Camden Coalition of Healthcare Providers

Camden Coalition Accountable Care Organization Gainsharing Plan

Section 1: Accountable Care Organization (ACO) Goals, Objectives, and Strategies

ACO Goals

The Camden Coalition ACO seeks to provide better care at lower costs for all Medicaid beneficiaries receiving care in Camden, NJ. The ACO engages hospitals, primary care, specialty and behavioral health providers, social services, community organizations, and local residents to work collectively to improve healthcare delivery, particularly for the most vulnerable and high cost patients. The ACO operates a number of citywide programs and supports members' separate efforts to improve care. The initiatives often coordinate traditional medical care with critical social services to address patients' comprehensive needs.

ACO Objectives and Strategies

The ACO's major strategies to improve quality and reduce costs are:

- use of data to coordinate care and drive innovation to address patients with complex needs
- care coordination and prompt follow-up primary care to prevent of avoidable hospital readmissions
- improving primary care capacity, particularly for specific high risk populations (e.g. women of child-bearing age)
- patient and community education and engagement
- expansion of mental health and substance use treatment
- programs and advocacy to improve, expand, and coordinate transportation, social services, and other social factors that impact health.

The major current ACO initiatives are discussed in greater detail below.

Use of health information technology to support population health

The ACO is committed to making health information technology and data actionable to identify opportunities for clinical interventions, coordinate care, and reduce unnecessary testing. The ACO's regional health information exchange (HIE) is the backbone of the ACO. The ACO has developed customized reports that allows the HIE to serve as a centralized system for population health surveillance to identify individuals that need clinical intervention and trigger clinical workflows. The ACO continues to expand its data sources, functionality, and user base and connect to other HIEs.

Reducing hospital readmission through Community Based Care Coordination and prompt follow-up primary care

Camden has some of the highest rates of per capita hospital utilization (both inpatient and emergency department) in New Jersey. The ACO provides an intensive care coordination program for individuals who are the highest users of the hospital

system (2+ hospital admissions within 6 months) and have the highest likelihood of readmission due to social, behavioral, and economic factors. An interdisciplinary care management team, including behavioral health specialists, identifies patients in the hospital through a regional health information exchange (HIE) and work intensively in the community with patients for an average of 90 days. The interdisciplinary team provides both clinical and social support, including home based medication reconciliation, support for medication adherence, and connection to resources in the community, to help patients achieve personal goals, enable better, health and reduced use of the hospital.

Research shows that seeing a primary care doctor within 7 days of leaving the hospital is likely to prevent a return visit to the emergency room or hospital. Based on this, the ACO and its primary care practices (PCP) have prioritized follow-up care for patients on discharge from the hospital through a program known as the 7 Day Pledge campaign. Seeing a provider within 7 days of hospital discharge has several potential benefits including: re-establishing caring patient-provider relationships, support in understanding discharge paperwork and medication adherence, discussion of overall health needs, and connection to support services. PCPs have modified scheduling practices and, with assistance from Camden Coalition staff, seek to schedule a comprehensive follow-up appointment within seven days of discharge from the hospital. The HIE produces a daily list of hospitalized patients attributed to each PCP and the PCP receives additional compensation from the ACO for conducting a more thorough visit for each patient treated within 7 or 14 days of discharge. Patients also receive transportation and incentives to attend the follow-up appointment (See: Exhibit 01-2016 Quality Plan).

Reducing ED utilization
Through the 7-day pledge the ACO reaches patients who are frequent users of the ED. Additionally, the ACO is working on a pilot to specifically target patient who have visited the ED 5 or more times in the last 6 months with no inpatient admissions. The goal of this pilot is to develop a standardized community based workflow with an interdisciplinary care management team to identify frequent users of the ED while they are in the hospital, and work with them in the community to help connect them to resources and achieve personal goals to reduce ED readmissions.

Improving maternal and child health
Camden Delivers aims to improve health among women of childbearing age. The program seeks to connect women to early pre-natal care and connect women to primary care after delivery. There is additional care coordination for pregnant women with multiple chronic illnesses. Data from the perinatal risk assessment, an assessment conducted during pregnancy to identify women at high risk for fetal or infant death or infant morbidity, has been added to the HIE to facilitate greater awareness of complicating social factors and coordination among women's health

providers. The goal of the assessment is to prevent or treat conditions associated with poor outcomes and to connect women to appropriate resources and services.

Primary Care Capacity Improvement
The ACO and its Quality Committee engages PCPs in a comprehensive quality improvement program focused on the seven quality metrics contained in the ACO's contracts with United and Horizon. The program features a quarterly dinner/lecture series for clinical and administrative champions at each practice; monthly individual practice meetings to review performance scorecards and develop targeted improvements; and a robust Quality Committee committed to continuous improvement of primary care within the ACO. Individual PCPs within the ACO are pursuing patient centered medical home certification, expanded use of electronic medical records, open-access scheduling, greater use of integrated, team-based care, and other initiatives to effectively and efficiently address the complex needs of patients in primary care.

Patient education and peer support
The ACO is committed to patient education and peer support to help those who suffer from chronic illness better manage their disease and avoid hospitalization. The ACO and its partners provide evidence-based patient education programs for diabetes and other chronic illnesses in both English and Spanish. The ACO operates the Faith In Prevention program that works with faith-based organizations to deliver health and nutrition education, create environmental changes in the community that promote health, and mobilize FBOs to support their community members when they are discharged from the hospital.

Expanding and Integrating Mental Health and Substance Use Treatment
The ACO is committed to expanding access to mental health and substance use treatment particularly for Medicaid beneficiaries. Members of the ACO are engaged in a comprehensive study and planning initiative known as the South Jersey Behavioral Health Innovation Collaborative. Members are also pursuing every opportunity to expand services and develop models of integrated, team-based care that comprehensively addresses the physical, behavioral, and psychological needs of patients.

Social Determinants
Social and economic factors play a significant role in the overutilization of acute health care services and the poor health outcomes experienced in Camden. The ACO is working with New Jersey Medicaid and its transportation broker to improve the quality and reliability of non-emergency medical transportation. The ACO has also developed a supportive housing program focused on individuals who are chronically homeless and high utilizers of the hospital system.

Some members of the ACO have additional care coordination services that are available to work with its own Medicaid patients. The ACO works closely with each member organization to ensure that care coordination is deployed efficiently and effectively.

Camden ARISE (Administrative Records Integration for Service Excellence)
Finally, through Camden ARISE, the ACO is working with local stakeholders to understand the relationships between high utilization of the hospital, homeless services, and criminal justice involvement using integrated data sets. The goals are to better understand how individuals access a range of public services in order to develop and evaluate programs that better serve the needs of the most vulnerable residents.

Section 2: Quality Standards

As described above the Camden Coalition ACO is pursuing multiple strategies to achieve its goal of improving quality and reducing costs for all Medicaid beneficiary. In coordination with MCO providers United and Horizon, the ACO identified the following 7 quality metrics to assess performance (Exhibit 01-2016 Quality Plan).

1. **7-day post-hospital follow-up visits for hospitalized patients:** The ACO aims to increase the percentage of patients reconnecting with primary care within 7 days of inpatient hospital discharge.

2. **7-day post-hospital follow-up visits for emergency department high-utilizers (patients with 5+ ED visits in a 6 month window):** The ACO aims to increase the percentage of patients reconnecting with primary care within 7 days of ED discharge.

3. **Onset of prenatal care (Healthcare Effective Data and Information Set (HEDIS) measure):** The ACO aims to increase the percentage of deliveries that receive a prenatal care visit in the first trimester of pregnancy.

4. **Attendance at postpartum appointment (HEDIS measure):** The ACO aims to increase the % of deliveries that have an OB post-partum visit within 21-56 days of delivery.

5. **Cervical cancer screens (HEDIS measure):** The ACO aims to increase the percentage of women ages 21-65 years of age who are screened with cytology in a three-year period and women ages 30-65 who are screened with cytology/HPV co-testing within a five-year period.

6. **Breast cancer screen (HEDIS measure):** The ACO aims to increase the percentage of women ages 50-74 years of age who have at least one mammogram to screen for breast cancer in a two-year period.

7. **Patient Satisfaction:** The ACO aims to increase the percentage of "satisfied" and "Very Satisfied" responses on the Patient Satisfaction survey (more details about the survey in Sections 6-7)..

Benchmark periods and targets
The ACO established a contract with United Healthcare in December 2013, marking December 2013 through November 2014 as the baseline year (Year 0) to specify the benchmark periods and targets for the seven quality metrics. During the baseline year, the ACO developed and refined the data infrastructure necessary to track the quality metrics. The target for year 1 (Dec 2014 to Nov 2015) is to improve performance on all seven metrics over Year 0. At the close of Year 1, the ACO and United will then converge on targets for Year 2.

The Horizon NJ Health contract was initiated in February 2015 with the first full month of data being March 2015. As a result, March 2015 through February 2016 serves as the baseline year (Year 0) for the Horizon contract. Similarly to the United contract, the ACO aims to improve performance on all seven metrics in Year 1 over Year 0. At the close of Year 1, concrete targets will be set for each metric in Year 2.

Data collection
The ACO has implemented a series of data systems and sources to assess progress on the quality measures. These data systems include a regional health information exchange, a web-based HIPAA compliant database *TrackVia* utilized by all partner primary care practices for data capture, a monthly scorecarding system to assess performance and claims data and other community based data sets.

For measures 1 and 2, *7-day post-hospital follow-up visits,* the ACO utilizes the HIE to identify all hospitalizations and ED utilizations for patients in the ACO, which serves as the denominator. For each utilization, the primary care practices in the ACO input in real time into TrackVia whether a follow-up appointment was achieved and the date of the follow up appointment in order to determine whether it fell within 7 days of discharge. While this data is self-reported by the practices, once a year it is triangulated with claims data from the payers for validation. We will work together to resolve any discrepancies.

For measures 3-6, the HEDIS measures, the ACO receives periodic extracts of data from United and Horizon to retrospectively assess progress. Finally, the ACO receives community based data sets to identify trends and progress for a subset of the HEDIS measures. The ACO receives Perinatal Risk Assessment data from the Southern New Jersey Perinatal Cooperative which allows tracking of the date women attended their first prenatal appointment (Measure #3). Additionally, the ACO pushes to OB/GYN practices in Camden lists of women who are due for their postpartum appointment and receives monthly updates on which patients did

arrive to their postpartum appointment (Measure #4). This data is logged in TrackVia in the same manner as 7-day post-hospital follow-up data. The ACO is still working on ways to capture self-reported data for cervical and breast cancer screens. This data is received periodically from United and Horizon to retrospectively track progress. The last metric Patient Satisfaction is discussed in more detail later in this plan.

The ACO has developed a scorecarding system to create a real-time feedback loop to assess performance against quality measures. Monthly the ACO uses Tableau to produce data visualizations of progress in key quality measures (Exhibit 02- De-Identified Scorecard). All ACO providers participate in monthly scorecard meetings with the Camden Coalition team to review operations, monthly deliverables, and progress and barriers to achieving quality measure targets.

The ACO will also be evaluated on a set of mandatory and voluntary quality metrics chosen by New Jersey Division of Medical Assistance and Health Services (NJ Medicaid) (Exhibit 03- NJ Medicaid Quality Metrics). The ACO has selected the following voluntary metrics, in addition to the 21 mandatory metrics:

Metric Type	**Metric**
Preventive	Cervical cancer screening
Chronic	Diabetic HbA1C Testing
Chronic	Diabetic LDL Screening
Chronic	Diabetic Eye Exam
Chronic	Use of Appropriate Medications for People with Asthma
Chronic	30-day Readmission rate following AMI

.As part of the ACO Demonstration Project, Rutgers Center for State Health Policy (CSHP) will use claims data to develop and report the baseline measurements of each state quality metric in the first year and annual scores for each metric in subsequent years.

Section 3: Cost-Savings Methodology

The ACO cost savings methodology will follow the recommendations put forward by Rutgers Center for State Health Policy (CSHP). In a July, 2012 publication (Exhibit 04-Approach for Savings Calculation), CSHP had proposed broad recommendations for calculating savings in Medicaid spending, building upon the framework established by the Medicare Shared Savings Program (MSSP), with several modifications to account for programmatic and population differences. The methodology uses the CDPS risk adjustment methodology.

To the extent that future iterations of this methodology are put forward, any shared saving methodology with the state and MCOs would be informed by these future iterations. It is anticipated and appropriate that these methodologies will iterate

and evolve based on the ever changing landscape of healthcare reform. It is important for the ACO and its partners to continuously re-examine and evolve methodology to ensure success for all stakeholders.

The ACO's contracts with Horizon and United each specify a cost-savings methodology. The United contract follows the Rutgers methodology but uses United's IPRO risk adjustment tool (Exhibit 05-United Contract). The Horizon contract specifies its own methodology for calculating savings (Exhibit 06- Horizon Contract). Both are being implemented according to the contractual timelines.

Section 4: Savings Allocation

The ACO is entitled to up to 50% of net shared savings in each of its MCO contracts. Each contract has a slightly different methodology for calculating how much of the shared savings the ACO receives, depending on the size of the shared savings and the achievement of quality metrics (Exhibit 05-United Contract; Exhibit 06- Horizon Contract).

The ACO will reinvest shared savings in activities that further the objectives of the ACO Demonstration Project, including payments for improved quality and patient outcomes, interdisciplinary collaboration for complex patients, expanded access for high risk patients, expansion of medical homes, support for the infrastructure of the ACO, and expansion of healthcare workforces and services.

The strategic planning committee of the ACO developed a shared savings reinvestment process to identify, prioritize, fund, and evaluate ACO activities. This reinvestment process is participatory and broadly inclusive of input from Coalition members and the Camden public. The Board of Directors of the ACO reviewed and adopted the proposed reinvestment process on 28 October 2015 (Exhibit 07-Gainsharing Reinvestment Resolution). The five step reinvestment process is described below.

1. **Produce financial model-** The Finance Committee of the ACO will engage in a participatory budgeting process to develop a financial summary of the resources coming into the ACO through a variety of sources, including shared savings, and ACO expenses.
2. **Identify and prioritize investment opportunities-** The Community Advisory Council and the Quality Committee of the ACO will identify and prioritize investment opportunities. City-wide need will be assessed through available data and input from the public and Coalition. From this, strategic areas for investment and potential interventions will be developed. The committees will then review, cost, and prioritize potential interventions.
3. **Reconcile Financial Model-** Once shared savings is received and prioritized interventions are costed, the Finance Committee will reconcile the financial model to identify any potential gaps where additional funding may be needed.

4. **Select and Implement Interventions-** The ACO strategic planning committee will review the reconciled financial model and prioritized interventions to select and recommend interventions for implementation. The Executive Committee of the ACO will provide final approval on interventions to implement.
5. **Evaluate-** For each selected intervention, targets and metrics will be developed to monitor progress. The Quality Committee is charged with performance based monitoring of the ACO to ensure performance standards are being met. As necessary, the Quality Committee will develop corrective action plans for practices if needed to bring performance up to required levels. Finally on a quarterly basis, the Quality Committee provides reports to the ACO Board of Directors summarizing progress on the performance standards. The ACO Quality Committee Policy describes this process in detail (Exhibit 08-Quality Committee Policies).

Section 5: Public Input

The Camden Coalition ACO values consumer participation. In 2013, the Camden Coalition hosted a series of three public meetings to educate the community about the ACO and to better understand the community's highest priorities among health care needs. In 2014, the Camden Coalition formed a Community Advisory Council (CAC) with volunteers who attended the meetings in 2013 to provide strategic oversight and help engage and educate the public. The CAC is coordinated by a steering committee of five board members and continues to grow. It currently consists of more than 25 Camden residents and meets monthly.

In 2015, the CAC hosted a series of three meetings to understand the public's health care priorities. Participants were asked to rank potential areas for health care investment. . The following areas of need were ranked highest:

- Access to Quality Mental Health & Substance Abuse Services
- Enhanced Care Coordination
- Access to Quality Preventative Health Services
    - Expanded Dental Services
    - Invest in Primary Care Facilities (Professional Development, Customer Service, Culture & Sensitivity Training)
- Chronic Disease Prevention
- Chronic Disease Management
- Reducing Obesity & Food Insecurity
    - Farming and Neighborhood Gardens - Fresh, Local Produce
    - Exercise Classes for Better Health
    - Quality grocery stores
- Public Health Education
- Enhance healthcare services for seniors
- Education for Camden City Residents to Become Medical Professional

In February 2016, the Camden Coalition ACO released a draft of a plain language summary of this gainsharing plan in Spanish and English on its website and through its partner organizations. The ACO feedback form and feedback phone line (described below) were modified to receive input into the gainsharing plan. On February 25th, the ACO held a public meeting to review and receive feedback on the gainsharing plan. After the feedback period closed, distribution channels and feedback were summarized in Exhibit 09 (Exhibit 09- ACO Gainsharing Plan Public Input). The Board of Directors of the ACO reviewed and adopted the finalized ACO gainsharing plan on 20 April 2016 (Exhibit 10-Gainsharing Resolution).

Section 6-7: Patient Experience & Patient Feedback

The ACO has developed two mechanisms to capture information about the patient experience, and to act upon findings to improve quality of care. These mechanisms are 1) an annual Patient Satisfaction survey and 2) a citywide feedback system accessible to patients and individuals working in the healthcare system in Camden.

Patient Satisfaction Survey

Survey Development

The Camden Coalition Quality Committee developed a citywide Patient Satisfaction Survey to be administered in all of the primary care practices participating in the ACO. The survey addresses both access and quality of care, through a 16 items that respondents rank on a 5 point scale as well as provide open ended written feedback (Exhibit 11- Patient Satisfaction Survey).

Survey Administration

The survey is administered annually (in June, July and August) to all practices in the ACO, to produce a sample representative of all ACO practices. Summer Associates collect at least 700 surveys, with a minimum of 25 surveys from each practice location. Practices with higher patient volume are sampled at a higher rate. The survey is administered, to patients who agree to participate, at various times throughout the day and week within each practice. This varying of times and days allows for a broader pool of patients surveyed. A team of trained bachelor's level summer associates distribute the surveys to patients while they wait for their appointments in the practice waiting area. Surveys are written in both English and Spanish. Summer Associates are available to administer the survey orally in English or Spanish if needed.

Survey Analysis

The Camden ACO conducts the analysis of patient surveys. The quantitative data is analyzed for each question and comparisons are made with previous years and with the city as a whole. A general inductive approach[1] is utilized to analyze and code the qualitative data according to the theme of responses and then tabulated to show the volume of certain categories of barriers. The results of the 2015 patient survey

[1] Reference on general inductive approach to analyze qualitative data: http://legacy.oise.utoronto.ca/research/field-centres/ross/ctl1014/Thomas2006.pdf

analysis are attached for illustration (Exhibit 12: Patient Satisfaction Survey Results 2015).

Survey Result Reporting
The Patient Satisfaction Survey data is shared broadly with the Coalition's Board of Directors, Quality Committee, and Community Advisory Committee; Managed Care Organizations; and primary care practice and hospital leadership. Clinical redesign staff use the results to work with primary care providers to improve quality and access to care in their respective practices

Citywide Feedback System
The ACO citywide feedback system is a centralized portal for all positive and constructive feedback related to healthcare in the city of Camden. The portal is an online web form that anyone can access from the internet or a smartphone (Weblink: English: http://www.camdenhealth.org/feedback/; Spanish: Spanish: http://www.camdenhealth.org/reaccion/), as well as a phone number (856-365-9510 x2095) that feeds directly to a voicemail box that is checked every day by a Program Manager for Quality Improvement, and overseen by a Director of Clinical Redesign Initiatives. Individuals can enter feedback into the online portal or leave a message on the phone line in real time, twenty-four hours a day.
Individuals entering feedback are given the option to include their full name, phone number and/or email address for the Coalition to reach them with a response to their feedback. Within 5 business days of receipt of the feedback, the ACO will respond to acknowledge receipt of the feedback and update on the status of the resolution.

Section 8: Hospital Revenue
The Camden Coalition of Healthcare Providers Medicaid ACO provides a low risk bridge towards value-based care for local hospitals. Healthcare across the United States and New Jersey is being driven swiftly towards value-based care, a model marked by payment models that shift risk away from payers and towards providers. These models incent certain high-quality outcomes along with decreases in the overall cost of care for a patient population under the care of a provider. Value-based care is being widely and increasingly embraced by private and public payers, employers, healthcare thought leaders, patients, and their advocates. For hospitals to thrive in this new environment they must develop sophisticated capabilities such as care coordination, health informatics, quality measurement and improvement, and population health management, especially for the care of chronic and behavioral health conditions.

While it is possible that the improvements in the health and healthcare of the patients served by local hospitals through the efforts of The Camden Coalition of

Healthcare Providers Medicaid ACO could lead to reductions in fee-for–service revenue, these reductions will be modest and effect receipts with relatively low profit margins. Furthermore, given that many admissions are in fact necessary and represent high-quality care, only a subset of admissions will be affected by ACO activities.

An analysis of five years of visit data from three New Jersey hospitals revealed that Medicaid patients accounted for 26% of total inpatient admissions, yet only 17% of receipts. More drastically, Medicaid patients accounted for 33% of Emergency Department visits, yet only 16% of receipts. Medicaid receipts per visit totaled 56% of that of other payer types for inpatient visits, and only 39% for emergency department visits.

While the risk of impact of the Camden Coalition of Healthcare Providers Medicaid ACO on local hospital revenue is modest, the capabilities developed through participation in the Medicaid ACO will be fully transferrable to the Medicare and private insurance arenas, and will enable them to compete and thrive in the new realities of value- based care.

2016 Camden Coalition Medicaid ACO Quality Improvement Plan

In 2016, all practices participating in the ACO will aim to improve performance on the quality metrics outlined below, as compared to performance in 2015, with support from the Camden Coalition. In addition to this citywide quality improvement plan, each practice will be provided with their 2015 data in order to develop practice-specific action plans to move toward ACO targets. These plans will be living documents that will be integrated into practice work sessions and scorecard meetings.

7-day post-hospital follow-up visits for hospitalized patients

The ACO will aim to reconnect 47% of hospitalized patients to primary care within 7 days of hospital discharge. Practices will contribute to this goal by aiming to improve their reconnection rates month to month.

Practices will:

- Use TrackVia daily to identify, reconnect and document reconnection activities for eligible patients
- Prioritize scheduling post-hospital follow-up visits for hospitalized patients
- Attend monthly scorecard meetings with the Coalition team to review progress and identify opportunities to for further success. All four champions should be in attendance.
- With support from the Coalition, move toward adoption of the 2016 post-hospital follow-up visit guidelines approved by the Quality Committee (attached)

As funding permits, the Camden Coalition will:

- Provide enhanced payments to practices for realized 7-day post-hospital visits[1] adherent to 2016 guidelines
- Provide taxi vouchers and gift cards to patients who attend their 7-day post-hospital follow-up visits

7-day post-hospital follow-up visits for ED high-utilizers

The ACO will aim to reconnect 25% of ED High-Utilizers to primary care within 7 days of ED discharge. Practices will contribute to this goal by aiming to improve their reconnection rates month to month.

Practices will:

- Use TrackVia daily to identify, reconnect and document reconnection activities for eligible patients
- Prioritize scheduling post-hospital follow-up visits for ED high utilizers
- Attend monthly scorecard meetings with the Coalition team to review progress and identify opportunities for further success. All four champions should be in attendance.
- With support from the Coalition, move toward adoption of the 2016 post-hospital follow-up visit guidelines approved by the Quality Committee

As funding permits, the Camden Coalition will:

- Provide enhanced payments to practices for realized 7-day post-hospital visits adherent to 2016 guidelines
- Provide taxi vouchers and gift cards to patients who attend their 7-day post-ED visits

Cervical cancer screening

The ACO will aim to ensure that 70% of eligible women ages 21-65 years of age who are screened with cytology in a three-year period and women ages 30-65 who are screened with cytology/HPV co-testing within a five-year period in 2016 over 2015.

Practices will:

[1] Specific program guidelines for enhanced reimbursements, gift cards and taxis are attached

- Work with Coalition staff to co-design robust internal systems to track progress on cervical cancer screens

The Camden Coalition will:

- Support practices in improving progress on this HEDIS metric through technical assistance, data reporting and analysis, and other support as identified by the Coalition and practice

Breast cancer screening

The ACO will aim to ensure that 60% of eligible women ages 50-74 years of age who have at least one mammogram to screen for breast cancer in a two year period in 2016 over 2015.

Practices will:

- Work with Coalition staff to co-design robust internal systems to track progress on breast cancer screens

The Camden Coalition will:

- Support practices in improving progress on this HEDIS metric through technical assistance, data reporting and analysis, and other support as identified by the Coalition and practice

Prenatal Care

The ACO will aim to ensure that 80% of women who delivered a baby received a prenatal care visit in the first trimester of pregnancy or within 42 days of Medicaid enrollment.

Practices will:

- Use TrackVia daily to identify and document reconnection activities for women who have recently delivered or whose estimated delivery date has passed
- Schedule well visits for these women as a way to reconnect to primary care in the internatal period as part of Camden Deliver initiative

As funding permits, the Coalition will:

- Provide enhanced payments to practices for realized internatal well visits as part of Camden Delivers initiative
- Provide taxi vouchers and gift cards to patients who attend their internatal well visits as part of Camden Delivers initiative

Postpartum Care

The ACO will aim to ensure that 65% of women who delivered a baby had a postpartum visit within 21-56 days of delivery.

Affiliated OB Practices (CAMcare, Cooper and Osborn) will:

- Use monthly list to identify, reconnect, and document reconnection activities for women who have either delivered or whose estimated delivery dates have passed.
- Schedule postpartum visits within 3-8 weeks of delivery as part of Camden Deliver initiative

As funding permits, the Coalition will:

- Provide taxi vouchers and gift cards to patients who attend their postpartum visits as part of Camden Delivers initiative

Patient Satisfaction

The ACO will aim to ensure that 80% of responses on the Patient Satisfaction survey are "satisfied" or "very satisfied".

Practices will:

- Participate in annual Patient Satisfaction survey collection in all participating practices' waiting rooms

- Review Patient Satisfaction survey results and identify strategies for improvement in categories that underperform the citywide average by more than 5%

The Coalition will:

- Build, launch and administer a citywide feedback portal where patients and practices can submit feedback about the Camden Coalition Accountable Care Organization
- Monitor and respond to complaints in a timely manner

Mutual Commitments

As members of the Camden Coalition Medicaid ACO, practices and the Camden Coalition commit to the following engagement activities in 2016:

Practices will:

- Select four champions to support ACO operations in 2016 (Note: champions can vary from 2016 to 2016):
  - Provider champion
  - Administrative champion
  - Scheduling champion
  - Medical Assistant champion[2]
- Participate in Quality Improvement dinner series (three 2-hour evening sessions) with representation from all 4 champions
- Schedule and participate in monthly scorecard meetings with the Coalition team at which operations, quality measures and monthly deliverables will be reviewed
- Schedule and participate in up to three 2-hour staff-wide work sessions with the Coalition
- Participate in structured quality improvement pilots co-designed by the Coalition and practice
- Schedule and participate in periodic workflow and visit audits by Coalition staff
- Provide routine data in an accurate and timely manner upon request

The Coalition will:

- Provide honoraria, patient incentives, practice payments and practice meals as funding permits to offset costs of participation in dinner series and work sessions
- Provide feedback, technical assistance and care coordination resources to support practices in Quality Improvement initiatives outlined above
- Work with your billing/coding department to conduct a current state analysis on billing practices to identify opportunities for enhanced revenue (including use of the TCM code) and improved quality measures
- Continue to provide one free TrackVia user account for each practice and technical support
- Continue to provide intensive care coordination services for super-utilizers
- Continue to maintain and expand functionality of the Camden Health Information Exchange
- Continue to provide legal and governance support to citywide ACO partners
- Continue to pursue an advocacy agenda informed by citywide ACO partners

[2] In some practices, the medical assistant champion and scheduling champion will be the same individual

PCP Payments & Patient Access Program

Payments will depend on real-time reporting of appointments and monthly reconciliation of a master list of emergency and hospitalized patients (whose discharge dates fall between the first and last day of that month) that will be provided on the 1st of each month. This complete monthly reconciliation must be submitted back to the Coalition by the 15th of the following month. Payments will be remitted quarterly, unless otherwise specified. All payments and incentives are provided by the Coalition and with Coalition funding.

	Enhanced Practice Payments	Patient incentives
7-day post-discharge follow-up visit (30 minutes)	$150 per appointment	• Cab fare to and from appointment • $20 gift card
14-day post-discharge follow-up visit (30 minutes)	$100 per appointment	• Cab fare to and from appointment • $20 gift card
7-day follow-up visits for ED High-Utilizers (30 minutes)	$150 per appointment	• Cab fare to and from appointment • $20 gift card
14-day follow-up visits for ED High-Utilizers (30 minutes)	$100 per appointment	• Cab fare to and from appointment • $20 gift card
Postpartum visits within 3-8 weeks of delivery	N/A	• Cab fare to and from appointment • $20 gift card
Internatal visits within 12 weeks of delivery	$100 per appointment	• Cab fare to and from appointment • $20 gift card

PCP Practice Activity Payments

Payments for practice activities will be distributed as the activities are completed, as funding permits.

Practice Activity	Payment
Signed Quality Plan & development of practice-specific action plan	$500 per practice
Practice work sessions	$1000 per session per practice site
Participation in Patient Satisfaction Survey	$500 per practice site
Honoraria for attendance at Quality Dinners	$100 per participant per dinner (up to 4 participants per practice unless otherwise specified)

Recommendations for 2016 Qualifying Components of Post-Hospital Follow-up Visit

The following chart represents the recommended guidelines for post-hospital follow-up visits for Camden Coalition ACO patients, along with which aspects are required in order to qualify for the enhanced $100-150 payment.

Timing of Activity	Activity/Guideline	Requirement
Before the Visit	Monitor list of discharged patients and reach out to schedule follow-up visit within 7 days	Part of current 7DP workflow; **required** for enhanced payment
	Offer to set up transportation and remind patient that they will receive a $20 gift card	Part of current 7DP workflow; **required** for enhanced payment
	Warm reminder call to patient the day before or day of visit (reiterate taxi and gift card)	Part of current 7DP workflow; **required** for enhanced payment
	Prep the patient's chart before the visit including printing the discharge summary/instructions (as available) and flagging any open gaps in care	New 2016 guideline; phased adoption of this guideline is **required** for enhanced payment
During the Visit	Perform medication reconciliation	New 2016 guideline; **strongly recommended for all ACO inpatients**
	Self-management teach-backs with patient	New 2016 guideline; **strongly recommended for all ACO inpatients and ED High Utilizers**

All of the guidelines outlined above will be discussed in monthly practice scorecard meetings. The Camden Coalition will be evaluating adoption of and adherence to these guidelines mainly through the honor system but with occasional chart and visit audits, along with qualitative evaluation in monthly scorecard meetings.

Signing below indicates your practice's participation in the Camden Coalition Medicaid ACO in 2016.

_____	_____	
Provider Champion Name	Provider Champion Signature	Date
_____	_____	
Administrative Champion Name	Administrative Champion Signature	Date
Jeffrey Brenner	_____	
Coalition Champion Name	Coalition Champion Signature	Date

Please indicate the names of the following individuals below (no signature required):

Scheduling Champion:_____

Medical Assistant Champion:_____

Camden Coalition
of Healthcare Providers

Select a Practice

- Acosta
- CAMcare
- Cooper Family
- Cooper IM
- Cooper Pediatrics
- Fairview
- Lourdes Pediatrics
- Osborn
- Project Hope
- Reliance Broadway
- St. Lukes
- Virtua

Select a Payer

- [x] Horizon
- [ ] UHI_Nic
- [x] United

Engaged | Camden Resident | United

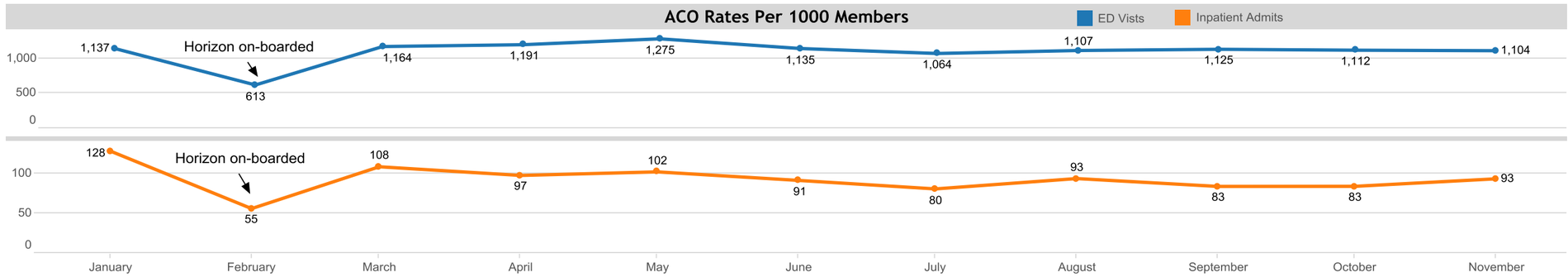
PCPin7Days, PCPCompleteCalculation
- Visit, No
- Visit, Yes
- Visit <= 7 Days, Yes

Follow-up Visit Payments Earned

	November
7-day payment	$20,550
14-day payment	$5,700
Total Reimbursed	$26,250

HEDIS	Baseline	Current
Breast Cancer		
Cervical Cancer		
Postpartum		
Prenatal		

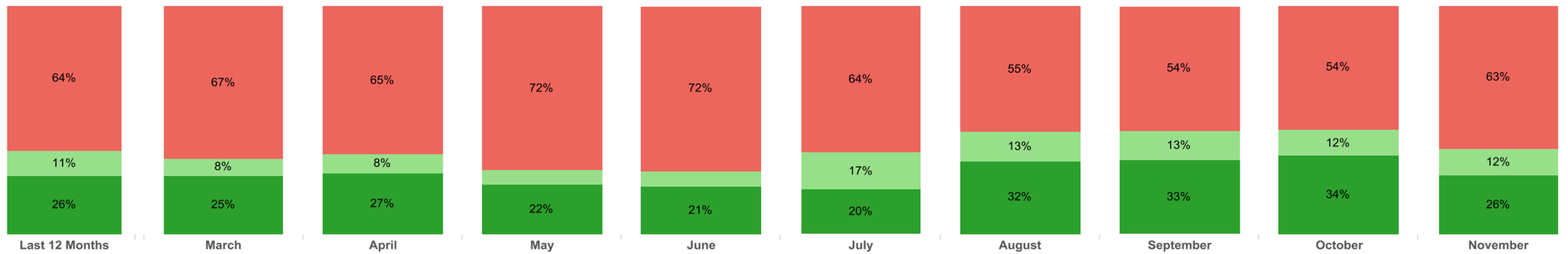
ACO Rates Per 1000 Members



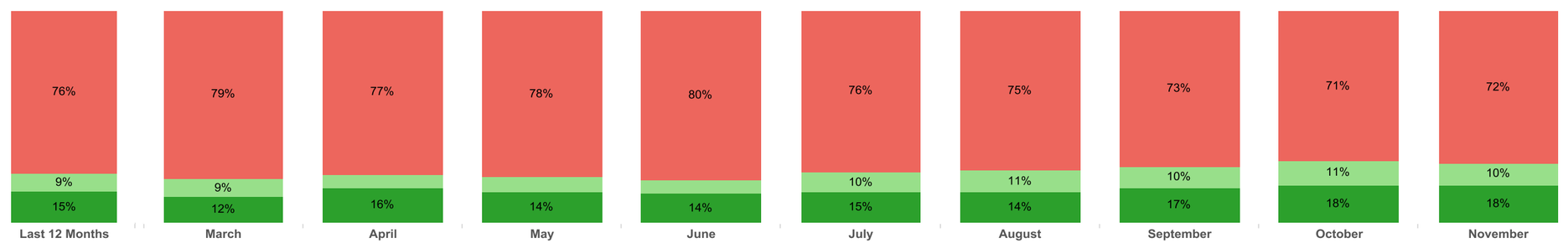
Hospital Utilization by Member Typology

Typology	January	February	March	April	May	June	July	August	September	October	November
Inpatient-High Utilizer	38	28	79	64	65	64	61	53	77	78	80
Inpatient-Standard	51	58	145	130	158	142	108	134	171	152	155
ED-High Utilizer	149	183	455	411	465	487	398	434	450	501	437
ED-Standard	640	881	2,109	2,230	2,398	2,050	1,854	1,871	2,837	2,691	2,415

ACO — All Inpatient Post Hospital Visits



ACO — ED High-Use Post Hospital Visits



NJ Medicaid ACO Demonstration Project

Quality Metrics (Updated)

Mandatory Measures

Prevention/Effectiveness of Care
Screening for Clinical Depression and Follow Up Plan
Annual Dental Visit
Well Child Visits first 15 months
Behavioral Health
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Anti-depressant Medication Management
Chronic Conditions
Annual Monitoring for Patients on Persistent Medications (year 2)
Annual HIV/AIDS Medical Visit
Resource/Utilization
Emergency Department Visits
Inpatient Readmission within 30 days
Preventable Hospitalizations
Provider visit within 7 days of Hospital Discharge
Return to ED within 7 days of Hospital Discharge
All Hospitalizations
Percent of PCPs for Successfully Qualify for EHR Incentive Payment
CAHPS/Satisfaction
Getting Timely Care, Appointments and Information
How Well Your Doctor Communicates
Patients Rating of Doctor
Access to Specialists
Health Promotion and Education
Shared Decision Making
Health Status/Functional Status

Voluntary Measures – Must Select 1 Measure from Prevention and Any 5 Measures from Chronic Conditions

Prevention/Effectiveness of Care
Childhood Immunization Status
Adolescent Immunization
Well Child Visits 3, 4, 5 , & 6
Adolescent Well Care
Weight Assessment and Counseling for Children and Adolescents
Frequency of Ongoing Prenatal Care
Medical Assistance with Smoking and Tobacco Use Cessation
Cervical Cancer Screening
Colorectal Cancer Screening
Tobacco Screening and Cessation
Breast Cancer Screening
Chlamydia Screening in Women 21-24
Prenatal and Postpartum Care
Acute Care
RSV in Neonates <35 weeks
Cardiovascular Disease

Cholesterol Management for Patients with Cardiovascular Conditions
Controlling High Blood Pressure
Complete Lipid Panel and LDL Control
Use of Aspirin or Another Antithrombic
Beta Blocker Therapy for Left Ventricular Systolic Dysfunction
Drug Therapy for Lowering LDL Cholesterol
ACE or ARB Therapy for Patients with CAD or LVSD
Diabetes
HbA1c Testing*
HbA1c Poor Control >9*
Control <8*
LDL Screening
LDL Control <100*
Neuropathy Monitoring*
BP Control <140/80*
Eye Exam*
Respiratory
Use of Appropriate Medications for People with Asthma*
Medication Management for People with Asthma
Use of Spirometry Testing in Assessment & Diagnosis of COPD
Pharmacotherapy of COPD exacerbation
Resource/Utilization
30 day Readmission Rate following AMI
30 day Readmission Rate following HF
30 day Readmission Rate following PNE
COPD Admission Rate
CHF Admission Rate
Adult Asthma Admission Rate

Demonstration Measures – These Measures will NOT be Included in the Gain Sharing Calculations

Follow up After Hospitalization for Mental Illness
Medication Reconciliation (year 2)
Mental Health Utilization
Transportation
Referrals/Connections to Social Supports (housing, food)
Identification of Alcohol & Other Drug Services

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Center for State Health Policy

A Unit of the Institute for Health, Health Care Policy and Aging Research

Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project

Derek DeLia, Ph.D.
Joel C. Cantor, Sc.D.

July 2012

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Acknowledgments

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Preface

The New Jersey Medicaid Accountable Care Organization (ACO) Demonstration Project, enacted by legislation and signed by the Governor in August 2011 (P.L. 2011, Ch.114), authorizes the establishment of community-based ACOs by coalitions of healthcare providers serving Medicaid beneficiaries. The New Jersey ACO law calls on the Rutgers Center for State Health Policy (CSHP) to provide technical assistance for the evaluation of gainsharing plans submitted by coalitions seeking state certification to become Medicaid ACOs. Addressing one important aspect of that charge to CSHP, this Paper provides a recommended methodological framework for calculating the extent to which ACOs have achieved savings in Medicaid spending.

In May 2012, CSHP released a preliminary version of this paper and solicited comments from stakeholders and others with expertise in ACO development and healthcare delivery reform. This final version reflects input from a variety of individuals who commented on the draft Discussion Paper. The final recommended methodology described in this report was developed by CSHP researchers with input from New Jersey Medicaid staff, but the Rutgers CSHP team is solely responsible for all recommendations and other content in the document. Neither the New Jersey Medicaid program nor any other office of state government has endorsed the methodology. Rather, this paper is intended to inform future state decisions about acceptable methods for measuring ACO savings.

Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project

Derek DeLia, Ph.D. and Joel C. Cantor, Sc.D.

Executive Summary

The recently enacted New Jersey Medicaid Accountable Care Organization (ACO) Demonstration Project enables the formation of ACOs that will be eligible for shared savings from the New Jersey Medicaid program. The New Jersey ACO law calls on the Rutgers Center for State Health Policy (CSHP) to provide technical assistance for the evaluation of gainsharing plans submitted by coalitions seeking state certification to become Medicaid ACOs. Addressing one important aspect of this charge to CSHP, this report outlines a series of technical issues that must be addressed to accurately measure the extent to which ACOs have generated savings in per capita Medicaid spending and provides a draft methodology that balances the analytic challenges involved. This methodology builds on the rules established by the Medicare Shared Savings Program (MSSP), which governs Medicare ACOs nationwide. Several features of the MSSP, however, require substantial modification to address differing program features and populations served by Medicaid. These include the development of Medicaid-specific risk adjusters, provisions to support ACOs with a focus on extremely high-cost (i.e., "super-user") populations, and provisions to limit financial risk to Medicaid ACOs. Additional rules must be created to address challenges that are unique to Medicaid ACOs. These include rules for determining how the Demonstration Project will account for instability in Medicaid enrollment and incorporate newly eligible Medicaid enrollees under the federal health reform law in 2014. This report incorporates changes made in response to an earlier CSHP Discussion Paper seeking comments on the proposed methodology.

Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project

Derek DeLia, Ph.D. and Joel C. Cantor, Sc.D.

Introduction

On August 18, 2011 the Medicaid Accountable Care Organization (ACO) Demonstration Project was signed into law (P.L. 2011, Ch.114). The law enables coalitions of healthcare providers and public health and social service agencies to create ACOs that focus on improved healthcare coordination and delivery for geographically defined populations of Medicaid beneficiaries. Specifically, a Medicaid ACO may take responsibility for all Medicaid beneficiaries in a "designated area", which is "a municipality or defined geographic area in which no fewer than 5,000 Medicaid recipients reside" (P.L. 2011, Ch.114, C.30: 4D-8.2). Medicaid ACOs that are successful at reducing per capita Medicaid spending for their defined populations, while meeting standards for healthcare quality and patient experiences with care, are eligible to receive a share of the financial savings they generate, a process referred to as *gainsharing*. The demonstration will last three years with the possibility of reauthorization to continue and expand Medicaid ACO activity throughout New Jersey.

The statute requires Medicaid ACOs to propose methods for defining how savings will be measured and shared. These methods (along with proposed measures of health outcomes and patient experiences with care) are subject to approval from the New Jersey Department of Human Services (DHS) in consultation with the New Jersey Department of Health and Senior Services. The DHS will draw on the expertise of the Rutgers Center for State Health Policy (CSHP), which is named in the statute, to provide technical assistance with a variety of analytic tasks that are needed to administer and evaluate the 3-year demonstration. These tasks include organizing data for DHS to assess ACO's proposed gainsharing plans and supporting the annual evaluation of the demonstration.

As specified in the statute, savings measurement must be based on a benchmark period prior to ACO formation to which future spending performance will be compared on an annual basis for Medicaid patients residing in the geographic area served by the ACO. Specifically, the savings measurement methodology must include:

> . . . expenditures per recipient by the Medicaid fee-for-service program during the benchmark period, adjusted for characteristics of recipients and local conditions that predict future Medicaid spending but are not amenable to the

> care coordination or management activities of an ACO. (P.L. 2011, Ch.114, C.30:4D-8.5)

Once the benchmark is established, the savings measurement must compare "the benchmark payment calculation to amounts paid by the Medicaid fee-for-service program for all such resident recipients during subsequent periods" (P.L. 2011, Ch.114, C.30:4D-8.5).

Within this framework, Medicaid ACOs are given considerable flexibility to design savings measurement methodologies, which include the specification of the benchmark period (i.e., beginning and end dates), adjustment for patient characteristics, and other considerations described below. This flexibility is useful for the purpose of giving Medicaid ACOs the opportunity to design savings methodologies that are most relevant to their local circumstances. But there is also substantial value in developing a common analytic framework for measuring ACO performance. A common framework would provide a rigorous, consistent, and transparent mechanism for DHS to approve and oversee Medicaid ACO activities across the state. It would also provide a much needed resource to provider coalitions that are well positioned to improve care coordination but lack the analytic capabilities to develop rigorous performance measures on their own. In addition, Medicaid ACOs generally lack access to critical data from outside their own population against which to benchmark their performance. Finally, a common methodology can be administered efficiently, without placing data collection and analysis burdens on individual ACOs. The common framework proposed here is not intended to preclude ACOs from developing their own performance measurement methodology. Rather, it provides a methodology that ACOs may choose to adopt or a rigorous standard against which other methodologies proposed by ACOs can be judged by DHS in its approval process.

This Discussion Paper outlines a proposed approach for calculating whether and to what extent savings are achieved by individual ACOs in the Demonstration Project. The paper also highlights a number of key technical decisions and analytic tradeoffs that must be made to identify savings and to ensure that these savings do not coincide with diminished patient outcomes. It is intended to provide a starting point for discussion among ACO stakeholders of saving measurement methods. We note that while CSHP developed this draft strategy with input from DHS Medicaid officials, it has not been formally reviewed or endorsed by DHS.

Previously Established Principles for *Medicare* ACOs

The key to any calculation of ACO savings is a comparison between per capita healthcare spending in the ACO patient population versus a "counterfactual" – i.e., what the corresponding spending would have been for the relevant population in the absence of ACO activity. The proposed methodology is based on the Medicare Shared Savings Program (MSSP), which was developed by the Center for Medicare and Medicaid Services (CMS) in the context of

ACOs that enter into shared savings agreements with Medicare.[1] Drawing on the Medicare methodology provides two advantages: 1) it has already been through thorough technical review at the federal level and has been vetted by stakeholders through a public comment process, and 2) the Medicare methodology will be familiar to provider groups considering the development of a Medicare ACO.

Despite these advantages, a number of details in the Medicare methodology can be problematic for Medicaid ACOs in New Jersey. Thus, the proposed methodology deviates from the MSSP in specific ways that are described below.

Under the MSSP, an ACO is given credit for savings when per capita spending among the relevant patient population falls below a target spending level that is based on recent spending patterns and projected future spending. (Under some Medicare ACO models, the ACO could also be financially penalized if per capita spending among the relevant patient population falls significantly above the target level.)

First, baseline spending is calculated as a weighted average of the previous 3 years of per capita spending among patients assigned to the ACO. The use of multiple years provides a relatively stable measure of baseline spending (i.e., one that is less subject to random fluctuations from year to year). The use of a weighted average allows CMS to place more weight on the most recent years of baseline performance. Specifically, CMS's weighted average uses a weight of 0.6 for the most recent baseline year (Y3), 0.3 for the prior year (Y2), and 0.1 for the least recent year (Y1) in the 3-year weighted average.

Second, because of medical inflation, the 3 baseline years are not directly comparable. Therefore, Medicare "trends forward" years Y1 and Y2 by using the national growth rate in per capita Medicare spending to place Y1 and Y2 into Y3 "purchasing power."

Next, the baseline spending level is "updated" using a projected amount of growth in per capita Medicare spending nationally. In other words, Medicare predicts the additional dollars that will be spent on Medicare beneficiaries per capita (assuming no changes resulting from ACO participation) and adds it to the baseline amount. This updated amount is the target level of spending for the ACO. If ACO spending falls below the target by a designated amount (explained below), then the ACO will be credited with savings.

It is important to emphasize that CMS determines the baseline trend factor and updated baseline target based on national spending trends, not trends among the ACO's patients alone. Thus, ACOs must reduce spending relative to a national growth standard, not an ACO-specific one.

Medicare sets a specific threshold called the minimum savings rate (MSR) to determine whether measured savings are sufficiently less than the targeted amount. At issue is the problem of "normal variation", which is the idea that per capita spending levels within an ACO

[1] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

can fluctuate randomly from year to year for reasons that are unrelated to care management activities. The importance of normal variation diminishes for ACOs with more patients. Therefore, Medicare sets smaller MSRs for larger ACOs. (For example, an ACO with 5,000 assignees would have to achieve savings that are at least 3.9% below the targeted amount, while an ACO with 60,000 assignees would have to achieve savings that are at least 2% below the targeted amount.)

Under the MSSP, gainsharing distributions from measured savings are contingent upon the ACO meeting a variety of healthcare quality standards. Failure to meet these standards would result in lower ACO payments (or larger financial penalties in models where ACOs are at risk for spending increases).

Finally, the Medicare approach includes the following additional technical adjustments:

- All expenditure amounts are risk adjusted using the CMS Hierarchical Condition Categories that were originally developed for risk adjusting premiums in the Medicare Advantage program.
- CMS expects per capita spending to grow at different rates for different categories of Medicare beneficiaries. Thus, CMS calculates separate trending and benchmark updating factors for four groups of Medicare beneficiaries: end-stage renal disease, disabled, aged dual eligibles, and aged non-dual eligibles.
- To minimize variation from catastrophically large claims, all Medicare beneficiaries (regardless of ACO assignment) with large spending amounts in a given year have their spending amount truncated at the 99th percentile of national Medicare spending (which is roughly $100,000) for the relevant year. In other words, patients with catastrophically high spending are included in the baseline and performance year calculations but their actual spending amounts are replaced by the 99th percentile amount for the relevant year.

Adapting the Medicare Approach for NJ Medicaid ACOs

With some modification, the Medicare approach can be adapted to NJ Medicaid ACOs. Below we propose specific modifications and list additional analytic decisions that must be made.

***Data*:** As required by statute, savings to be shared with ACOs must be based on per capita spending by the Medicaid fee-for-service population in the relevant geographic area. These savings will be measured using Medicaid claims data for the fee-for-service population. (Only the Medicaid portion of spending for Medicare-Medicaid duals eligibles will be included.)

***Managed care organizations*:** Unlike the MSSP, the Medicaid ACO Demonstration Project allows Medicaid managed care organizations (MCOs) to voluntarily participate in gainsharing arrangements with Medicaid ACOs. In such cases, MCOs and ACOs would negotiate separate savings measurement and gainsharing arrangements that would be independent of (i.e., have no impact on) arrangements that apply to the Medicaid fee-for-service population. To avoid the complexity of holding ACOs responsible for multiple measurement and gainsharing standards, it may be useful for MCOs to follow standards similar to those created for Medicaid fee-for-service. Specifically, per capita spending among Medicaid managed care patients would be measured using payment information available in patient encounter records. In cases where services are reimbursed through capitation payments, per capita spending could be imputed based on capitation rates or other available data for the relevant services and patient groups.

***Baseline spending*:** The numerator for per capita baseline spending will come from the most recent 3 years of claims/encounters records for all Medicaid services provided to Medicaid enrollees living in the ACO's designated geographic area before year 1 of ACO activity. The denominator will come from Medicaid enrollment files. To ensure that spending amounts apply only to the time when individuals were enrolled in Medicaid, baseline spending will be calculated on a per person per month basis. The same weighting used by CMS for Medicare ACOs would be applied.

***Trending factor for early baseline years*:** The trending factor will be based on the statewide growth rate in per capita Medicaid spending.

***Update factor for projected spending growth*:** The update factor will be derived from a one-year projection based on most recent 3 years of statewide Medicaid data. An adjustment will be needed to account for increases in Medicaid reimbursement rates for primary care that occur under the Patient Protection and Affordable Care Act (PPACA). Specifically, the federal government will provide funding to the states to increase these rates in 2013 and 2014. After 2014, state have the discretion to maintain or discontinue these enhanced reimbursement rates. These reimbursement changes can distort measurement of ACO savings performance since they will cause per beneficiary spending to rise and fall in ways that are not related to ACO care management. Moreover, this distortion will be greatest in ACOs where primary care utilization is most prevalent. Thus, we propose that per capita spending calculations be done using pre-PPACA reimbursement rates consistently through the baseline and demonstration periods. A similar approach would be used for other reimbursement changes that may occur during the demonstration period (e.g., behavioral health reimbursement under the state's anticipated 1115 waiver).

***Unstable Medicaid enrollment*:** Unlike Medicare, Medicaid beneficiaries often "churn" on and off the program. As a result, spending calculations can be distorted during periods of disenrollment. For example, a patient with a 3-month gap in enrollment may appear to have a decrease in spending when in reality the individual may have used other services such as hospital charity care that are not recorded in Medicaid claims data. To compensate for churning, we propose that calculations be based on the number of patients per month of enrollment. For example, an individual enrolled in Medicaid for 12 months of the first performance year would have their total annual spending divided 12 to produce an average monthly amount. An individual who was in the program for only 4 months would have their total spending divided by 4. Average monthly amounts for each individual would be aggregated to produce an average per patient per month value for spending within the ACO during the baseline and performance periods.

***Minimum threshold for savings*:** We propose not to use an MSR threshold for the initial implementation of New Jersey Medicaid ACOs. Although normal variation may lead to apparent ACO savings when none exist, it may also prevent the identification of true savings when such savings do exist. The added MSR requirement for ACOs to receive incentive payments may greatly discourage participation. Moreover, NJ requirements that ACOs invest in effective care improvement plans provides assurance that all ACO payments from recognized savings payments are appropriately invested for the benefit of enrolled populations. The need for MSR thresholds can be revisited later as the state and stakeholders gain experience with ACO arrangements.

***Risk adjustment*:** We propose that all spending amounts be risk adjusted using the Chronic illness and Disability Payment System (CDPS), which currently forms the basis for setting payment rates to NJ Medicaid managed care plans.[2] We encourage comments on the applicability of the CDPS for all Medicaid patients as it is currently used only for specific eligibility categories enrolled in Medicaid managed care plans.

***Trending and updating for eligibility and service categories*:** Following CMS's approach for Medicare eligibility categories (e.g., dual eligible, End Stage Renal Disease, etc.), we propose to create different trending and updating factors for specific Medicaid populations. Currently, some stratification categories are included in the CDPS. Nevertheless, there may be additional variation in healthcare spending trends within specific eligibility and service categories over time. Failure to account for this differential variation could penalize ACOs with disproportionately large numbers of patients in categories with rapid spending trends beyond

[2] R Kronick, T Gilmer, T Dreyfus, and L Lee, "Improving Health-Based Payment for Medicaid Beneficiaries: CDPS," *Health Care Financing Review* 21, no. 3 (2000): 29-64.

the ACO's control (e.g., due to new treatment modalities or technologies). Similarly, an ACO with a disproportionately large number of enrollees from a slowly growing spending category could be inappropriately rewarded.

Thus we propose to include separate trending and updating factors for the following eligibility categories: General Assistance, dual eligibles, non-dual eligible aged, blind and disabled (ABD), and all other enrollees. One might also include separate factors for service categories where costs are expected to grow at different rates. Such categories may include hospital inpatient, ambulatory care, pharmacy, long-term services/supports, behavioral health, trauma, and all other services. Service categories would have to be created to avoid the creation of incentives to deliver services in disconnected silos, which is a practice that ACOs are philosophically designed to reduce. In developing separate trending and updating factors, it is also important to keep the number of categories at a manageable level. This is especially important when eligibility categories are combined with service categories. For example, 4 eligibility categories and 5 service categories would lead to 20 cells for which calculations would have to be made. In addition to increasing the complexity of the savings calculation, a large number of cells makes it more likely that some cells will be sparsely populated giving unreliable estimates of spending growth.

***Newly eligible Medicaid enrollees*:** In 2014, a new category of enrollees will enter the Medicaid program under federal health reform. This newly eligible group will consist mainly of poor childless adults who are unlikely to be similar to preexisting enrollees in terms of healthcare utilization and spending. Because this group will have no baseline Medicaid spending history, their inclusion into shared savings calculations will be complex.

To estimate per capita baseline spending for this newly eligible population, a blended estimate will be derived from preexisting data for Medicaid eligibles with income up to 24% of the Federal Poverty Level (FPL) and individuals whose hospital use is currently financed through the state's Hospital Charity Care Program. Among all current Medicaid enrollees, those who are eligible for the program because their income is below 24% of the FPL are most similar to those expected to gain coverage under federal reform. Current Hospital Charity Care users include much of the population who will gain Medicaid coverage. Although Charity Care users include undocumented immigrants who are ineligible for the federal Medicaid expansion, there is no clear way to remove these individuals from the proposed blended estimate. This estimate will be used to impute what Medicaid utilization would have been during the baseline period had these newly eligible individuals been in the Medicaid program during that period. To improve the accuracy of the imputation, estimated amounts will be stratified by age and sex and applied to individual enrollees accordingly. The imputation might be enhanced further by including information about Medicaid spending for parents with income and recent hospital use that is similar to the experience of newly eligible enrollees as measured in Hospital Charity Care

records maintained by the NJ Department of Health. We welcome comments on methods for imputing baseline spending for this newly eligible population.

***Quality of care*:** The statute requires ACO gainsharing plans to "reward quality and improved patient outcomes and experiences with care" (P.L. 2011, Ch.114, C.30:4D-8.5). In the MSSP, the distribution of total savings (or losses) shared with the ACO are contingent on meeting specified quality goals. While a similar approach may be used in the Medicaid ACO Demonstration Project, criteria for distributing gains is beyond the scope of this discussion paper, which is concerned only with establishing whether savings have occurred.

***Truncation of extreme spending levels*:** We propose not to truncate individual spending levels for Medicaid ACOs as is done in the MSSP. Much of the focus among NJ Medicaid ACOs will be to coordinate services for the most frequent users of expensive but preventable hospital and emergency department care. Truncating the spending of these individuals would limit the incentive payments to Medicaid ACOs doing this work.

We recognize that this decision involves important analytic tradeoffs. A small number of outlier patients with anomalously high spending in the performance period can make an ACO that was successful at reducing spending overall look like it failed to do so. Similarly, a few outlier patients in the baseline period can make an ACO appear to reduce spending in the performance period when, in fact, spending levels have just returned to a normal level. This problem can be especially acute for ACOs with a small number of Medicaid fee-for-service enrollees where per capita averages are much more sensitive to outliers. (Although ACOs must have a minimum of 5,000 Medicaid patients in their geographic area, many enrollees are likely to be enrolled in managed care plans.) A middle ground might involve a threshold that is set higher than that envisioned under the MSSP (e.g., $200,000 rather than $100,000). We recommend that the impact of outlier patients on shared savings formulas be monitored closely as part of the evaluation of the demonstration that is required by the statute.

***Patients at the end of life*:** Another important issue is how to deal with patients who die during the demonstration period. In the MSSP, mortality-based outcome measures were not included in the final set of quality benchmarks. In addition, the MSSP excludes the expenditures of individuals who die during the ACO agreement period. This exclusion is made to take away any incentive that Medicare ACOs would have to avoid the most critically ill patients or to withhold beneficial care from them. However, the exclusion also takes away incentives for ACOs to improve the efficiency of end-of-life care. In addition, the New Jersey statute requires that Medicaid ACOs maintain a commitment to be accountable for the costs all Medicaid fee-for-service recipients living in the designated area (P.L. 2011, Ch.114, C.30:4D-8.4). Thus, it is our understanding that all end-of-life spending must be included in savings calculations, but

because savings estimates are likely to be very sensitive to costs incurred by patients in their final months of life, we recommend close monitoring of these expenses and their impact on savings calculations.

***Impact on hospital revenue and financial stability*:** Some Medicaid ACO activities are expected to reduce hospital inpatient admissions, which could reduce hospital revenues. Thus, the statute requires applicant ACOs to submit an assessment of how ACO activity is expected to create changes in "both direct patient care revenue and indirect revenue, such as disproportionate share hospital payments, graduate medical education payments, and other similar payments" (P.L. 2011, Ch.114, C.30:4D-8.5). While these considerations form an important part of the ACO approval process, they would not alter the methodology used to demonstrate whether the ACO generates savings and are thus not part of this discussion paper.

***Evolving issues*:** The New Jersey Medicaid ACO Demonstration Project is designed to give communities the opportunity to rapidly form and test the ACO concept for Medicaid enrollees. To enable rapid and minimally complex administration, the proposed savings measurement methodology does not make adjustments in response to a variety of complex analytic issues. Instead, we propose that the issues listed below be monitored during the course of the demonstration. Some issues that are found to be quantitatively important should be addressed as part of the evaluation of the demonstration and, possibly, inform changes to ACO savings calculations over time.

- Patients who routinely enroll and disenroll from Medicaid may have a medical risk profile that is different from other Medicaid patients. The direction of difference (i.e., higher or lower risk) is not clear. This difference could affect savings calculations if an ACO takes responsibility for a disproportionate number of such individuals. We propose to examine whether individuals with unstable Medicaid enrollment generate systematically different levels of healthcare expenditures relative to those with stable enrollment.
- The accuracy of the proposed imputation in per capita spending for new Medicaid enrollees cannot be known in advance. At issue is whether new enrollees have systematically higher or lower expenditures than the imputation would suggest. We propose to examine how spending generated by new enrollees under the federal Medicaid expansion compares to their imputed spending.
- New Medicaid enrollees may have certain approved services incurred within 90 days before enrollment reimbursed by Medicaid. Moreover, the rules governing this look-back period may change under the state's anticipated 1115 waiver. The evaluation

should consider how the 90-day look-back may affect expenditure calculations during the course of the demonstration.

- During the course of the demonstration, coverage for particular services (e.g., dental care) may change. We propose to monitor these changes to determine whether they influence per capita spending calculations during the benchmark and performance periods.

Conclusion

The proposed approach to measuring savings generated by Medicaid ACOs is designed to balance the principles of analytic rigor, transparency, timeliness, and feasibility with existing information systems. As experience with the demonstration accumulates, these methods should be carefully evaluated and revised. Such an evaluation can be accomplished using the databases that will already be developed for evaluating the impact of the demonstration on healthcare spending and patient outcomes as specified in the Medicaid ACO Demonstration Project.

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Camden Coalition
of Healthcare Providers

RESOLUTION OF THE BOARD OF DIRECTORS
OF THE CAMDEN COALITION OF HEALTHCARE PROVIDERS

RESOLUTION 2015-10-5
ACO SHARED SAVINGS REINVESTMENT PROCESS

WHEREAS the Camden Coalition of Healthcare Providers was certified as a Medicaid Accountable Care Organization (ACO) on July 1, 2015;

WHEREAS the Medicaid ACO law and regulations require the ACO to adopt a comprehensive ACO strategic plan, known as a gainsharing plan, that lays out the ACO's goals, strategies, initiatives, quality metrics, patient satisfaction and feedback process, shared savings contracts, public engagement, and shared savings reinvestment priorities;

WHEREAS the law and regulations require the ACO to reinvest shared savings in activities that further the objectives of the ACO Demonstration Project, including payments for improved quality and patient outcomes, interdisciplinary collaboration for complex patients, expanded access for high risk patients, expansion of medical homes, support for the infrastructure of the ACO, and expansion of healthcare workforces and services (10:79A-1.6(d)(7)(iii));

WHEREAS the Camden Coalition's Strategic Planning Committee has been charged with developing the ACO gainsharing plan, including the shared savings reinvestment process to identify, prioritize, and fund ACO initiatives;

WHEREAS the Strategic Planning Committee has proposed a shared savings reinvestment process that is participatory and broadly inclusive of input from Coalition members and the Camden public;

WHEREAS the Board of Directors has reviewed the proposed Reinvestment Process at its board retreat;

BE IT RESOLVED that the Board of Directors hereby adopts the proposed shared savings reinvestment process to be incorporated in the draft gainsharing plan to be released for public comment.

Date approved: October 28, 2015

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Board Chair

Camden Coalition
of Healthcare Providers

ACO Quality Committee Policies

Purpose: The purpose of the ACO Quality Committee is to provide oversight and strategic input to the health care quality issues and value of services for the Camden Coalition ACO. The committee is charged with supporting the establishment and governance of the Medicaid ACO Demonstration Project, specifically measurement and reporting of quality programs on a regular basis. The ultimate goal of this committee is to improve the quality of care and services provided to all Camden residents.

Authority: The ACO Quality Committee derives its authority from the Bylaws of the Camden Coalition, and is required by the laws and regulations authorizing the Medicaid ACO Demonstration Project in New Jersey. The primary responsibilities of the Quality Committee shall include but not be limited to review and report on the following:

1. Quality of care
2. ACO Performance
3. Patient experience

Composition: The Quality Committee shall be made up of both physician and non-physician members of the Board of Directors of the ACO, participating providers, and other stakeholders according to the requirements of the Medicaid ACO Demonstration Project and the Coalition's bylaws (Appendix A).

Meetings and Member Commitment:

- The Committee will meet at least 4 times a year, with authority to convene additional meetings as circumstances require.
- All Committee members are expected to attend each meeting, in person. Occasional participation via tele- or video-conference is permitted; however, in person attendance is preferred.
- Minutes from every meeting will be prepared for approval
- From time to time committee members may be engaged in between meetings to move projects forward

Responsibilities: The Committee will carry out the following specific responsibilities:

1. Establish and monitor the ACO Quality Plan on behalf of the Board of Directors. Ensure that the Quality Plan goals are consistent with the highest standard of medical care as well as the strategic goals of Camden ACO

2. Distribute best practice recommendations/guidelines for ACO

3. Monitor ACO feedback

4. Approve and monitor corrective action plans for low performing ACO practices

5. Consult on development and implementation of gainsharing strategies as they relate to physicians, relationships with physicians and hospitals, and quality plan compliance

Reporting Responsibilities:

1. This committee will report quarterly to the Board of Directors on Committee activities, issues and related recommendations

2. Review any other reports the ACO issues that relate to Committee responsibilities

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Exhibit 09: ACO Gainsharing Plan Public Feedback

Gainsharing Plan Public Distribution Channels

Date	Distribution Mechanism
January 6, 2016	Presentation to and review of gainsharing plan by Camden Coalition Strategic Planning Committee
January 20, 2016	Presentation to and review of gainsharing plan by Camden Coalition Board
January 28, 2016	Presentation to and review of gainsharing plan by Camden Coalition Community Advisory Committee
February 1, 2016	ACO feedback form and feedback phone line modified to receive input into the gainsharing plan http://www.camdenhealth.org/feedback/ http://www.camdenhealth.org/reaccion/ 856-365-9510 x2095
February 4, 2016	Gainsharing plan distributed via email to Camden Coalition primary care practice partners as well as
February 6, 2016	Plain language summary and full version of gainsharing plan placed on Camden Coalition website https://www.camdenhealth.org/the-camden-coalition-aco-saving-money-improving-lives/
February 6-March 2, 2016	Gainsharing plan reviewed in person with Camden Coalition primary care practice partners 2/10: Osborn Family Health Center 2/11: Cooper Family Medicine 2/17: Reliance Medical Group 2/18: St. Luke's Catholic Medical Services 2/18: Fairview Village Family Practice 2/18: Virtua Family Medicine 2/23: Project HOPE 3/2: Cooper Physicians Office 3/2: Cooper Ambulatory Pediatrics
February 9, 2016	Gainsharing plan distributed via email to Camden Church's Organized for People network
February 25, 2016	Public Meeting at the Camden Coalition to review Gainsharing plan

Camden Coalition
of Healthcare Providers

Synthesis of Feedback

- Clarity on Shared Savings
    - Further clarification of how any shared savings money will make it's way back to primary care providers in the city
- Enhanced Engagement
    - Continue to involve the community actively in determining priorities of the ACO and getting feedback around services within the ACO
    - Enhance the diversity in age, race, gender, and religion of the Camden Coalition Community Advisory Committee
    - Develop bridges between the various local community advisory boards in Camden
    - More opportunities for networking, dialogue, and lessons learned sharing between primary care practices in the city
    - Continue to use the phone line as a feedback mechanism for the ACO for patients who do not have computers
- Health Related Areas to Address in Camden:
    - Need for more substance abuse treatment services within Camden and outside Camden
    - Health Education
    - Increased Peer Support
    - Improving the quality of care delivered, suggestions included:
        - ACO standards/protocols for post hospital follow up visit
        - ACO standards for breast cancer screening

RESOLUTION OF THE BOARD OF DIRECTORS
OF THE CAMDEN COALITION OF HEALTHCARE PROVIDERS

RESOLUTION 2016-4-1
ACO GAINSHARING PLAN APPROVAL

WHEREAS the Camden Coalition of Healthcare Providers was certified as a Medicaid Accountable Care Organization (ACO) on July 1, 2015;

WHEREAS the Medicaid ACO law and regulations require the ACO to adopt a comprehensive ACO strategic plan, known as an ACO Gainsharing Plan, that lays out the ACO's goals, strategies, initiatives, quality metrics, patient satisfaction and feedback process, shared savings contracts, public engagement, and shared savings reinvestment priorities;

WHEREAS the Camden Coalition's Board of Directors, Executive Committee, Strategic Planning Committee and Community Advisory Council have previously reviewed and provided input to a draft ACO Gainsharing Plan;

WHEREAS the Camden Coalition solicited public input from its members, practices and the broader Camden community by posting the draft ACO Gainsharing Plan on its website, sharing a summary document with practices, and hosting a public meeting at the Camden Coalition;

WHEREAS the Camden Coalition received significant support and incorporated the relatively minor substantive suggestions received through its public input process to create the proposed final ACO Gainsharing Plan;

WHEREAS the Board of Directors has reviewed the proposed final ACO Gainsharing Plan;

BE IT RESOLVED that the Board of Directors hereby approves the proposed ACO Gainsharing Plan to be submitted to the Department of Human Services for its review and approval.

Date approved: April 20, 2016

Kevin Barnes

Board Chair

Camden Coalition of Healthcare Providers

How long have you gone to this practice?

Visit Type: Sick

Well

PRACTICE NAME

This survey is anonymous and confidential. Your satisfaction with the care that you received is important to us, and we hope that you will complete the following survey. Your feedback will help us improve services at this practice.

1. Do you have health insurance?

Please Circle One:	1 Yes	2 No	3 Unknown

2. How satisfied are you with the level of concern that your doctor's office had for your questions or worries?

Please circle one:	1 Very Dissatisfied	2 Dissatisfied	3 Neutral	4 Satisfied	5 Very Satisfied	6 Not Sure	7 N/A

Please explain why you chose this answer:

3. How satisfied are you with the level of care you received at your doctor's office?

Please circle one:	1 Very Dissatisfied	2 Dissatisfied	3 Neutral	4 Satisfied	5 Very Satisfied	6 Not Sure	7 N/A

Please explain why you chose this answer:

4. How satisfied are you with how well the medical staff at your doctor's office listens to you?

Please circle one:	1 Very Dissatisfied	2 Dissatisfied	3 Neutral	4 Satisfied	5 Very Satisfied	6 Not Sure	7 N/A

Please explain why you chose this answer:

5. How satisfied are you with the amount of time the medical staff at your doctor's office spends answering your questions?

Please circle one:	1 Very Dissatisfied	2 Dissatisfied	3 Neutral	4 Satisfied	5 Very Satisfied	6 Not Sure	7 N/A

Please explain why you chose this answer:

6. How satisfied are you with the office staff's (For example: receptionist, person who scheduled your appointment) helpfulness and politeness?

Please circle one:	1 Very Dissatisfied	2 Dissatisfied	3 Neutral	4 Satisfied	5 Very Satisfied	6 Not Sure	7 N/A

Please explain why you chose this answer:

7. How well does the medical staff at your doctor's office ensure that private matters are discussed with you in an area where no one else can hear?

Please circle one:	1 Very Poorly	2 Poorly	3 Okay	4 Good	5 Great	6 Not Sure	7 N/A

Please explain why you chose this answer:

8. How well does the medical staff at your doctor's office explain the steps you need to take to improve your health?

Please circle one:	1 Very Poorly	2 Poorly	3 Okay	4 Good	5 Great	6 Not Sure	7 N/A

Please explain why you chose this answer:

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9. In the last 12 months, when you phoned this office, how easy was it to schedule visits for the days and times you needed?

Please circle one:	1 Very Difficult	2 Difficult	3 Neutral	4 Easy	5 Very Easy	6 Not Sure	7 N/A

Please explain why you chose this answer:

10. In the last 12 months, when you phoned your specialty office, how easy was it to schedule visits for the days and times you needed?

Please circle one:	1 Very Difficult	2 Difficult	3 Neutral	4 Easy	5 Very Easy	6 Not Sure	7 N/A

Please explain why you chose this answer:

11. In the last 12 months, when you phoned this office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?

Please circle one:	1 Never	2 Almost Never	3 Occasionally	4 Almost every time	5 Every Time	6 Not Sure	7 N/A

12. In the last 12 months, when you phoned this office after regular office hours, how often did you get an answer to your medical question as soon as you needed?

Please circle one:	1 Never	2 Almost Never	3 Occasionally	4 Almost Every	5 Every Time	6 Not Sure	7 N/A

Camden Coalition of Healthcare Providers

Time

13. What barriers make it difficult for you to visit your primary care provider?

Please circle all that apply:	Transportation/ Parking	Office Hours	Finances	Scheduling	Other

If other, please list additional barriers:

14. What could be done differently to make your experience at this doctor's office better?

15. Within the past 12 months we worried whether our food would run out before we got money to buy more.

Please Circle One:	1 Often True	2 Sometimes True	3 Never True	4 Unsure

16. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

Please Circle One:	1 Often True	2 Sometimes True	3 Never True	4 Unsure

Patient Satisfaction Survey Report

Background

In June and July of 2015, our second cohort of Summer Associates administered the second annual Patient Satisfaction Survey across all of the participating practices in the ACO.

Survey Tool

They used the same survey as 2014 so that this year's results could be compared to the baseline from last year. This survey was developed by the Camden Coalition's Quality Committee and was an aggregate of the various existing surveys used by all member practices represented on the Committee.

3 new questions were added to the survey in 2015 that were not asked in 2014. The first addition was a question related to the overall level of care the patient received. This was added at the recommendation of our Community Advisory Council. The other two additional questions were tacked on to the end of the survey and are validated questions designed to screen for food insecurity. These questions were added as part of a citywide initiative to collect Camden city data on food insecurity because such a data set does not exist – all existing food insecurity data sets are at the county or census-tract level.

Survey Collection

The six summer associates, all undergraduate students pursuing the premedical sciences, health management or social work, conducted all survey collection in person in the waiting rooms of our 13 practices across the city. The surveys were conducted on paper and were available to patients in both Spanish and English. All patients who agreed to take the survey were offered the opportunity to have the survey read to them and filled out for them, or to fill it out on their own.

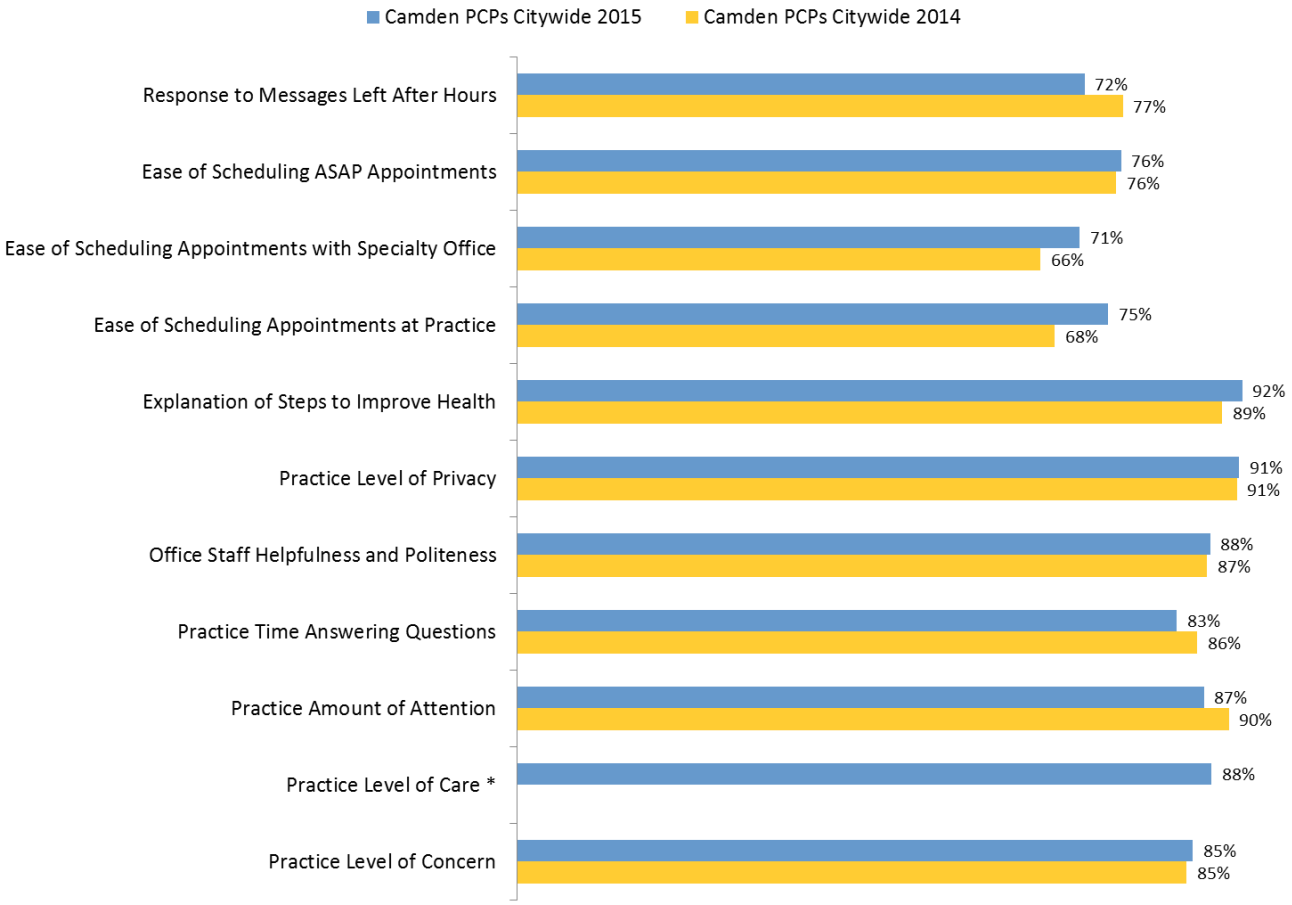
All patients in the waiting room were offered the opportunity to take the survey regardless of whether they were a Camden resident and regardless of insurance coverage. In addition to the core survey questions, we also asked patients to answer whether or not they had insurance, how long they had been a patient of the practice, and whether they were at the clinic for a well or sick visit.

At least 25 surveys were collected from each practice, with higher numbers of surveys collected from practices with higher volume. The number of surveys collected from each practice was not calculated based on panel size of the practice but was random and based on clinic flow. 761 surveys were collected in total.

The summer associates brought healthy snacks and bottled water with them into the waiting rooms. The snacks and water were made available to all patients in the waiting room, not just those filling out the survey.

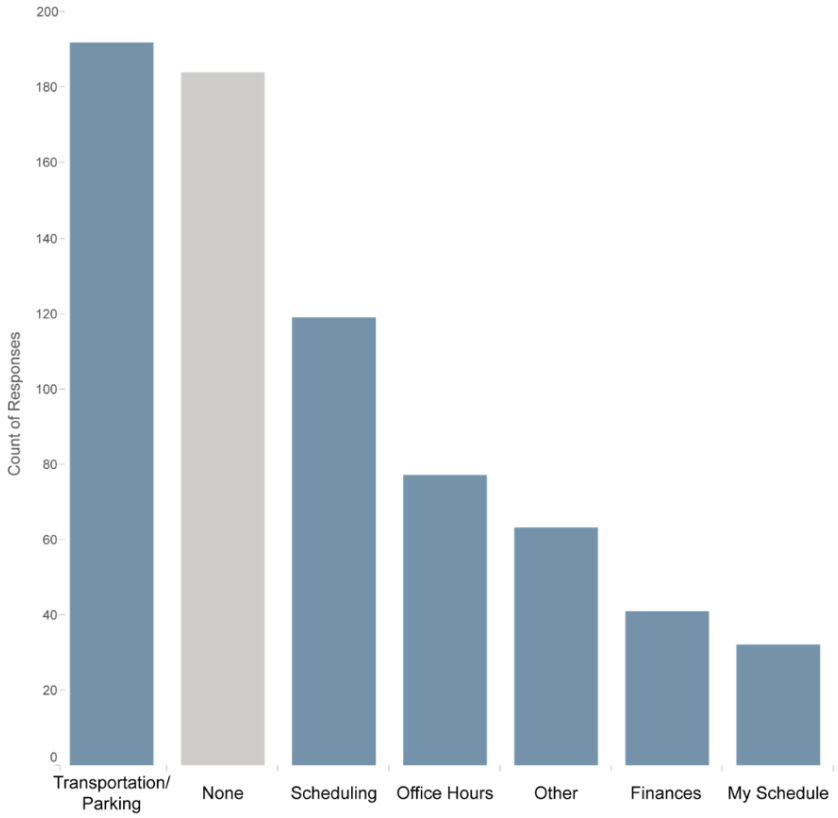
Results

The results to the quantitative questions show improvement in almost all categories. The categories in which satisfaction fell were: 1) response to messages left after hours (dropped from 77% to 72%); 2) practice time spent answering questions (dropped from 86% to 83%); and 3) practice amount of attention (fell from 90% to 87%). The following chart shows the percentage of 4s and 5s (Satisfied and Very Satisfied) scored on each question:

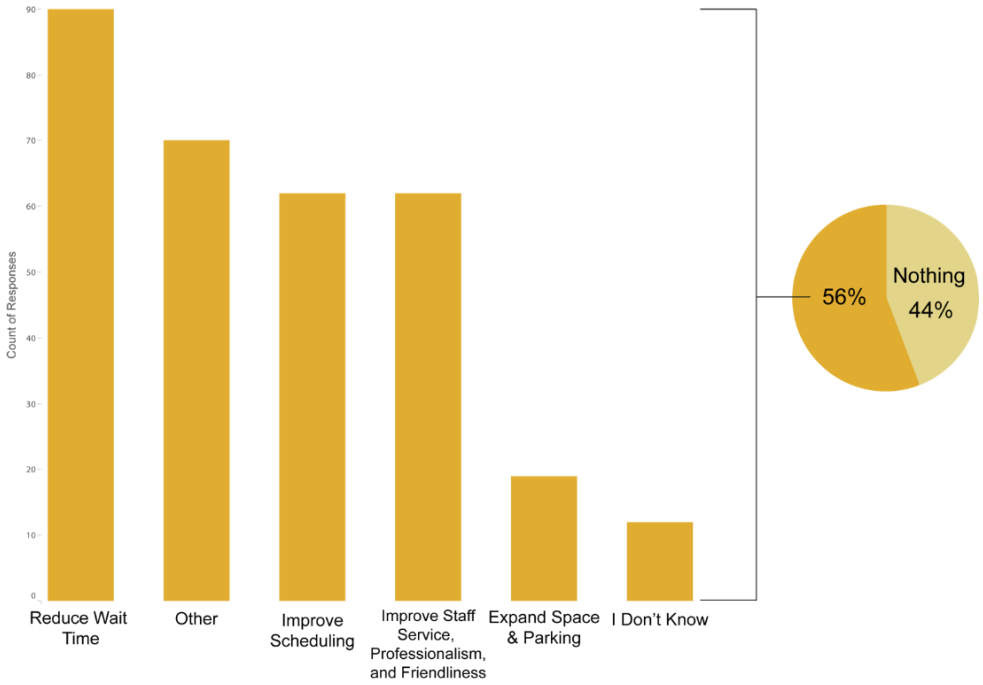


Over the course of the next few months, we will share this data with individual practices, our Quality Committee, and other stakeholders. We will identify concrete strategies that practices can implement in response to the dip in certain categories. In addition to the high level summary data, we have detailed reports for each practice in which they can read all of the open-ended responses that their patients had on each question.

In addition to the Likert scale questions, patients were also given the opportunity to reflect on the barriers that they face in accessing primary care. Here is a break-down of what patients reported as barriers from a list of pre-populated categories:



Patients were also given a chance to reflect on the question "What could be done differently to make your experience at this doctor's office better?" Patients responded as follows:



Next Steps

From the data that was collected and analyzed, we have created the following set of artifacts:

- Citywide quantitative and qualitative overviews (included above)
- Citywide food insecurity presentation (included above)
- Practice-specific quantitative one-pages that compare the practice's 2014 and 2015 scores with that of the city as a whole in 2015
- Practice-specific qualitative reports that include a breakdown of every answer to each question and all of the open-ended responses provided by patients
- Practice-specific food insecurity reports to show which practices may benefit from an increased focus on food and nutrition resources

Citywide data will be presented to the Camden Coalition Quality Committee and Executive Committee, as well as internally to the staff.

Practice-level data will be presented to practice leadership along with a facilitated discussion on takeaways from the data and ways to incorporate feedback and opportunities for improvement.

Larger themes related to the barriers that patients face in accessing primary care will be shared with our Legal & External Affairs team to incorporate into the Coalition's policy agenda. Citywide barriers to care data will also be made available to community partners if and when they request it.