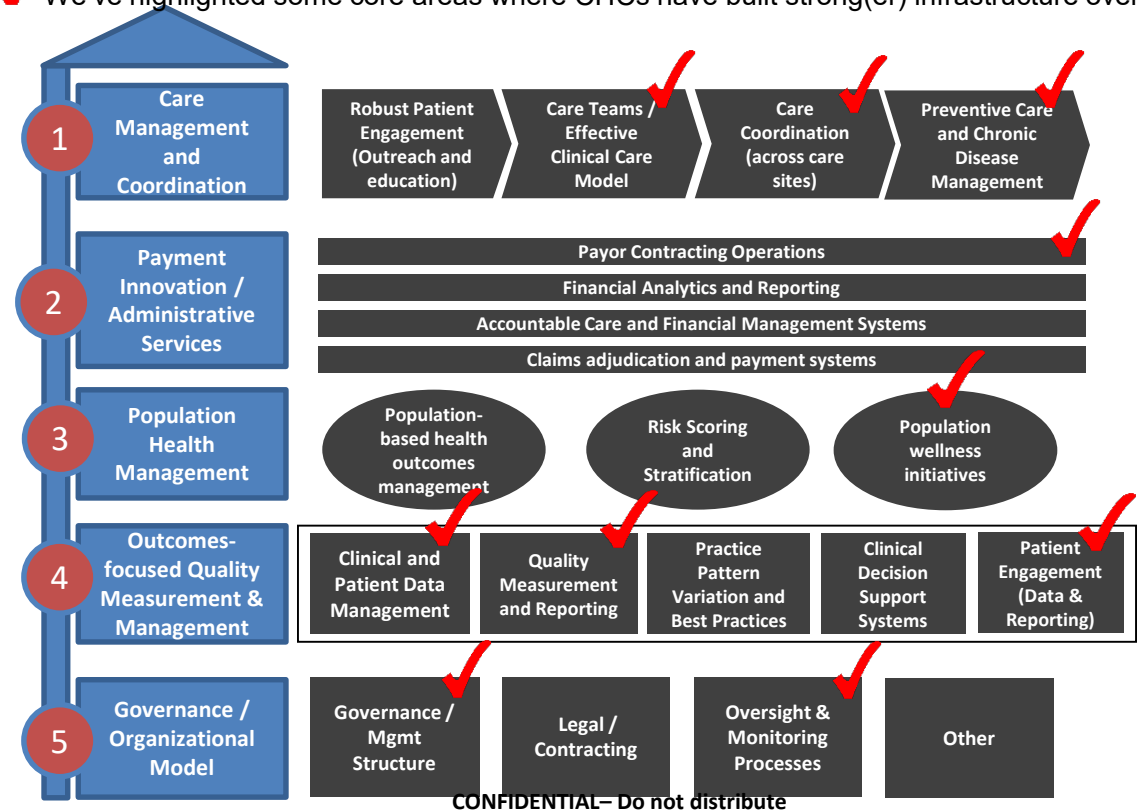
The ACO model is built on five core elements. We have used these areas to help organize our approach to ACO adoption and implementation priorities.



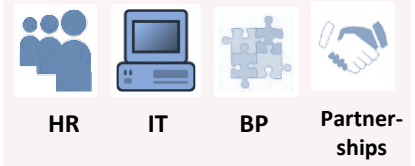
Most health centers and advanced primary care practices, have implemented various systems and infrastructure needed to support many aspects of an ACO, however opportunities remain to further strengthen their readiness and performance in these new models.

Community Health Centers have a number of strengths that will serve them very well in this new environment

We've highlighted some core areas where CHCs have built strong(er) infrastructure over the years.



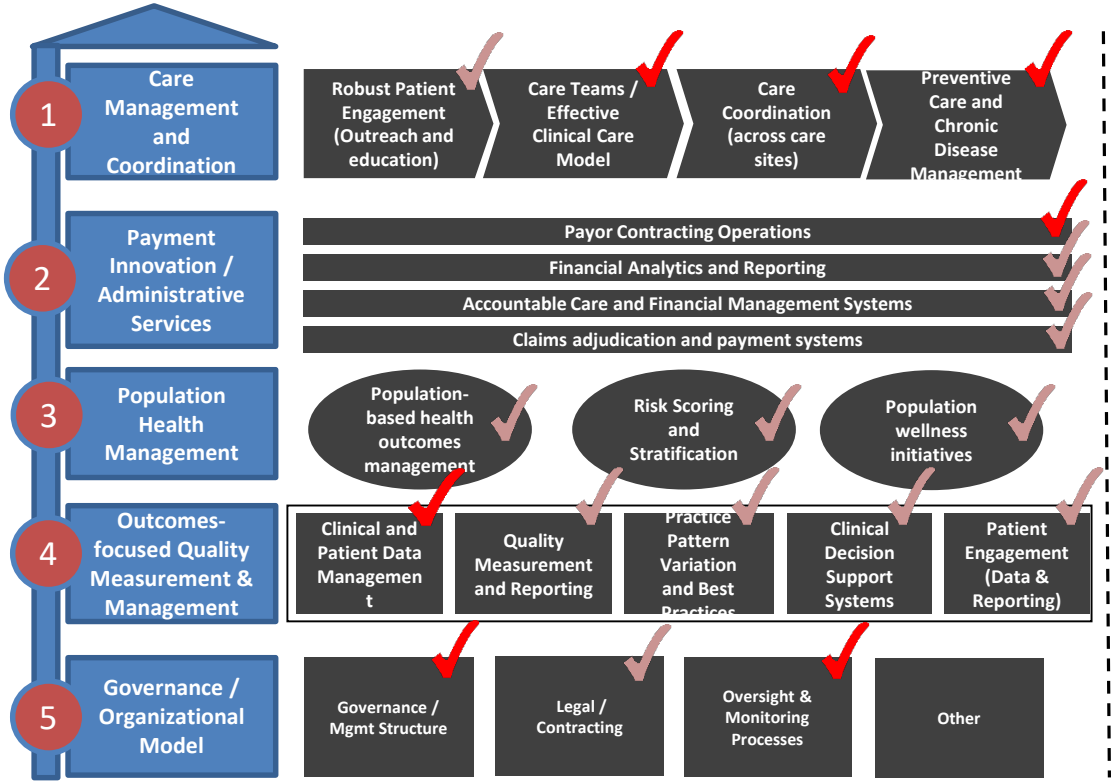
Infrastructure Considerations



Key question for CHCs:
For each of these functional areas, what type of infrastructure (e.g., talent/skills, IT, workflows, or partnerships) must you build or leverage to drive performance?

Together, and with our health plan partner, we have a number of capabilities that will allow us to further strengthen our infrastructure and success in an ACO system

Health Plans or other partners can provide complimentary infrastructure to practices as we transition to the ACO model.



Infrastructure Considerations

HR IT BP Partner-ships

What areas must we build? Are there areas that are better performed by a partner? Where are the incremental gaps and who is best suited to build these new capabilities? The CHC? The Health Plan? The Hospital partner

EBNHC ACO will be a "Model A" ACO

Model A: Partnership Plan

Program Cycle 2
2022-2027

- Exclusive group of PCPs; all members enrolled receive primary care from these PCPs.

Payment Methodology:
- Prospectively accountable
- Paid a capitated rate for members
- At risk for losses and savings beyond the capitation rate (Upside and downside risk)

Requirements:
- Must meet requirements of MCOs, including capital reserves and other financial considerations.
- Must meet the requirements for ACOs, including provider-led governance and MA Health Policy Commission certification

Infrastructure Considerations:
- Performs many of the administrative functions of that MassHealth MCOs perform (e.g., paying claims, maintaining the provider network, prior authorization, etc.)

Model B: Primary Care ACO

Program Cycle 1
2017-2023

Care Coordination:
- Exclusive group of PCCs; all members enrolled receive primary care from these PCCs.

Payment Methodology:
- Retrospectively accountable – no capitation
- Accountable through shared savings and losses - Choice of two risk tracks
- Payments based on TCOC and quality performance for the attributed members

Requirements:
- Does not need to meet MCO requirements

Infrastructure Considerations:
- Attributed members receive non-BH care from Mass Health's FFS network, which is paid for through the MassHealth claims system
- Members receive BH care through MBHP

Model C: MCO-Administered ACO

Model Highlights:

Structure:
- ACO that is part of the primary care provider network for one or more MCOs.
- MCO may contract with multiple Model C ACOs as part of its network.

Care Coordination:
- Exclusive group of participating PCPs
- Members who enroll in an MCO may be attributed to ACO based on their PCP

Payment Methodology:
- Members receive care through MCO network, which is paid by MCO
- Accountable to MCOs through shared savings and losses payments - ACOs will choose from three Risk Tracks
- MassHealth must approve contracts between ACO and MCO in order for ACO to be DSRIP eligible.

Requirements:
- Does not need to meet MCO requirements

Infrastructure Considerations:
- Similar to existing relationship between MCOs and contracted primary care provider groups.

EBNHC's Approach

- EBNHC intends to transition from Model B (Primacy ACO – MassHealth) to Model A (Primary Care / Managed Care Organization).
  - We engaged Boston Medical Center Health System (BMCHS) to partner with them to create a new ACO for the next program cycle (2023-2027).
  - EBNHC leadership identified significant strategic, clinical, and financial benefits that this opportunity offers. We collaborated with BMCHS to submit a joint bid to MassHealth, which they approved in early November.
  - **EBNHC's participation in the C3 ACO will end on March 31, 2023 and we will become our own ACO in partnership with WellSense on April 1.**
- **BMC's WellSense Health Plan** will be responsible for the health plan administrative requirements. **EBNHC** will be responsible for care delivery program requirements.

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WellSense HEALTH PLAN

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Key differences from last program cycle

MassHealth ACO Program Cycle 1 (2017-2022)

- Governance and structure: EBNHC is one of 19 FQHCs that are part of C3. In ACO strategy planning activities, EBNHC shares decision-making power with the other 18 FQHCs in C3, which are much smaller than EBNHC and have different needs and interests
- Admin functions: MassHealth performed health plan administrative functions for C3 members: provider network maintenance, claims adjudication & payment, prior authorization, member enrollment, and others
- Payment model: MassHealth continues to reimburse C3 organizations through FFS payments
- Risk-taking: C3 is responsible for financial savings/losses based on members' TCOC, which is spread across FQHCs
- Incentives: EBNHC is eligible for retrospective bonus payments (or losses) based on quality metric performance
- Data: MassHealth Medical claims

MassHealth ACO Program Cycle 2 (2022-2027)

- Governance and structure: EBNHC is the exclusive primary care provider in the ACO. In ACO strategy planning activities, EBNHC and WellSense will share equal decision-making power
- Admin functions: WellSense will perform health plan administrative functions for ACO members (e.g., removes auth requirements at BMC for ACO members.)
- Payment model:WellSense will pay for some primary care services through per member per month rates (capitation)
- Risk-taking: EBNHC will share financial savings/losses with WellSense based on members' TCOC during performance year
- Incentives: EBNHC is eligible for retrospective incentive payments based on our own performance on quality and health equity metrics (split to be negotiated)
- Data: Access to integrated BH, health plan, and hospital data.

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Key Priorities and Program Highlights

- Mastery of Financials (payments, costs, and rate development):
  - Covered Lives / Member Attribution / Member Months
  - Quality Incentives
  - Equity Incentives
  - PC Sub-cap and Tier payments
  - Care Management Funding
  - MCO Admin costs
  - Core Medical pay rates (exlcuding PC Subcap)
  - TCOC Gains/Losses
  - Program costs, investments, and other expenses
- Strategies for care management, delivery, and complex care management
- Strategy and infrastructure to support Quality and Population Health and supporting analytics capability
- Performance Improvement Capability and Process
- Plans for Member (Patient) Engagement
- Pharmacy
- Behavioral Health
- Care Disruption and Risk Management

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EBNHC's milestones to build the ACO

#	Milestone Name
OBJECTIVE 1: Become an approved MassHealth ACO in partnership with WellSense	
1A	Develop a structure for engaging with BMCHS prior to JOC creation
1B	Complete MassHealth ACO procurement process
1C	Establish a joint venture agreement between EBNHC & WellSense to participate in the program
1D	Complete MassHealth readiness assessment activities
OBJECTIVE 2: Prepare EBNHC organizational infrastructure to support ACO operations	
2A	Establish the health plan's network of PCPs, specialists (incl. BH), facilities, and pharmacies
2B	Develop and implement a data exchange/IT system integration plan to support baseline ACO operations
2C	Begin development and execution of a population health & quality strategy for the ACO
2D	Establish guidelines for collaborating with BMCHS staff on ACO operations
OBJECTIVE 3: Prepare EBNHC organizational infrastructure to enable the ACO to meet programmatic requirements	
3A	Identify EBNHC's responsibilities for enabling the ACO meet MassHealth's program requirements
3B	Advocate to MassHealth on changes to program requirements to best meet needs of EBNHC patients
3C	Implement necessary changes to infrastructure levers to fulfill responsibilities under MassHealth's Primary Care Sub-capitation Program requirements
OBJECTIVE 4: Successfully enroll eligible individuals in the EBNHC ACO prior to April 1	
4A	Select a name for the ACO
4B	Review marketing & enrollment materials
4C	Inform patients of the new ACO's impact on their future health insurance coverage and access to EBNHC providers
4D	Execute mitigation plans for EBNHC patients incorrectly assigned to a different ACO via the state's auto-enrollment process prior to April 1
OBJECTIVE 5: Minimize care delivery disruptions for members due to MassHealth program changes	
5A	Minimize care disruptions related to prior authorizations for members switching from C3 to the EBNHC ACO
5D	Minimize care disruptions for any MassHealth member related to FY2023 formulary changes

Example only

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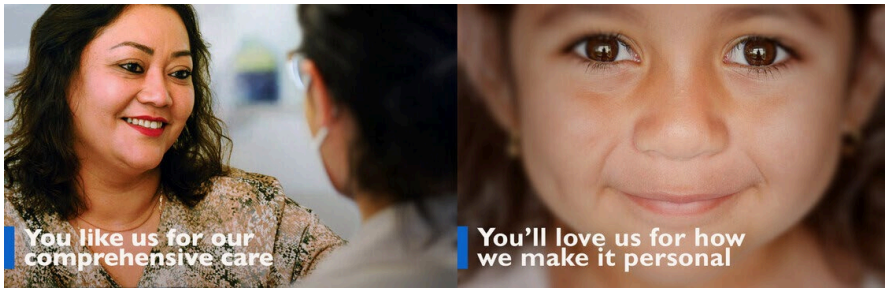
Clinical Opportunities

- **Aligned Hospital & Primary Care Collaboration**
- **Care access**
- **Superior analytics**



Payment innovation: Overview of MassHealth Primary Care Sub-capitation Program

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Community Health Centers and the MassHealth ACO Primary Care Sub-Capitation Program

- Starting April 1st, 2023, a new value-based sub-capitation model for primary care providers participating in the MassHealth ACO program will launch. Practices will receive additional funding to support new care delivery expectations based on the practice's selection of one of three tiers.
- Community Health Centers are critical participants in this new flexible payment model.
- Nearly 50% of patients served at CHCs are MassHealth members, and CHCs provide more than 20% of MassHealth members' primary care. As a result, CHCs' participation and success is critical to achieving MassHealth's policy goals for strengthening primary care.
- CHCs are well positioned to lead the way in the sub-capitation program, including the focus on behavioral health integration, team-based care, health equity and health-related social needs.
- CHCs are expected to receive new financial investments of $50-$70+ million through the sub-capitation program, over and above the $120 million invested through the CHC rate restructuring in January 2022.

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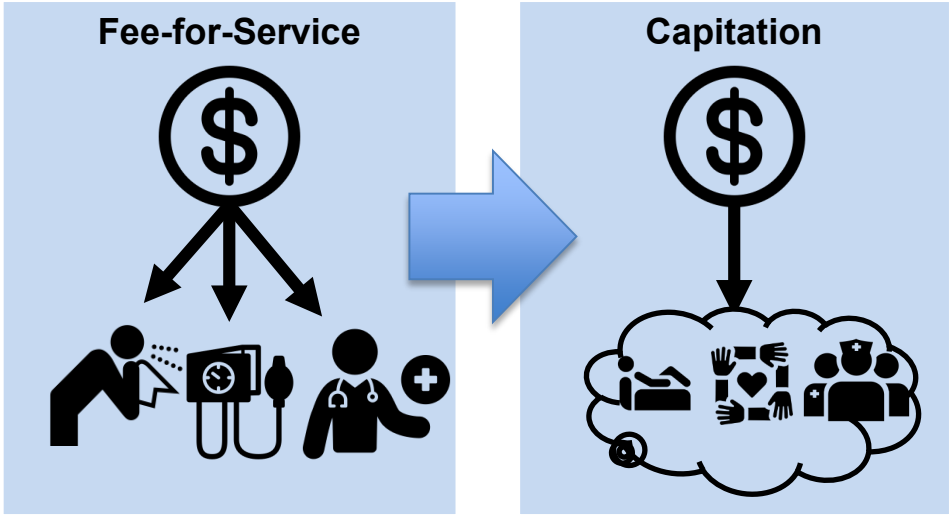
Incentivizing team-based care

- Primary Care Sub-Capitation is a **fixed amount of money (or capitation)** paid to the primary care practices for each month for each patient who is enrolled with that practice for primary care. This is moving away from a fee for service payment model.
- **Primary care groups are rewarded more funding who prove to provide enhanced primary care services** such as (IBH, care coordination, after hours and weekend, video telemedicine, LARC placements, etc) aka tiers
- This is an opportunity to truly **innovate the way we are reimbursed and ultimately deliver care to patients**, where partnered care team members who may not currently bill now are funded



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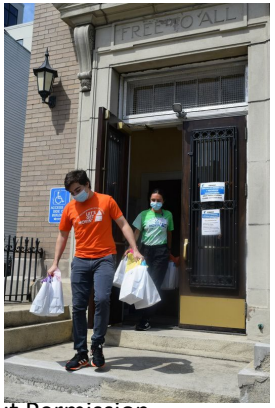
Flexible Services

- In October 2018, the Center for Medicare and Medicaid Services (CMS) approved MassHealth's protocol for a $149 million Flexible Services Program as a component of the DSRIP program.
- The Flexible Services Program may pay for health-related nutrition and housing supports for certain ACO members.
- The Flexible Services Program supports the broader MassHealth goal of addressing the health-related social needs of its members as part of the ACO program.

Pictured here are members of EBNHC's new Community Wellness and Resource Center opened in 2020



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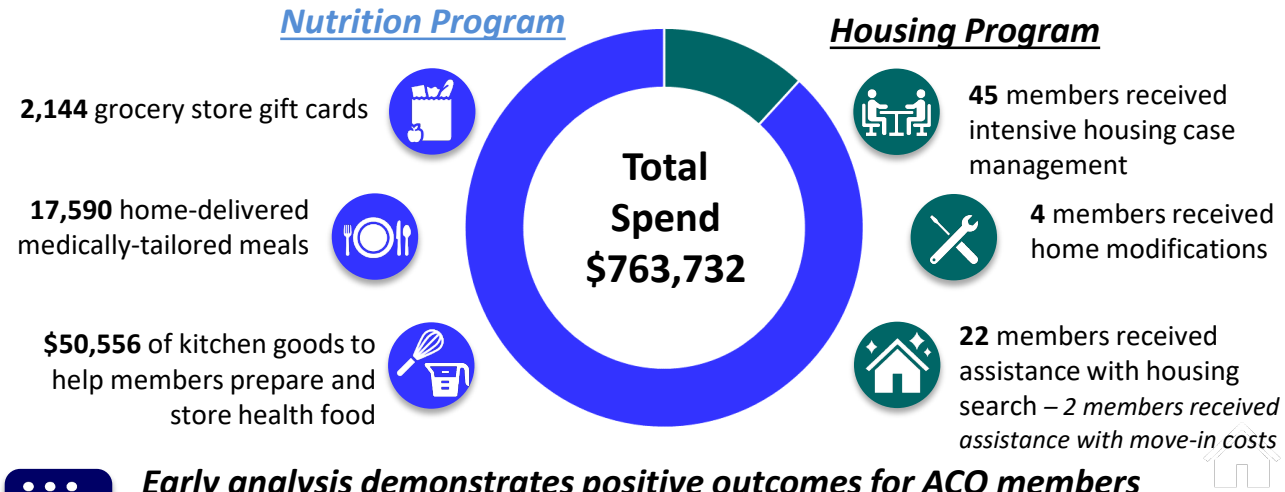
Flexible Services Annualized Impacts



Early analysis demonstrates positive outcomes for ACO members referred to Flexible Services statewide

Preliminary findings reveal:

- ***Improvements in food security and food stability***
- ***Reduction in average total cost of care***
- ***Lower ED utilization***
- *provement in housing stability*

Lessons we've learned

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Lessons Learned

- Acknowledge the tension between FFS and VBC
  - Provider organization cannot lean into visit-based model and team-based model at the same time.
  - Must achieve sufficient incentives through capitated payments to switch from a visit-based to a team- and non-visit-based approach. What is your critical mass or target percentage of VBC lives in order to make the full pivot
  - Consider a broader range of factors—including patient safety and outcomes, physician work-life balance, patient convenience, workflow, and the difficulties of changing practice models under fluctuating payment systems.
  - Percentage of capitation received may need to be accompanied by having multiple private payers paying a consistent capitated payment level for primary care.
- Being nimble: Decision-making and governance model can affect your organizations speed to act.
- Consider provider/team engagement and potential provider/team incentives
- Understand early strength and weakness regarding data collection, data integration, and data analytics and how these activities will affect your ACO and your strategic needs.

Thank you

Greg Wilmot

President & CEO

East Boston Neighborhood Health Center
Mobile. 617-970-8519
E. wilmotg@ebnhc.org

Jackie S. Fantes, MD, FAAFP

Chief Medical Officer

East Boston Neighborhood Health Center
Mobile. 617-895-7593
E. fantesj@ebnhc.org