

Medicare-Medicaid Accountable Care Organization Model
Webinar #2: Beneficiary Assignment and Financial Methodologies
Event Transcript

Leslie Vasquez: Good afternoon everyone. Thanks so much for joining today's webinar. I'd like to welcome you to today's event entitled: Beneficiary Assignment and Financial Methodology. I am Leslie Vasquez and I'll be moderating today's event. Before we get started I just want to cover a couple of quick housekeeping rules so we can have a successful webinar. First, we're recording this event and we're going to make it available on the CM at my webpage. Secondly, we will have a formal question and answer period at the end of the event so we encourage you to submit any questions you may have into the chat window in the kind of right-hand side of the screen. If you could submit the questions to everybody it'll just make sure that everyone can see your question that's answered ... Sorry, your question that is pending an answer and will help the flow of that Q&A.

If you have a technical issue or question, just go ahead and post that into the chat window at any time. Our producer will be able to assist you with your question or issue. Finally, a .pdf copy of the slides from today's presentation will be downloadable. Basically you can click on the link that's under the download, the file download pod in the lower right-hand corner of your screen and save that to your hard drive. We will make a short survey available at the end of the presentation just so you can provide feedback. Your feedback's confidential but it will help us to improve how webinars are delivered in the future.

With that, I'd like to go ahead and turn things over to our presenter representing the model team, Brede Eschliman.

Brede Eschliman: Thanks Leslie. Before we begin I would like to take a moment to inform today's learning event participants that all comments made on this call are offered only for general informational and educational purposes. As always, the agency positions on matters may be subject to change. CMS' comments are not offered as and do not constitute legal advice or legal opinion and no statements made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules and regulations.

Participants are responsible for ensuring that their actions fully comply with applicable laws, rules and regulations and we encourage you to consult with your own legal counsel to ensure such compliance. Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual opinion only. CMS is not seeking group advice. With that disclaimer, we'll go ahead and get started with today's webinar.

To give you a sense of where we are in our webinar series, we had our first webinar, which was a model overview, on May 11th and you'll find the link to the recording of that webinar in this title slide. Today we will be going over

beneficiary assignment and financial methodology. Next week on June 15th we will be going over the Medicare state-shared savings methodology, which is a feature that's really unique to this model, and you'll find the link to register for that on this slide as well.

This is an overview of our agenda for today. First we'll do a general overview of the beneficiary assignment and financial methodology and describe what all that entails. Then we'll go through five components of those methodologies, first the target population, then the assigning of beneficiaries to an ACO, the calculation of expenditures, the calculation of a benchmark and finally the calculation of shared savings and losses.

We'll start with the overview of the beneficiary assignment and financial methodology. I wanted to show this diagram to clarify what we're going over today. Our model includes two different levels of financial reconciliation. There's the ACO level reconciliation which uses a benchmark that is specific to a single ACO's expenditures. We also have a state level reconciliation which aggregates all of the state's MMACO's performance. That component will be covered in next week's webinar so today we're really only discussing the ACO level reconciliation.

In our model, because it's a Medicare/Medicaid ACO model, MMACOs may generate both Medicaid savings and Medicare savings. If states generate Medicaid savings then the state will share the savings with the MMACOs, assuming they meet certain eligibility criteria. If the MMACOs generate Medicare savings, CMS will also share those with MMACOs. Additionally, CMS could share some of those savings with states as well, solving financial reconciliation with the MMACOs.

Today we're just going to be going over the reconciliation process with MMACOs because, as stated, the state level reconciliation we'll be going over next week. One thing I want to mention here is when we say Medicaid savings here, we designed the model intending for that to be Medicaid fee for service, however if you are in a state that has a high level of MCO penetration and you are interested in something like this, please be in touch with us anyway so that we can discuss that with you. The model that we're walking through today was designed for Medicaid fee for service.

This slide shows a high-level diagram of what we mean when we say 'Beneficiary Assignment and Financial Methodology'. You'll see first we define what the target population of this model is. Next, we assign individual beneficiaries to MMACOs, beneficiaries who meet the eligibility criteria of that target population. Next, we calculate those expenditures for a given ACO. We compare those expenditures to a benchmark and finally, based on that comparison, we will calculate shared savings or losses to be shared with the ACOs. We'll walk through each of these steps today.

One thing that's important to know about our model is it does include both Medicare and Medicaid expenditures. The Medicare beneficiary alignment and financial methodology, CMS does both of those things through the Medicare Shared Savings Program. You'll hear me a lot refer to the Medicare Shared Savings Program and how for the Medicare pieces of it CMS will complete those through that program and the Medicaid pieces will be completed under the MMACO model. We do build on that existing program but what our model does is we add Medicaid accountability for those Medicare Shared Savings Program beneficiaries who have dual Medicare-Medicaid coverage. As part of the development process, states will work with us, CMS, to develop a financial methodology for calculating Medicaid savings and losses and CMS will calculate Medicare and Medicaid benchmarks separately for each MMACO.

Because we do build on the Medicare Shared Savings Program, participation in that program is a requirement for MMACOs. CMS will calculate Medicare savings or losses using the Medicare Shared Savings Program methodology for both the Medicare-only and the Medicare-Medicaid beneficiaries who are assigned MMACOs through that program. CMS will calculate Medicaid savings or losses using the Medicaid financial methodology that states and CMS develop together through our model. For the Medicare-Medicaid beneficiaries who are assigned MMACOs through the Medicare Shared Savings Program and also if states choose, for additional Medicare-Medicaid or Medicaid-only beneficiaries who are assigned to MMACOs through the MMACO model.

Now that we've gone through that brief overview, we'll start with a discussion of the target population. That, as you can see, is the very first step in our model [inaudible 00:09:07]. We start with the target population for the Medicare Shared Savings Program which is used to calculate the Medicare benchmark. What the MMACO model does is we identify what subset of that target population is also included in the MMACO target population which is used for the Medicaid benchmark. Additionally, if states choose to do so they can have an additional target population outside of the Medicare Shared Savings Program. Those could be either Medicare-Medicaid enrollees or just Medicaid enrollees, depending on what the state wants to do. That additional optional subset, together with the Medicare-Medicaid enrollees from the Medicare Shared Savings Program will go into the Medicaid benchmarks under the MMACO model.

For the groups that are used for the Medicare benchmarks, CMS will use Medicare Shared Savings Program eligibility criteria to identify who that target population is. For the Medicaid benchmark under the MMACO model, states and CMS will determine those eligibility criteria together as part of the application process. One of those criteria will include Medicaid fee for service coverage.

The next step is beneficiary assignment. To orient you, that's the second step here after the target population. In this step we will assign beneficiaries who

meet the criteria for the target population to individual MMACOs. To be clear, not all beneficiaries who meet the criteria for the target population will necessarily be assigned to an MMACO. Only those beneficiaries who are identified through the assignment methodology will be.

First, CMS will assign beneficiaries to MMACOs for Medicare accountability through the existing Medicare Shared Savings Program methodology, which is a plurality of care methodology. Essentially, this means that we assign beneficiaries to an MMACO if they have received the plurality of their primary care services from that ACO. The only difference is that CMS will use the prospective methodology that's used for the Medicare Shared Savings Program track three for all MMACOs regardless of the financial risk track that they choose. An MMACO could still choose a different financial risk track but they will have their assignment done through the assignment methodology that's used for track three.

Next, CMS will apply eligibility criteria to the Medicare Shared Savings Program assigned beneficiaries to identify the subset who will be included for Medicaid accountability as well. CMS and states will determine those criteria together as part of the application process and they will include, at minimum, dual enrollment in Medicare and Medicaid.

Finally, if states choose to include an additional target population for Medicaid accountability, CMS will need to run assignment for those beneficiaries as well. This will entail applying a plurality of care assignment methodology to beneficiaries who meet certain eligibility criteria. States and CMS will design that methodology and determine those eligibility criteria together.

Next we will discuss the calculation of expenditures. Here you can see where we are in the process. We have identified the target population. We have assigned beneficiaries to individual MMACOs and now what we will do is calculate the Medicare and Medicaid expenditures for those assigned beneficiaries for a given performance year. For the Medicare expenditure calculation CMS will measure Medicare parts A and B expenditures for the assigned population through the Medicare Shared Savings Program. I'm not going to go into detail on that process today because it's already an established program and we want to focus on what's new for the MMACO model, but if you want more information on that you can see page 34 of the document that we've provided a link to on the slide.

For Medicaid expenditures, we'll start with the beneficiary level calculation. CMS will measure expenditures for all Medicaid covered services for each assigned beneficiary during the performance year. This includes the cost for all Medicaid services provided to the beneficiaries who are assigned to that MMACO, not just the services that are actually provided by the MMACO. We will cap the individual beneficiary's expenditure at a certain truncation threshold to protect MMACOs from outliers and we will also apply a completion

factor to account for claims that are submitted after the claims run-out period that we've built into the model.

This shows you graphically what that process looks like. We'll start with claims preparation where we will gather all the covered Medicaid services. As part of our development process, states and CMS will together choose whether to include certain payments. That could include Medicaid DSH payments, non-DSH supplemental payments and health home payments as examples. Once we've gathered those claims for a given beneficiary, we'll truncate them, we'll apply the completion factor and then we'll have the individual beneficiary's Medicaid expenditures for the performance year.

The next thing we do is we aggregate all of those individual beneficiaries' expenditures to the MMACO level. When we do that we get an overall per-beneficiary per year or PBPY Medicaid figure for the MMACO. We are planning to stratify those expenditures by at least three categories and those include a category of care delivery, either Medicaid medical institution, home and community based services or community-other. Two categories of mental illness. The presence or absence of serious mental illness which will include substance use disorders and age 65 and older or under 65.

Once we have those expenditures the next thing that we do is we calculate the benchmark that we're going to compare them to. This is where we are in the process. We've calculated the expenditures, now we need to determine what the benchmark is. For Medicare the benchmark estimates what the assigned beneficiary's Medicare parts A and B costs would have been in the absence of the program. I'm also not going to go into great detail about this, but you can find more information on the link here, page 46 of the Medicare Shared Savings Program text document.

For Medicaid, the purpose of the Medicaid benchmark is to estimate what assigned beneficiary's Medicaid costs would have been in the absence of the model. There are a few steps that we take here. First, we calculate an MMACO's Medicaid expenditures for three historical baseline years and we call this the Historical Medicaid Benchmark. Then we adjust those baseline expenditures to account for changes in risks and also cost growth between the baseline years and the performance year. This results in what we call the updated Medicaid benchmark, which is the final benchmark that we use.

This gives you a sense of what that looks like. We typically use three baseline years' worth of expenditures. We'll take baseline years one and two and we will apply trending and risk adjustment so that they are expressed in terms of baseline year three, then we will average together the three baseline years into a Historical Medicaid Benchmark. I should mention here that the three baseline years may not necessarily be weighted the same. We might weigh a certain year more than a different year or we may take a simple average. That is something that we plan to determine with states as part of the development process. Once

we have that Historical Medicaid Benchmark we again apply trending and risk adjustment to bring them into terms of performance year dollars, since we're comparing it to the performance year, and that gets us an updated Medicaid benchmark.

To give you a sense of how the different components of that methodology will be developed, CMS is developing the risk adjustment methodology for Medicaid expenditures and that will be universal across the states. We will apply the same risk adjustment methodology across the states. CMS will also develop the trend factors for Medicaid expenditures in collaboration with states because we need states' help in identifying appropriate reference populations with which we can calculate those trend factors. Finally, as I mentioned, states and CMS will work together to determine the weights assigned to each baseline year for the Medicaid benchmark.

The final step in the process is the shared savings and loss calculations. At this point we've compared the expenditures and the benchmarks and we are using that comparison to determine whether or not MMACO has generated savings or loss and whether or not they will be sharing in those savings or those losses.

For Medicare, CMS will compare an MMACO's performance year Medicare expenditures to the Medicare benchmark to determine whether that MMACO generated savings or losses. For more information on that you can see page 45 of the specifications document. For Medicaid, the first thing that we do is we compare an MMACO's performance year Medicaid expenditures to the Medicaid benchmark to determine whether they generated Medicaid savings or losses. States and CMS together will determine the Medicaid risk tracks to offer to MMACOs in the state which will include both one- and two-sided risks. One-sided risk tracks are those where MMACOs will only share in savings, which means if they generate losses they will not be liable to share in those losses. For two-sided risk tracks, MMACOs are responsible to share in both savings and losses.

The typical process for calculating shared savings or losses, once we've determined whether an MMACO generated savings or losses, is to compare the preliminary savings or losses to a minimum savings or loss rate, apply a savings or loss sharing rate and finally apply a savings or loss cap. We'll walk through each of these steps in detail on the next slide.

To start, if the Medicaid savings or losses are greater than a minimum savings rate or minimum loss rate, the MMACO remains eligible ... Excuse me one moment while we deal with a technical difficulty. Okay, we're back. If the Medicaid savings or losses are greater than a minimum savings rate or a minimum loss rate, then the MMACO remains eligible to share in those savings or losses, although as I just mentioned, only MMACOs who are in two-sided Medicaid risk tracks will share in those Medicaid losses. The MSR or the MLR is a percentage of the Medicaid benchmark and states and CMS together will

determine what MSR, MLR or range of MSR-MLRs to use. The reason we mention a range here is that because often as an incentive for MMACOs to participate in two-sided risk tracks they will have a different MSR-MLR that makes them more likely to share in savings if they do attain savings.

If Medicaid savings or losses do exceed the MSR or the MLR then the next thing we do is we apply the Medicaid sharing rate or loss rate. This is a percentage that we apply of the savings or the losses. The sharing rate will take quality scores into account which rewards MMACOs for better quality. The loss rate may or may not take quality into account, that's something that states and CMS will determine together. That may differ for different risk tracks as well. States and CMS will determine the formulas for calculating those Medicaid sharing rates or loss rates.

Finally, the model will cap Medicaid savings or losses Medicare at a percentage of the Medicaid benchmark. States and CMS will together determine what that savings or loss cap is. This cap may change over years, it may also be different for different risk tracks. States will pay the final Medicaid shared savings amount to MMACOs or will receive the final Medicaid shared loss amounts from MMACOs. Although CMS will do the bulk of the administrative work in calculating these shared savings or shared losses amounts, states will actually be the ones to pay out those savings or receive those losses from MMACOs because they are Medicaid expenditures.

I want to do a brief overview of the responsibilities of the state versus CMS in developing this methodology. As you've probably been able to tell over the course of this presentation, there are a lot of details about this methodology that are not yet final and that's because we wanted to give states the ability to have some input into the design that's being implemented in their particular state. Although we have the skeleton of what this will look like, some of the details have not been worked out yet and will not be worked out until states start the development process with CMS. States and CMS together will determine the Medicaid target population, the Medicaid beneficiary assignment methodology, the Medicaid risk tracks that will be offered and the differences between those risk tracks, the Medicaid shared savings and losses calculation and the Medicaid reference population and trends.

CMS will be taking on the Medicare assignment and financial methodologies because these are done through the Medicare Shared Savings Program and CMS will also be developing the Medicaid risk adjustment which will be applied universally across states. For more information, we have some links here to our ACO models web page on the innovation center web site, the request for letters of intent and FAQ and also our e-mail inbox where you can e-mail us if you have any questions.

I think now I'm going to turn it back over to Leslie.

Leslie Vasquez: Thanks Brede. All right. Let's go ahead and conduct our Q&A period. If you have any questions for the model team, please go ahead and post them in the chat window. We will address all questions in the order in which they are received. All right. It looks like we've got our first question. Let me go ahead and read it off: In decisions where you say states and CMS will share responsibility, will the decisions be state-specific or does CMS intend to take input from all participating states, then make a decision that will apply to all states uniformly?

Brede Eschliman: That's a great question. What we mean by that is that these components will be state-specific and that's why we wanted to wait until we can collaborate with states to develop these pieces because we do want any things that are unique about the state to be taken into account when we design those. They will not be applied to states uniformly, they will be state-specific.

Leslie Vasquez: Thanks so much. It looks like we've got some additional typing in the chat window where someone else is typing a question. All right, we've got a couple of additional questions. Our next question is with regard to downloading past webinars from the website: Do you have a mailing list?

Maria Alexander: If you're not able to ... If you're having trouble downloading webinar links or information from the website you can e-mail that inbox, the mmaco@cms.hhs.gov, tell us what you're looking for and we will figure out a way to get it to you.

Leslie Vasquez: Thanks Maria. Our next question: Why can't the state have a say in risk adjustment methodology for Medicaid?

Brede Eschliman: We are developing that in partnership with CMS' actuarial experts. We wanted this to be the same across states. There might be slight differences, for example if there are differences in what Medicaid services are covered, then we're building in the opportunity to apply the risk adjustment methodology slightly differently, if need be, in different states. That is something that we wanted to do with the actuarial experts here at CMS.

Maria Alexander: I'll add that if states have specific concerns about how risk adjustment would be done in Medicaid, we're more than happy to hear those suggestions from you. As Brede said, we're developing the methodology right now and it's not that we wanted to do that without state input, it's that we felt it was important for the methodology to be consistent across states to the extent possible, so that's why CMS would own that work. You're more than welcome to send us those suggestions if you have experience that leads you to specific concerns that you'd like us to address or consider.

Leslie Vasquez: Thanks so much. Do we have any additional questions for the team to address?

Brede Eschliman: One thing we wanted to point out is that we understand that a lot of your questions might be specific to your state and we are more than happy to have

one-on-one conversations with anyone who is interested. Please feel free to reach out via our e-mail inbox and we'd be happy to set up a call where we can answer your state-specific questions, give you more background information if there's anything that was confusing and talk through wherever you are. This would not constitute a commitment to participate by any means. We're happy to talk to people even before they've submitted letters of intent.

Leslie Vasquez: Thanks Brede. If anyone has any additional questions for the presenters, we have plenty of time to address any questions that you may wish to post to the team. It looks like a couple of folks are typing into the chat window so we'll stand by for those questions.

Brede Eschliman: One more thing, because we are paused, that we should mention is the Medicaid assignment and financial methodologies will need to go through the typical approval process, so just because CMS is involved in the development of the MMACO model team does not exempt those from having to go through normal CMS approval channels. For example, if the changes would require state plan amendment or a waiver application, those would still need to occur. Additionally, if there is any state-specific legislation that would need to be passed in order to implement the model, that would also have to be done.

Leslie Vasquez: All right. It looks like we have our next question in the chat. The question is: Will a prospective or retrospective trend be used when trending to the rating period?

Brede Eschliman: We're most likely planning to use a retrospective trend because we are hoping to be able to identify a reference population in the state with which we can calculate that trend and we'll need to know their performance year expenditures before we can do that. We're hoping that that can be responsive to any changes in Medicaid in the state. The trend, the profits we're calculating in the trend is not final yet, that's something we will be doing with states, but most likely we will plan to use a retrospective one.

Leslie Vasquez: Thanks Brede. It looks like we had an additional person typing a question into the chat window. We can go ahead and address that now if you'd like to ask your question. All right. Our next question: How will consumers know they are in this model?

Maria Alexander: This is Maria Alexander from the MMACO team. The Medicare Shared Savings Program has the same rules around ways that beneficiaries would be made aware that their provider is participating in an ACO and I would refer you to the Medicare Shared Savings Program documentation for that. In terms of any additional notification that would occur on the Medicaid side, that's something that we would work out with states as we're developing the model and we would want to make sure that that aligns well with what's being done in the Medicare Shared Savings Program such that we're not causing confusion for beneficiaries, but we have not been prescriptive about exactly what that would

look like as we know states may have thoughts about how that could best be done or may have existing rules or regulations within their state about what kind of notifications are required for beneficiaries. That's something we would work out with the states on the Medicaid side and then ACOs would be required to continue to follow the rules under the Shared Savings Program.

Leslie Vasquez: Thanks Maria. Our next question: Could you repeat the timeline regarding any needed SPAs/waivers. Those would need to be approved and completed prior to LOI or prior to actual implementation?

Maria Alexander: Thanks for that question. For more information on this I would refer you to the request for letter of intent as well as the webinar that we did on May 11th to summarize a few of the key timelines and deadlines now. The MMACO model offers multiple start dates for when the first performance period would begin in a state. Right now the options are January 1, 2019 or January 1, 2020. The deadline to submit a letter of intent for 2019 is August 4th of this year, so that's August 4, 2017. The deadline for 2020 is August 3, 2018. You should note that those deadlines are what we here at CMS see as the last possible date that a state could essentially begin to think about this model and still be ready to go for that start date of 2019 or 2020. We definitely encourage you to engage with us well before that because the timeline may really vary by state.

In response to the question about whether SPAs or waivers need to be approved or completed prior to LOI, they do not need to be completed prior to the letter of intent. They do need to be completed before CMS and the state would enter into a participation agreement or before we would release a request for application from ACOs. That would be sort of part of the development process is that CMS and the state would work together to determine many of the aspects that Brede discussed today as well as other aspects of the model including what quality measures to use and things like that and then that state's application or the results of those discussions would need to go through a clearance process at CMS and the state would need to secure any necessary Medicaid approvals which could be a state plan amendment and/or any Medicaid waivers.

As you can probably tell, there's a lot of different pieces there that need to occur and we think look like a pretty lengthy preparation process and we're very willing to work with states closely during that process. We see it as a collaborative process and definitely encourage you to reach out to us sooner rather than later. We're not looking for states to come to us with a fully-formed ACO model or methodology, we're really looking to work with you to develop that, but then it would need to go through those various approval processes.

Leslie Vasquez: Thanks for clarifying, Maria. Our next question: Has CMS selected a particular risk adjustment model that each state program will be required to use?

Brede Eschliman: We haven't completed the work of the risk adjustment model yet. It will be ... I will say that CMS will do the operational work of actually calculating the risk scores, so states will not be required to obtain any particular risk adjustment software in order to do this, CMS will do that work on behalf of states.

Leslie Vasquez: Thanks Brede. I think we've got a follow up question regarding the timeline: What if you belong to an ACO that crosses multiple states.

Maria Alexander: Thanks for that question. This is Maria Alexander again. In the Medicare Shared Savings Program, I believe this is what it's referring to, there are ACOs that may have providers and assigned beneficiaries that exist in multiple states. You could continue to participate in the Shared Savings Program and have those beneficiaries assigned across the states that you're participating in. For purposes of the Medicaid benchmarks that we discussed today, that benchmark would only include beneficiaries that reside within the state that is participating. It could be that you're in multiple states and both of those states are participating and in that case we would need to work with those states to figure out what that might look like.

I think in a more likely scenario your ACO might cross, say, three states, one of those states is in the MMACO model, you would continue to participate in the Shared Savings Program, your Medicare benchmark would include expenditures for beneficiaries in all of those states subject consistent with the Medicare Shared Savings Program rule and then on the Medicaid side, your Medicaid benchmark would only include expenditures for beneficiaries that are in the state that's participating in this model and meet the target population eligibility criteria for the model.

I know that can be a lot to follow so if that's not clear or if you have additional questions, do feel free to e-mail us. We're happy to jump on the phone to explain it further or respond to you by e-mail.

Leslie Vasquez: Thank you. Do we have any additional questions for the model team? Looks like we have another question being typed into the chat window. We'll just stand by. All right. Our next question: Just to clarify, savings would be based on those enrollees prospectively enrolled in the MMACO model, not those that would be hypothetically eligible but not participating.

Brede Eschliman: We do plan to conduct beneficiary assignments prospectively and that will be the set of beneficiaries who are included in the financial expenditure calculation at the end of the year. In terms of those who would be hypothetically eligible but not participating, I'm interpreting that as they fit the criteria for the target population but were not assigned to an actual MMACO and that is true, those beneficiaries would not be included in a benchmark. You would only be included in the benchmark if you are assigned to a specific MMACO and you meet the criteria for the target population. Did that answer your question? Feel free to type again if not.

Leslie Vasquez: All right. It sounds like that clarified sufficiently. I see we have additional questions being typed in the chat window. For other members of the audience, we do have plenty of time to address your questions so please feel free to type them into the chat. Our next question: Will beneficiaries be allowed to voluntarily align with ACOs like NextGen?

Brede Eschliman: There are some beneficiary overlap rules between different Medicare shared savings models or programs. If the beneficiaries are .. The beneficiary assignment process for the Medicare Shared Savings Program will take those overlap rules into account. If those overlap rules state that a beneficiary aligned to NextGen will not be in the Medicare Shared Savings Program then by definition they will not be in the MMACO model because of that. It's really the overlap rules of the Medicare Shared Savings Program that will determine whether those beneficiaries will be included in that population.

As far as the Medicaid side, that was something we would work out with states. Whether or not we need to develop beneficiary overlap rules for other Medicaid Shared Savings Programs in the state. It may be the case that if you have other Medicaid ACOs in the state, we would not want those beneficiaries assigned to both the MMACO model and to that other Medicaid ACO in the state, but that's something that we would work out with states individually.

Maria Alexander: To clarify that further, I think the question may be more specific to an option under the Next Generation ACO model in which beneficiaries can, rather than being aligned just through claims-based attribution but whether they can proactively, for lack of a better term, 'sign up' to be aligned with the ACO. That's not something that currently ... Actually I should, Elizabeth November, if you're on the line and can clarify whether that's currently an option in the shared savings program. I know it was considered at one point but we would be consistent with the rules of the shared savings program but Elizabeth, if you're on and want to clarify that for the shared savings program, that would be great.

Elizabeth November: Sure. Hi, this is Elizabeth. I hope you can hear me. There are voluntary alignment policies for the shared savings program so I believe that would be an option. I believe it's an option for ACOs participating in all tracks of the program as well. More about that can be found through the program policies that are available in the program documentation that's accessible through the program website so I would encourage you to take a look at that. Thanks.

Maria Alexander: Thanks Elizabeth.

Leslie Vasquez: Thank you both. Do we have any additional questions for the team?

Maria Alexander: Leslie, it doesn't look like we have more questions coming out at this point. We can wrap up but, again, I want to be sure to remind folks that if you do have questions, please feel free to e-mail us. We're happy to discuss by phone or by e-mail and look forward to hearing from you.

Leslie Vasquez:

All right. Thank you so much. We will go ahead and adjourn. If our attendees could bear with us just a moment we are going to post a couple of polling questions in the window for you to provide feedback on the event. Again, just thanks so much for attending today. If you could provide feedback with the polling questions on the screen, your feedback is confidential and is only going to be used to improve future learning events. Our next learning event is scheduled for June 15th, next Thursday, at 1 p.m. Eastern. If you download a copy of the slides we are including a copy of that registration link just for easy reference. We do encourage you to visit the model team's website to access additional resources. The event is now closed. Thanks everyone again and have a wonderful afternoon.