FINAL TRANSCRIPT

WEBINAR TITLE: Medicaid Value-Based Payment Approaches and Key Design Considerations
DATE: October 5, 2017
TIME/TIME ZONE: 3:00 p.m. Eastern Time

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PRESENTATION
Scott Leitz: Good afternoon, and welcome, everyone, to this afternoon's webinar: Medicaid Value-Based Payment Approaches and Key Design Considerations. My name is Scott Leitz, and I'm with NORC at the University of Chicago. I want to thank everyone for joining us today.

Over the next 90 minutes, we're going to be giving an overview of approaches both from a design and an implementation perspective of value-based payment models in Medicaid. We really are thinking about this as a little bit of a value-based payment 101 for state Medicaid programs.

A couple of logistics before we get started with the main portion of the presentation this afternoon. All lines will be muted, and that we ask that folks don't put your lines on hold since you will be muted. To participate in a polling question, there will be one or two of those throughout the question today, you will be exiting out of full screen mode to do that, and then we ask that you use the chat box on your screen to ask a question or leave a comment and that you address the question that you have for the presentation to the host that will allow us to take in and process those questions as they come in.

We do have some goals and learning objectives for today. It's really the goal of webinar today that by the end of it you will have a sense of why state Medicaid programs may wish to explore implementing value-based payment approaches; hopefully gain an understanding of the general options and approaches available to state and Medicaid agencies; gain an understanding of the considerations for states to select, design and implement value-based models within their Medicaid programs; understand various options and approaches states can use in working with managed care organizations in the implementation of value-based payment models. While it's important to note that while we'll be covering a lot of these options and talking about them throughout the course of the webinar, we also want to note that there's many different flavors in between the different approaches that we'll be discussing and we'll get into that a little bit as we go throughout the presentation.

So for our agenda today we'll do a little bit of a welcome and introduction on the front end; we'll spend a little bit of time talking about just what value-based payment is so it'll be familiar territory for some of you and hopefully maybe some new territory for some others; we will

discuss some of the common value-based payment approaches used within Medicaid, both within fee-for-service and within managed care; we will touch on a few of the key value-based payment foundational design elements and then also touch on some other considerations that states might have in thinking about value-based payment for their state Medicaid programs; and then because so many states now use managed care organizations to deliver services to their Medicaid enrollees, we'll touch on some of the considerations for implementing value-based payment within a managed care organization environment. And then what we'll do throughout the presentation is we'll sort of pause after each of the major sections, presentations and take questions. Again, you can pose those in the chat box addressing it to the host.

As I mentioned at the outset, I'm Scott Leitz. I'm a Senior Fellow at NORC at the University of Chicago, and I'm the Project Director for the Medicaid Innovation Accelerator Program Value-based Payment and Financial Simulations Project. I'm joined this afternoon by my co-presenter, Tricia McGinnis, who's Senior Vice President at the Center for Health Care Strategies. Many of you know Tricia and CHCS for all the wonderful work they've done over time in Medicaid, and in particular around value-based payment. Tricia and I will sort of be co-presenting throughout the afternoon and we really do look forward to a great and interactive presentation this afternoon.

So before moving into our presentation on value-based payment, I want to turn it over to Katherine Griffith from CMS' Center for Medicaid and CHIP Services to give a brief overview of the Medicaid Innovation Accelerator Program.

Katherine Griffith: Great. Thank you Scott. Good afternoon everybody. I am Katherine Griffith. I'm the Senior Advisor for the Medicaid Innovation Accelerator Program. We are really excited to have everybody on the line. I think we have record-breaking registration for this webinar so we know it is a topic of interest for everybody and excited to have everybody here to provide this introduction. As you'll learn later, this is actually the first in a series of value-based payment webinars that the Medicaid Innovation Accelerator Program is hosting over the next few weeks. Following this one there will be webinars on value-based payment on substance use disorders and maternal and infant health as well as children's oral health. So then you'll learn more about those later.

Before we get into what you're all here for, I just want to review the purpose of the Medicaid Innovation Accelerator Program. Many of you guys know probably of the technical assistance program within CMS and based out of CMCS that we partner closely with CMMI and we support state Medicaid agencies' delivery system reform effort. So we are not a grant program. We are really here to support the states and offer technical assistance to great contractors like NORC and CHCS.

The next slide provides a high-level overview of the different subjects and areas that IAP addresses. We have four program areas and as well as four functional areas. The functional areas are levers within delivery system reform that we found assist states with their delivery system reforms and then the program areas are specific topics we are helping and assisting

states develop delivery system reforms in. This webinar is obviously under the value-based team and financial simulation functional area, as well as some of the subsequent webinars in the series. Obviously the substance use one is under our substance use disorder program area.

So I'm going to pass it back to Scott but again thank you all for joining and we look forward to your questions and participation and feedback at the end. Thanks Scott.

Scott Leitz: Great. Thank you Katherine. As we move into our presentation this afternoon, one thing we wanted to get—we're interested in learning a little bit about is the level of knowledge of folks who are on the webinar today and what level of knowledge you have on application of value-based payment principles you might all have. So we have a poll question that we'd like to pose for you all. And it's up. I think we can—if you are able to, we'd love to get your responses to the poll and we can let you know what those look like. So we'll do about 15 seconds for the poll.

And I think we're closing the poll now. It looks like mostly folks indicated that they've heard of value-based payment and alternative payment models that they can give examples of VBPs from their state Medicaid programs, and that we have a fair amount of knowledge of at least a starting point of this. So it's really good to know where we're at and the fact that there's a lot of interest in both learning more about value-based payment as well as how to implement such models in state Medicaid programs.

So we thought it would be useful since we are going to be talking a lot this afternoon about value-based payment to actually define what we're talking about when we say that. Like everything, there is no single definition that's going to capture all of what we're trying to say about value-based payment but what we really came up with here is a definition that talks about value-based payment as payment models that range from rewarding performance in fee-for-service, all the way through models that involve capitation. These might include alternative payment models and comprehensive population-based payments. You can also think about the fact that this is a broad set of performance-based payment strategies that really have a goal of linking financial incentives to providers' performance on a set of defined measure of quality and/or cost or resource use. So it's a way to really link payment and quality outcomes to the—or cost and quality outcomes to payment systems within state Medicaid programs or more broadly.

Over the course of the past decade, plus I think you've heard a lot about and I think more and more about value-based payment and as various programs and payers in the system are starting to turn more to it or express a great deal of interest in it, we wanted to talk for just a second about why that is. So why are people interested in value-based payment? What problem or set of issues are we trying to solve for in thinking about value-based payment? And how does the application of value-based payment really help address these concerns or issues?

This slide sort of lays out I think at a really super high level, and there's a lot of reasons why people think about value-based payment, but one of those is the fact that the current system that we have is really rooted in a longstanding payment model of fee-for-service, and fee-for-

service is a very appropriate under a great number of circumstances but—and to remind people, fee-for-service of course is a system where providers are paid a certain amount for each service that they deliver—and while that certainly functions well from a delivery system and paying perspective, meaning providers do get paid for the services that they deliver, it can also create some incentives that may not lead to the best outcomes. Providers for example at a really high level the more you do the more you get paid under a fee-for-service system, and payment doesn't necessarily vary by quality of care and there aren't a lot of very well built-in incentives for high quality care in a fee-for-service system where quality isn't a component of measurement.

It also doesn't lead to any focus on upstream focus. For example, prevention in population health aren't necessarily rewarded in a fee-for-service system, and in fact they can actually be disincented in a sense that the more higher disease burden that folks have as they enter the system may lead to actual more services down the road and if we're able to invest more on the front end and focus a bit more upstream that might actually help lower cost overall. So changing the way that providers are paid to deliver care, providing incentives to deliver higher quality care and bend the cost curve and improve value is something that value-based payment very much seeks to do. It may not be the only way to do that, and in fact it's one of the incremental ways, most likely, but it's one that people are increasingly interested in looking at. As we mentioned earlier, value-based payment can encompass a range of approaches intended to better align incentives for providers to deliver a high-quality care and reward value in the health system.

In thinking about how best to talk about the various approaches to value-based payment, we've found that a very useful model to look at is one that has been put together by the Health Care Payment Learning and Action Network (HCP-LAN), what they call the Alternative Payment model framework. For those of you who are less familiar with the HCP-LAN, as it's sometimes called, it is an organization or a sort of facilitated work that is facilitated out of the U.S. Department of Health and Human Services but is inclusive and collaborative across public sector and private sector organizations and they've put together a very valuable and useful framework for thinking about stages or categories of value-based payment. I might mention that states are increasingly using this framework sometimes in the contracts that they're working with provider organizations or managed care plans with within their Medicaid programs and sometimes using it in discussions that they're having as they start down the path or road of value-based payment, but as you can see it's really, the framework, is really divided into four categories.

As you move from the left side of the framework to the right side of the framework, we move from sort of the world that has historically been where it's fee-for-service with no real link to quality and value moving to category 2 which is really fee-for-service that starts to link to quality and value and that might be things like paying for reporting just to getting data in the door paying for performance where there's bonuses for quality performance. They're moving into category 3 are models that are really built off the fee-for-service architecture but start to introduce things like shared savings and shared risk and more sophisticated or more complex

models of payment. And then finally, as we move to category 4, which is more really population-based payment which again gets to models that really look at paying globally for the health outcomes and cost outcomes of entire populations or subpopulations within programs.

This slide sort of takes that same or similar framework but lays it all slightly differently. So what you see is again sort of starting on the left-hand side, fee-for-service, and moving all the way as you move to the right towards more levels of provider risk, moving all the way up through capitation. So I wanted to note a couple of things about this slide and what happens. As you move from the left to the right, two things really do happen. First, the model to the right tend to involve greater levels of financial risk or risk assumption by provider organizations. Fee-for-service is a very much on the left-hand side of the traditional model that we've always worked with within the health system. But if you go over to the right and get into shared savings, shared risk and capitation, in the purple, those are highly accountable models where providers are taking on higher levels of risk and higher levels of care coordination and integration.

One thing that also occurs as you move from the left to the right is that the degree of provider integration and accountability also starts to increase as we do that. We put this slide up because I think it's important for states to really think about moving into a value-based payment model for their populations, where they are on either the HCP-LAN framework or a framework such as this one, where their providers are and their ability to accept higher degrees of risk and where they would like to be ultimately, what's their starting point and where would they actually like to end up as they incrementally put in place value-based payment models.

So before we move to the next section and talk in more detail about some of the common value-based payment approaches used in Medicaid, I wanted to just pause and see if there are any questions that folks have.

Operator: Thank you. We will now begin the question-and-answer session. If you have a question, please press star, one on your telephone keypad. If you wish to be removed from the queue, please press the pound sign and the hash key. Once again, if you have a question, please press star, one. We have Shannon Love online. Please go ahead.

Shannon Love: Hi. Thank you so much for taking my question. I'm wondering if there's been an assessment made on risk for fraud, waste and abuse with the program that you're presenting with value-based? It seems like to me that especially with fee-for-service that there'd be more risk for waste or abuse within Medicaid than there is with capitation. Can you tell me if you guys have explored that?

Scott Leitz: Yes, it's a great question. Within the context of this particular project it's not something that's being specifically explored. I do think that one of the things that you raise though is an interesting question around as you pay for more increment of things within any given program, whether it's Medicaid, Medicare or on the commercial side of payment, the more providers are paid the more units that are paid for might lead to opportunities for higher levels of things that might occur that might not be consistent with what good operation of a program would be. I think one of the reasons that states have traditionally looked to

movements to managed care or in this case value-based payments it starts to aggregate up some of that and hold providers and/or managed care organizations more accountable to outcomes for the payments that they're receiving as opposed to paying for each increment.

I won't get into the whole context of what occurs around. There's a whole inspector general aspect to fraud, waste and abuse that's a little bit outside of the scope of this. The only thing that I would just add is that within the context of value-based payment, one of the real goals here is really to pay for outcomes, really good patient outcomes for set prices or at least definable prices that put the right incentives in place. So great question and hopefully that helped to address it to some degree.

Shannon Love: It does and thank you so much for your time. I'm assuming that you're going to present how outcomes are being—are going to be measured through the value-based program, how patient outcomes will be measured. So I guess you'll cover how is that measurable. Is it all the patients they are well, they are cured from a disease or they recover well from a surgery? That's my second question is how do you measure these patient outcomes?

Scott Leitz: Yes, a great question. We will touch a little bit later on it. That's a very important aspect of it because there's both a cost element here as well as a quality of outcome measurement as well.

Shannon Love: Okay. Thank you so much.

Operator: We have Donna Jones. Please go ahead. Donna, your line is open.

Okay, we have no further questions at this time.

Scott Leitz: Okay, thank you. With that, I'm going to turn it over to my co-presenter today, Tricia McGinnis from Center for Health Care Strategies.

Tricia McGinnis: Thank you Scott, and good afternoon everybody. I'm delighted to join today's webinar and talk a little bit about VBP. So I'm going to kick off where Scott left off and give a high-level bird's eye overview, what exactly we mean and give some common examples of what falls under value-based payment.

The four most common VBP approaches are: pay-for-performance, which falls into the HCP-LAN category 2; clinical episodes and shared savings/risk, which corresponds to HCP-LAN category 3; and capitation or global payments, which corresponds to HCP-LAN category 4. In the following slides I'm going to give a quick bird's eye view of each of these but in subsequent slides Scott's going to give us a little bit more detail about some of the key methodology questions and decisions that states often think through as they are deciding which models to pursue and how those models will help the states achieve their goals.

So pay-for-performance is one of the most common, I would say, basic level value-based purchasing models that are out there. It's typically layered on top of the existing fee-for-service or other payment arrangements that are already in place, and basically what pay-for-

performance does is it incentives the provider organization behavior by directly linking payment to performance on well-defined quality, patient satisfaction or efficiency metrics.

For example, oftentimes provider organization under pay-for-performance may be rewarded for ensuring that all their diabetic patients receive the appropriate screenings and treatments that are part of a diabetes evidence-based practice. Pay-for-performance can involve either rewards or penalties to drive change and behavior. Ideally, provider organizations under pay-for-performance have an upfront understanding of performance expectations, the quality, the measures that they're held accountable for and the associated financial gains or losses and they can then use that information to drive internal decision-making on how to change care is delivered to achieve those payments or those rewards or avoid the penalties.

From a payer perspective, this direct link between performance and payment enables payers to really target specific areas that are in need of improvement. For example, a bonus can reward providers who are delivering specific services, like immunizations, that may be traditionally underutilized but have important implications for health outcomes. And conversely, penalties can be really effective when targeted to penalize for the overuse of certain services.

Clinical episode payments are a bundled payment for a set of services that occur over time and across settings. As payment can cover a set of services that are delivered in a certain setting, it can cover services delivered as part of a procedure, for example, a knee replacement, or it can cover services that are associated with a condition, such as pregnancy.

The intent of a clinical episode payment really is to create incentives for extreme outliers who may be well above the average cost or in some instances well below the average cost to bring their cost more in line with the average expenditures, while maintaining or improving quality outcomes. Providers will—under a clinical episode payment, providers are on the hook for any cost that exceed that episode payment, and providers therefore have the incentive to break out of their silos and really work across settings to lower the aggregate cost of delivering those services. Payment is also contingent, as I said, upon meeting quality performance measures that are defined at the outset to make sure that while providers are working to lower the cost of care associated with those services, but it does not happen at the expense of quality.

Payments for episodes often are structured on top of fee-for-service payment so that once the episode is complete the cost associated with that episode are tallied and if those costs come under the benchmark amount for that episode a provider gets a portion of those savings. Conversely, the payment may be made prospectively to providers. So a payment for the episode may be made before the services are incurred and the providers can either keep a portion of the savings if they come under the cost, or if they actually incur more cost than received they are on the hook for covering those costs.

Shared savings and shared risk basically builds on a similar concept to an episode of care but it takes it one step further by branching out to a wider set of services. So similarly shared savings and risk payments keep the existing fee-for-service infrastructure in place, but under this model a target spend amount is set or the total cost of care benchmark which is based on estimates of

projected spending that providers might otherwise have spent for care of a certain patient population. Under this model, providers who spend less than they otherwise would have or spend less than that benchmark, are rewarded, and providers who spend more than that benchmark are penalized. So the providers who come under the benchmark they will get a portion of the savings, the difference between what they actually spent and what was projected to receive.

So that's where the shared savings comes into play. The amount of the reward or penalty under a shared saving model, again, depends on—as well on how the provider performs on a predetermined set of quality patient satisfaction or efficiency metric. So quality is always very tightly tied to payment in all of these models. Typically a shared savings model is based upon a wide array of services that cut across care in a wide range of settings that can include primary care, hospital care and specialty care. By bringing costs down providers are able to reap a portion of the savings that are due to their efforts. This method brings providers—gives providers a great amount of latitude to develop their own cost savings and quality improvement initiatives in ways that are really tailored to address their specific patient needs. So it really is structured to give providers the flexibility they need to best meet the needs of their patients. As well it also incentives providers to identify and focus on improving care for high cost patients.

Payments for savings or losses are typically assessed retrospectively after the care has been delivered and claims are paid, so typically six months after the predefined time period covering the payment model. This payment timing can be challenging for some providers, particularly those who need to make up for investments to drive the care delivery improvements that are required to achieve the cost savings. So that's worth being aware of.

From the payer perspective, a lot of payers start with shared savings and really create a glide path into the financial risk category. They're typically often under a lot of models in Medicaid, for example, shared savings only or upside only are in place for the first year or two and then in year two or three transition to the downside risk payments. Typically under shared savings and shared risk, providers share in a portion of the savings and risk with the payer. They are not fully on the hook either way.

Under capitated or global payment, fee-for-service payments now completely and largely go away. They're now replaced under this last payment model. Instead, providers receive an upfront payment for each of their assigned patients and that payment is designed to cover a large range of predefined services that a patient may need. As long as providers meet specific quality access and patient satisfaction requirements, they get to keep the difference between the payment and the actual expenditures. So if expenditures are higher than the payment amount, providers bear the full financial risk. However, if expenditures come below the global payment or capitated payment amount, providers get to keep that full savings that accrue directly to them.

Under this model, providers have wide flexibility to determine how to best use that funding. So, for example, providers often invest in high-value services. They're not covered under fee-for-

service, such as care coordination, phone consultations, home visits and other types of high-value services that often result in better health outcomes and lower cost that typically aren't covered under a fee-for-service arrangement. Because this payment is made upfront, providers have access to financial resources early on to make those investments. However, it's worth noting that providers need to have skills in order to effectively manage the financial risk across their patient population. They need to be able to analyze their data, be able to manage services across the full spectrum and this can be a challenge that not all providers are ready today to take on. From the state's perspective, this model presents a strong set of financial incentives for provider behavior change and can create greater budget predictability as well if the providers participating are truly capable of managing the risk and adopting new care delivery approaches.

At this point time, we'll open it up for questions.

Scott Leitz: Great. Thanks Tricia. A reminder to folks to send questions that they have to the chat box, to the host, and we will field them as they come in.

Tricia McGinnis: So one question is under the capitation payment. Are there any constraints on what plans our providers can use the savings for? So I will start it off but obviously we'll invite my colleagues at CMCS and Scott just chime in as well. I'll comment primarily on the provider side because plans are bound by the Medicaid managed care regulation, which cover what they can and cannot use their capitation payments for. So generally, under a provider cap arrangement, there is—there may or may not be constraints. So that could be set out by the state to determine and definition.

But as I mentioned earlier what these payments are supposed to do is enable providers to invest in services that may not necessarily be part of the fee-for-service coverage, may not be necessarily part of the traditional Medicaid benefit package but uses those dollars to make those investments in order to improve health outcomes and control cost. So those could be upstream interventions, say, to help pediatric asthma patients who perhaps have mold in their homes and need home remediation services to mitigate those factors that are sending the child to the hospital. On their capitation arrangement providers could use their cap payment to pay for those types of services. I mentioned care coordination, home visiting, other services that may not be a direct clinical service per se, but are expected to produce improved health outcomes.

Scott or Katherine, do you have anything else that you'd like to add to that?

Scott Leitz: No, Tricia. I thought that was a really great explanation for that particular question that came in. There is another that came in that I think while not exactly the same but also relates to capitation that maybe we can talk a little bit about, which is this capitation enhanced providers—enhance providers from accepting high acuity patients, meaning does it sort of put in place any types of incentives that actually might disincent from accepting high acuity patients. I'll start with that one, but Tricia, I'd be interested in your thoughts.

One thing that is one of the challenges, and I'll touch on this in the next section that we'll get into is, in all of these value-based payment models some of the—the general elements that Tricia just talked about are certainly important and they reflect kind of an overall approach, but then underneath that overall approach there are methods that need to employed or should be employed to really try to mitigate where some of the issues might be. In this case, the issue of high cost patients, for example, and the incentives that are in place, if you're a provider serving more—higher acuity patients you're likely to have higher cost as a result of that because your patients have a higher acuity level. In models that really look at total cost of care, for example, that potentially is a concern because if you are doing really good work with high cost patients your patients are still going to be somewhat higher cost than perhaps providers who are serving a lower acuity population, and that's why things like risk adjustment and outlier—taking out outlier cases are so important. As I mentioned, I'll touch on some of those things in the next section that we're going to talk about, but it's a really good question.

Tricia, anything to add on that?

Tricia McGinnis: No, no, I think that was a great response, Scott.

So here's a good question that I'll take and maybe we'll then pass that along to you, Scott. A question around sort of what are some of the most common pay-for-performance metrics in these types of arrangements? They really do vary. I would say a typical starting point for any state is to look at the HEDIS metrics that it’s using to hold its managed care organizations accountable or other institutions accountable and evaluating the degree to which that is—those areas are low performing within the state and then using those. So comprehensive diabetes care is very common, pediatric immunizations, well-child visits, those types of measures are very common.

Increasingly, in Medicaid, we're also seeing measures around behavioral health those for patients with depression as well as patients who have more acute behavioral health needs, you have severe and persistent mental illness follow-up after hospitalizations. We also see increasingly a mix of metrics that combine both efficiency and quality. So, for example, looking at hospital readmissions for things that could have otherwise been—have been prevented, particularly among patients that have chronic conditions. States I think typically as a starter point look for measures that are endorsed by an organization, like NQS. Oftentimes depending on the data that's available to them they rely on measures that can be collected primarily using claims data and typically they involve a really wide array of stakeholders—in determining—including providers in determining what kind of measures are going to be most appropriate for that state, where are the opportunities for improvement and what are the measures that providers have confidence in and feel like they can control as part of the payment arrangements.

Scott Leitz: Great. Thanks Tricia. One has come in that I think is a really important topic that we'll sort of touch on today but I think it's one that's worth definitely raising in this context, which is, sort of what about the social determinants of health and how do those fit into these types of models because we're really talking—at least up to this point we've really been talking

about the medical cost of things. So the questioner asks, for example, housing and food instability and how has that impacted on these models? Again, I'll start, Tricia, but feel free to chime in because I know you've been thinking a lot about this question as well.

A couple of things to think about there. The first is that one of I think the goals, quite honestly, of really well designed value-based payment approaches, and we're getting to that point now but it hasn't been the case up to this point, is really to start to put in place incentives for the health system, providers, but others, to really care about the social determinants of health. The reason that is is if you design a payment model that encourages and that measures providers based on their total cost of care, the cost of the services that they're delivering to their defined population, and on the outcomes that they're getting for those patients, it starts to put in place incentives for the upstream things that impact on medical outcomes. We know that medical care is a small slice of what actually drives patient sickness burdens and patient outcomes. Other things that come into play around food insecurity, housing instability, social service needs, play a very large role. So a couple of things to comment on there.

One is that the models themselves I think well designed and as they advance actually start to put in place incentives for everyone to care about those upstream things a lot more because you're going to get better, lower cost, higher quality outcomes if you're investing in some upstream elements. One model that is out there, for example, within Hennepin County in Minneapolis, in Minnesota, is Hennepin Health model, which really is serving a population of very low income, below poverty individuals where it is a holistic model that intends to both—they receive a capitation rate from the State of Minnesota, it's similar to what a managed care organization receives and then the Hennepin Health Plan takes that but then it wraps in mental health services, social services and other needs in an attempt to holistically manage that population. So as states and others are thinking about designing these models, thinking about how to include those services that might lower the medical cost, which people are being measured on under these models, in a more upstream manner becomes pretty—awfully important in the broader scheme.

Tricia, do you have anything to add on that one?

Tricia McGinnis: No, the only thing that I would add, Scott, is in some of the work that we're doing we're already starting to see this play out at the provider level. For example, one provider organization in Spokane is working with a local shelter to take homeless patients who are ready to be discharged from the hospital and take them in and provide some interim respite care rather than keeping them in a hospital, which is very expensive and is just not an appropriate place but clearly being on the street isn't either, and the provider is paying the shelter a fixed fee per bed for those services.

So that's just one example but we're already seeing a lot of investment in this area and I think—and I really do attribute a lot of the uptick in that in value-based purchasing because it creates a much better sort of back-end incentive alignment for providers and that makes business sense for providers to make those investments where it just didn't before under fee-for-service but they're now out there, particularly under a shared savings arrangement, a shared risk or a

capitation arrangement there are more resources available for providers to make those investments.

Scott Leitz: Great. Thanks Tricia. One that's come in that I'm going to kind of pose to you and I'll also take a stab at is, can we provide some examples of how value-based payment arrangements are more flexible or might be more flexible than relying on traditional Medicaid payment mechanisms? I don't know if you have any thoughts on that one, Tricia.

Tricia McGinnis: Well I think it picks up on the theme that we're talking about now. So the first three models of A13 or pay-for-performance episodes and shared savings, they keep the fee-for-service infrastructure in place. I think really where the flexibility comes in is really around the payment that is received. It gives providers flexibility that they don't otherwise have under a rigid fee-for-service payment structure to make the types of investments that we've been talking about because they now have access to additional revenue that can be used for those purposes. I think it also gives providers more flexibility because of that potential for revenue. It gives them more flexibility to really figure out how to—what the opportunities are for better coordination; how to work not only with other providers but how to structure teams, again, that they might not have the resources to pay for under fee-for-service; a care management team with nurses or a community health worker that can really work more closely with the patients; spend more time than frankly a provider has under a fee-for-service payment arrangement; spend more time with that patient and frankly also help the provider out, help the front line clinician who really just has the 15 minutes, does it help them create and expand their capability to meet patient needs?

So I think it's both flexibility in terms of the types of services that providers can invest in, but also flexibility for them to really focus and spend the time, on how they want to spend the time and really improving patient care by thinking of more creative ways of how to structure their office staff.

Scott Leitz: Yes, the only thing I'll add—and that's a great overview and one thing that I thought of while you were discussing that was really this notion of one of the things frequently is built into the models of value-based payment that maybe was missing in some of the more traditional fee-for-service models was an emphasis and I think a greater degree of ability for providers to get information and data from either state Medicaid programs or others to really along the lines of sort of investing and managing populations. A key element—and I'll touch on this as I go through some of the next set of slides—is really the data and the data that's now being used and available to providers that maybe previously had been missing. That introduces an element of flexibility and the ability of providers to figure out ways to manage populations that they are very, very close to because they're actually delivering the care for those populations.

So that's another sort of element I think here that while not directly related to a dollar flow, is an important aspect of because it's really an information flow that goes along with that.

Tricia McGinnis: That's a great point, Scott.

Scott Leitz: Great. Well I think we will move on to the next section of our presentation this afternoon, which is really in thinking about today's webinar, we thought it would be important to not just describe generally some of the options and approaches that states might take, which mean obviously those are really, really important so that we have common grounding of what some of those approaches might be, but also spend a little bit of time talking about what some of the design elements are that go into these options. So I'm going to spend a few minutes talking about six of these elements.

They're not in any way intended to be a complete list, and I also want to say not all these elements are applicable fully to every aspect of the four approaches that Tricia just described, but we wanted to capture just a sense of some of the things that need to considered. One of the things that you'll see in that is one that's already come up, this notion of quality and how we include quality and outcomes in aspects of this. But the design elements that I'll talk about his afternoon are—and I won't be able to fully do all of these justice because underneath them are some fairly also important decisions that occur, but hopefully by at least introducing the topics and the ideas you'll get a sense of what some of those key elements are, and that would—those will be the patient population of focus, services that are included in a value-based approach; how to measure and sort of think about financial performance measurement and benchmarking; this notion of quality performance measurement and alignment; how patients are attributed in value-based payment models and the important topic which we've already touched on briefly, risk adjustment.

A question that state Medicaid programs will wish to give thought to is, which population of enrollees are they most interested in focusing on? I think initially, as the slide says, value-based payment approaches were applied and they're intended to—it attempted to sort of try to move things upstream, right, to try to move more of the services to upstream factors to actually kind of prevent people from needing to seek care downstream. So a lot of the Medicaid value-based payment approaches have initially focused on populations whose expenses were a little bit more medically traditional, if you will—that might be acute care population, adult populations, some of the chronically ill folks where some of the costs were maybe a bit more predictable—and so that was sort of the initial focus and has been the initial focus of a lot of value-based approaches. Now I think some Medicaid programs have also looked at it and said, "We cover a lot of births. So we cover a lot of costs of pediatrics—we cover a lot of kids in these Medicaid programs," and so some of the approaches around thinking about which population to focus on have really started to migrate towards some of those kid populations and how do we put in place more value-based design elements for pediatric population or peds populations.

I think as approaches have evolved within states what we've seen after this initial wave of acute care and more adult populations is an interest in states, "Okay, we've done this now. We've learned a little bit around how to work with our providers, our advocacy communities, our patients in these spaces to put in place more value-based models for our acute care populations. How are we now to expand that into other populations and think about, for example, moving to more value-based payment and long-term supports and services for the

disabled, for the elderly and other populations?" That aspect of this is not as far along but increasingly states are seeing an interest in those areas.

One thing that the last bullet point really tries to emphasize is that given the different stages that providers are at depending on the types of patients that they serve, and the difference in the patient populations themselves in terms of the medical and nonmedical needs that they might have, it'll be just important to sort of think about which of the approaches towards value-based payment are most appropriate for the population that you're thinking about. Where on that LAN framework do you need to start and incrementally move and where do you want to be to by the end?

Another aspect that states need to consider, and this is particularly true for ACO development, but also true for states that are looking at bundling of payments is, which services do you include in the cost calculations, or do you include for accountability? The general idea here is to create accountability around cost and quality that's within the control of the participating provider to coordinate and deliver and so generally the cost associated with services that fall within the reasonable control of providers in a value-based payment approach are often those services—and are often targets—that target the services and should be appropriate to the population that they're treating. So like that's easier said than done, right, but it's really about the defining up who it is that you're trying to serve, what that population is, and then what costs associated with that population are reasonably within the control of the provider who has accountability for serving that—for delivering services to that population.

In general, those services will include a spectrum of medical benefits. For example, in ACO models under Medicaid, frequently shared savings are calculated across a set of services that might be the range of covered benefits for a given population. For episodes of care or bundles of care, services include—typically services will include—for calculation would include the range of those services that typically would be in a course of treatment for a given condition, and in these emerging areas that I just mentioned where long-term supports and services or home and community-based services I think we're very much in an early stage of really defining what the services bundles would be as you start to measure cost of care for those populations that are utilizing LTSS or HCBS services and we're kind of on the front end a little bit of doing that collectively right now.

One thing that's important in models that have accountability to cost is ensuring the focus isn't solely on cost, or financial outcomes, but rather you don't want to set up a situation where providers are focused so much on cost that the quality of care may not be—may be something that gets sacrificed along the way. That's certainly not a situation or an incentive that state Medicaid programs are interested in setting up. So it's important to include—and most models—most value-based payment models do include the notion of quality performance measurement. How you do that and what's appropriate to do that really varies by the population that's being looked at and there are a number of existing quality measurement and patient outcome measurement systems that states can draw from, some of have developed their own if their state is engaged in doing measurement development.

And then those measures are typically deployed within the programs themselves, within the value-based payment models themselves, so payments for value-based models are either—are wholly affected or at least partly affected by quality performance and it could be done in a number of ways that are bulleted out there via bonus payments under the VBP arrangement, by doing withholds for failing to meet quality benchmarks, in shared savings arrangements by having either lower or higher percentage of shared savings being paid depending on whether a provider is able to meet certain quality standards or not paying shared savings if a certain benchmark isn't met within the quality program.

So there's a variety of ways that states are deploying or can deploy quality measures to ensure that outcomes are being paid attention to while the cost of care is also being paid attention to. One thing that states I think are increasingly interested in is making sure that they are aligning the measures that are chosen for value-based payment with other state and federal initiatives such as MACRA and MAT implementation.

Another area is financial performance measurement and benchmarking. In thinking about how well we're doing in value-based models, most of these are built off of some measurement of financial performance. So, in general, in thinking for example in an accountable care organization environment, total cost of care would be calculated across that included set of services that we talked about a slide or two before. For an attributed population—I'll talk about attribution in just a moment—for a chosen time period typically would be a year and then claims data and encounter data are typically used to then tally up the costs across that spectrum of both services and population to get a total cost of care measurement.

Frequently that total cost of care measurement is then compared to—as a baseline is then compared to what a growth rate into the future would be, and trend rates that are used to sort of grow that total cost of care over time are typically in line with the expected managed care rate, trends and can sometimes be negotiated or either directly negotiated or administratively sent to the providers who are actually operating in the program.

There's also frequently a mitigating factor which is oftentimes providers have claims that may be a little bit outside of their control where there will be outlier claims and those are typically shaved off at a certain level depending on the size of the provider and the size of the attributed population that that provider is serving.

Then finally, there is oftentimes a minimum savings threshold that is applied before something like a shared savings might be achieved. What this helps to do is to look at ensuring that whatever savings relative to that baseline that would be calculated isn't occurring randomly, that it's actually occurring above a certain threshold, and then states have to make decisions around whether in a shared savings environment they share back to that first dollar or just those savings above that minimum savings threshold.

One thing that states encounter in thinking about developing value-based payment within their Medicaid programs is how to in a sense assign patients for the purposes of calculating total cost of care to a provider or a provider organization. The assignment that occurs within Medicaid

programs typically there's freedom of choice within some parameters. For enrollees who seek care at a variety of different providers an assignment to a provider isn't something that typically occurs and so there has to be a manner in which those patients are attributed to the provider for the purposes of a calculation of total cost of care. There's a variety of ways that that occurs but generally speaking it involves assigning patients to the primary care provider for which that patient has had the most established care patterns—that's typically that provider who sees that patient the most would have the costs of that patient attributed to that provider.

If the state is using a medical home model, patients are oftentimes generally assigned that way for the purposes of cost calculations. But the point in raising this particular slide is simply that in an environment where patients are seeing a variety of different providers, calculating total cost of care can be challenging to know which provider to actually assign those costs to and attribution models are typically deployed as a way of doing that. There's a lot of discussion around how well those models work and that's something that I think is a healthy discussion that will continue and hopefully continue to refine and evolve the manner in which and the degree to which those types of models achieve their purpose.

And then the final element that I'll just mention is risk adjustment. What risk adjustment is is a way to adjust for differences in patient complexity. This is a key to ensuring that year to year or patient population comparisons are consistent. As we talked about a little bit earlier, one of the things value-based payment models really should strive to not put in place is an incentive for avoidance of complex patients. In fact, they should really try to adjust for those providers who are seeing more complex patients and risk adjustment is a way to do that. It's a way to ensure that providers are not penalized for serving complex patients and it can be used, and we see this done quite a bit, to adjust for both cost of patients that are being served as well as the quality of those patients.

Risk adjustment is utilized across a variety of value-based payment approaches. We see it certainly in risk adjusting total cost of care for shared savings models so that year-to-year comparisons between that total cost of care should the risk of the population that's being served in an attributed model shift so that those comparisons are apples-to-apples. We also see risk adjusting episodes of care reflect patient complexity that might be coming in.

The final thing that I'll mention before we move to questions on this particular part of this presentation is that states are increasingly interested in examining how factors that are nonmedical. Traditionally risk adjustment models really capture the medical complexity of individuals but I think one of the things that's increasingly acknowledged is that the medical claims don't always capture the full complexity of a given population. So things that are nonmedical, social determinants of health related, states are very interested in looking at how to include in their risk adjustment models. Again, this is fairly new work that's occurring but probably will be very important moving forward as these models become more prevalent.

And with that, I think we'll pause and take questions.

One that's come in asks about how do the design elements align with some of the requirements that MACRA has for advanced APMs? It's a very good question. Tricia, I'll ask you to also weigh in on this. One of the things that I think that MACRA and some of the work that's being done in the implementation of MACRA is really start to look at the importance of quality reporting and inclusion of that over time. I think that when we think about the value-based payment models that—and foundational elements that I just talked about, at least some of those foundational elements, I think MACRA really speaks to some of those, particularly around the reporting aspects of this and the risk and some of the things that are built into risk adjustment models.

So I think that's one of the things that states are going to really want to think about as they think about quality reporting is—within the context of their value-based payment models is, how do they really align their quality measures that they would like to include in their Medicaid-based value-based purchasing models with those that are being utilized under MACRA so as to reduce provider burden, measuring the things that are important but also kind of not driving providers crazy as they're doing that.

Tricia, anything to add on that particular one?

Tricia McGinnis: The only thing that I will add, Scott, is that under MACRA and as MACRA goes on, there will be increasing interest from providers, particularly the two under MACRA shifts into the advanced VBP models, and those are category 3 and 4 in the HCP-LAN, so the global payment shared savings and risk arrangements, but those providers, in addition to the quality measurement alignment, will be more interested in participating in similar risk arrangements for Medicaid because they will get increasing credit for participating in those.

So I definitely think that as MACRA moves ahead that there will be increasingly opportunities for alignment across the quality measures. The models themselves and alignment on some of the methodological questions that you were raising, Scott, will become increasingly important. It also creates a nice opportunity for states, particularly those who feel like perhaps they're not getting the traction that they would hope to get with their provider community, that hopefully by creating those alignment opportunities and with the advent of MACRA that there will be more opportunities there for states to engage their providers, for sure.

Scott Leitz: One that's come in really asks about this whole notion of some of the nonmedical social determinant factors that go into—potentially into risk adjustment models. As I mentioned previously, the question is, what are some nonmedical social determinant factors that states are considering for inclusion in their models? As I mentioned earlier, I think those models they've been around for 20-plus-odd years now and have done a very good job of creating very good baseline risk adjustment for things that are medical in nature and I think that it's increasingly acknowledged that, while those are important factors in starting to smooth some of the risk across various provider groups and various patient complexity groupings, that a lot of factors go into that.

So a number of things that states are thinking about in terms of how to adjust for that—for those things that are nonmedical and more social determinant related. I'll just mention a few.

Homelessness is frequently thought about. States are thinking about ways to get better information around the degree to which a given Medicaid enrollee may lack stable housing and try to factor that into the risk adjustment model that they have.

Previous incarceration is another measure that states are thinking about as a way to try to capture some of the instability that might be in a person's life that might be impacting on the costs that they have as they seek care in the medical system and that might make them a slightly more complex patient to manage the care for than other patients.

There's another limited, certainly limited English proficiency is one that states are looking at as both what are the costs associated with that from a medical perspective but also from an interpreter perspective, and then how does LEP really impact on patient outcomes both from a cost and quality perspective. Again, this is a pretty nascent field and an area that a lot of states are interested in but are kind of I think just getting down the path of moving into. It'll be interesting to see because I think that this is an area that will increasingly grow as an area of focus over time.

And Tricia, I didn't know if you had anything to add on that particular one.

Tricia McGinnis: No, I think you've covered the spectrum there, Scott. It's a great answer.

Scott Leitz: Great.

Tricia McGinnis: Scott, perhaps in the interest of time, do you want to move ahead, and while I know we'll have a lot of questions for the end.

Scott Leitz: Tricia, let's do that. Why don't we go ahead and move on into the next section. I know we've been receiving a ton of questions, folks, as they've been coming in, so thank you for sending them in. We're trying to get to as many as we possibly can during the presentation here, and our apologies while we sort through them. We're going to trying to get to some of them at the end as well. But Tricia, great idea. Why don't you move ahead with the next section and then we can kind of move it from there?

Tricia McGinnis: Sounds great. So I'm going to touch upon some of the key issues that shape how states develop their value-based purchasing strategies.

So here's just a list of the few. I think honestly we could probably have an entire day-long seminar on this topic. But I want to do hit on a few—these few because these are the ones I think that we see cropping up most consistently in our work with states.

So first, one of the first steps that they take is just really understanding the baseline of what the current levels of adoption of value-based purchasing are in their states, what types of models are providers engaging in, what types of payers are engaging, understanding what—and if there aren't any models in place or very few models in place, really engaging providers in particular to

understand what types of models that they're most interested in, particularly in the days of MACRA where providers are increasingly strategic and savvy about figuring out how, what they're doing in Medicaid can align with what's going on in Medicare and requirements under MACRA. In order to do this it really takes a lot of stakeholder engagement. Any state that we work with, be it through the IAP program or the State Innovations model, stakeholder engagement early and often is a really important factor.

The second piece that we've alluded to a lot is alignment. It's basically what we are seeing is that states are likely to get a lot greater traction with their provider community if they're able to build off of models that already being used either in Medicare markets or in the commercial markets. So information on the types of models that providers are participating under Medicare that information is available through CMS' website. It's an excellent source of that type of information. But also talking with the commercial health plan carriers in your market to understand what types of strategies they're pursuing because if it's—the more the payers are in sync with one another the easier it's going to be to get providers to participate in these types of programs. So, for example, Massachusetts Medicaid right now is implementing an ACO program that really leverages the fact that there is high uptake in Massachusetts of ACO and capitation payment arrangements that have been in place for a while in their commercial and Medicare markets.

So alignment really can be key, a key piece of your strategy as a states to really driving participation on uptake and success under these models.

Another important component that we'll talk about later in the next slides is just whether VBP how to implement it either via direct contracting between the states and the provider organizations or hospitals or how to implement via managed care contracts for the states that have managed care in their Medicaid programs.

Success under value-based purchasing models, as Scott was alluding to earlier, really is going to depend in part around the degree of data availability, particularly for providers that are bearing some type of financial risk for their performances. These models often require access to a wide range of data that maybe typically providers don't have access to, particularly claims and payment data for—that patients—are associated with patients across a full spectrum of providers, not just that providers associated—the providers associated in one particular provider organization but it also requires data analytic capabilities, the ability to exchange data, so really understanding the level of readiness among providers, particularly providers that may not have been part of—been able to participate in some instances under high tech, behavioral health providers, long-term supports and services providers that often don't have this type of infrastructure in place.

Finally, states will need to consider their own resources that are at hand to design, launch and maintain these programs. There is a wide range of staff levels that it takes to really design and launch and maintain these models over time. For example, episodes in global payments, the level of analyses and development that goes into those types of—those programs, particularly

upfront can be pretty high. So that's going to be an important piece to this equation as well for states to figure out.

So now I'm going to talk, pivot a little bit about again at a fairly high level because I imagine we'll have some subsequent webinars on the topic to talk about how value-based purchasing is implemented within Medicaid managed care and some key approaches that states are taking today.

So for states with a significant portion of their program under managed care, they'll want to think about how to work with their MCOs on value-based purchasing adoption. This clearly will be a key part of their strategy. In general I would say that states are using these customary key approaches that we have outlined on these slides. I'll talk in a follow-up slide about it and give you some concrete examples of what that looks like.

So the first really is basically encouraging adoption. For example, states can use their MCO procurement processes to ask questions about the level of value-based purchasing contracts in place already, enquire about MCOs' strategy around VBP, what are their plans moving forward. Basically do a deep dive and get really concrete with the MCO about what it's doing to really understand which MCOs that are bidding have a strong foothold in this place. States can also think about supporting or encouraging adoption by developing core model components that might make it easier for MCOs to develop or adopt a model.

So, for example, in New Jersey Medicaid, they developed a shared savings methodology but they did not require the plans to adopt but that plans could use as part of their ACO program, again, because the resources that are required to develop these payment methods, as Scott was talking about, some of the key design issues, those resources are not as significant. So thinking about ways that states can make the load lighter and support its MCOs in adopting different features.

Finally, just thinking about how to leverage quality and efficiency transparency that may be available in the marketplace. For example, in New York States, they just released a statewide report card around provider performance and that can increasingly encourage MCOs to adopt VBP particularly for providers who may not be performing well.

Second, and probably at this point I would say the most prevalent statement (phon) we are seeing, really is around a wide variety of incentives for MCOs to adopt VBP models. So, for example, many states who use their managed care organization they withhold, they can withhold up to 5% of the capitation payment to incentive MCOs to meet their VBP—certain VBP benchmarks, adoption benchmarks. For example, in 2016, HHS set some benchmarks around VBP adoption in Medicare that 80% for 2016 would be in value-based purchasing and that 30% of contracts in Medicare would be in categories 3 or 4 or advanced VBP models. Many states are using similar benchmarks and then withholding a portion of capitation to create a financial incentive for managed care organizations to adopt those models.

Other states like Rhode Island, are using incentives through waivers to provide additional funding to MCOs that successfully adopt certain VBP models. Under its current waiver Oregon is examining rate setting incentives. So Oregon will be looking at how to use capitation rate setting to reward its coordinated care organizations which functions similar to MCOs that are both efficient and have high quality care. So using rate setting and tying that most explicitly to the types of outcomes that we hope to achieve through VBP. Finally, states can think about how to use auto-assignment rules to reward MCOs that have high levels of value-based purchasing adoption. The final option really is requiring either through contractual requirements, state legislation or regulatory requirements and require MCOs to adopt typically specific models.

So this slide just give—and again, this is by no means comprehensive—this is just a few examples of approaches that states are taking around implementing value-based purchasing and managed care. So, for example, in Minnesota and Tennessee, their MCOs or Medicaid managed care organizations are required in Minnesota to adopt their integrated health partnerships basically for those providers that are uncertified as a integrated health partner and MCOs that contract with those providers are required to participate in a shared savings, shared risk arrangements. Similarly, in Tennessee, their managed care organizations are required to participate in a standardized statewide episode of care model and patient-centric medical care model. This type of approach obviously can be very effective in getting widespread adoption.

Another common approach that I alluded to earlier is looking at holding a specific percentage of payments that—making—setting targets for what percentage of provider payments need to be in a VBP arrangement. Just similar to the goals that HHS set for Medicare, states are increasingly setting very specific goals within their managed care contracts and requiring and either incentivizing or requiring the MCOs to meet those targets. States—this is just again a smattering of the states that are doing this. Arizona, New York and Pennsylvania and Washington are some of the states that are taking that approach but I expect to see more and more states adopting that over time and through the IAP project are working with a few states on setting those types of targets.

Some states are—on top of that approach too are thinking about how to increase those requirements over time. So maybe starting with a relatively lower level of benchmarks, say, requiring 10% of contracts to be in VBP and then over five years increasing that level to 35%. New York and Arizona are taking that approach. Tennessee is requiring in addition to requiring MCOs to adopt a specific model are also requiring its MCOs to participate in multi-payer alignment initiative around those VBPs to again make sure that it's easy for providers to participate. And then finally launching VBP projects.

In the interest of time, I'm going to quickly go through some key considerations. First and foremost, as the slide previously suggested, states can be either incredibly flexible in letting the MCO's choose the types of models that they adopt or being incredibly prescriptive in requiring them to adopt certain models. That will be a key upfront decision that states will need to make

deciding what type of levers to use to enforce and prod the MCOs to adopt, whether those be financial incentives, requirements, and choosing the strategy that is most viable in their state.

And then finally deciding what counts. What types of models of the four models that we talked about, do all four of them count in setting—if MCOs are required to adopt VBP? Are all of those valid or maybe a states really wants to focus on more advanced models, such as shared savings and risk and capitation payments.

So those are all key decisions that states need to make, again, in partnership and in consultation with their MCOs and their providers.

So with that, I will turn it over and see what questions that we have from the audience.

Scott Leitz: Great. Thanks Tricia. That was a really great overview. The managed care aspect of this is so important since so many states have really moved in that direction.

One that's come in that you maybe addressed a little bit but I just want to pose it again is, this notion of sort of how states can think about evolving their requirements, if they have that, or their either voluntary or involuntary requirements within managed care over time to capture the evolution of value-based payment within MCOs. The question really is related to how do—do you have an example or two of how states have started at a certain place in their contracts, for example, with managed care companies, and then evolved those contract requirements to maybe become a little bit more directive or capturing even more of an aggressive approach to value-based payment?

Tricia McGinnis: Sure, that's a really good question. So states are definitely looking to see how to phase in increased requirements over time. So, for example, Arizona I believe started with a requirement that 5% of provider payments be tied to value-based purchasing and have increased those subsequently every year within their managed care contracts, and I believe around the 30%-ish range within Arizona. I see that increasingly among other states. There's also—states are also exploring whether to—an approach where maybe in the first year or two pay-for-performance is a type of model that counts but then as the program matures in years three, four or five maybe those models no longer count as to what an MCO can get credit for. Because the idea really is, at least for, as you said in an earlier slide, that they still build upon themselves, and whereas pay-for-performance may be a great place to start over time, increasingly the level of financial accountability and putting some risks as appropriate and that the providers are capable of assuming that, then you want to kind of gradually move providers along that spectrum.

So we definitely see those approaches.

Scott Leitz: Great. Thanks Tricia. I know that we're just about at time and I want to thank everyone for all the questions that were submitted—there were a ton—and we got to as many as we could. So thank you all for submitting such great questions today.

One last slide, some key take-aways from today. Clearly value-based payment is increasingly being looked at and states are increasingly using it or looking at using it and it's really been about providing a better delivery system and getting the incentives for higher quality, lower cost and improved patient outcomes in place.

I want to really pitch the HCP-LAN framework because it provides a really super useful framework for looking at approaches that can be used in value-based payment and we would encourage states to consider where they are on that LAN framework and then where would you like to be and what are the steps, as Tricia just talked about within managed care for example, how do you start to move yourself from on the left-hand side further to the right and where do you want to be within that framework for your states Medicaid programs?

So while there are certain key design elements that go into value-based payment, it's really each state that has to really think about the fact that everyone's coming from a slightly different starting place, consider the situation that you happen to find yourself in, where are you at on the framework for example, where are your providers and some of the other considerations along this aspect, and then apply those value-based designed in a way that works for your states.

I want to again thank everyone for joining the webinar today. We want to ask you to please take a moment to complete the evaluation survey. The slide here mentions the various other upcoming webinars. There are several that'll be coming up. I think the survey just popped up on the site so we encourage you to take time to do. And with that, we will thank you all for joining us this afternoon.

Operator: Thank you. Ladies and gentlemen, this concludes today's webinar. Thank you for joining. You may now disconnect.