

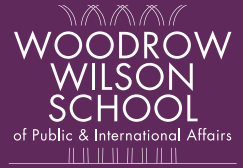
# State Strategies: Value-Based Payment for Medicaid Populations with Complex Care Needs

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## IN THIS BRIEF

- ✓ **Medicaid is the biggest customer for long term services and support (LTSS)** in states.
- ✓ **A few states have adopted value-based payment models in LTSS contracts** to help improve care – especially for seniors and those with disabilities – with their managed care contracts.
- ✓ **States must consider options in creating value-based LTSS contracts**, including (1) possible payment approaches, (2) quality metrics, and (3) the levers available to them in the contracting process.
- ✓ **Three states provide examples for others**—Tennessee, Minnesota, and Arizona already use value-based models to purchase and assess LTSS services.

## Introduction

Driven to improve care coordination and contain costs by moving away from a volume-based payment model, an increasing number of states are implementing risk-based managed care programs to deliver long-term services and supports (LTSS).<sup>1</sup> As the primary payer for LTSS, state Medicaid programs have a significant interest in ensuring that entities with which they contract deliver high quality and cost-effective care to members.<sup>2</sup> States can learn from value-based payment models being applied elsewhere to create more accountability for the quality and cost of LTSS.<sup>3</sup>

Purchaser attention to LTSS inherently focuses on strategies for seniors and younger individuals with disabilities as they are the primary users of LTSS. Seniors and individuals with disabilities often have costly, diverse and complex care needs that require a range of long-term care services. Yet state and health plan value-based strategies are largely built around primary and acute care services with much less emphasis in most states on alternative payment designs for LTSS. In 2015, the National Association of Medicaid Directors (NAMD) surveyed state Medicaid agencies on their value-based purchasing strategies and found that only six of the responding states included information about payment reform strategies for long-term care services, with wide variation in the type of reform activity reported.<sup>4</sup> Some states categorized their Managed LTSS (MLTSS) implementation plans or integration of LTSS into existing contracts as features of their value-based purchasing strategies. Many states that responded to the survey indicated that value-based payment models for LTSS would be considered in future payment reform strategies.

This brief examines Medicaid payment reform strategies that states may wish to contemplate for their populations with complex care needs that are receiving LTSS. The brief identifies current payment models for LTSS, observes the role of quality in these models, and describes state levers to advance efforts in value-based purchasing for seniors and individuals with disabilities enrolled in managed care.

**Improving care for seniors and people with disabilities**

Generally, state purchasers and health plans are applying value-based strategies for persons with complex care needs using models that are consistent with those implemented for other populations, with some modifications, as described in Table 1.

Table 1: Value-Based Payment Approaches for LTSS	
Payment Model	Contextual Information for LTSS
<b>Pay-for-performance</b>	The challenge of small numbers is in large part contributing to pay-for-performance (P4P) programs as the preferred value-based LTSS payment model. At the state level, P4P programs are largely aimed at improving the quality of care in nursing facilities. Tennessee’s <a href="#">Quality Improvement in Long-Term Services and Supports (QuILTSS)</a> program directs P4P payments through Managed Care Organizations (MCOs) to nursing facilities for performance improvement in specified quality domains. P4P programs are relatively easy to design and implement, and are appropriate to encourage entry into value-based contracts. Payers can structure P4P programs to initially reward providers for reporting on specific measures and then for improvement or achievement on those measures.
<b>Supplemental per member per month payments</b>	Some states are supporting primary care providers that serve a large number of individuals receiving LTSS with supplemental per member per month (PMPM) payments for services traditionally not reimbursed under fee-for-service (e.g., care management, care coordination). This model is value-based when the payment is attached to performance on quality measures or cost targets.
<b>Shared savings/ shared risk</b>	Contracts with shared savings and risk arrangements may include total cost of care for a defined set of services (e.g., primary care), for a subpopulation (e.g., individuals who are dually eligible for Medicare and Medicaid) or for the full population. These arrangements often exclude LTSS because of the small population served by a given provider for a given health plan, provider capacity to manage under a total cost of care contract, insufficient reimbursement or payment rates, and lack of financial alignment across Medicaid and Medicare programs. When shared savings and shared risk arrangements are implemented, they are generally more appropriate for larger, integrated health organizations with adequate financial reserves.
<b>Episode-based payments</b>	While few payers develop episode-based payment arrangements for LTSS, it is possible to do so, (e.g., for home health agencies for post-acute care <sup>5</sup> or for personal care services). <sup>6</sup> These arrangements can involve prospective payment (i.e., “bundled payment”) or fee-for-service payment with retrospective reconciliation to a prospectively defined episode budget.

Many states and health plans are successfully implementing value-based models, despite unique challenges for value-based approaches for LTSS, which are enumerated below.

- **Small numbers.** The LTSS provider system is often made up of many small, independent providers that serve a small number of health plan members. Smaller providers may lack the infrastructure for value-based contracts and the reserves to enter into more advance risk-bearing payment models. Health plans are subject to significant administrative costs to manage multiple value-based contracts with many providers, each serving relatively few members. The issue of small numbers largely drives the preference for pay-for-performance models for LTSS.<sup>7</sup>
- **Provider readiness.** The readiness of LTSS providers to enter into value-based contracts is highly variable. States can support entry by LTSS providers with grants and other capacity-building opportunities, and can phase in performance-based incentives for structure or process measures.
- **Population characteristics.** The heterogeneity of the population creates small population cohorts and other measurement challenges.
- **Measures.** Lack of standardized measures and benchmarks presents hurdles related to tracking quality and holding health plans and providers accountable for performance. The National Quality Forum (NQF) issued a final report from its Measuring Home and Community-Based Services Quality project. The report contains recommendations aimed at promoting quality measurement for home and community-based services.<sup>8</sup>

## 2 | Quality Considerations

### States need to choose appropriate measurements for their LTSS Value-Based Payment arrangements

Current measurement strategies – and measure sets – are oriented toward the medical model of care and facility-based care. Measurement strategies for value-based LTSS payment may need to consider domains that are more difficult to measure, including quality of life, independence, and functional status. The limited number of relevant LTSS measures in existing, standardized sets has contributed to state innovation in developing measures. State representatives can learn from and build upon work being done by their counterparts in [Minnesota](#), who worked collaboratively with providers and health plans to identify LTSS and behavioral health measure sets for its value-based payment initiative (see Table 2).<sup>9</sup>

Table 2: Measures Implemented by the Minnesota Department of Human Services (DHS) for the State’s Value-Based Purchasing Initiative for Seniors and Individuals with Disabilities

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Advanced care planning</li><li>• Anti-depressant medication management</li><li>• Care of older adults</li><li>• ED utilization</li><li>• Fall with fracture</li><li>• Fall risk management</li><li>• Flu shot</li><li>• Follow-up after hospitalization for mental illness</li></ul> | <ul style="list-style-type: none"><li>• Inpatient admissions / readmissions</li><li>• Management of high risk medications</li><li>• Medication reconciliation post-discharge</li><li>• Plan all-cause readmissions</li><li>• Physician Orders for Life Sustaining Treatment (POLST) documentation</li><li>• Pressure ulcers</li><li>• Use of antipsychotics for people with dementia</li><li>• Use of high risk medications in the elderly</li></ul> |
|--|--|

## 3 | State Levers

### Contracting to advance payment reform for individuals with complex care needs

States can support and direct value-based strategies in a number of ways, including supporting entry into value-based contracting for LTSS providers through grants or capacity-building opportunities. States can phase in performance requirements, initially focusing on reporting and then moving to implementing performance-based incentives for structure or process measures. States can also apply the following levers to promote their value-based purchasing strategies for individuals with complex care needs.

- States can **structure their Medicaid MCO contracts that include LTSS and populations with complex care needs to encourage or direct value-based payment models**. For example, states can include explicit targets for value-based payments for implementing data-sharing and reporting requirements,<sup>10</sup> and for directing provider contracts. [Arizona](#) established value-based payment targets for the state’s Arizona Long Term Care System (ALTCs) plans, and [Minnesota](#) requires plans that serve seniors and individuals with disabilities to enter into value-based contracts with primary care, long-term care, and/or behavioral health providers through the state’s Integrated Care System Partnership (ICSP) initiative. The Kansas Medicaid program implemented a P4P incentive for nursing facilities to improve quality and incorporated a withhold measure with MCOs to promote contracting with nursing facilities that improved quality.<sup>11</sup>

- States can *propose waiver terms* that support efforts to promote value-based purchasing for LTSS and include requests for financial support through federal waiver programs like Delivery System Reform Incentive Payment (DSRIP). States can also use waivers to implement their MLTSS programs.<sup>12</sup>
- States are using their *Dual Eligible Special Needs Plans (D-SNP) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP) contracting authorities* to further integrate the financing, delivery and coordination of Medicare and Medicaid services for individuals with dual eligibility, thereby expanding opportunities for value-based payment.<sup>13</sup> Seniors and younger individuals with disabilities represent the greatest proportion of individuals who are dually eligible for Medicare and Medicaid benefits, and D-SNP and FIDE-SNP managed care programs are designed around an array of services including LTSS. Aligned financing and delivery of a comprehensive set of services for individuals who are dually eligible creates opportunities for health plans and providers to implement value-based payment arrangements. States are not permitted to require individuals with dual eligibility to enroll in the same health plan for MLTSS and Medicare services; however states may structure their programs to encourage alignment.<sup>14</sup>

## Conclusion

States have significant interest in ensuring that they, and the populations they serve, are getting the best value for the purchase of LTSS. States and health plans have opportunities to design or expand value-based payment strategies for populations with complex care needs to create more accountability for the cost and quality of care provided. States can look to align value-based strategies across programs and consider how to expand current strategies for populations with complex care needs receiving LTSS. States can also consider aligning value-based payment models with national frameworks, such as the Health Care Payment Learning and Action Network (HCP-LAN) or the payment models CMS defines in the final rule implementing the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.<sup>15</sup> Some states that are driving value-based purchasing strategies for LTSS are seeing health plans and providers design new approaches with the aim of improving the care provided to members.

## Appendix: Case Studies

### Tennessee's QuILTSS

In Tennessee, seniors and individuals with disabilities covered by Medicaid (TennCare) are enrolled in the state's CHOICES Managed Long-Term Services and Supports (MLTSS) program. The state sets the rates of reimbursement for nursing facility and Home & Community-Based Services (HCBS) and directs payments, including performance-based incentive payments, through its risk-bearing MCOs.

With input from stakeholders, technical assistance provided by Lipscomb University School of TransformAging and the support of the Robert Wood Johnson Foundation's State Quality and Value Strategies Program, the state implemented the Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative. QuILTSS aims to improve the quality of nursing facility care and home-and-community-based services by creating financial incentives for high performance. TennCare, through its MCOs, has issued more than \$18 million in bonus payments to nursing facilities for performance improvement activities since the implementation of the program in August 2014.

Providers must meet minimum standards of performance in order to be eligible to receive any portion of the quality incentive payment. The State has established the following quality framework and implemented a scoring methodology to assess performance improvement.

1. Satisfaction (member, family and staff) – 35 points
2. Culture change/quality of life (i.e., respectful treatment, member choice, member/family input, meaningful activities) – 30 points
3. Staffing and staff competency – 25 points
4. Clinical performance (antipsychotic medication and urinary tract infection rates) – 10 points

Nursing facility scores on quality improved each quarter and the number of nursing facilities with higher scores was reported to have continued to increase in the first year of implementation.<sup>1</sup>

*Tennessee expected to launch a similar QuILTSS model for HCBS in January 2017.*

#### Additional information:

[www.lipscomb.edu/transformaging/resources/tareport](http://www.lipscomb.edu/transformaging/resources/tareport)

[www.tn.gov/tenncare/topic/quiltss](http://www.tn.gov/tenncare/topic/quiltss)

[www.tn.gov/assets/entities/tenncare/attachments/QuiltssFramwork.pdf](http://www.tn.gov/assets/entities/tenncare/attachments/QuiltssFramwork.pdf)



1. Presentation by representatives of the Division of Health Care Finance & Administration in Tennessee at the 2015 HCBS Conference: [https://www.eiseverywhere.com/file\\_uploads/490fee54559417e49f9370e6efbd35fd\\_MLTSS.pdf](https://www.eiseverywhere.com/file_uploads/490fee54559417e49f9370e6efbd35fd_MLTSS.pdf). Accessed October 27, 2016.

## Minnesota Integrated Care System Partnerships

The Minnesota Department of Human Services (DHS) requires health plans that serve seniors and individuals with disabilities to enter into value-based contracts with primary care, long-term, and/or behavioral health providers. Called the Integrated Care System Partnership (ICSP) initiative, it was inspired by partnerships between health plans and providers that previously emerged organically from the state's Minnesota Senior Health Options (MSHO) program. DHS sought to improve service delivery integration, care coordination, and health outcomes through payment reforms with explicit links to quality by encouraging similar partnerships. A recent evaluation of the MSHO program found that the program was successful in improving care for seniors. The report cited fewer hospital stays, fewer emergency department visits, more visits with primary care providers, and enrollees more likely to utilize hospice care as compared to a control group of enrollees.<sup>1</sup>

A separate evaluation of the ICSP initiative completed on behalf of DHS found that the ICSP initiative encouraged plans and providers to try new payment arrangements and may have accelerated the integration of quality performance into payment arrangements. The opportunity for additional revenue (e.g., shared savings, performance-based bonuses) motivated some providers to invest in delivery system changes, including funding for community health workers and investments in care coordination. It also strengthened working relationships between providers and plans.

DHS convened a measurement work group comprised of providers and health plan representatives to identify LTSS and behavioral health measure sets for the initiative prior to implementation. The measure sets are posted on the ICSP website (below).

It was through the ICSP initiative that Essentia Health, an integrated delivery system, and Blue Cross Blue Shield of Minnesota, an MSHO plan, entered into a shared savings agreement to improve care coordination for seniors. The organizations saw opportunities for cost savings from improved care coordination, care transitions, and management of chronic diseases, which would contribute to a reduction in hospital admissions and emergency room visits. The amount of savings which Essentia Health is eligible to receive is determined by performance on two HEDIS measures: plan all-cause readmissions and use of high risk medications in the elderly.



### Additional information:

#### ICSP Evaluation Presented to Managed Care Organizations and Providers:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_163573#](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163573#)

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_180116](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_180116)

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7427-ENG>

1. Anderson WL and Long SK. "Minnesota Managed Care Longitudinal Data Analysis" Office of the Assistant Secretary for Planning and Evaluation and Office of Disability, Aging and Long-Term Care Policy, U.S. Department of Health and Human Services, Washington, DC 2016. <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.

## Arizona Long Term Care System (ALTCS) Value-Based Payment Target

Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, contracts with managed care organizations (MCOs) to provide coverage for long-term care services for seniors and individuals with disabilities through its longstanding risk-based Arizona Long Term Care System (ALTCS) program. Established in 1989, the ALTCS program provides acute care, behavioral health services, case management and long-term services and supports (LTSS), including home and community-based services for eligible seniors and individuals with disabilities. Arizona requires ALTCS plans to operate a dual special needs plan (D-SNP) in the same coverage area. A D-SNP is a special type of Medicare Advantage plan for individuals who are dually eligible for Medicaid and Medicare benefits.

AHCCCS directed ALTCS plans and D-SNPs to have a minimum of 25 percent of their total payments to providers in value-based models for contract year 2016 and 35 percent in contract year 2017 (AHCCCS has also implemented value-based payment targets for its acute care plans and regional behavioral health authorities). The state provides guidance on what would qualify as a value-based payment model, but allows plans flexibility to implement models appropriate for their populations and businesses.

Plans must meet the value-based payment target in order to access any portion of the 1 percent of the capitation rate the state withholds. Plans can then earn back the withhold for performance on the following five measures:

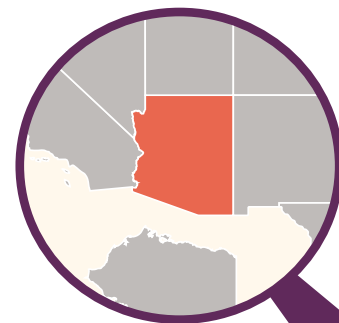
- emergency department utilization;
- readmissions within 30 days of discharge;
- HbA1c testing;
- LDL-C screening; and
- flu shots for adults 18 years and older.

The target is motivating ALTCS plans to innovate in improving the quality of care for seniors and individuals with disabilities. One ALTCS plan has established a pay-for-performance (P4P) initiative with a network of attendant care agencies. The agencies are eligible for financial bonuses for performance on measures including flu shots, employee retention, physician visit log, bone density, advanced directives, and HbA1c and LDL-C test kit assistance.

### Additional information:

Arizona's value-based payment initiative is available here:

[www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/](http://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/)



## Endnotes

1. Musumeci M. "Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers" (Washington, DC: KMCU, November 2014); <http://kff.org/medicaid/issue-brief/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers/>.
2. LTSS represent 32 percent of state Medicaid expenditures on average (and more than 40 percent in 14 states). Truven Health Analytics, April 2016. <https://www.medicaid.gov/medicaid/lts/downloads/lts-expenditures-2014.pdf>.
3. The Health Care Payment and Learning Action Network (HCP-LAN) developed a framework for defining alternative payment models. See "Alternate payment model (APM) framework: final white paper" January 12, 2016; <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.
4. Burns M, Waldman B, Taylor E. "The Role of State Medicaid Programs in Improving the Value of the Health Care System", National Association of Medicaid Directors, March 24, 2016. AZ, FL, MN, TN, TX and VA included value-based purchasing strategies in their response to the NAMD survey. <http://medicaidirectors.org/publications/namd-report-the-role-of-state-medicaid-programs-in-improving-the-value-of-the-health-care-system/>.
5. See the CMS Home Health Value-Based Purchasing (HHVBP) model: <https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model>.
6. A coalition of providers in Vermont, including a home health agency, hospital, and mental health services agency were engaged in discussions with state representatives about the Medicaid agency developing a bundled rate for personal care, respite and companion care services.
7. See "Tricky Problems with Small Numbers" by Nancy McCall for the RWJF State Health and Value Strategies Program for strategies to mitigate the problems associated with a small number of attributed lives: <http://www.statenetwork.org/wp-content/uploads/2016/04/SHVS-Mathematica-Tricky-Problems-with-Small-Numbers-April-2016.pdf>.
8. National Quality Forum. Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement. Final Report. September 2016.
9. See findings from an evaluation of Minnesota's value-based purchasing initiative for seniors and individuals with disabilities enrolled in managed care: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_163573#](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163573#). Minnesota Department of Human Services (DHS) contracted with the authors of this report to evaluate the initiative.
10. Michigan included terms in its MCO contracts directing health plans to use specific data (e.g., claims, pharmacy, etc.) to address health disparities, improve community collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including: enrollees in eligibility categories designating a disability; persons with high-prevalence chronic conditions; enrollees in need of Complex Care Management, such as high-risk enrollees with dual behavioral health and medical health diagnoses who are high utilizers of services; and people with Special Health Care Needs. Texas STAR+Plus plans are required to submit to the state proposals for value-based payments to providers, which must integrate quality.
11. To promote person-centered care in nursing facilities, Kansas Medicaid (KanCare) implemented a voluntary P4P incentive through the Promoting Excellent Alternatives in Kansas (PEAK) Nursing Homes program. KanCare previously placed a portion of the MCO capitation at risk based on increasing the number of "PEAK-certified" facilities in their contracted networks and increasing the number nursing facility days in PEAK-certified facilities as a percentage of overall nursing facility days. For more information on PEAK, see <http://www.kdads.ks.gov/commissions/scc/peak>.
12. Massachusetts has proposed restructuring its Medicaid program through an 1115 waiver in which it requests DSRIP funding to support infrastructure development for LTSS providers, including "community partners" with expertise in community-based options and person-centered planning for LTSS and behavioral health needs. Virginia is seeking authority to implement an MLTSS program through an 1115 waiver and is requesting DSRIP funds to accelerate provider readiness to enter into value-based payment arrangements. In April 2016, Virginia released an MLTSS RFP, which specified that selected contractors would be required to meet specific expectations and benchmarks for value-based purchasing based on the Health Care Payment Learning & Action Network (LAN) alternative payment model framework. For more information, visit: [www.mass.gov/eohhs/gov/departments/masshealth/1115-waiver-proposal-information.html](http://www.mass.gov/eohhs/gov/departments/masshealth/1115-waiver-proposal-information.html) and [www.dmas.virginia.gov/Content\\_atchs/rfp/RFP2016-01MLTSSApril29,2016.pdf](http://www.dmas.virginia.gov/Content_atchs/rfp/RFP2016-01MLTSSApril29,2016.pdf).
13. The Medicare Improvements for Patients and Providers Act (MIPPA) requires that D-SNPs hold contracts with states for coverage of a minimum set of requirements. States have the flexibility to add more requirements. States are not required to contract with D-SNPs. The Integrated Care Resource Center (ICRC) has provided technical assistance to states interested in leveraging their D-SNP contract authority to advance their alignment and coordination efforts. See [www.integratedcareresourcecenter.com/optionsForMMIntegration/specialNeeds.aspx](http://www.integratedcareresourcecenter.com/optionsForMMIntegration/specialNeeds.aspx) for more information.
14. Arizona requires ALTCS plans to offer companion D-SNPs for Medicare services and the state is supporting efforts to educate members about enrolling in the same plan for both Medicare and Medicaid benefits. Minnesota requires MSHO plans to have a companion D-SNP. The state restricts enrollment in MSHO to individuals who have elected to receive their Medicare and Medicaid services from the MSHO plan. Virginia is implementing an MLTSS program in 2017, and will require any MLTSS health plan that does not have a companion D-SNP to obtain D-SNP certification by 2019.
15. More information about value-based requirements of MACRA can be accessed here: <https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-and-alternative-payment-model-incentive-under>.

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