Medicaid Innovation Accelerator Program (IAP) Maternal and Infant Health Initiative (MIHI) Value-Based Payment (VBP) Technical Support National Dissemination Webinar:
Utilizing Value-Based Payment to Incentivize Maternal and Infant Health Care Delivery Models
Webinar Date and Time: Thursday, May 17th, 2018 2:00 – 3:30 PM EST
Webinar Transcript

Crystal Tyler: [Intro: Logistics]

We have three learning objectives for today's webinar:

1. Identify payment models and contractual approaches that incentivize the use of maternal and infant health care delivery models within Medicaid and CHIP populations.
2. Outline considerations for incorporating care delivery models into state value-based payment (VBP) initiatives.
3. Describe Medicaid experiences, opportunities, and challenges when aligning maternal and infant health care delivery models with VBP initiatives.

(next slide) During today's webinar, we'll provide an overview of the Medicaid IAP and the Maternal and Infant Health Initiative (MIHI) VBP technical support program, describe and provide examples of innovative care delivery models and Medicaid VBP approaches in maternal and infant health. Next, representatives from New York and Ohio will describe their respective experiences with home visiting and the Pathways community HUB model.

(next slide) We have several presenters today. I'm Crystal Tyler from IBM Watson Health. Dr. Whitney Witt is the Director of the Center for Maternal and Child Health Research at IBM Watson Health, and Dr. Thom Flottemesch is a Senior Research Leader within IBM Watson Health.

(next slide) From New York, we have Dr. Douglas Fish, who is a Medical Director in the New York State Department of Health, Office of Health Insurance Programs, Policy Division, and Amy Jesaitis who directs maternal and infant health home visiting within the New York State Department of Health, Division of Family Health.

(next slide) From Ohio, we have Kara Miller, who is a Section Chief of Care Management and Quality Improvement within the Ohio Department of Medicaid, and Dr. Mark Redding, the Quality Director and co-founder of the Pathways Community HUB Institute and the Director of Community Care Coordination in Risk Reduction Research at Akron Children's Hospital.

(next slide) First up we have an overview of the Medicaid IAP and the MIHI VBP technical support opportunity by Dr. Whitney Witt.

Whitney Witt (WW): Thank you Dr. Tyler. I'd like to start with an overview of the Medicaid IAP. It is a 4-year commitment by two of the centers within CMS, the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation. This is considered a technical assistance model that is part of the Innovation Center but is led and lives in the Center for Medicaid and CHIP Services, so it leverages the work that occurs across both of these centers. The IAP's primary goal is to help build states' capacity and support their ongoing innovation through targeted technical support. Specifically, the IAP seeks to increase the number of states moving toward delivery system reform across program priorities. Finally, it is important to note that this is not a grant program, it is targeted technical support to states. In 2017, IAP launched the MIHI VBP Technical Support Opportunity for Medicaid and CHIP agencies. Through this

initiative states selected, designed and are testing VBP approaches to sustained care delivery models that demonstrate improvement in maternal and infant health outcomes.

(next slide) Today's webinar is the second presentation in a series of national webinars that focus on VBP reform to improve maternal and infant health care and outcomes. The first webinar were an introduction to VBP and an overview to VBP approaches in maternal and infant health. Today's webinar will focus on utilizing VBP to incentive maternal and infant care delivery models. The next webinar in this series will occur later this year and will showcase states' experiences in designing and testing VBP approaches to improve outcomes.

(next slide) There are four states participating in this technical support opportunity. First, we have Nevada. Their focus is to reduce the proportion of Medicaid-insured infants admitted to neonatal intensive care units. Next, we have Colorado and they are working to increase screening and successful referral rates for postpartum depression among women covered by Medicaid. Mississippi is working to improve birth outcomes by reducing tobacco use among pregnant women. Finally, we have Maine. They are working to increase the proportion of mothers covered by Medicaid who are screened and receive medication-assisted treatment (MAT) for opioid use disorders (OUD).

(next slide) Let's talk about maternal and infant health care delivery model. What do we know about healthcare delivery models, costs and care associated with adverse birth outcomes?

(next slide) Adverse birth outcomes such as preterm birth and low birthweight disproportionately affect Medicaid beneficiaries. Preterm birth specifically accounts for one-third of all infant deaths. The average healthcare utilization costs are much higher for preterm births compared with uncomplicated deliveries. Consequently, preterm birth is a key cost driver and accounts for approximately one-half of all pregnancy-related costs. In fact, in 2017 alone costs were projected to top $32 billion when adjusted for inflation.

(next slide) Medicaid is a key source of financing for births among families with low and modest incomes. Although there is variability across states, Medicaid pays for almost half of all births in the United States. It also pays for a higher proportion of preterm births than private insurers. For the first 14 states in dark blue, the darkest color on this map, Medicaid finances between 54 and 72 percent of all births. A high number of Medicaid-financed births, particularly complicated births, carry potentially avoidable health complications and high costs.

(next slide) There are several care delivery models that are expected to have demonstrated success in improving maternal and infant health outcomes in the U.S. However, these examples are not exhaustive of all the different care delivery models out there. I will highlight a few:

- Birth centers provide family-centered home-like care to healthy pregnant women that reduces unnecessary medical intervention and increases patient comfort and satisfaction.
- The community collaborative caring model ensures that at-risk pregnant women receive necessary healthcare and social support during and after pregnancy by providing transportation to healthcare settings, expanding the state's home visiting program, educating patients, and providing care coordination.
- The doula model provides pregnant women support and advocacy. It has been implemented as a stand-alone model and has been incorporated into home visiting and birth center models as well.
- Home visiting is designed to improve prenatal, maternal and newborn health by providing services and information or guidance in a way that overcomes traditional barriers to effective and timely care. There are home visiting programs within Medicaid that represent a variable but comprehensive set

of services. Alternatively, many states choose to offer only certain aspects of these programs or only discrete home visiting services.

(next slide) Promising health delivery models stand to improve maternal and infant health outcomes across the life course such that we would expect to see increases in contraception use during the preconception period. We would expect to see increases in prenatal care during pregnancy. During birth we would expect to see increases in breastfeeding while also observing decreases in maternal morbidity, nonmedically indicated C-sections, preterm births, low birthweight, and infant mortality. During the interconception period, maternal and infant health delivery models are expected to increase contraception use, well-child visits, and pregnancy spacing.

(next slide) Now a real-time polling question: How familiar are you with maternal and infant health care delivery models? Please select one of these options: (1) I have implemented a maternal and infant health care delivery model. (2) I am aware of care delivery models to adjust maternal and infant health outcomes but have never implemented a model. (3) I am new to the term maternal and infant health care delivery models.

Show the results. Over half of you responded that you are aware of maternal and infant health delivery models but have not implemented a model, so hopefully, this presentation will be helpful to you as you move forward in payment and delivery reform.

Now I'm going to turn this presentation to my colleague Dr. Thom Flottemesch, who will talk about payment reform in maternal and infant health.

Thom Flottemesch: Thank you, Dr. Witt. As I'm sure a lot of you are aware there is a considerable change going on in both the way care is delivered as well as how Medicare is currently paying for it. I'd like to first present a general framework that many have probably seen before that gives us a way to level the playing field and talk about payment reform models. Then I'd like to present specific examples of how those payment reform approaches have been applied within the maternal and infant health space. Following that, I'd like a brief discussion about considerations one should have when designing or implementing a VBP arrangement. I'd like to highlight three specific things in that discussion: (1) Health information technology. (2) Medicaid contracts and your current arrangements. (3) Consideration of the broader healthcare environment.

(next slide) I'm sure a lot of you have seen this before, the Learning in Action Network Alternative Payment Model Framework or the LAN. It presents us with a way of categorizing payment arrangements where a lot of where we start at is what would be to the right, fee for service, where there's no real consideration of quality or value. Then we start linking to quality metrics and moving to a population-based payment. Maternal and infant health is an interesting aspect with this because it has a very clear and defined episode and it also has a very broad impact in terms of both social determinants of health as well as impacting two different individuals at the same time.

The point I would like to make is it would be very easy to look at this and think category 4 would be superior to category 3 being superior to category 2, but that's not necessarily the best way to use this tool. The best way to think about it is what is the exact type of care I'm trying to promote; how do I want to incentivize it; and what is the best approach to incentivizing that? The best way to motivate that discussion is to look at some examples.

(next slide) If we think about an example where a category 2 type of payment arrangement has been very successful and had a positive impact, we can think about the Louisiana 17P Progesterone Program. There is a very specific item they wanted to incentivize and they were monitoring it very closely, and they had a

very clear goal. A pay for performance was a very impactful way, where if they would have bundled that into a larger payment or used one of the other models, it might have missed their mark or what they were exactly targeting. In contrast, if we think about fee for service architecture based upon shared savings on based upon preventing certain types of action, we have examples from South Carolina where they implemented a nonpayment policy for elective Cesarean or a C-section, and how Tennessee implemented high-quality care during the perinatal period by sharing the savings or the downstream savings with providers during that perinatal care period. Finally—and we'll have a lot more detail—what Ohio is doing with a bundled payment model that allows its managed care organizations to incorporate a larger aspect of care and really address some of the larger needs of the maternal and infant health population.

(next slide) So when thinking about how to design a VBP arrangement, there's a list of things that really should be considered. This is definitely not a top-down type of approach. To be successful you need lots of players and lots of stakeholders to come to the table. It really starts with what population are we trying to impact. For instance, one of the states we're working with, Colorado, wants to impact maternal mental health. That's a population they want to target and they know exactly what services they want to include in their VBP approach, particularly increasing the number of screenings as well as increasing the number of successful referrals. But in order to do that, it boils down to can they measure what they want to change? That always comes back to what health information technology do they have access to? What health information technology are they planning to implement in the near future? And how can they coordinate what they want to do with their payment model with how they are changing the data systems available to them?

Along with that, this can often be a bone of contention, the next two, when working with providers and managed care organizations and medical groups, which patients are we trying to impact? How are we trying to impact them? In other words, how do we attribute them? Who am I really responsible to and what is my baseline or benchmark level of performance that I need to meet or exceed in order to have a bonus payment or in order to share savings or avoid some sort of penalty? Finally, especially in the maternal and infant health space, every pregnancy is a unique experience, and risk adjustment is an important thing in terms of determining which is and how do we rate this provider's level of performance versus another provider's level of performance?

Then finally, when we're implementing the VBP approach, we're not doing it in a vacuum. There are two very important factors we need to think about. That is the current contracts and the broader healthcare environment.

(next slide) I don't intend to go through all this in detail, but when you're thinking about designing a VBP approach it boils down to measurement. The three key factors I always think about: (1) Are the measures relevant and are they reproducible? (2) Are they producible in a timely format? There's always billing lags, payment lags, and data validation exercises that need to be considered. (3) What other changes are happening both within your payers as far as implementing electronic medical records as well as Medicaid MMIS system.

(next slide) The next thing is what are your current Medicaid contracts and care arrangements? Because given your current Medicaid structure, how can you easily change your payment structures? What authorities do you need? And what other state initiatives are going on? Because you want whatever you're doing in the maternal and infant health space to align with your greater healthcare goals for this population rather than being something that's working independent of them. That is why it is very important to be aware of the overall state goals as well as having the right stakeholders at the table when designing a VBP system.

(next slide) Finally, both our state presenters will really be emphasizing the broader healthcare environment. What other initiatives are facing providers? What are the goals of your private payers or broader managed care organizations? What other community-based organizations and initiatives are going on and can be coordinated and brought to bear with this? Also, what are the shortcomings you identify? What needs are you really trying to address with a provider-based incentive system?

(next slide) A poll question here. How would you describe your familiarity with VBP approaches? (1) I'm well-versed in VBP approaches. (2) I am aware of VBP approaches but don't consider myself an expert. (3) I am completely new to the term VBP.

(next slide) Let's see the results: This is wonderful. This is the exact type audience we were hoping for today. People that are aware of but not experts, and hopefully we can give you some real-world examples of how innovative payment models are being used by states, particularly in the maternal and infant health space. I'm going to turn back to Dr. Tyler for a brief Q&A before we get to state presentations.

Crystal Tyler: Thank you both to Dr. Witt and Dr. Flottemesch for your presentations. The first question is for Dr. Witt: *Tell us how the quality measures fit into the Medicaid IAP model?*

Whitney Witt: The quality measures fit into the model in that the VBP approaches are trying to improve the quality of care so the measures become very important in being able to determine if the reform is working. Many of our states are thinking about different metrics and different data sources to use to measure quality so they can monitor and evaluate whether or not these reforms are working.

Crystal Tyler: For Dr. Flottemesch: *How do you reconcile the immediate financial savings from a bundled payment with long-term costs from a decrease in incentives to insert postpartum LARC (long-acting reversible contraception)?*

Tom Flottemesch: Could I reflect back? The gist of the question if I heard it correctly was how do you balance the benefits of long-acting reversible contraception versus a bundled payment for a maternal episode, because you are introducing the possibility of a perverse incentive where providers may not offer LARC because it's a way for them to reduce the services while start garnering their bundled payment. I believe that is the question.

Crystal Tyler: I believe so.

Tom Flottemesch: This is a really good example, as I said before, when one looks at the LAN framework you should not think of category 4 being naturally superior to category 2, because the states that have encountered this, having a carve-out for LARC and also having a special arrangement where providers—even if a mother's maternal or Medicaid coverage may expire—can still bill under that for replacement of LARC or removal of LARC after a 9- or 12-month period is a way to get around that. So, having a specific carve-out, very similar to the example we have of 17-P injections, alleviates or removes that perverse incentive and targets a specific action that you want to incentivize.

Crystal Tyler: I'll save two questions for later in the presentation. Next, state perspectives from New York and Ohio.

(next slide) From New York, we have Dr. Doug Fish and Amy Jesaitis, who are presenting on New York State's home visiting model in the Delivery System Reform and Incentive Payment and VBP Program.

Doug Fish: We have two major transformations going on in New York State. The first is our Delivery System Reform Incentive Payment Program, or DSRIP, as we affectionately refer to it. The second is helping us prepare for a world of VBPs.

(next slide) I'll describe where our perinatal projects lie within our DSRIP program and the objectives overall of this 5-year program. It says 5-plus because we had a planning year. It started in 2015 and goes until 2020. But in 2014 we had a planning year where the applying healthcare entities could do a community needs assessment and this community needs assessment informed the projects that were ultimately selected by what would end up being 25 successful applicants. We call them performing provider system (PPS) or PPSs to help lead our transformation efforts. So, the stated goal is to reduce avoidable hospital use, and this includes both emergency department visits as well as inpatient hospitalizations, by 25 percent over the five years of the program. Doing this by removing the silos that exist between hospitals and healthcare centers and their communities, by developing integrated delivery systems—both clinical as well as electronic integration, by enhancing primary care and community-based relationships and making sure that primary care providers know what resources are in the community for these community-based referrals, and the importantly integrating behavioral health and primary care. So, this can be bringing primary care providers into behavioral health settings or bringing behavioral health specialists into primary care settings. All of this to build on the CMS and state goals of the triple aim of improving quality of care, improving health, and reducing costs.

(next slide) Amy Jesaitis will talk about our perinatal care projects selected by the performing providers system in Western New York and in one case of our Prevention Agenda Project in Central New York and then also and New York City.

Amy Jesaitis: Our DSRIP program, Perinatal Project Objective, is to reduce avoidable poor pregnancy outcomes and subsequent hospitalization, and improve maternal and infant health through the first two years of the child's life. Three interventions were provided as options for the PPSs. Four of the PPSs selected this maternal and child health (MCH) focus. Interventions they could select from were: (1) Implementation of an evidence-based home visiting program. (2) Establishing a care referral community network based on a regional center of excellence. (3) Implementation of a community health worker program on the model of New York's Maternal and Infant Community Health Collaboratives program. Two PPSs programs selected number one, none selected number two, and three selected number three. As Dr. Fish said they represented different parts of the state. There were three in the Western part and the one in the Bronx.

Another initiative we had for another area, decreasing premature birth, two PPSs selected that one and they were in Central New York and Western New York.

(next slide) You can see the models we allowed folks to choose from. We selected these models because New York is already funding these models through the Maternal, Infant and Early Childhood Home Visiting Initiative, a federal grant for home visiting, and through DOH dollars. The first two, Healthy Families New York and Nurse-Family Partnership, are evidence-based models. The third, the Maternal and Infant Community Health Collaborative—we call it MICHC—is a longstanding DOH program of community health workers (CHWs) and its evidence-informed while not evidence-based. The MFP is for first-time pregnant women. They need to enroll before 28 weeks of pregnancy, they get a nurse home visitor that comes at regular intervals, the frequency of visits depends on where the woman is in her pregnancy or the age of her infant or toddler. It's an especially good program for high-risk pregnancies, and families can be enrolled until the child's second birthday.

Healthy Families New York is on the Healthy Families America model. It's for pregnant and newly parenting women. Women can enroll anytime during the prenatal period or up until their infant is three months old. They use trained lay professionals. The primary focus has been child abuse prevention but there's also evidence for improved pregnancy outcomes in child development. Families can stay enrolled in Healthy Families up until the child turns five or enters Early Head Start, Head Start, or a pre-kindergarten program.

Our MICHC community health workers work with women who are preconception, during their prenatal period, interconception or postpartum. So, they have a lot more flexibility in when they can enroll clients. They're engaged for a variety of times. It's as long as the woman needs their services, and those services are provided by community health workers who are lay professionals, and the Department of Health has been providing training for those lay professionals.

Typically, a home visitor will have a caseload of about 25 clients. If they have very high-risk families they might have fewer clients or if they have a caseload of lower-risk clients they might have more. Referrals are typically made through medical practices, WIC clinics, community-based organizations, and schools. In our project, the PPSs need to track the patients engaged in the project.

(next slide) You can see perinatal measures. There are seven measures associated with the project. The ones most likely to be influenced by the visiting programs are low birth weight, the well-care visits, timeliness of prenatal care, timeliness of postpartum visits, and childhood immunization status. It's not that the other ones can't be affected but they're less likely to. We did retire one just this year, the frequency of ongoing prenatal care.

(next slide) I want to talk about how we're trying to integrate initiatives. It's important to try to integrate the initiatives because we don't have the bandwidth to do a lot of things well. We're trying to by integrating reduce impact whenever possible. In New York State, the Prevention Agenda began in 2008 and we're currently undergoing and updating through 2024. The Prevention Agenda is New York States' health improvement plan. One of the focus areas is promoting healthy infants, women, and children. There are three indicators in the Prevention Agenda related to the DSRIP perinatal measures: (1) Premature births. (2) Maternal mortality. (3) Well-child visits. One of the recommended interventions in the Prevention Agenda for the MCH population is evidence-based home visiting for high-risk pregnant women.

(Amy) I forgot to mention on the slide of perinatal measures that these measures aren't due to us and they don't have to report on them until years four and five, the pay-for-performance years, so we don't have any data yet from the PPSs on those measures.

(next slide) In terms of preterm births, we have seen a decrease over the years, small but steady. The data ends in about 2015 when the DSRIP project started. We're always about two years behind for our vital statistics data so any day now we should be getting the 2016 numbers.

(next slide) On maternal mortality, we've seen a similar slow decrease. Unfortunately starting in 2014 we saw it picking up again following the natural trend of an increase in maternal mortality.

(next slide) Looking at the percent of children with the recommended number of well-child visits, we have seen a 4.7 percent increase in the children receiving the recommended visits, and if these trends continue I think that will help the DSRIP projects and they will probably push it even higher. So, we'll see that and hopefully, meet the Prevention Agenda goal.

(next slide) Moving on to considerations for adding home visiting, these considerations are based on what happened in our DSRIP projects as well as what's been happening statewide in-home visiting. I find that often in meetings where people say "Let's do home visiting. That's going to cure that problem," home visiting is great and has a lot of good outcomes, but it really is not the panacea for everything in MCH.

So, there are some important questions to ask when you want to add home visiting to a community. You have to really look at the current landscape, what's happening already in-home visiting. You might ask how many other home visiting models are implementing? Are they evidence-based? Are they

homegrown? Are they promising practice? Do they have similar eligibility requirements, serve the same population? Are they full? Is there a waiting list? If models are implementing and they have a lot of empty slots it's probably not a good idea to introduce another model into that community. It's also important to look at acceptability of home visiting. In some communities, people hear home visiting and they think CPS, Child Protective Services. They're worried somebody's going to come into their home and take their child, so when they're referred they're a little nervous. So, looking at how it's termed is important as well as whether it's acceptable in that community. We have some communities where there's really a high declination rate for home visiting services, so we're working on improving the acceptability and reducing the stigma. People also say, "Why am I getting it and nobody else is getting it?" or "Why is it only the Medicaid people getting it?" So, we have to really work on the stigma and that's important to look at, acceptability.

A third thing to consider is the cost of the models. They vary dramatically across the models. The ones we're implementing, it goes from about 3,800 per client per year to 9,000 per client per year, and nursing with the partnership is a more expensive model because of the professionals, nurses, hired to do the home visiting. Some of the benefits of home visiting are seen a little later out. If you're looking for cost savings in medical care and you're implementing a model that's good for school readiness, you're not going to realize the benefits in your medical system. But schools are going to reap the benefits of that home visiting, so the costs are also important to look at and which model in terms of what the benefits are.

(next slide) Then looking at some of the challenges or lessons learned, we only had one of our PPSs that successfully launched the evidence-based model. The rest did the CHW model. So, we can't really say evidence-based facility but the ones who did that did find that they decreased referrals into foster care and they increased breastfeeding, so that was good. But the other ones with CHW paid attention to expanding existing programs instead of implementing new programs.

One of the issues found in the communities was there was competition for enrolling the pregnant women, especially first-time pregnant women. Everybody wants the first-time pregnant woman because she's much more motivated to do well and they have better outcomes with them. So, we found they were all trying to enroll the same pool of women. It also was hard to get high-risk women so they tended to get the easier to get women, increasing the competition. There are plenty of women having babies across New York State and plenty of high-risk women having babies, but they're harder to get so they tend to go to the fewer and easier to find.

Coordination is really important. It's critical for not duplicating services. We had a few where we would find a woman enrolled in two programs or three programs. They all wanted her because they want the numbers. They want to be able to report to their funders that they're seeing so many clients. So, we wanted them to coordinate and make like a decision tree: Who's going to get which kind of woman? If she's high-risk and before 28 weeks maybe she should go to NFP if it's the community or if she's high-risk for child abuse maybe she should go to Healthy Families instead. But to coordinate services or do bi-directional referral. So, if my program's full I'm going to refer to your program. And they didn't want to do that because they were afraid they would lose clients down the road. So, we really are stressing coordination with the programs. And we want to try to fill all programs, so again if one program's full they need to refer to another one or have a feedback loop that said they didn't want our services; do you know something else they could use?

Another issue is reach. When you look at all the clients and patients that could be served and how many you can fund with a home visiting model. Say you can only afford four nurses and you're reaching 100 people, but you have 5,000 people enrolled who have babies every year, you're not going to get that

greater reach into the population. One of the issues was that none of the PPSs were able to serve as many women as they had proposed. I think part of that might be the acceptability and also there's an issue of referrals. Not all practices are willing to make the referrals. Some of them don't understand about home visiting so they don't want to make the referrals, and then others it's just an added burden to try to make those referrals so they don't do it. But it was an issue that none of them was able to serve as many as they thought.

The last challenge or lesson, really a challenge, is attribution of the home visiting services. If you have a home visiting rich community where you have four or five models operating and you see an improvement in outcomes unless you know for sure that woman was in the program that you fund it's hard to say it's one specific program. Again, sometimes they were in two programs unfortunately so could you say one was more effective than the other? You don't know. So, it's important if you're going to do it to figure out a way to know—a good data system would help that—which program the woman was in and for how long. The other thing is if the woman enrolled and only stays for 15 months if she should stay for two-and-a-half years, then can you really say it was the program helping her or did it help until that point she left?

Douglas Fish: (next slide) I'm going more into detail about how we're envisioning and how our VBP system is designed. Dr. Flottemesch has nicely laid out a VBP framework. I think New York's Medicaid VBP arrangements fit well into his categories 3 and 4.

(next slide) This is an example of what our VBP maternity care arrangement looks like. There are two ways expectant moms in New York State could be cared for under a VBP arrangement. One would be a total cost of care arrangement. This is all members attributed to a primary care provider and that would include expectant moms in that arrangement. Or this VBP maternity care arrangement which would be specific to the obstetrical provider. We have a CMS-approved roadmap and in that roadmap, it offers guidance to our provider communities as to who the state recommends. The attributing provider for this particular arrangement for maternity care it would be the obstetric provider who is rendering the majority of services to the expectant mom.

This arrangement has three components: (1) The prenatal care component, which includes the pregnancy episode. This goes back 270 days prior to the birth. (2) The delivery postpartum care component and this includes the delivery, whether a vaginal or Cesarean section delivery, as well as 60 days post-hospital discharge for the mom. (3) Newborn episode. This includes the component of the infant's birth and 30 days post discharge for the infant.

The VBP care arrangement is an arrangement we offer and so far, we have not had any communities or providers take this arrangement up yet. There are concerns they have around the attribution piece as well as the inclusion of the neonatal intestine care unit piece. This is an arrangement that is made available through Altarum using their Prometheus grouper.

(next slide) On our various VBP levels, we have three levels—one, two, and three. Level one and level two are retrospective reconciliations against a target budget. This target budget is set based on three years' worth of historical costs, a growth trend, a risk adjustment, and a performance adjustment. Services are rendered. Claims are submitted by the provider to the managed care organization. The managed care organization pays those claims on a fee for service basis.

Level one is upside only where if there are savings if we come in under that target budget 50 percent of the savings, gets shared if we meet quality metrics.

Level two is a 90/10 recommended sharing if there are savings to share. However, if there are losses then those losses would be assumed by the provider organization.

Then a level three is a prospective payment system, a capitated payment system, per member per month, again tied to quality metrics. So that's also an upside-downside arrangement.

(next slide) These are tied to quality measures. The dollars only get shared if quality metrics are met, so if they meet performance measures. This is a list of performance measures that include measuring the wrong contraceptive care, measures around Cesarean section for nulliparous signal term vertex births, low birth weights, prenatal and postpartum care, etc. There are both maternal and infant-related measures. We have recommended a couple measures to be paid upon. That means they could be used in a pay for performance means—prenatal as well as postpartum care. This is [00:48:10] with prenatal care as well as postpartum visits. This measure did lose its endorsement in 2016 but it is still a measure the state uses with our managed care organizations and still one we are using in the DSRIP program as well as in our VBP program.

They choose which measures they want to pay on. Say they choose four measures. It is suggested that they meet at least half of those measures. So, a contract between a provider and plan would say that they're meeting 50 percent of those measures, so they'd have to meet past two of those measures. How they meet the criteria that are used to meet those measures are left up to the provider and the plan to determine. The state does not dictate what includes improved performance.

We do require the state choose at least one of these measures to pay on. We recommend that again it be that prenatal/postpartum care measure, but they can choose one or the other measures or more of them to pay on as well.

(next slide) As we look to our take-home messages, Amy will talk about the DSRIP aspect and then I'll speak to the VBP component.

Amy Jesaitis: One thing I want to point out is we did have a small sample. Only four of the 25 participated in this and only one of those actually implemented an evidence-based home visiting model, so it's hard to draw firm conclusions, even looking at the processes. The pay-for-performance measures aren't yet available. The data aren't yet available. So, we can't see how they did, although if they follow the trends from the Prevention Agenda dashboard data they should be doing okay and hopefully even increasing faster than the statewide trends.

In terms of integration, I want to emphasize that it's so important to make sure that whatever is introduced is really integrated into the existing system well so there's a smooth coordination between programs and all programs can be fully enrolled.

Douglas Fish: From the VBP component, I really think that we see our DSRIP program as our path to sustainability for continuing the gains and successes we've made in the perinatal home programs as well as our other projects. We're working to address provider concerns over our maternity care arrangement and trying to get some adoption there. We worked very hard to align our quality measures with those of other payers and with what providers are already used to reporting on to the managed care organizations through our quality insurance reporting requirements.

Crystal Tyler: We have time for one clarifying question and will save the rest for remaining of the presentation. Regarding your levels trend: *What were the three trend points listed for level one? Risk trend, growth trend…Please clarify.*

Douglas Fish: There's historical cost and then it's a performance adjustment, a growth trend, and a risk adjustment. Performance meaning on past performance. So, if you're a high-performing provider then you get some quality bonus points added to your target budget allowing you a percentage higher target

budget. So, if you have a higher target budget then you've got more room within which to operate and have costs.

Crystal Tyler: One more clarifying question: *Did you indicate whether the MCO has to provide all four VBP options to providers?*

Douglas Fish: It's left up to the provider and the managed care organization which level they choose. In fact, level zero doesn't count. I didn't mention that we do have a commitment to CMS that by 2020 as the DSRIP program winds down that 80 percent of the managed care organization expenditures to providers needs to be in some value-based arrangement. But to account for that it needs to be in level one, two or three: Level one, no risk; level two has downside potential risk as well as level three.

Crystal Tyler: (next slide) Kara Miller and Dr. Mark Redding will present on the Ohio Pathways Community HUB Model.

Kara Miller: Over the next few minutes I will introduce Ohio Medicaid's quality strategy, how it aligns with our state health improvement plan, and how Medicaid leverages partnerships with managed care plans to improve population health.

(next slide) In Ohio's effort to reform and modernize the Medicaid program, the Ohio Department of Medicaid developed an agency-wide quality strategy that prioritizes paying for value rather than volume and care provided to our covered population, which is almost three million Ohioans. Ohio's Medicaid population has been organized into four population streams noted here on the left: women's health; individuals with chronic conditions; individuals with behavioral health conditions; and healthy children and adults. This facilitates a population health management approach versus a traditional approach of managing a rate cell or an eligibility category. Initiatives, noted as gears in the middle of the visual, have been designed with attention to scale across the state, harnessing transparent, timely, and actionable data, community engagement—which is our work with community partners engaged in improving the health of their communities, addressing social determinants of health, and investing in VBP efforts through Ohio's Comprehensive Primary Care Initiative, which is our version of a patient-centered medical home, and then also implementing episodes of care.

Medicaid is working to achieve better population health outcomes and equities in those outcomes, and you can see examples of these outcomes we've selected for each of our population streams. They're listed on the right-hand side. One of our priority initiatives is to improve the racial gap in preterm birth and infant mortality rates, which is very relevant for today's discussion.

(next slide) I want to turn to our State Health Improvement Plan for a minute. In 2016, a state health assessment described many opportunities to improve health outcomes, improve health equity, and control spending. Led by our Governor's Office of Health Transformation and many of our other sister state agencies, and with input from many stakeholders, the State Health Improvement Plan lays out a multi-year plan to guide Ohio's efforts to achieve measurable improvements in key priorities which are listed here: mental health and addiction; chronic disease; and maternal and infant health.

In doing a bit of a deeper dive into maternal and infant health in Ohio, to be able to illustrate why this was selected as a priority issue, in 2016 Ohio's infant mortality rate ranked us at 45th in the nation, which is one of the worst and is often an indication of poor population health in our system. A racial disparity also exists in the rate of babies dying in Ohio. African-American babies are dying at a rate three times higher than that of white babies in Ohio. So, with Medicaid paying for over 50 percent of the births in Ohio and also being the largest payer in the State of Ohio, this is why we felt it was very critical for us to play an active role in efforts to improve birth outcomes and reduce infant mortality in Ohio.

(next slide) Here we're back at Medicaid's quality strategy again. I want to elaborate on a point about alignment, with a quick side-by-side comparison of our State Health Improvement Plan with the Medicaid quality strategy. You can see we deliberately aligned our quality strategy with the overarching State Health Improvement Plan. We feel we can be more successful if we take a systems-level approach and bring together partners like public health, community-based organizations, healthcare providers, and our managed care plan partners, data, and VBP efforts to more effectively address the many drivers, like access, social determinants of health, and risk factors that influence the health of a population and the vitality of our community.

(next slide) As I mentioned, Ohio's contracted care plans are a key partner in improving our population health outcomes. Of the three million Medicaid beneficiaries, nearly 90 percent of the population is enrolled in a managed care plan. Ohio's managed care plans are paid per member per month capitation payment by ODM to provide for all of an individual's healthcare needs, and they are at full financial risk. Medicaid has established an extensive set of evaluation measures that are routinely calculated to maintain health plan accountability and determine their overall impact on population health outcomes.

(next slide) In our arrangements with the managed care plans, like I mentioned, we calculate national measures—most of them are HEDIS—that we hold plans accountable to. There are measures for each of the Medicaid population streams that I highlighted earlier in the quality strategy. To emphasize our goal around system alignment across our various initiatives so that we're able to have a greater impact, you can see here where our measures align with our State Health Improvement Plan, which is noted on the left, and then to the far right, many of our plan contract measures also align with our comprehensive primary care initiative so that both providers and plans are working towards the same goal.

Back to our contract measures and focusing on the women's health space, which is that very last row in the table, minimum performance standards are set for each measure and there are incentive opportunities built into the accountability strategy. In 2018 we made a change from a pay-for-performance system to a quality-based assignment and a quality withhold incentive system. This change is intended to provide more direct incentives for performance improvements and better health outcomes, so while there are only a few measures listed here that we've selected to focus on for women's health, the expectation is that our managed care plans take a life course perspective when addressing this population, which means they should be addressing preconception, interconception care, family planning, etc., and we want them to have an entire view of their women's population.

The state is not prescriptive about strategies that must be undertaken. Managed care plans are expected to customize interventions or quality improvement initiatives for each population risk level and community that they're serving. For example, if we think about high-risk pregnant women, the plans may connect them to centering programs, home visiting, community workers, and it's important to mention HUBs. This is also an opportunity where the managed care plan partners can partners with HUBs in Ohio to improve birth outcomes. The HUB model does fit into Ohio's overall population health management and VBP strategy. To that end, Dr. Redding will provide more information about the HUB model.

(next slide) Mark Redding: To try to summarize my comments in just a couple sentences, the lens we are looking through with this is individually modifiable factors of risk—medical, behavioral health, and social determinants—represent the source for health and socioeconomic outcomes that we all hope to change. This now 20-year-old, multistate Pathways Community HUB Model can serve as an example of how comprehensively identifying and addressing risk can fit within a pay-for-value approach.

My wife Sierra and I started working with community health workers and care coordination a little more than 25 years ago, starting in arctic Alaska and then Ohio. When we arrived there right out of training, I

thought we were there to teach the CHWs (community health workers) but we were the ones who received the education. Because we tried to only focus on the medical components. The community health workers taught us that, for example, if an expectant mother does not have housing and access to medical care and is suffering from significant depression, each of these risk factors are intrinsically linked together for her, and addressing just one of them, say the depression or just the housing or just the medical care, may not change the outcome. The evidence now clearly supports that we must accept and embrace the complexity of medical, social, and behavioral risk factors to improve the outcome. Instead of it being about one or two major factors, it's about the whole multifactorial group and how they work together to produce these results.

We realized that population-related risk factors such as access to healthy foods in the grocery store or racism or safety in neighborhoods are also critical. But the capacity in the system is primarily within being able to address these individually modifiable factors, and if we do a good job with that, we can inform population health-related initiatives.

(next slide) Some of the factors are immediate, like smoking or homelessness, and some are more upstream, like nutrition or parenting education for parents of a newborn. Addressing preventive risk factors offers the greatest improvement in both outcomes and cost.

(next slide) So the lens of these interlocking and interconnected factors is somewhat new.

(next slide) It is this currently fragmented and siloed approached to care that our nation has where different programs, different staff, different resources, different forms to fill out are all combined into a siloed, fragmented, and ineffective approach for addressing multifactorial issues that the person may have.

(next slide) It's our belief that pay for performance strategies that accomplish this multifactorial assessment of risk and assure risk mitigation can impact not only health outcomes but also social, economic and behavioral health. It's fascinating that the profile of potential risk for infant mortality, school and job success, chronic disease control and others are at a high level extremely similar. They all require consideration of housing, food, access to medical and behavioral healthcare to achieve both the medical and the socioeconomic wellness we are aiming for. For example, even if a fifth grader who is flunking out in school has a great teacher and a brand-new iPad, how can he succeed if his family does not have housing? If his mom is consistently depressed? Or if there is no consistent access to food?

The health and social service system could begin to purchase work products that assure the comprehensive identification and mitigation of risk.

(next slide) So how do these concepts play out in our current system of care? We have two general service areas: care coordination, which is the work of assessing or identifying the risk factors and then assuring that the individual connects to intervention, and direct service, which represents the service or intervention itself. It is this care coordination component of our system that we think needs the most help.

(next slide) With today's current approach to care coordination for an at-risk family, Marisol is expecting, does not have prenatal care, and needs to complete her GED. Angelina is 18 months old and she used to have pediatric care and was identified as having developmental delays but has not been treated for these. Marisol has just received an eviction notice. Per our community health workers, this is actually a very simple family where they face families with six or eight people in the same household, all with multiple risk factors.

(next slide) There are multiple agencies that could be serving their family, each with their own focus and specific risk factors. One may be focused on medical home, another lead exposure, another on Marisol's asthma medications. We have found in multiple communities, individuals, and families that have up to 15 care coordinators. Six care coordinators is quite common in maternal and infant health. There is no required collaboration amongst the care coordination agencies and none of them may address the eviction notice. In today's payment model, these agencies are responsible primarily for processed items like caseloads, chart notes, and have no specific accountability for the reduction of risk.

(next slide) The Pathways Community HUB Model is developing almost statewide in a couple of states and is present in about 30 communities nationally. The care coordinator, most often a community health worker, reaches out to the most at-risk individuals. The community health worker is supervised by a team structure of social workers and medical personnel. A complete assessment of medical, social and behavioral health risk is completed. Each identified risk factor is then assigned a specific Pathway, and then that Pathway seems to track and confirm that the risk factor has been addressed.

So, if you are the care coordinator and your 24-year-old asthmatic client who has been in and out of the ER multiple times is found to be homeless and have no medical home, each of those risk factors becomes a Pathway. You do not get paid for the medical Pathway until you confirm she has shown up for that medical home visit, and you don't get paid for the housing Pathway unless you assure she now has safe housing, food, education, immunizations, prenatal care, home environmental improvement and many other health, social, and behavioral health factors tracked in that same way. Similar to how UPS assures you receive the package orders with the delivery receipt, the simple nationally standardized Pathways serve to confirm that packages of intervention that address the risk factors have been delivered.

(next slide) As quality and payment measures, they have been within funding contracts now for almost 20 years, with some modification and improvement. The ages served ranged from twinkle to winkle. The care coordination they support is focused on a broad array of medical, social, and behavioral health domains, primarily including maternal and infant health but also chronic disease in adults, employment, the justice involved, and others. In all cases the payment ties to confirmed risk reduction and related outcomes.

(next slide) This model requires assessment and reassessment at least monthly, steadily working through a prioritized set of risk factors.

(next slide) This works towards an organized, multifactorial approach to wellness and better outcomes.

(next slide) The next complexity layer of this model is the community HUB. As many of you know there are many agencies that provide care coordination within communities. The HUB serves as the air traffic control center. The HUB does not hire the community health workers and does not directly provide the care coordination service. The HUB contracts with the local agencies that have the community health workers and those agencies as part of the community network provide the care coordination. These care coordination agencies are often small entities, including nonprofits, churches, community service centers, FQHCs, and others. They often have a workforce that is highly culturally competent and connected to the community.

Without the HUB, these agencies often do not have the bandwidth to contract with larger organizations like managed care, public health, and others. The HUB provides the standards, training, technical support, and tracking of the risk assessment and Pathways completed. When a new client is enrolled at one of the care coordination agencies, the first thing is to check in with the HUB to make sure there is no duplication of service. A HUB then ensures the quality of service and an evidence-based approach to the identification and reduction of risk.

Nationally, there are now multiple evidence-based models for care coordination as were highlighted in the New York presentation, yet only a small percentage of national funding actually funds evidence-based or evidence-focused models.

(next slide) The HUB can contract with multiple potential funders spanning health, social service, behavioral health, and others. This brings sustainability and contractual expertise to small, locally connected community teams of agencies. Through braided funding to the funders, the HUB can ensure that the appropriate clients and risk reduction work products that they desire are provided as part of these multi-domain contracts without having multiple care coordinators in the home.

(next slide) Community HUBs are certified nationally through the Rockville Institute in Maryland with support from the Kresge Foundation. A process for documentation and approval of each standard Pathway are held within certification. Pathways span individually modifiable factors of medical, social, and behavioral health risks. Several of these 20 nationally standard Pathways have multiple subcomponents of measures. Certification requirements help assure payers the basic training, supervision, quality, and confidentiality requirements are in place. There are now several evidence-based models of care coordination nationally that are similar that can be embraced and brought to a community HUB structure to further improve the results.

(next slide) Risk reduction tracking reports that look at individual caseloads, programs, and now entire states can demonstrate at a population level which risk factors have been identified, which ones were addressed, and interestingly and importantly, the ones that can't be addressed. So, in this small sample of real data, housing is only able to be addressed in one-third of the time for expectant mothers, and for those that it was addressed, it takes up to two months to address those risk factors. This population-level data was brought to county leaders, who are now working with Metro and housing leaders, churches, legal aid, and others to improve this individual and population-level risk factor.

(next slide) Each of the Pathways has a billing number assigned. This billing system is not recognized at the national level yet but it is utilized by all five Medicaid managed care programs in Ohio and it is developing within Washington State and Michigan. There is a relative value unit structure that relays to each Pathway and allows for more efficient contracting of HUBs with managed care, public health, and others.

(next slide) There are many different categories of funding currently supporting HUBs nationally. The most common are state waivers and managed care. As dollars come into HUB, the HUB retains a percentage and the large majority goes to the care coordination agencies. All layers of the funding, when they reach the HUB, are tied to performance, including some new incentive programs for the community health workers themselves.

(next slide) Multiple domains of health, social, and behavioral health improvement have been documented and published.

(next slide) Maternal and infant health has the most peer-reviewed publications, demonstrating significant reductions in costs of care, and this study demonstrated a 60 percent reduction in low birth weight. That is actually much less than a reduction that Alaska and other international programs have shown with extremely effective care coordination. The county rate for infant mortality in the county with the longest history of the HUB was recently reported as African-American infant mortality being half that of Caucasian and the focus was African-American pregnant women.

(next slide) The HUB model represents a different approach. In the HUB model more than 50 percent of all funding tied to the level of the individual to confirm mitigation of medical, social, and behavioral health

risks. In comparison to other current accountability structures in pay-for-value, HEDIS has some similarities, as most HEDIS measures confirm that a risk factor has been addressed. The differences include that HEDIS measures are almost completely medically focused, and HEDIS uses a percentage-based method of financial accountability that is rarely utilized in American business systems that have been our model to follow. American business systems focus on the completion of very specific, critical work items. When the financing in pay-for-value related to HEDIS is examined at the individual level and the specific risk factor that is being addressed, the amount can be very small, in some cases less than a dollar per member per month. Fee for service, for example, does not have accountability for outcomes. Pay-for-value based on cost savings, which currently appears to be the largest financial accountability driver, does not necessarily focus on quality of care, and may or may not resolve in improved overall outcomes. Because of actuarial adjustments over time, the most effective cost reducers in cost savings contracts may experience a decrease in overall income over a 5- to 10-year period.

Though in need of greater study and research, payment for risk reduction through Pathways may represent the clearest connection of dollars to critical work item completion that is directly connected to outcomes. Insurance companies supporting these contracts, with the assistance of state and federal Medicaid programs, are leading the way to highlight this potential.

(next slide) In summary, there are two fundamental pillars of this work. Come to Mansfield and meet community health workers that we have gotten to know well and others across the state of Ohio and across the country. For example, one of our best ones was born right in the very high-risk community where she lives. Her dad is a local pastor. She knows everyone and is highly connected to the patient she serves. You will find her at the grocery store on the weekends buying formula for a young mother who has run out or at the hospital, on a holiday, delivering a car seat when everyone else is closed. It is amazing what she can accomplish in supporting her clients to cut back or quit smoking, to go back to school, to achieve employment, to read to her children, to put the baby on her back to sleep, and many other risk reductions that hinge on the individual's behavior. This relationship impact is a cornerstone of effective care coordination and is found in all the evidence-based models. At a population level, these community-connected approaches then put jobs, training, and infrastructure right within the community that needs them the most.

The second pillar item is similar to American business models within systems like airports. Every important work item is defined and financially accountable for quality. This model of accountability for work products in private businesses produces multifactorial outcomes such as the 2,500 planes that take off almost every day from the Atlanta airport. Those systems of getting work items completed offer tremendous examples of how our health and social service systems could work. The nationally certified community HUB model and its focus on confirmed risk reductions may provide a glimpse into this opportunity. Thank you.

Crystal Tyler: Additional information on the HUB Pathway model will be found in the resource list. Now we will open to questions on any part of the presentation. First, on the Pathways Community HUB Model: *Can the presenter speak to how base funding for a HUB model is established relative to average and variable costs?*

Mark Redding: When HUBs are beginning, they definitely need startup funding and support and they need a strategy to transition to this highly accountable pay-for-performance structure. So, startup funding is critical, and about a year to a year and a half of time is needed for that community network to crank up to the performance standards that are presented. That said, we believe, and this is unpublished information, that community HUBs have led to payment for community health workers and sustainability

for community health workers that may be better than any other option out there, as we now have community health workers in the field for close to 20 years, based on these payment structures.

Crystal Tyler: For our New York presenters: *Describe how you see the sustainability of community health worker funding beyond the DSRIP funding and dollars?*

Amy Jesaitis: In terms of case studies who we've been supporting through the Department of Health public health side, we're committed to continuing that program at this point. In terms of DSRIP, it might depend on how well they did when they get their performance measures.

Douglas Fish: In terms of DSRIP it winds to a conclusion in early 2020. These kind of successful models could be included then in a VBP arrangement so that would be another funding stream. So, if they're showing a return on investment or the community feels this is a project they want to continue in, then those savings that they would share in an arrangement could then be used to fund a community health worker or other staff to maintain the model they desire.

Crystal Tyler: For New York on quality measures: *Can you describe why the frequency of ongoing prenatal care was retired as a perinatal measure?*

Douglas Fish: This was retired by NCQA, National Committee for Quality Assurance. That's the measure steward. Because this is a process measure, it's a measure that was based on expert opinion and was not evidence-based, so it had lost its endorsement. And the committee that works with NCQA decided that it no longer met their endorsement requirements and so they retired it. Similarly, the prenatal/postpartum care measure, that too has lost its endorsement, but NCQA has maintained its commitment to continue to steward that measure and make it available. We feel even though it's a process measure that if you're not getting the visits you're not getting the care. So, there's value. But there is a tension that exists between having the ultimate outcome measure that you would like and where they don't exist is it better to have a process measure or is it not? So, it fell really, I think relative to that conversation.

Crystal Tyler: A question for either state: *Describe how you integrate the newborn provider payment with the OB provider payment since they're different providers.*

Douglas Fish: Right now it's part of a global payment and the maternity care is through a global payment that I think includes the first 30 days of the infant. I would have to double check that. In our maternity care arrangement, of course, all the services would be bundled in an episode that includes 30 days post discharge for the infant and then 60 days post discharge for the mom.

Kara Miller: I'm not able to provide insight on that but I can ask here and maybe provide some information after the webinar.

Mark Redding: I would add that in the HUB model there would be a specific set of risk factors and related Pathway payments for the infant as well as the mother both pre and after delivery.

Crystal Tyler: *Did any of the models that were presented today require state or local level policy change?* I think they're referring to legislative or regulatory policy change.

Douglas Fish: In New York, I don't really think so. Our DSRIP programs and VBP programs are under our 1115 waiver, so that's funded through an 1115 waiver program with CMS. But these specific perinatal projects did not require any specific changes to statute or regulation.

Crystal Tyler: For Dr. Redding, Ohio: *How does the Pathways model leverage the pediatric primary care setting and its interdisciplinary team?*

Mark Redding: Some of the community HUBs nationally have done a great job in integrating this community-based HUB which has home visiting and intensive outreach of community health workers into the client's home with the primary care medical home and medical home team. Akron Children's is one of the entities working on that and implementing the medical home model across their network of providers. When that can be done, it's a tremendous strength because obviously within the medical home you can only go so far to identify and address social, health, and behavioral health determinants. But that care coordinator in the medical home has a community partner within a HUB that can actually go out to the home and enroll the client in intensive care coordination, and they can share with permission from the patient the risk factors that they're addressing and working through, and keep the primary care provider up-to-date with all that. That's tremendous and similar again to the gold standard model in Alaska where the primary care provider is really linked to the care coordination that's happening for the client.

Crystal Tyler: Thanks to all our presenters. Now key takeaways.

(next slide) Thom Flottemesch: The three things I'd really like to emphasize for everyone is:

- The first, which our two states really illustrated, is that care delivery models can be implemented in a variety of care settings, and they can be integrated into part of current VBP initiatives but also broader state initiatives.
- The second thing that was very clear is the states we had speaking today did their homework. There's a lot to consider when you implement one of these models. There's a list to reiterate some of the things we talked about before, but the thing I would really emphasize is that strong supportive relationships and related education are critical if we think about how New York allowed their provider organizations to match what they were doing and the same thing is happening in Ohio.
- Assuring payment drives both micro and macro system changes, and that can be transformative if we think about how we're impacting individual care. In the maternal and infant health setting care is broader than just what happens in the clinic and in the hospital. It's what's happening in the everyday life and that also goes to the care setting as well.

(next slide) One last thing is we ask you to complete a short feedback survey. The webinar slides and material will be available here in a couple of weeks, and the entire presentation as well.

Thanks, everyone for joining and a very special thank you to all our presenters. It's been a wonderful presentation.

[end of tape]