NWX-HHS-AOA-1 (US)

Moderator: Lauren Solkowski
November 19, 2014
1:00 pm CT

Coordinator: Welcome and thank you for standing by.

At this time all participants are in a listen only mode.

During the Q&A portion of the call if you would like to ask a question you may press star 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time.

Your host of today's call is Ms. Lauren Solkowski. Thank you. You may begin.

Lauren Solkowski: Wonderful. Thank you so much. Good afternoon and thank you everyone for joining us today for the Administration for Community Living Targeted Technical Assistance Webinar on Rate Determination.

As the Operator mentioned I am Lauren Solkowski with ACL and will be facilitating our webinar.

For today's webinar we have invited Health Management Associates to discuss the Medicare/Medicaid rate setting for providers and plans that dual demo rate methodology as well as payment to providers and a few other emerging issues.

We've also invited Sandy Atkins with the Partners in Care Foundation to present on the community-based organization perspective in reaching rate agreements with healthcare entities.

So before we begin with our presentations I have a few housekeeping announcements to run through.

One, if you have not done so please use the link included in your calendar appointment to get onto our WebEx. So that you can not only follow along with the slides as we go through them but also to ask your questions when you have them through the chat function.

If you do not have access to the link that we emailed you, you can also go to www.webex.com. Click on the Attend a Meeting button at the top of the page and then enter the meeting number which is 662915979. That is 662915979.

If you have any problems getting onto the WebEx please call the Technical Support number at 1-866-569-3239. That was 1-866-569-3239.

As our Operator mentioned all of our participants are in a listen only mode. However we do welcome your questions throughout the course of the webinar. There are two ways that you can ask your questions. The first of which is using the chat function in WebEx. You can enter your questions here.

We will sort through them and then answer them as best we can once we take breaks for questions after our - each speaker presents.

And the second way after the speakers wrap up we will also offer a chance for you to ask your questions through the audio line. When that time comes the Operator will give us instructions as how to queue up to ask your questions.

If there are any questions that we are not able to answer during the course of the webinar we will be sure to get them answered. If you think of other questions once we have completed the webinar, please feel free to email them to me. I have listed my email address in the chat box located on the right hand side of the screen.

Also as the Operator mentioned we are recording the webinar. We will post the recording, the slides and a transcript of the webinar on the ACL web site as well as in n4a's MLTSS Network web site. I have entered the ACL site. The n4a site as well. As I said my email address in the chat box located there on the right hand side of your screen.

So with that I would like to introduce our first two speakers. We have JoAnn Lamphere and Tony Rodgers with the Health Management Associates. JoAnn is a principal in the Denver office of HMA. She consults with private sector organizations that are simulating improvements in healthcare delivery.

With them she identifies and analyzes strategic options to achieve integrated person-centered care for complex and vulnerable population groups.

Also through a contract with n4a and ACL she partners with aging and disability organizations to increase their business capabilities for delivering managed long-term services and support and engaging with the health sector.

Also from HMA we have Tony Rodgers. Tony is also currently a principal with Health Management Associates. Prior to rejoining HMA he was appointed by the Secretary for Health and Human Services to the position of Centers for Medicare and Medicaid Deputy Administrator, Center for Strategic Planning.

As the CSP first Director, first center Director he was responsible for CMS long range strategic planning, policy analysis and Medicare and Medicaid Program research and evaluations.

While Deputy Administrator he led the development of the CMS Innovation Center's State Innovation Models Initiative. Also known as SIM which provide states with grants to plan, design and test innovative healthcare delivery and payment reform models.

So thank you so much to both of you for joining us today. And with that JoAnn I will turn it over to you.

JoAnn Lamphere: Great Lauren. Thanks so much for that introduction, that kind introduction and good afternoon everyone. We're going to start this discussion with a quick summary overview of Medicare and Medicaid.

We believe this is important because we found that many AAAs are confused about what program covers which services and how providers get paid for these different services. And it's impossible to interpret rules regarding dual rate setting without having being reminded of some basics with respect to Medicare and Medicaid.

If you go to Slide 3, you'll see that traditional Medicare operated under a fee-for-service basis. Covers Part A which is hospital inpatient, nursing homes for the first 100 days; Part B for doctors and therapies; and Part D for prescription drugs.

And government traditionally paid providers for services based on DRGs or physician fee schedules or whatever.

Medicare Advantage has been growing in the Medicare Program. It's a voluntary Part C and now about a third of all Medicare beneficiaries are enrolled in Medicare Advantage. And Medicare contracts with private insurance companies to deliver services. Plans are paid on a certain amount per enrollee. The plans pay providers.

And that sometimes the plans offer Part D drug coverage, sometimes they don't.

But what's important is that the Medicare Advantage plans often offer other benefits, additional benefits such as dental, vision, Silver Sneakers that can make that coverage very attractive. So it's in addition to traditional Medicare.

Under Medicaid which is Slide 4, states determine what Medicaid will cover within certain federal parameters. And they'll pay for whatever is in their state plan and their so-called waiver services. And it's a state's responsibility to set Medicaid rates with CMS's approval.

And traditionally that operated under a fee schedule. And now more and more Medicaid is now run through managed care. It started with moms and kids. But it's growing now for vulnerable populations such as the aged people with physical disabilities, foster care kids, behavioral health and so forth.

And each state's method of paying for services is unique. And it reflects the policy objectives of that state. In other words, are there shortages in the - among health providers? Well the state might decide to pay more.

Does the state have quality concerns about what the providers are doing? They might offer, you know, a pay for performance incentive.

And states receive federal match, at least 50% for all their approved spending.

And payment rates can be negotiated between the state and the plan. They can be competitively bid or they can be administratively set.

The Balance Budget Act, I guess it was of 1997, established. They said that rates, Medicaid rates had to meet a standard of reasonableness with sufficient documentation. They needed to be actuarially sound and they needed to be appropriate for the populations covered and services provided.

And then there's capitated rate developments for the plans and it could be either blended rates providing a single rate for all Medicaid services or have separate capitation rates and (sales) for each category of service.

If you go to Slide 5 we're going to move into the dual demonstrations now. And, you know, these - it's officially called the Financial Alignment Demonstration but colloquially it's Dual's Demo.

And everything follows from this goal which is the goal of the Financial Alignment Initiative is to increase access to seamless quality programs that integrate primary, acute, behavioral, prescription drugs and long-term services and supports for the beneficiary.

Now right now there are 13 demonstrations that have been approved in 12 states. Go to Slide 6, aimed at improving care coordination.

And there are two financial models. About ten of the states are using a capitated model which is what we're going to focus on during this presentation.

And a state, CMs and a health plan enter into a three way contract. And the plan receives a prospective blended payment to provide comprehensive services.

Managed fee-for-service is where the state and CMS enter into an agreement and the state is eligible to benefit if - from savings if they achieve them.

Washington State is implementing a hybrid model. Minnesota is doing neither. They're doing administrative alignment or financial alignment.

If you go to Slide 7 you'll see that there are key principles that are used by the Dual Demonstration in setting rates. One is that rates are risk adjusted. They might be risk adjusted based on the medical condition of the person, the age or functional status or whatever.

The rates need to provide incentives for using home and community-based services to reduce institutionalization.

There are rules established for signing beneficiaries to various plans. In other words, you know, if they might not choose or they get confused. Beneficiaries need to be distributed across the plans.

Rates must be budget neutral. And the plans that the state contracts with must have at least a 3-star rating. CMS is very committed to offering quality services. And the rating seem to be a best indication of quality at this point.

The rates must be actuarial sound and they must reflect geographic variations such as urban and rural.

I'd like to turn the discussion over to Tony now who will go into the nuts and bolts and details of how these capitation rates are set.

Tony Rodgers: Thank you JoAnn. So setting capitation rates on the Medicare and Medicaid side is a unique process of blending rates. Med - capitation rates are set based on historical claims cost data or encounter data that's priced based on a fee-for-service rate prices.

And typically it is a base rate that's trended over three years. In most cases states and federal government try to use a three year trend to determine where the base rate should be established.

And then there are adjustments made to any capitation rate paid to a health plan. These adjustments are made based on policy.

And you see it both on the Medicare side and the Medicaid side that if Congress changes the benefits or sets a policy that's eventually adjusted into the rates such as the wellness visits. What's new with the ACA, add an adjustment to the rates. On the state side you have program changes and policy changes that adjust into the rates.

And then the other factors that are used are service utilization. The actuaries for the state will project forward what the service utilization will be and what the cost trend data will be.

The delivery system differs as in every state due to the fact how capitation rates are created. For example in some states behavioral health is carved out. In other states it's in. In some states they have safety net providers with special rates. And so these are other adjustments that go into the capitation rate.

The - today most states are attempting or doing risk adjustment. It's still early. Not all states are risk adjusting the population. But at least in the Dual Program, those rates are risk adjusted which means if you have sicker people your rates will be higher over time.

And then as JoAnn mentioned there's geographic adjustments that are made based on county or geographic areas that are considered the service area that the health plan is contracting for.

Now within the rates are what we call administrative loads and special contingency, risk contingency factors. And typically these are health plan specific administrative costs associated with implementing of the tip or benefit or a particular program like the Duals. There's a certain amount of money allocated for that.

Care management if it's a separate allocation can be an adjustment to the capitation rates or it can be part of the medical cost that's factored into the medical cost portion of the rate.

And then there's these pass through requirements. Every state seems to have some specific areas where they say you must pass through these dollars to this provider, this way.

And so in the Dual Program you'll see pass through requirements for say the plan has to pass through dollars to a specific provider.

And the reason why that's done is because often times the state is using local match dollars, county dollars to match Medicaid dollars. And the counties want that money to come back to them specifically.

Then there's reinsurance pool dollars that are - can be adjusted. Some states do reinsurance. Some states require the plan to go out and get reinsurance and savings adjustments and quality withhold.

What's unique about the Dual Program or the Dual Demonstration is for the first time there's a kind of broad use of quality withholds as part of the adjustment to the rate.

There's also a specific savings adjustment that's made on the initial rates so instead of getting the full capitation there's an automatic 1%, 2% adjustment for savings so that the Dual Program will demonstrate savings because you're already picking that money off the top.

Next slide, so if you look at the capitation model the basic process is determine your baseline, apply your savings percentages, make your specific adjustments based on Medicaid policy within the state. Typically Medicare is since it's a national does not have a lot of unique state specific adjustments other than geographic.

And then you formulate your capitation payments to the plan. Now some states have a fixed capitation. Here's what it is. That's what you get.

Other states have some wiggle room. They have what we call a range where they can have a low end and a high end. And that gives them some wiggle room for unique issues related to a particular county or Medicaid Program. They can pay that program an incremental more if certain things are being done by that program.

For example states will often use a differentiated cap rate if you contract with safety net providers. If your network has predominant number of safety net providers they may differentiate your rate so that - those are the kinds of payment adjustments that are unique to each state.

Next slide please.

So as you look at the capitation rates and in process, and the other baseline and you have your rate determination, there is this process that goes on where the plans because this is a three way contract in the Dual Program, the plans do comment on the rates. Let's put it this way. They use their actuaries and there is this backroom kind of validation. If the plans are saying the rates are really too low for them to contract, there may be some movement in the rates.

But once the rates are established then the methodology that Medicare uses and Medicaid uses are kind of locked in from year-to-year.

Next slide, and because it's a joint rate setting process eventually Medicare and Medicaid as this Dual Program goes on will look at where the savings really is accruing to. If it's on the Medicare side or is it on the Medicaid side.

And they make some internal negotiations between Medicare and Medicaid on how to account for that savings.

If you look at Medicare so this is where the financial alignment becomes important. The Medicare is contracting for the Part A and Part B services. The Part D or the drug services are separately determined. They're not technically part of the Dual Demonstration setting process. But they are accounted for in the Dual Demonstration.

Spending assumptions are calculated for the Medicare Advantage Plan and the fee-for-service Medicare. So this is they take a percent of what is the percent of individuals who are going to be in Medicare Advantage or in Medicare cash versus what percent are coming in through fee-for-service. And they weight those two percentages.

And the reason is because they've noticed that the risk factors in - if you're in Medicare Advantage versus fee-for-service are different. And so they're trying to adjust out any windfall to plans if for example they have lower risk factors coming from the Medicare Advantage population that are going to be participating in the Dual Program.

Beneficiaries who come in from fee-for-service, the rates are set with historic claims data. But members coming in from managed care or from a MA plan you will encounter data. You're looking at special adjustments that are made for geographic areas, service area adjustments, etcetera, that historically had been made in Medicare.

And then you - when you're coming in from the MA you're looking at the baseline for the average MA plan for that population.

So you're not making any assumption. It's a specific amount of baseline for a particular MA plan but rather the population as a whole and that's how you - CMS is adjusting the baseline in terms of average cost, average turn and etcetera.

And then the baselines also include some specific plan assumptions if there are some unique risk factors in the population that if a specific plan may have to absorb, those things are also part of it.

And if you - in Medicare you have this bid process. So the plans are actually using their MA bid and then CMS in the Dual Program is making additional adjustments based on the movement of MA lives into the Dual Program because remember in the Dual Demonstration you have to have both the Medicaid and the Medicare side.

So you're moving people around who currently may be in an MA plan or currently may be in a fee-for-service. And now they're coming into the Dual Demonstration and there is this passive enrollment or in some cases there are - and we'll talk about opt-out. But all this is changing where those members end up. And so these plan specific adjustments are necessary.

Next slide, so in terms of Medicare Part D there's really not a change in Medicare Part D. There's a projected baseline. There's an assumption actually that drug spending may go up in the demonstration.

So there is that opportunity. There is in some states they're taking the individuals who have the low income subsidy and they're rolling them into the demonstration as kind of the passive enrollment or even a lock in.

And so these payments now are becoming part of the Dual Demonstration payment.

But the rules are the same as they currently are with the bid process for the Part D health plans as well as the adjustments that Medicare makes still apply to the Dual Demonstration.

Next slide, so as we look at the Medicaid baseline you have Medicare has done its thing. And then on the Medicaid side you have many states who are moving from fee-for-service into managed care for the dual population because whether they are what we refer to as Stage 1 Disabled or if they're elderly and disabled or seniors and disabled, whatever nomenclature you use, these individuals have been typically served by the Medicaid Program for all the wraparound services that are associated with Medicaid that are not provided in Medicare.

And that all states are - who are moving their members into a capitated environment now have to come up with the trend factors and do the actuarial analysis, etcetera.

And it's not always as accurate because they're using making a lot of different assumptions. And we'll talk about that in a minute.

So the Medicaid baseline is based on the fee-for-service data that the state has. The managed care component of those what benefits are being given to managed care versus which ones are still carved out.

And then historic spending, that's reflected in the services and utilization. And depending on what is carved in and what's carved out determine what the baseline managed care rates will be.

Next slide, so this is just an example in California. But this - other states that are doing capitated managed care, this is typical. The states long-term care services have specific rates established with them. They look at bringing those - that system under a common health plan.

So programs that may have been waiver programs before like home and community-based waiver programs or they may have had some other specialized waiver programs are now coming in under the Dual Demonstration Program.

So what they want to occur is that the health plan begins to coordinate care across the Medicaid and Medicare benefit. What Medicaid typically pays for is the copayments, the deductibles for the inpatient and Part D services plus it provides wraparound services. Pays for the nursing home after 30 days, pays for home and community-based services, pays for what we would refer to as social service wrap, home health, etcetera, homemaker, meals on wheels, etcetera.

And so now these services are being carved into the benefit package associated with the duals. So the states are - have set the rates.

In the case of California those rates are based on an assumption that there are a certain percent of individuals who are currently in nursing homes or institutional or at - in institutions, nursing facilities.

There's a certain number of visits - certain number of individuals that have high community support needs like adult daycare and have significant home-based support needs. There are certain individuals who have basically one or two modest community-based service like for example home health worker

who goes to their home or someone who's doing homemaker but that's it. They don't need additional support. And then there are certain individuals that are basically healthy.

And so those four categories are used to create a blended rate so the percent of people in nursing home, percent of people in what they call high community-based need, low income community-based need and then well equal a blended rate that the State of California is developing. That's the rate they give the health plan.

Now if the health plan has greater nursing home days then the blended rate would justify it. They'll lose money. If it has less nursing home days they won't - they will actually make money.

Next slide, if you can move to the next slide, thank you.

So this is an example side-by-side of Medicare base rate so you have the base rate, you have the reduction to - from - for savings both in the Medicare and the Medicaid side. You have the administrative load factors, you have the profit margin that's allocated to the rates and then you have your Part A and Part B Medi-Cal - medical distribution on the Medicare side.

And then on the Medicaid side you have these factors of institutional, home and community-based, low and healthy. And from those two things come the blended rate. And that blended rate is what the health plan gets.

Next slide, so the expected savings is supposed to come from a change in utilization. And this is why it's important to have strong community-based services and (Area) Aging can really provide some unique services that actually reduce the inpatient or the use of acute care services so once the

aggregate savings is determined now the plan has to meet that savings amount, a trend factor.

Next slide, so when we talk about blended rate this is a good example, an easy way to see how the financial alignment blends rate. You have the Medicare side and the Medicaid side. From the health plan's point of view it's a little more complicated because they have to look at how they blend the benefit package.

But the one benefit of blending the payments is that they no longer have to have say well, this is a Medicare service so we have to keep it separate. They can look across the entire benefit package and cost. And come up with strategies that reduce the overall cost of care for the dual patient.

And from the beneficiary's point of view they should see this as integrating their care across the dually system so they don't feel like they're in one system or another. They don't have to about whether it's Medicare paid or Medicaid paid. It's all one system to them.

Next slide, we talked about rate adjustments factor. Some of the unique issues here is that there's risk adjustments that says if you have higher risk individuals. And these are individuals that the health plan's going to really want to manage well in terms of case management and care management.

And you have quality incentives. And so the health plans are - there's a quality withhold which means that unless they produce the quality services they actually do not get that money back.

And so the health plans are incentivized to really improve all the performance. And again this is an area where their aging programs can help.

Next slide, so there's some additional adjustments like coding intensity which just means that CMS makes the assumption that health plans do a better job in coding claims and so that there's this risk if you will factor that says part of the risk of individuals is not a real risk change but rather it's just you're doing a better job coding the claims. Therefore we're going to take that money back. We're going to make an assumption you do a better job and so that's called the coding intensity adjustment which accrues back to CMS.

Next slide, in terms of Medicaid risk this is kind of a new area and as I showed you with California what they're doing is saying we're going to set a, if you will, an estimate that X amount of people are going to be in nursing homes. X amount of people are going to be in home or community-based. X amount of people are going to be well.

And if you meet those factors you'll be fine. And you can - so the incentive is for the health plan to move people away from institutional care and lower the institutionalized services and increase the home and community-based services, more aggressive care management, more aggressive case management, more community and home-based support.

Next slide and this is an example of how that's being driven. So automatically within the rate there's an expectation that inpatient days will be less, skilled nursing days will be less, physicians cost or physician.

Lauren Solkowski: Tony, I don't - we'll - I think - we can't hear you.

Tony?

Coordinator: I'm sorry, his line dropped.

Lauren Solkowski: Oh okay.

JoAnn Lamphere: Do you want me to step in?

Lauren Solkowski: That (unintelligible). Thanks JoAnn. See if we can get Tony back on.

JoAnn Lamphere: Until Tony comes back on I'll try to stay on the issues. The Slide 21 is showing how reducing service utilization is automatically built into the rate. The assumption that CMS is using is not that providers would be paid any less. It's that people would be using less care than before.

If you go to the next, Slide 22, it is a summary of how Medicare and Medicaid do the different adjustments that we highlighted earlier. Savings adjustments, risk adjustments, coding intensity adjustments, quality withholds and so forth but it compares Medicare and Medicaid.

If you go to Slide 23...

Tony Rodgers: Hi. This is Tony Rodgers. I guess I just dropped off.

JoAnn Lamphere: Beautiful. We're on Slide 23 Tony.

Tony Rodgers: All right. Apologize for that, don't know what happened.

Okay, so we're on payments' rates will vary by plan in terms of how much capitation each plan is getting. I think what's important about this slide is that as you - as - from a plan's point of view what they really are looking at is their ability to manage this population differently than it's been managed in fee-for-

service or that it's been managed in even Part C Plans versus Medicaid and by blending it together.

So the CMS has a lot of discretion on how they want to make the demonstration work.

And what's really important is that those providers and health plans are stakeholders in the participation in the demonstration. And a lot of this information that's collected is going to be used for long term policy changes.

And this is why it's so important to understand and to participate in the demonstration because this is going to drive both state and federal policy in the future.

Next slide, so basically I want to go through this real quick because of our time, when Medicaid has made a payment and Medicare and etcetera, the funds are not comingled. They are separate payments. So Medicare is making a payment and Medicaid. Where they become integrated is at the plan level.

And the plan has discretion on how that - the dollars come in. But it's not a single payment. It's really two payments and it's based on these other - these methodologies that are Medicare specific methodologies and Medicaid specific methodologies.

The reason why that's important is if you've been primarily funded through Medicaid that methodology is what's probably going to affect any payments that are made to you in the future. There may be opportunities though that a health plan can see that it can actually reduce its Medicare cost by using (Area) Aging in a broader fashion in terms of care coordination or being able

to help them with patients who are being discharged and getting them back into the community and setting up, etcetera.

So there may be some real opportunities to expand your service for these individuals.

Next slide, this is kind of how plans negotiate. On the Part C, you know, Part A and B, typically is negotiated through a fee-for-service although (CAT) plans are moving more towards capitating providers and full capitation.

The - what's important is on the community-based side is understanding how the plan wants to pay for certain services that (Area) Aging Programs can make. And the key here is understand the policies, for example in the Dual Program there's the high opt-out rate.

So if you're capitated and there's a high opt-out rate that really creates a problem because one minute you make a payment that month for that person and the next minute they've opted out. You're not getting a payment for that person.

So you really have to look at how the policies within the Dual Program will work and decide whether you want more of a fee-based, you provide the service, you get paid versus a capitation-based payment.

Next slide, these are areas in long-term care services that are examples of fee assistance that plans are going to be looking for and you probably already know them. And whether this is something you can provide or contract with a plan for.

The key again is understand the policies because there'll be additional reporting policies and the cost associated with that. There's a question of how many members will be assigned to you. What level of service you'll, you know, you'll have to provide out. You know will it have to be something where you have to guarantee certain services are provided within a certain period of time and whether you have the staff to do that or the service capability to do that.

But these are the areas where a good example of community-based support services plans will be contracted for.

Next slide and these are just provider negotiation strategies. I know that you'll be talking a lot about that. But the key is to be familiar with the population you'll be serving and your own capability and the unique requirements. Reporting requirements, specific service requirements, whether you have to work with other care managers or case managers, what kind of systems requirements are placed on you in terms of being able to participate in whether it's health risk assessment and being able to enter data into that.

So because of the time I won't go into a lot of detail but I think this gives you a good example of the kinds of areas that you might want to consider in terms of your provider negotiation.

Next slide, couple unique issues to think about, high opt-out rates currently in the demonstration create real variance in how people are assigned and it's creating a lot of issues related to beneficiaries low enrollment rates. Most demonstrations are going to start off very slow in terms of enrollment.

So understanding how that fits into your negotiation strategy is important. Core adherence to providing health risk assessment, plans are really looking

for strategies to improve health risk assessment uptake. Beneficiary confusion and so they're looking for ways to educate beneficiaries and show them the positive benefits of the demonstration. Lower level of medical risk than anticipated, people who are at higher risk seem to be opting out; people at lower risk seem to be opting in.

And then (star) rating issues, so some of the plans have delayed their participation in the program.

So those are some of the current issues, and want to go to the next slide.

JoAnn Lamphere: And I guess we would just summarize all of this to say it's clear that there are many complicated rules concerning the financial alignment demonstration. The rules are particularly complicated with respect to Medicare and Medicaid.

But we hope that this webinar has clarified the actual process of what goes into a rate and how rates are set under the Dual Demonstration.

Our intent is that that locked box has been opened and that some sunshine and transparency has come in. And as a result you'll be able to negotiate with plans to provide the services that help to accomplish not only the financial alignment objectives but reach your mission with Older Americans Act.

On the last page there are several resources that we would recommend that you check if you'd like to learn more about the rate setting and coverage issues related to the duals.

Lauren Solkowski: Excellent. Thank you both so much to JoAnn and to Tony. That was a very comprehensive thorough presentation.

And at this point before we move to our third presenter we will open it up for question and answer. So Operator if you could please provide instructions for asking a question through the audio line.

Coordinator: Sure. Thank you so much. If you'd like to ask a question at this time please press star 1. Unmute your phone and when prompted record your first and last name. Again that's star 1 to ask a question. And please record your name when prompted. One moment please, for your first question.

Lauren Solkowski: Great, thank you. While we're waiting for questions to come in I am going to pull the chat. I don't see a question on the chat box yet. But as I had mentioned earlier these slides, I know that was a lot of information presented. The slides and a transcript of the presentation will be posted for your reference to go back and listen to.

As well as I mentioned earlier in the introductions of Health Management Associates they are a - do have a contract with n4a and ACL. So if you do have other questions that you think of once we are off webinar please, you know, let me know and we can definitely get into contact with JoAnn and/or Tony to help answer some questions that you have.

Operator do we have any questions?

Coordinator: Yes we do. Our first question is from (Laura Plass). Your line is open.

(Kora Plass): Oh that's (Kora). And my question was first of all, thank you for an interesting presentation. My question was related to the low enrollment, if you had any idea why, maybe because it's new. But then I was also interested in the high opt-out. If you had any, you know, understanding of the reasons behind that.

Tony Rodgers: So I'll give you some information that has come out recently. There is a strong segment of providers who have kind of pushed - told the patients not to join the demonstration for whatever reason. They're - and low enrollment areas, there's been a lot of confusion by individuals of whether they're losing something because now they're in the health plan. They may have been in a fee-for-service. Now the health plan's taking responsibility for them.

So I do think though over time beneficiaries are going to see the extra benefits as valuable to them. And will come back in.

And the good part is that even though they opted out they can opt right back in again.

But there's been I think a lot - there's a much greater need for education. Let's put it that way. There needs to be much more upfront education. And I think then you'll see enrollment grow.

The opt-out rates are high because beneficiaries are defaulting to opt-out when they don't understand what's going on. So, you know, instead of - they're seeing provider. They're not sure if that provider is in the network. They're not sure if they'll continue to see it. So they just opt-out.

And a lot of those beneficiaries are now beginning to opt back in. So yes, I think in the second year we'll see whether this program is going to stay at low enrollment or improve.

(Kora Plass): Thank you.

Coordinator: Thank you.

Lauren Solkowski: Thanks.

Coordinator: And as a reminder if you'd like to ask a question please press star 1 on your phone at this time.

Our next question is from (Mary Kaschak). Your line is open.

(Mary Kaschak): Hi. (Mary) from n4a, thank you JoAnn and Tony, that was really helpful. And I just had a question, although others on the line may even already know this. I'm not sure.

But Tony when you were talking about the states that have a set rate and those that may have a range, I was wondering if there is a place where we can find which states have the range and what states have the set rate.

And you also mentioned that the range may be based on and correct me if I'm wrong because I was trying to take notes but that was a lot of information, whether or not the plans are contracting or working with safety net providers.

And I would assume but I'm not sure that AAAs and other community-based organizations that provide home and community-based services would be considered the safety net providers in those states or those situations. Is that correct that they would be considered safety net providers?

Tony Rodgers: I believe in most states they are requiring plans to enter in either ran MOU or agreement with the AAAs as part of the service provision to the members.

Now they are giving plans some discretion on what's in those MOUs in terms of there's a core set of services but then the plan and the AAA can negotiate even a broader set of services.

The - in terms of the set rates, most of the rates are on - you can - most states have published the rates either on their web site in terms of how the rates were calculated. But they don't give specific plan rates but they can get - they'll give you what the rates - how the rates were set.

The reason why they haven't give - they don't give specific plan rates is because of the risk adjustment. So they don't know based on the risk adjustment what plan will get, you know, exact amount it...

(Mary Kaschak): Right.

Tony Rodgers: ...will get. So but they do say this is the rate and then we risk adjust from there.

(Mary Kaschak): Okay, thank you.

Coordinator: Thank you. There are no other questions in the queue at this time.

Lauren Solkowski: Great, thank you so much. So with that we will move to our third speaker, Sandy Atkins.

Sandy I will introduce you. Sandy is the Vice President for the Institute for Change at the Partners in Care Foundation. She's in charge of the HomeMeds dissemination, consulting, evaluation and new initiative development.

Prior to joining Partners in Care Sandy served as the Executive Director of Hospice of Pasadena. At the USC Andrus Gerontology Center she directed the Center for Long-Term Care Integration, a state funded effort to help counties integrate Medicare and Medicaid systems for the aged, blind and disabled population.

So thank you Sandy for being with us today and you are welcome to begin.

Sandy Atkins: Hi everybody, excuse me. It's very interesting to go after a presentation that's almost completely different from mine. I did a lot of work actually in the area of dual capitation at USC. What we did was we took all of the waiver personal assistance, Medicaid and Medicare data for the year 2000 and put it together to see what the total cost was to people.

And it was in the range of $3,500 a month for dual eligible due to their total expenditures on average.

And what I hear about the capitation rates the plans are getting it kind of takes my breath away how low it is when you think there's 14 years of inflation between those actual costs and the rates that people are getting.

But nonetheless I'm finding that it's actually with our Partners in Care at least in California we're having a lot of success contracting with a variety of plans not just the plans for duals.

So you know that the only mandate in California to do business with the aging and disability network that I'm aware of is that the existing waiver, HCBS Waiver Program, they have to retain the current providers for about 18 months.

So we've got about 18 months to start our steps and show what we can do and then they go anywhere they want to for these kinds of services.

But we - probably everybody knows that the current waiver population, you know, they were caps on the number of people that could be served, only certain counties had the opportunity. You know all of that.

And that there are a lot of people that need home and community-based services that are not currently in a Waiver Program but have, you know, one step down in need.

And so the same plans that are doing the dual capitation are coming to us for their other populations that are slightly less needy.

And I'm finding it kind of interesting that they're looking at different ways of care management. So the waiver at least as we were doing it is basically till death do us part care management.

And we're getting contracts that vary a lot in intensity. So, you know, one plan will say, you know, I can only afford this much. So we go back to the drawing board and talk about well we can do half as many questions on their assessment. We leave out the medication inventory. We leave out something.

And then we don't have to do care management forever. We can do it for renewable three month period because our experience is that to put a service plan in place very often takes at least three months because you've got to make changes to buildings and get permits. You know there's a lot of stuff for ramping and things like that that take time.

So we have contracts that are just - do an assessment and tell us what we should do. We have contracts that are do everything for us for a limited amount of time.

So it's very interesting the variety of contracts we have with the dual's plans.

And in addition to that we're being - negotiating with medical groups that are taking capitation from the dual's plan so they, you know, they have - the - most of the money and they're at risk for the nursing home.

So we have enough evidence that some of our interventions not only delay or divert people from nursing homes but also have the potential to save money on hospitalization and emergency room use and the rehab, the Medicare portion of the nursing home stay before it converts over into long-term care.

So there's a good variety of that going on with our contracts. And they were talking about capitation.

And so far I mean we have really a total of 20 contracts. Some of them for Partners in Care only, some of them for our network. And none of them to date is going to be a risk or capitated contract.

And I believe the main reason for that is that it doesn't serve anyone's purpose to set a capitated rate before you have experience with the population and the services. So they don't want to overpay and we don't want them to underpay us.

So we're both skittish of any kind of capitated at risk arrangement at least in our pilot phase say for the first year when we can test our targeting criteria. We can test the interventions. A number of our contracts are actually doing

randomized control trials on the services we're doing compared to their usual case management approach.

So but we're used to acting like a capitated plan for the waiver because in essence we're getting a fixed amount per member per month in the waiver. So we know we can do it for that much. And we've got enough experience to know what we could do if they say, you know, we can't afford the amount that the state's been paying but we can afford this much. What can you do? So we know a lot about our operations and how to do that.

So I'm going to flip through the slides. I hope this isn't too terribly elementary. This is basically how we're approaching our pricing for contracting with a variety of kinds of health plans, medical groups, hospital systems, ACOs.

So what we're finding is that in the services we're offering there's no competition that's so exact to what we do that our customers really have an anchor price in mind which is really kind of good.

Excuse me, I'm getting parched here.

It's kind of good because we can put our - a price out there that we think is reasonable, will cover our costs and our learning curve because there's learning involved in all of these things.

So what we usually do is we offer - we make an offer at the high end of what we think is a reasonable rate. We present the measure ROI that we have calculated on any experience we have. And that's basically what you would call the value to the health plan and in addition to some of the less tangible things that we've talked in the collaborative like quality ratings and

incentives, incentive programs. With health plan member retention is like number one on their list.

So if you can show that you improved member satisfaction and decreased their turnover rate you're probably in even if you have a breakeven ROI.

And what we're tending to be competing against so far in the wider market that's not just dual's plans is do-it-yourself or I didn't know this but apparently the young people now call it DIY. So it's the build versus buy.

So our job is to prove that we can do it for less than it would cost them to do it themselves or that we have better outcomes. And we're doing pretty well at that. We have one, kind of the first group now. We have been pushing back on price and so we're working on, you know, what's in their mind about what we're doing and how they think they could do it for as little as we're offering. And then also what give do we have in our pricing model.

So one thing that we're finding is that the first year of the contract is always a pilot. We're finding one year contracts with a lot of measurement and extra work built into it so that we can prove our (worth).

And the volume will necessarily be low in a lot of cases. We do have a few contracts where they're giving us 50,000 names and they want us to entice their members who participate in Stanford and other evidence-based programs. And then we use the statewide - our statewide network of providers to give the actual services.

And if we - they're assuming that we won't get any more than 2% or 22% of those members to sign up for one of the evidence-based workshops. And if we

do better than we've got it, we really will have some volume so we have some good incentives in that contract.

But since the first year of the contract is a pilot if we price it wrong the payment will be pretty short lived. So, you know, we're willing to negotiate and come up with a price that we can sell at and just for the experience.

And so the last bullet on that slide basically in some ways we think that building a resume and the learning curve may be worth losing a little bit of money in the short run. Obviously we can't lose money we don't have in reserve some place or, you know, or a credit line.

But it's very important to get these experiences and get people that can recommend us.

So here's how we evolved our pricing model which basically it's a cost-based model. So we found a program in our agency that fully allocates costs both direct and indirect.

And for us that was our Waiver Program. So we used that to build the model. How do we figure out what our administrative costs and indirect costs are going to add to the direct cost of the program?

We don't - we didn't use any of our grant funded program because they artificially limit things like indirect and the types of things you can spend money on.

And we found that our waiver really allowed us to allocate a lot of organizational expenses that our grants weren't allowing us to allocate.

So we derived a percentage of the variable direct program costs based on the administrative support and other fixed direct cost plus the indirect cost.

And I have a spreadsheet that we can share. Lauren has it. If I get through this then maybe we can have her show a little bit about how we work with it.

Then we apply that percentage to the direct program cost. And you would see in our model that we overestimate almost everything so there's room to negotiate but also room for us to earn a margin.

So for example pick the highest level of salary even though you may be hiring people in at a lower salary. We take the luxurious level of how much time we allocate in our planning knowing that we're working on greater efficiencies. But that way we know we're covered.

And we also know that if we have kind of a - if we're locking horns over price we know where we can make some adjustments to come up with something that is, you know, less luxurious but will still meet our needs.

Next slide, the types of costs that, you know, I'm sure you all know this but just to be sure you - that we're speaking the same vocabulary, you have direct costs that are variable. So variable costs change based on the number of clients.

So for each client, each participant in a Stanford Workshop you've got to buy a book. So that's a direct variable cost.

For every home visit you've got two hours of staff time. If it were a part timer you would, you know, just pay them for that time. So that's a variable cost.

The direct fixed costs are first of all they're kind of difficult to gauge for our small pilot programs because we're building something and that exaggerates our direct costs. And really it comes to kind of a startup cost that I'll cover in a bit.

So we do it as a percent allocation because we just don't - we don't know a better way. And I'm sure there are economists that can tell us an easier way to do it.

But one of the things that has happened to us is that we have a phone call on Monday and they would like a price on Wednesday. So we have a dynamic Excel model where we just plunk in all of our assumptions and what their population is and what kinds of services they want because we have multiple levels of service depending on every customer that we have.

So then we can also use the direct fixed cost in sort of a backward model where we look at a breakeven analysis approach. The indirect costs, I know the SCAN Foundation for example did a model where they recommended against including indirect costs. We're willing to negotiate on that.

But we think it's important to keep the agency whole and sow we build indirect costs into our model.

And we build in margin. As they say, no margin, no mission.

And something new that we're still getting a grasp on is the network cost. What it costs - what it adds to the cost to manage a network and then does that offset any of the other - the direct fixed costs or the indirect costs.

And in our model I've kind of color coded some areas like IT Systems, things like that that could wind up being network management costs or they could be direct costs depending on how we're rolling out the program.

So what are the variable direct costs?

And staffing as you know is the number one. So we did it - we actually did a time study. I would say, you know, our biggest slowpoke population of staff to come up with what would be the most it could possibly take us to do this kind of intervention.

And then we considered inefficiencies built-in. For example when we did that time study we found out that our care managers who are - some of whom are RNs and not, you know, not making low wages as well as well-paid masters of social work people, were spending as much time doing data entry as they were in the home visit.

So we're working on IT Systems that let them do direct data entry or having an administrative assistant do the data entry. Not having - not paying an RN to do data entries.

Some of our programs require an LCSW to sign off on each assessment. And so we allocated 15 minutes as a direct cost. But say for example in our network if our network members don't have an LCSW that would flip over and become a network cost for them rather than a direct cost for us.

And the program variations like I said lead to a lot of cost variations. So for example we go into the home and do HomeMeds and an assessment. And in some cases we just hand the assessment off to a case manager. In some cases

they want us to turn that into recommendations and a service plan. In some cases they want us to actually arrange the services.

So the first instance of everything we do a one hand off and check back to make sure that all the services were completed or longer term case management for at least 90 days if not more depending on the needs of the client.

So the model has to be able to accommodate all of these variations fairly quickly because nobody's willing to wait anymore for, you know, a week or two for you to figure out what you're going to offer.

And then of course the service plan startup, if you do a Waiver Program you know that the first three months are a lot of extra expense because you're bringing people up to a good standards of living and then after that you might just have maintenance, meals and some assisted transportation and you're not repeating expenses for equipment and home modifications.

And of course each population will have a different profile in our cost. So the number of hours it takes to arrange a service plan varies on how intense the needs are.

So when we have our exchange population which tend to be younger we're budgeting fewer hours versus the typical frail waiver population has many more hours because they have many more multiple chronic conditions and more pent-up demand for help.

And of course you know your other direct expenses like mileage and parking. And again in our model we try to build in a high average distance traveled at

the federal funded rate then, you know, if we have to refine the model to get a better price we know we can cut some of that down.

The HomeMeds license and pharmacist review, the pharmacist review depends on the client. So for example if it's a medical group that has a pharmacist on staff they want to do it themselves. If it's a health plan that does not they want us to make the arrangement.

So whether that's a direct variable cost or no cost at all or even possibly a network cost depends on the model that we're building.

And of course materials and handouts, the PHR for care transition, the book for Stanford Program, etcetera.

Our fixed direct costs tend to be oversight and supervision so you've got a Program Director that goes - that looks at everything and everybody.

But you probably - when you're having the beginning contracts and they're on a pilot basis, we don't always just haul off and haul - and hire somebody just because we have a contract because if the volume is 200 cases over a year there's not enough money in the system. So we divert pieces of people into the contract and don't budget for full time people.

And of course you have your admin staff that are direct for the program. So people that would be faxing reports back and forth and doing data entry that kind of thing, if you have to acquire or license an IT System specific to the program, and of course you've got your cell phones, mobile hot spots so if you - now that we want to do data entry in the home everybody needs a mobile hot spot.

But that's a cost that changes based on the number of clients you have. It's a flat expense per month. And then the general program supplies, copying, general admin so those are the direct costs that tends to be fixed or shared costs across programs.

Indirect costs, you know, we talk internally about this all the time. So HR, if you build a model that doesn't include your indirect costs your HR Department will be having to hire people and manage them and review job descriptions and all of that. The Finance Department will have more billing. In fact it could be a lot more billing because the case rate involves many more transactions than grants do and if you're doing a network version so we're subcontracting our network members which means we bill the health plan. Then the network members bill us. So we're doing transactions in both directions which is going to be very finance intensive.

So if it's just for our own billing then it's an indirect cost. If it's for the network then it goes into the network cost, of course communications. Rent, if you have to acquire space and have more people or need more equipment which actually is a startup cost so forget I said that.

Insurance, we found that with one of our contracts the limits on the insurance doubled in some cases. So, you know, the premiums didn't double, thank you. But we have other coverage that we never had before, cyber policy for example.

So all of these are real costs and it will - the new work will contribute and add to the fixed agency direct cost up to a certain extent. So you might need to - now we need to hire an assistant for the HR Department. That's really because of our contracting but it comes out an indirect allocation.

And if your bottom line is healthy then you can negotiate the price down. So if you don't actually add staff and everything is absorbed into the way things are then you can negotiate on your price by assuming that the allocation of your indirect will stay at the same place it's been.

There we go. The network costs, the value to the plan that because it could be an added cost. If they just contracted with us it would be a limited geography and they'd have to be negotiating the contract over and over again.

So as an example one contract costs us $40,000 in legal and I'm sure their lawyers were no less engaged than ours. And we spend at least 2000 hours of executive level time over I'd say about a year between introducing ourselves, negotiating the contract, planning for the rollout and then actually getting the contract started.

And the plan is every hour that we're spending they have a team doing the same thing. And maybe even more people.

So there's a reason why it would be good for the plan to operate through a network and to have to pay somewhat higher rates for that.

And the other cost that we often have is startup cost. And this is what we find the grants help with because a lot of times you just can't allocate the startup costs appropriately to something like a case rate.

So but we have gotten grants for our startup cost from foundations and from healthcare foundations. We have also had healthcare organizations that were willing to advance us money against the expected volume for the first couple months and then deduct that from future invoices.

And then we've also had contracts where in the initial phases at least while we were all learning each other, they were willing to guarantee a minimum volume which helps us cover our fixed cost.

So the kinds of startup costs that we've had of course furniture and equipment if you have to expand into new office space. You have to pay for your supervisors and management staff before you have income from the contract because they have to develop the policies and workflows and hire and train the staff.

Then normally you'd get your staff on, all of your staff onboard before the services start because you want to train them. You want them to shadow your existing workers, things like that.

And then we've had to build some infrastructure, add insurance, add security provisions and acquire new software and things like that that were startup costs. So it's important to figure out how you're going to keep yourself whole and cover those startup costs because that's one thing we have not rolled into our pricing.

Just - we're doing our network as a subcontract. So that means that basically Partners in Care at this point is working as the network office so the Quasi MSO entity. So the kinds of costs that we have in our model include the billing that we have to do, the insurance differential attributable to the contracts for the network and in some cases we have to bolster our own insurance because a network member doesn't have and can't get their own insurance for those things. The legal related to negotiation and managing the network, marketing, sales, contract negotiations, these are all costs that we've incurred.

And the only way to recoup it is to have a network fee. We have credential everybody so we've spent the last about a month putting together a training manual for our network and hiring someone that's going to use that same work to help us with the accreditation, the NCQA accreditations that we're putting together. We have to submit our paperwork pretty much at the end of December and their site visit is going to be in February.

We also and for some contracts have fiscal intermediary expenses because at this point we are not licensed and we are not accredited.

So some of the requirements for contracts imposed by the State Department of Managed Healthcare or by the legal counsel of the healthcare entities that hold a contract are such that they won't let them - the group bill directly to Partners in Care or to our network so we've had to pay a medical group which added about $50 per intervention.

We operate some contracts through a staffing agency because they wouldn't allow us to directly subcontract but they would allow a staffing agency.

There are also call center costs. The cost of maintaining good customer relations with plans and we've also had requirements that we pay for external patient satisfaction surveys and do a lot of metrics analysis, dash boarding and things like that.

See if I can do this. Lauren, could you advance to the next slide please? My screen isn't - if there is one or was that the last (one)?

Lauren Solkowski: I think it was the last one. Yes.

Sandy Atkins: Oh, well then do you want to do questions now or do you want to switch to the Excel model just so that we can kind of show them? We only have a couple minutes so maybe questions would be better. Then we can do the Excel models another time.

Lauren Solkowski: Okay, sure. Operator if you could please provide instructions for asking a question.

Coordinator: Yes. As a reminder if you'd like to ask a question please press star 1 on your phone. And please record your name when prompted. Again that's star 1 if you'd like to ask a question. One moment please.

Lauren Solkowski: Thank you. And in the meantime Sandy I think while we're waiting I am going to pull up your spreadsheet and...

Sandy Atkins: Okay.

Lauren Solkowski: ...I'll see if - okay, let me share.

Sandy Atkins: See which one you have. Yes. You need to expand the view to larger than it is.

So just as an example, in lower right hand - oh there we go. Okay. So as an example this would be - I have different colors for the different lines of services so that I can kind of keep track of things visually as well as the formulas.

So everything in this spreadsheet is built on a formula so that if I change the social worker salary because right now the social worker salary is at a high level and, you know, if I changed it to $45,000 it would go all the way

through the model for each service line that involves - so Lauren go up to (B-6). I feel like I'm playing bingo.

No, (B-5), I'm sorry, my glasses (unintelligible).

((Crosstalk))

Lauren Solkowski: Okay. Okay.

Sandy Atkins: Change (B-5) to $45,000.

Lauren Solkowski: That - okay.

Sandy Atkins: So we've been able to hire coaches for $45,000. And then the price goes down. The total price goes down. And each component goes down.

And then under assumptions for example, the next section down from the - down, down, down, down, down, down.

Lauren Solkowski: Oh okay.

Sandy Atkins: To assumptions. So if we say we've got a population that isn't as intensive as this population it's only going to take them one hour to develop a service plan. Then you could take the social worker and make that one hour and then the case aide could be one hour.

And that would then fold right back into the model. And change - so just try changing service plan, case conference to one hour.

And then you see the price just change from 459 - from 555 to 459. So that would make us customize this to a certain population.

And then we have assumptions further down for example, assumptions about how much staff we have to hire and whether this is going to be a program where we have to divert existing staff or if we can afford to hire staff.

So in the monthly volume if you changed it from 20 to 100 then you'd see that our FTEs went from about one-half an FTE of social worker to about two.

So now we know what our staffing needs are. So we have those assumptions. That doesn't affect the price but it affects our costs insofar as how much we can allocate new staff or have to spread our existing staff.

So then below that is our percentage allocation for what I call administrative or other direct so this was based on a placing model we'd already worked out. You can see that if we were doing the intervention ourselves we probably put the fiduciary. We're on a monthly retainer for that medical group to use their physician as our Medical Director. So that would - I'd put a percentage in that column and it would raise the overall percentage for the administrative direct cost.

We don't usually change our indirect because that's calculated when we do our audit at the end of each year.

But some - if you can see the blue, the finance staff for example in our indirect, if we're doing the intervention it would be there. But if somebody else is doing the intervention it would move down to the finance - to the network cost for example.

And what would be our direct cost for sales for let's say a startup cost might wind up being an indirect network cost.

So it's, you know, just sort of the concepts of it all add into a model where we can change our assumptions. We can move things to a different line depending on who our customer is.

So roll back all the way to the top Lauren. And you can see in the green there what we've - the way we have it is the variable direct cost so that's, you know, the staff, the mileage, parking, then the fixed direct and administrative cost, that's the allocation based on the formula I showed you below is computed on top of the variable direct cost. That's how our waiver does it by the way in California.

And then the indirect is calculated on the sum of those. And then you can add in a margin. We put in a 5% margin. Our Board would have us at more like a 20% but I don't think we'd be competitive if we had that much of an add-on.

So you can see that if we did the intervention ourselves without the network it would be, you know, 247 just to do the assessment, then hand over a care plan. You'd add $106 to set up the services, our care transitions which has, you know, certain number of hours built into it would be the next rate. And the evidence-based programs which have other assumptions built into them.

And like for example the model if you've got an evidence-based program you can make assumptions about how many billable participants there'll be. And of course that changes the profitability of it and the cost. So that can actually bring the cost down for the health plan.

So then on top of that and we, you know, we discuss this model all the time. And we have disagreements.

So once you negotiated a price, you know, is the network fee, you know, or an MSO fee built on top of the total cost or is it as a percentage of the other cost?

So, you know, having built this model based on what we think are reasonable costs for delivering the interventions we of course would want our network partners to have indirect and have a little margin on what they get.

So that kind of shows you the difference between a network cost and a non-network cost.

Now these aren't actually, you know the exact numbers that we use but it kind of gives you the idea.

And with that I think we have used up our time. And but I'm happy to answer questions.

Lauren Solkowski: Thank you so much Sandy. Yes. Apologies for going over but we do welcome your question. Let me go back.

Operator did we have any questions come in through the audio line?

Coordinator: At this time we do not have any questions.

Lauren Solkowski: Okay. Let me just check quick before we go if - okay. No question on the chat.

But thank you again to all of our presenters for very, very comprehensive and informative presentations.

Again if you do think of any questions following the webinar please feel free to email them to me at my email address that is listed there in the chat box.

And I think that's it. So thank you again. One other thing if you would like to have a request for the slides before that they are posted, please just send me an email and I will send them to you.

So again thank you to everyone for joining us. And enjoy the rest of your day.

Sandy Atkins: See you soon in December in DC.

Lauren Solkowski: Yes, very soon. Thank you.

Sandy Atkins: And thank you.

Coordinator: Thank you. Thank you. This concludes today's conference. Participants you may disconnect at this time.

END