

TRANSCRIPT

Medicaid Innovation Accelerator Program: National Learning Webinar

Estimating Changes in Medicaid Expenditures for Various Value-Based Payment Approaches – Oregon's Experience

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Speakers:

Scott Leitz
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- Scott Leitz: [00:00](#) Good afternoon, welcome to today's Medicaid Innovation Accelerator Program webinar. The name of today's webinar is, Estimated Changes in Medicaid Expenditures for Various Value-based Payment Approaches, Oregon's Experience. My name is Scott Leitz, I'm a senior fellow at NORC at the University of Chicago, and I want to welcome all of our participants on today's webinar. We're excited to have you as a part of this exciting discussion this afternoon.
- Scott Leitz: [00:32](#) Before we get started with the actual webinar, just a few logistics.
- Scott Leitz: [00:36](#) Next slide please.
- Scott Leitz: [00:40](#) During the webinar all lines will be muted, please do not put your line on hold because oftentimes in doing so, it has hold music that comes up. Please use the chatbox on your screen to ask questions or to leave a comment, we welcome comments and questions throughout the webinar. And then finally, just for your information, today's webinar will be audio recorded.
- Scott Leitz: [01:08](#) Next slide, please.
- Scott Leitz: [01:13](#) For learning objectives, by the end of the webinar we're hopeful that participants in the webinar will be able to learn about the Medicaid Innovation Accelerator Program, or IAP as we'll frequently refer to the program throughout today's webinar. And Oregon's goals and objectives for developing the Value-Based Payment estimation technical resource tool that they had and used throughout the course of this IAP opportunity.

Scott Leitz: [01:41](#) To learn how Oregon used the resource to inform its value-based strategic design consideration, and how it will continue to be used by the state to help meet its long-term Value-Based Payment goals. To understand the methodology for developing the resource, and to learn how your state can use this tool to examine changes in Medicaid expenditures for various Value-Based Payment approaches.

Scott Leitz: [02:05](#) Next slide, please.

Scott Leitz: [02:10](#) The agenda, we'll have introductions first. Secondly, we'll talk a little bit about what the Innovation Accelerator Program is, and the technical support that's being provided underneath it, as well as Oregon's goals in taking up this technical support opportunity. We'll have a demonstration of the technical resource by Justin Timbie from RAND, and then we'll pause at that point for some Questions and Answers (Q&A). And then we'll hear some of Oregon's experiences using the tool, and also pause for Q&A after that point.

Scott Leitz: [02:44](#) Next slide, please.

Scott Leitz: [02:50](#) Our presenters this afternoon, in addition to me, who will be moderating the discussion throughout today, will be Justin Timbie, who is a senior health policy researcher at RAND. As well as Zachary Goldman, who is an economic policy advisor at the Oregon Health Authority.

Scott Leitz: [03:10](#) Next slide, please.

Scott Leitz: [03:12](#) Before moving into the meat of the presentation today, I'll spend just a couple of minutes talking about what the Innovation Accelerator Program is, as well as Oregon's goals under this opportunity.

Scott Leitz: [03:23](#) Next slide.

Scott Leitz: [03:25](#) The Medicaid Innovation Accelerator Program, or IAP, is a commitment made by the Centers for Medicare and Medicaid Services, to build state capacity and support ongoing innovation in Medicaid through targeted technical support. The goal of IAP is to increase the number of states moving towards delivery system reform across the various programmatic priorities. It's important to note that this is not a grant program, but rather a technical targeted support opportunity.

Scott Leitz: [03:53](#) Next slide, please.

Scott Leitz: [03:58](#) The Medicaid Innovation Accelerator Program really looks to tackle delivery system reform by focusing on four programmatic areas that are seen in the columns listed here. Improving care for Medicaid beneficiaries of complex care needs and high costs. Promoting community integration through long-term supports and services. Supporting physical and mental health integration and reducing substance use disorders. Those four programmatic areas are further supported by functional areas, which include support for states around data analytics, quality measurement, performance improvement, and Value-Based Payment and financial simulations. The information provided today and the Oregon experience was really provided under that last bullet point, Value-Based Payment and financial simulations.

Scott Leitz: [04:47](#) At this point, I'm going to turn it over to Zachary from Oregon, to talk a little bit about Oregon's interest and approach in looking at the Innovation Accelerator Program opportunity. Zachary, can I turn it to you?

Zachary Goldman: [05:03](#) Yeah, sure, thanks. Hi, everyone, Zachary Goldman here. I wanted to orient folks on the three requests that we had of the team. The first one was, some technical support in developing one, a standardized set of definitions. What do we mean by Value-Based Payment? What's included, what's not? And secondly, we wanted some assistance creating a Value-Based Payment roadmap, how we get from where we are today to where we want to be in five years. That was a really important piece.

Zachary Goldman: [05:32](#) The second request, though, was some support identifying what levers we had at our fingertips, so that the state could encourage some uptake of Value-Based Payment models in two particular areas. One is behavioral health providers, and secondly, how can we leverage Value-Based Payments. Or, at least think about Value-Based Payments in the space of addressing social determinants of health, which is a really key priority area. Both behavioral health and social determinants of health are key priority areas of our governor, of the legislature, and of leadership here at the Oregon Health Authority.

Zachary Goldman: [06:06](#) Thirdly, though, and most relevant to today's conversation, we wanted some support conducting some financial simulation analyses. Because we wanted to predict and empower our coordinated care organizations with some tools so they could predict the potential impact of Value-Based Payments on both cost and quality axes. Throughout our work, we've always been

looking at both quality and cost, and trying to better understand how Value-Based Payments can advance both of those goals.

Zachary Goldman: [06:39](#) With that, let's move to the next slide. I'll kick it back to Scott for a poll question.

Scott Leitz: [06:47](#) Great, thanks, Zachary.

Scott Leitz: [06:53](#) Our poll question is, has your state used data to assess the potential impact of a Value-Based Payment arrangement on outcomes of interest? Such as Medicaid cost savings? You see the options are yes, no, or unsure. We'll wait a moment while you all enter your answers.

Scott Leitz: [07:42](#) And I think we'll close the poll. And it looks like about half of you on the call have used data to assess the potential impact of Value-Based Payments on outcomes for your programs. And some are unsure or an unknown commodity right now, but at least half has, so it's a knowledgeable audience that's already engaged in this activity. We sense the information here provided will be of great interest both to you and those of you who are thinking about it.

Scott Leitz: [08:11](#) With that, I think we can turn to the next slide, and I'm going to turn it over at this point to Justin Timbie from RAND, for a demonstration of the tool they developed on behalf of the Innovation Accelerator Program for Oregon. Justin, can I turn it to you?

Justin Timbie: [08:28](#) Sure. Thanks, Scott.

Justin Timbie: [08:32](#) As was mentioned earlier, Oregon requested support for simulating the potential impact of introducing VBP approaches within its existing program of coordinated care organizations. And as part of that IAP technical assistance, we developed an Excel-based model that simulates changes in state payments under four different VBP approaches, pay for performance (P4P), patients enter medical homes (PCMH), accountable care organizations (ACOs) and bundled payments. And so, although we developed this resource for Oregon and it has many features that are unique to the Oregon context, with some simple modifications, the resource can be adapted for use by other states.

Justin Timbie: [09:22](#) Like all of the financial simulation support provided to states under the IAP program, we followed a few basic steps for developing the resource. First, the support team developed,

reviewed and finalized the analytic plan through an iterative process with the state. In parallel, as the analytic plan was being developed, we identified the data that were available and could be used for the analysis. And then our work with Oregon, this included financial data, including enrollment, payment, and aggregate expenditure data. And as part of the work, we conducted an evidence review to obtain the most up to date estimates of the impact on costs of different VBP approaches. Finally, we built a model, in this case it was an Excel-based template, to estimate changes and state payments under different VBP approaches.

Justin Timbie: [10:22](#) As you'll see in a moment, the technical resource is an Excel Workbook with a total of nine tabs. The first three tabs are instructional in nature. They provide background information on the development of the resource, descriptions of each tab, and descriptions of each variable used in the calculations. The next five tabs show the key data inputs. Some of these data were provided by Oregon, such as Coordinated Care Organization (CCO) level enrollment, payment, and expenditure data. Other tabs contain data that we compiled and used to drive a few key parameters, like expenditure growth rates and evidence on the impact of VBP approaches on changes in expenditures. Then, spend some time walking through the final tab, the VBP estimation tab, so you can see how all these inputs come together to estimate changes in state payments.

Justin Timbie: [11:18](#) Without further ado, I'll share my screen and begin the walkthrough. And I will say, for accessing this technical resource, please email Kevin Koenig at NORC and his email will appear soon in the chatbox. And he'd be happy to send you the template.

Justin Timbie: [11:55](#) Okay. If anyone's having trouble viewing the Excel file, there are two options to make the screen larger. In the top right corner of the webinar screen, there's a small square icon. And you can make the webinar full screen by clicking on that square. That's in the top right corner of the screen. On the bottom right side of the screen, there's another small square icon that says, "Actual Size." You can click on that icon to zoom in and make the content larger.

Justin Timbie: [12:28](#) The first tab that you'll see when opening the workbook is the background tab. It describes the purpose of the tool and the data that are needed, which we'll go through in detail. And it provides more details about the evidence review that we conducted.

Justin Timbie: [13:45](#) The next tab, “desc_tabs,” is a table of contents, that describes each of the nine tabs in the workbook. And you can see the nine tabs arrayed across the bottom of the screen. Column A contains the name of each tab followed by a description. And before I turn to the tabs that are colored, which we'll walk through individually, I want to mention the third tab called “desc_variables,” which is another informational tab. This is a reference for you, and you can see from the description in row four, this tab defines and describes all of the variables used to produce the estimates in the estimates VBP tab, which is the orange color tab. And I won't go into all of those details, all of the descriptions of the variables now, because I will discuss most of them when I walk through the “estimates_VBP” tab.

Justin Timbie: [13:44](#) The next three tabs, one green and two yellows, contain the data inputs, the CCO level expenditure data, enrollment and per member per month (PMPM) payment data, and data used to derive growth rates. And you can see that each of these three tabs, the green and the two yellows, has the prefix data in their names. The next two tabs are the blue tabs, and they contain information from our evidence review. We'll go through those, as well. And, the orange tab, called “Estimates VBP,” is one of the most important tabs in the workbook. As you'll see shortly, in this tab, there are several white cells in which the user selects values of several variables, from dropdown menus, for each row in the tab. There are also gray cells that contain the model outputs, including enrollment and payments in the projection year.

Justin Timbie: [14:40](#) We'll now go through all the color tabs in more detail, but I think I'll just pause here and see if there are any questions that have come through the chatbox.

Scott Leitz: [14:55](#) One question is, how are the specific Value-Based Payment models—whether it be PCMHs, or P4P or ACO or shared savings types models or even bundled or even episode-based payment approaches—listed in the background tab, identified for use in a technical resource?

Justin Timbie: [15:18](#) Okay, so we wanted to make sure that we covered the most prevalent types of VBP models, that are in use today. We also wanted to make sure that we had VBP approaches that spanned both ambulatory settings, like PCMH, the medical homes, and also those that tended to focus more on hospital-based care. So we included bundled payments, as well. These four types of Value-Based Payment models tend to be the most prevalent, and so that was our starting point.

Scott Leitz: [15:56](#) Great, thank you.

Scott Leitz: [15:58](#) This is the only question that came in. But participants, feel free to send in questions as you have them along the way. I think, otherwise, Justin, you can go ahead and proceed.

Justin Timbie: [16:10](#) Okay, sounds good. We'll turn to the green tab. And here, for each CCO, we used aggregate data on expenditures within nine service categories. In Column C, you can see that these categories range from "hospital services" to "other." Column D contains total service expenditures for the service category. And when a user inputs expenditure data into the worksheet, the worksheet will calculate the percentage of total expenditures accounted for by each service category. And you can see that in Column E.

Justin Timbie: [16:52](#) For example, if I replace total physician expenditures for CCO 1 with zero dollars [in Column D], you'll see that the share of expenditures adjusts automatically to account for that relative share of spending on that service category. These values in Column E are what's used in subsequent calculations. I will say here that all of the data in this tab and the next couple are fictitious for the purposes of this walkthrough. We've replaced Oregon's data with completely fake data.

Justin Timbie: [17:33](#) Okay, so the next tab is the first yellow tab, ["data_CCO_MM_PMPM"], and this contains enrollment counts and payment rates by beneficiary enrollment category for each CCO. First in Column C, you'll see something called "CCO type." In Oregon, there are five different types of CCOs identified by letters, which reflect different types of services that the CCO is responsible for providing. So, CCO-A is the most comprehensive, and these CCOs provide physical health, mental health, non-emergency medical transportation, and dental services.

Justin Timbie: [18:10](#) Payment rates to each CCO will vary by the CCO type, and by enrollment category. In Oregon, there are 12 enrollment categories, which you can see in Column D. The number of member months by enrollment category for each CCO are reported in Column E. And then finally, the payment rate per-member-per-month for beneficiaries in each enrollment category, for the relevant CCO type, is reported in Column F. Again, these enrollment and payment data, like the expenditure data on the prior tab, were provided to us by the state in the format that you see here. We've just changed the data for the purposes of the webinar.

Justin Timbie: [18:55](#) Okay, next [yellow] tab is “data_growth.” This tab shows how two key parameters are derived. First in Columns B and C, we derive the average annual growth rate in enrollment in Oregon's Medicaid program. The growth rate is derived by compiling enrollment counts for each year, all the way back to 1991, which you can see in Column B. We then calculated annual growth rates in enrollment for each year, from 1991 to 2014, which you can see in Column C. Now, finally, we calculated an average annual growth rate, and you can see from the orange shading in Column C that we're averaging over the period 2000 to 2013 for this calculation. The average annual growth rate in enrollment in Oregon Medicaid, 3.8%, is reported in Row 28. And this value is used in subsequent calculations to project enrollment into the future.

Justin Timbie: [20:01](#) Using an identical approach, we derived the average annual growth rate in expenditures per enrollee, and that derivation is shown in Columns D and E. As you can see in Row 28, we use an average expenditure growth rate of 3.1% in our subsequent calculations.

Justin Timbie: [20:22](#) The source of this information is the CMS State Health Expenditure Accounts, and data from Oregon are shown in the worksheet, but data for each state are available at the link that you see on the screen.

Justin Timbie: [20:39](#) Okay, so the next tab is “sources_VBP,” and this tab contains the results of the evidence review that our team conducted. For each article identified in the review, which is listed in Column B, we indicate the VBP approach that was evaluated in the study, and that's in Column C.

Justin Timbie: [20:59](#) From each study, we abstracted estimates of changes in expenditures for specific services, due to participation in each VBP approach. And so you can think of these as impact estimates, and where necessary, we converted these estimates to relative reductions in expenditures, or percent changes in expenditures from baseline values. These impact estimates are listed in Column E.

Justin Timbie: [21:27](#) And then Rows 4 and 8, further down the screen, you can see some blue rows, and those contain the median impact estimates across the studies that we reviewed for each combination of VBP approach and service type. And it's these medians that are used in the subsequent calculations. For example, to highlight a couple of rows here, and so in this example our estimate for the impact of a PCMH model on spending for physician services is zero percent, which you can

see here in Row 8. And so we obtain that by virtue of that being the median value across the three studies that were included in this review.

Justin Timbie: [22:19](#) Okay, so that was our evidence review. And the next tab, "data_VBP," is simply a synthesis and reorganization of the information in that prior tab. It shows just the median impact estimates for each combination of VBP approach and service type. It basically gets everything into a format that can be used by formulas in the other tabs. And, not going to spend much time, any more time, on this tab.

Justin Timbie: [22:51](#) Before we get to the last tab, again, the most important tab, I will pause and see if there are any more questions that came through the chatbox.

Scott Leitz: [23:06](#) The first question that's come in is, can the Value-Based Payment, or VBP evidence expenditure estimates be updated with data points, up from more current VBP studies?

Justin Timbie: [23:22](#) Yeah, absolutely. The evidence review that we conducted and we showed on the prior tab, I think is current through fall of 20 ... Well, it happened I guess between fall 2017 and winter of 2018. So any study that was published in basically 2018 through the present is not reflected in these estimates. A user of a tool could carry the evidence review forward from the end of 2017 to the current time and update those median impact estimates.

Scott Leitz: [24:09](#) Great, thank you.

Scott Leitz: [24:11](#) Another question's come in, and you sort of addressed this one, but maybe you can just describe it again. In the "sources_VBP" tab you talk about using the median impact estimates from the evidence. Can you say a little bit more about what you looked at there and the meaning of median in the context of this particular model tool?

Justin Timbie: [24:38](#) Yeah, exactly. It's always a challenge sorting through the evidence and coming up with a single summary measure of impact across studies that obviously draw on different samples, different contexts, occurred at different times. And so, our approach was to take simply the median across all different studies within that category, the category VBP approach, to come up with a single estimate. And, there's lots of different ways that that could be done. We could have used the mean, a weighted mean, or any number of different approaches. But for

simplicity and for this tool, we thought that the median was a sensible approach.

- Scott Leitz: [25:35](#) Great, thank you. Those are the questions that have come in to this point.
- Justin Timbie: [25:43](#) Okay, in that case, I will proceed to the final tab, which is “Estimates_VBP.” This is the tab, as I mentioned before, where the user selects a number of different options from dropdown menus, and where all the calculations occur. Each row in this tab corresponds to an individual CCO, which you can see in the first column, which is Column E here. As I mentioned previously, the white cells represent user inputs, and the gray cells, beginning in Column M, contain formulas that perform all the necessary calculations.
- Justin Timbie: [26:22](#) Among the white cells, we've already discussed CCO type and beneficiary enrollment category. There are a few inputs that we haven't discussed before. The first is projection year in Column H, and that represents how far into the future you would like to project expenditures, currently set at 2020 for all CCOs.
- Justin Timbie: [26:44](#) Next, the VBP approach is in Column I. And so the user selects which of the four VBP approaches from this dropdown that each CCO will be implementing. Here, you can see the four types that we have available in this technical resource [PCMH, ACO, Bundled Payment, ACO, P4P].
- Justin Timbie: [27:00](#) I'm going to skip Column J for a moment, and then move to Columns K and L, and you'll see these are the target service type one and target service type two. And these are the types of services that each CCO might be prioritizing for improvement under the VBP approach. There are only two options here, “hospital services” and “physician and other professional services.” And at least one of these has to be selected, but both can be selected, which is why we have two fields for target service type.
- Justin Timbie: [27:33](#) For each of these service types selected, operationally, what the model does is to apply an expenditure reduction to that category of service and only that category, using the median impact estimates from the literature.
- Justin Timbie: [27:49](#) Scroll back to Column J for a moment, “VBP Effectiveness for Population Service.” In this dropdown menu, there are three choices. Based on the user's selection, a different multiplier is applied to the median VBP impact estimate. “Average,” means

that the median impact estimate from the literature is used. "Below average," means that the VBP approach is 25% less effective than the median for that population and service type. "Above average," means that the VBP approach is 25% more effective. And so we built this multiplier into the model to account for differences in the relative effectiveness of a VBP approach, because the impact of the payment model might depend on the complexity of the patient population.

- Justin Timbie: [28:41](#) Okay, so moving onto the gray cells. The first calculation in this section occurs in Columns P and Q, and it's the calculation of payment amounts in the projection year, so 2020, under the status quo. This is the scenario in which VBP does not exist, so it's the status quo. In Column P, we report payment amounts in PMPM, and in Column Q, we report aggregate payments. And we calculate these by projecting forward the base year enrollment counts, and the base year payment amounts, using the growth rates that we derived on the tab "data_growth."
- Justin Timbie: [29:26](#) I'm going to find these so that we can see the remainder of the columns, and then I will move on to the next four columns, which are R through U, in the center of the screen. So these don't involve calculations, per se, but they're populated with data from other tabs that are needed to calculate changes in expenditures.
- Justin Timbie: [29:54](#) First in Column R, it's populated with each CCO's share of total expenditures associated with service type 1, so hospital services in this first row, this first example.
- Justin Timbie: [30:08](#) Column S is populated with the expected percentage change in expenditures for service type 1. And this percentage reflects the VBP effectiveness multiplier, which in this example, the first row was above average.
- Justin Timbie: [30:26](#) In this example, again, the first row of data that we see here, the CCO is targeting both hospital and physician and professional services. Columns T and U are also populated and show similar information for physician and professional services.
- Justin Timbie: [30:46](#) Finally, in the last four columns, in orange, the worksheet calculates payments under each VBP approach, which we will compare to our status quo estimates. In Columns V and W, we have PMPM payment rates and aggregate payments, respectively under the VBP approaches. In column X, we have the change in payments from the status quo, due to VBP. And

then finally, last column, column Y, is the change in payments expressed as a percentage.

Justin Timbie: [31:21](#) Again, for this first example off CCO 1, and this VBP model here that we selected with PCMH, and so a PCMH model is expected to reduce the state's payments for Temporary Assistance for Needy Families (TANF) enrollees in 2020 by around \$45,000. Which is equivalent to less than one 10th of 1% in lower payments.

Justin Timbie: [31:55](#) As you can see with these last couple of calculations, what this workbook does, is to first calculate unexpected reduction in expenditures for each selected VBP approach. Those lower expenditures are translated directly into lower payments by the state. And then finally, the difference in payment amounts under the VBP approach relative to the status quo are calculated as a way to quantify the potential benefit to the state of each VBP approach.

Justin Timbie: [32:31](#) With any Excel-based model, you can certainly change inputs and obtain updated estimates in real-time. For example, I will hide a couple more columns so as to not be distracting. For example, we can alter the projection year in this simulation with 2020 for all CCOs. But this can be changed to 2025, or any other number and you'll see that the orange columns will update.

Justin Timbie: [33:08](#) The VBP approach, obviously, there's a dropdown menu. This can be changed from PCMH to ACO. Again, those numbers, the change in payments for the ACO option are larger, so more savings to the state. That's a function of the impact of ACO relative to patient centered medical home. And, of course, we could also assume that an ACO model is less effective for a TANF enrollee population, the impact is below average, and you can see the savings to the state is slightly lower.

Justin Timbie: [33:57](#) To wrap up, I'll just say that we view this workbook as a template and we're often referring to it as a template, that states, in conjunction with their data partners, can adapt in several ways to fit each state's unique context. And so, for example, rather than CCOs, the unit of analysis can be any provider or provider network, such as an ACO. The beneficiary enrollment categories can be changed as appropriate for each state. And as we mentioned earlier, the evidence review can be expanded. Or if users want to simply input their own impact estimates and not rely on the literature at all, that's easy to do, as well. All of the formulas in the workbook are relatively straightforward, so analysts that have experience with Excel

should be able to adapt the workbook fairly easily to fit each state's unique context.

- Justin Timbie: [34:58](#) Okay? And with that, that concludes the walkthrough. I'll turn it back over to Scott.
- Scott Leitz: [35:07](#) Justin, great, thanks. Thanks, Justin, and thanks for that really wonderful review of this flexible and practical tool that you all developed.
- Scott Leitz: [35:17](#) A couple of questions have come in. The first relates to, I think, just how to think about Column X [in the "estimates_VBP" tab], which is that change in payments from status quo to what the Value-Based Payment is. Do these data points help Medicaid agencies determine or give them some guidance around which parameters lead to increases or decreases in their overall Medicaid spend?
- Justin Timbie: [35:49](#) Yes, that is the general idea. Looking at Column X, the relative magnitudes of those changes in payments from the status quo, users can work backwards to the various input values, the enrollment categories, the specific model, the relative effectiveness parameter. And can see to what extent those selections are driving those differences. With the example that I showed with the eight rows, we were toggling different models across all the CCOs, different enrollment categories, and different levels of relative effectiveness. It's hard to isolate the drivers in that kind of an approach, but certainly a lot of those inputs can be homogenized. For example, a user can select ACO across every unit, every CCO in this example, and see how that one factor is driving the change in payments.
- Scott Leitz: [37:01](#) Great, thank you.
- Scott Leitz: [37:02](#) One additional question, and then we'll pivot over to Zachary to talk about Oregon's use of the model. But, I'm curious, based on building this resource that you've done and the programming and the specifications, any thoughts on overall guidance on how other states should approach starting to use this resource? This particular resource for their own states?
- Justin Timbie: [37:24](#) Yeah, so I think the first couple of steps would be to decide which VBP approach is the focus. Most states will want to focus on just a single VBP approach, rather than the four that we offer in the tools simultaneously. And once that VBP approach is identified, perhaps updating the literature review for that one approach to make sure it's as current as it can be. And then

identifying the units of analysis, is what would be really the next step, whether it's an ACO or a practice or a hospital. Because all of the data inputs, the expenditures, the enrollment, the payments, have to be at that level of analysis.

- Justin Timbie: [38:19](#) I guess the other thing is that this model was built to estimate the impacts of VBP for specific enrollment categories, but states need not do that. They could roll up their enrollment categories to larger groups, or simply look at all enrollees together across all the categories. And then massaging the data into the format that's needed for the tool would be a final step so that it can be inserted directly into the tabs that we went through.
- Scott Leitz: [38:55](#) Wonderful, thank you so much.
- Scott Leitz: [38:58](#) As we pivot now to turn over to Zachary Goldman, who you heard a little bit from earlier, very briefly, from the Oregon Health Authority, to talk about Oregon's experience using the research, just want to remind folks that we will have another Q&A after Zachary's presentation. So, if you have questions, either on Zachary's presentation or on Justin's, please feel free to send those in and we'll get to as many as we can.
- Scott Leitz: [39:22](#) With that, Zachary, can I turn it to you?
- Zachary Goldman: [39:26](#) Sure, yeah. In the next slide, what I'd like to do is, tell folks a little bit about our strategy and what we had hoped to get out of this model, which we did. And then how we used it.
- Zachary Goldman: [39:40](#) First, just to level set for a moment, we sought a model that was incredibly dynamic, that met the needs of our diverse state. We have urban areas, we have rural areas, we have frontier areas. And each have their own experiences with regards to the different models of Value-Based Payments they could consider, and other factors. We needed this model to be dynamic to examine those specific impacts of the different approaches.
- Zachary Goldman: [40:09](#) Secondly, we needed it to be very flexible and usable. The use case had to be clear. And the reason it's in Excel, I think is to achieve that. If it were based in some statistical software that only a handful of folks have, then that wouldn't really meet the needs. The fact that it's really easy to use and accessible was key, and a resource for both the Oregon Health Authority and the coordinated care organizations themselves. Which, if folks aren't familiar with our approach, our CCOs are our Medicaid managed care organizations.

Zachary Goldman: [40:48](#) Thirdly, on this slide, the data collected and the different evidence collected in itself was incredibly helpful. So, that “sources_VBP” tab, even if you don't use the model as it were, I would highly encourage you at least look at the “sources_VBP” tab. Because, essentially that's a summary of all the diverse and really interesting research that's out there on Value-Based Payments. The evidence that's collected for this resource is of value, and a really good resource for folks.

Zachary Goldman: [41:22](#) Next slide, please. Great.

Zachary Goldman: [41:27](#) What we're hoping is that this new resource will allow the incoming class of CCOs, what we're calling CCO 2.0. This starts in January 2020. We're hoping that this allows them to simulate their own impacts of the Value-Based Payment approaches that they may take and what works for their population, what works for their networks, which models might be more preferable than another. So I think this is helpful in both the current CCOs of today, as well as the next class of CCOs starting in just half a year.

Zachary Goldman: [42:04](#) We also referenced this tool as we thought about the Value-Based Payment targets that we've established in CCO 2.0. And I won't go too far into detail, but essentially, the Oregon Health Authority has required coordinated care organizations to invest in Value-Based Payments. And that percentage of v Value-Based Payments increase over time, so this dovetails really nice with the predictive capacity of this resource.

Zachary Goldman: [42:36](#) Secondly here, this resource is flexible, as I mentioned before, and can really be modified in a number of ways. And that's important as the Medicaid program evolves over the coming years.

Zachary Goldman: [42:49](#) In terms of a couple of lessons learned, as we think back and look back at our experience, it would have been better to include the users of the resource a little earlier in the development of this tool. There were some complicating factors in that the Oregon Health Authority was in the process of developing the CCO 2.0 policies and requirements. And so our engagement with potential applicants to become a CCO was limited because of that work. There was nothing we could do about it but just looking back and just generally, it's great to involve the users of the resource in the development of the tool itself.

Zachary Goldman: [43:31](#) And then lastly, it would have been great to adjust the timing of Value-Based Payment guidance, such that this tool could have

been delivered with other informational and background context for what are Value-Based Payments? What is their general potential? How might a CCO go about launching a Value-Based Payment, et cetera? Just additional context and background would have been good, looking back. But other than that, it's great to have the tool. It's incredibly flexible and dynamic and checks off all the boxes that we're hoping for.

- Zachary Goldman: [44:11](#) Next slide, please?
- Zachary Goldman: [44:14](#) Let's just open it up and see if anyone has any questions for us in Oregon.
- Scott Leitz: [44:22](#) Thanks, Zachary. A couple of questions that have come in. It sounded from the way the question was phrased that the information Oregon provided to RAND to help build the model, it had a base year. Does Oregon have any plans to update that to more recent data or on an ongoing basis? Have you given that any thought? Or do you have any plans to do that?
- Zachary Goldman: [44:58](#) We're not there yet, but we are definitely considering that. The data that drive some of these values, as Justin mentioned, in Oregon are publicly available. That's part of our capitation rate development work that we do and the reports that we publish. Going forward, given that we do have some new coordinated care organizations serving in new areas, starting in January 2020, we very well could update it, though with the new data.
- Scott Leitz: [45:34](#) That's helpful to know. If I heard you correctly, the data that you were using that was feeding into this was largely data that was already being developed for your capitation rate studying purposes? Did I hear that correctly?
- Zachary Goldman: [45:47](#) Correct.
- Scott Leitz: [45:52](#) And then, do you have any feedback, from what you heard from folks who worked with the data or CCOs that have worked with the tool or know of the resource, any feedback that you've received about the tool? Is it easy to work with? Has it been understandable for folks as you've gone about the process of rolling it out, both to the staff who'd be working with it, as well as the broader stakeholder community?
- Zachary Goldman: [46:20](#) Yeah. I think it's been pretty clear. We have some questions about how some of the formulae are structured. But, because it's in Excel, and there's really no mystery, all the formulae are there. You just have to click on it and look at the different tabs

it's referencing. I think it's fairly clear, and it's fairly intuitive to those with an Excel background, and those familiar with Excel formulas.

Scott Leitz: [46:50](#)

That's great to hear.

Scott Leitz: [46:52](#)

You're the leading edge of looking at this type of a tool and developing and working with it. And I'm curious if you, and you touched on this a little bit, I think, on your lessons learned. But I'm wondering if you'd be willing to expand a little bit on what advice you might have for other states or for stakeholders who might be interested in pitching to the state that they should maybe look at this sort of a tool. Either in the approach of how the data is worked with, or thinking about maybe working with leadership within a Medicaid agency or a health authority. Any advice that you have on any of those points, anything that you'd have to add there?

Zachary Goldman: [47:35](#)

Sure, yeah. I think what has worked well in Oregon is our diverse engagement with, not just the coordinated care organizations, or in the other states, the Medicaid managed care entities, but the provider community as well. Whether that be hospitals or the independent physicians association groups, or the other medical groups. I think that's been a success for us thus far to figure out which Value-Based Payments are already in the market, whether it be Medicare or on the commercial side.

Zachary Goldman: [48:09](#)

What work can be leveraged by Medicaid policies to advance the goal of Value-Based Payments? And what are the roadblocks in the community between payers and providers, et cetera? It's only through engaging those diverse stakeholders, can you begin to understand what the market looks like. I think that's worked well for us thus far, and I think that's worked well for us as we develop the CCO 2.0 policies and requirements. That will start fairly shortly.

Scott Leitz: [48:48](#)

Super. Those are great pieces of advice and great takeaways.

Scott Leitz: [48:53](#)

Well, thank you. I don't believe there's any further questions that have come in at this point, so, Zachary, thank you for your presentation.

Scott Leitz: [49:05](#)

Yeah, we can move to the next slide.

Scott Leitz: [49:10](#)

A great set of presentations today from both Justin at RAND and Zachary from Oregon. Some of the key takeaways from today is

that the resource developed for Oregon used aggregate data from the CCOs in Oregon. And Value-Based Payment evidence estimates from the literature to forecast changes in state payments, following the implementation of particular Value-Based Payment approaches. And Justin walked through that range of approaches for you.

- Scott Leitz: [49:39](#) The resource, as Zachary just described, was used by Oregon to examine the potential impact of various Value-Based Payment approaches in cost and quality. And hopefully, will help the CCOs meet their 2020 Value-Based Payment targets. A key takeaway here is that other states can modify the design of the resource, rather, and incorporate their own data. And as we heard, this is data that frequently, hopefully is already in development from other purposes within the state Medicaid programs. To help better understand the potential impact of Value-Based Payment approaches on Medicaid expenditures.
- Scott Leitz: [50:24](#) Next slide, please.
- Scott Leitz: [50:27](#) We want to wrap up by thanking everyone for joining today's webinar. It was a really excellent discussion and presentation on this tool that's been developed. Hopefully, other states will find it of interest. We do hope to see you for the following upcoming Medicaid IAP Value-Based Payment webinars. One on August 27th, which relates to insights and key considerations for implementing Value-Based Payments in children's oral health. And then one on September 5th, key lessons learned in transitioning to Value-Based Payment to improve maternal and infant health outcomes.
- Scott Leitz: [51:05](#) We do ask that you please take a moment to complete a short feedback survey. Otherwise, this will conclude today's webinar. Thank you, all.
- Speaker 4: [51:21](#) And that does conclude today's conference. We thank you for your participation and ask that you please disconnect your line.