# SB 227 Primary Care Collaborative Meeting

## Monday, February 25, 2019
## 6:00 p.m.
## Medical Society of Delaware
## 900 Prides Crossing, Newark, DE 19713

### Meeting Attendance

**Collaborative Members:**

| **Present:** | **Email:** |
|---|---|
| Senator Bryan Townsend | Bryan.Townsend@delaware.gov |
| Dr. Nancy Fan | nfanssmith@yahoo.com |
| Representative David Bentz | David.Bentz@delaware.gov |

**Staff:**

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| Juliann Emory | Juliann.Emory@delaware.gov |
| Read Scott | Read.Scott@delaware.gov |

| **Attendees:** | **Organization:** |
|---|---|
| John Fink | Bayhealth Medical Center |
| Kathy Collison | Division of Public Health |
| Karyn Scout | AmeriHealth Caritas |
| Steven Costantino | Department of Health and Social Services |
| Steve Groff | Division of Medicaid & Medical Assistance |
| Rebecca Byrd | The Byrd Group |
| Lisa Zimmerman | Department of Health and Social Services |
| Weston Riesselman | Christiana Care Health Systems |
| Elizabeth Scheneman | Department of Health and Social Services |
| Chris Manning | Nemours |
| Rosa Riviera | La Red Health Center |
| Jamie Clarke | Nemours |
| Chris Morris | Aetna |
| Kathleen Willey | Quality Family Physicians |
| Jennifer Mossman | Highmark DE |
| Dr. Jason Hann-Deschaine | MSD/Delaware Pediatrics |
| Faith Rentz | DHR/Statewide Benefits |
| Sylvia Canteen-Brown | Delaware Pediatrics |
| Kiki Evinger | Department of Health and Social Services |
| Katherine Impellizzeri | Aetna |
| Stephen Cozzo | AmeriHealth Caritas |
| Pam Price | Highmark |
| Susan Conaty-Buck | DCNP |
| Wayne Smith | Delaware Healthcare Association |

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|---|---|
| Kelly Krinn | Health Management Associates |
| Art Jones | Health Management Associates |
| Jennifer Schwartz | Christiana Care Health Systems |
| Dr. Charlie Jose | Graham Center |
| Dr. Jeffrey Hawtof | Beebe |
| Tom Stephens | Westside Family Healthcare |
| Kevin O'Hara | Highmark |
| Todd Graham | Highmark Health Option |
| Emmilyn Lawson | AmeriHealth Caritas |
| Christine Schiltz | Parkowski, Guerke & Swayze |
| Cheryl Heiks | Webster Consulting |
| Dr. Andrew Dahlke | MSD |
| Tyler Blanchard | Aledade |
| Nick Biasotto | MSD |
| Maggie Bent | Westside Family Healthcare |

**Meeting was called to order at 6:00 p.m.**

**Dr. Charlie Jose, Graham Center**

- The Graham Center is housed under AAFP, we have editorial independence
- The main question that we are asking is how does primary care do under value-based payment systems?
- The studies in this presentation come from two reports we have produced. The first year we looked at how PCMHs did in terms of cost utilization and quality, and in the second year we looked at ACOs.
- There were three main study types. Some compared to FFS care, some had PCMH-like features, but didn't have the certification compared to FFS care, and last type we looked at PCMHs that were mature and looking at the details of their components.
- This is an overview of these studies in total of 45 included.
- Just because a study is classified as mixed doesn't mean it's bad – that might just mean that the statistical significance wasn't strong enough. Often the sample size is small and that impacts the statistical significance. Mixed results might also be the result of what population.
- A majority of studies were positive or mixed; only a few studies were negative.
    1) There are two main themes: 1) Greater cost savings have been observed from more mature PCMHs and 2) Greater cost savings have been observed from higher risk patients.
- There was one study with negative outcomes from a PCMH model, but this study looked at only one study population of breast cancer patients.
- In terms of assessing the cost outcomes, we are talking about cost to the entire system not just the primary care costs.
- Looking at quality, the studies have mixed results. The studies assessing patient satisfaction all trended toward positive.

- Regarding utilization the results were largely mixed. The ED utilization increased in two studies but decreased in 5 studies. Some showed decreased ED utilization, but increased inpatient utilization.
- Overall, the utilization outcomes are not as clear as the cost outcomes.

**Dr. Fan**

- What was the demographic of the providers in the studies – were they physician-led, team-based, NP-led, etc? This would be useful to understand as we talk about team-based care and access.

**Dr. Charlie Jose, Graham Center**

- I don't know, but I'll report back.
- Cost and quality trended toward positive, but not uniformly. Practices need time to transform in order to increase cost savings.
- A lot of the ACO evidence is very similar to the PCMH evidence. The greatest improvements were from mature ACOs and among the higher risk patients.
- In one study looking the MSSP ACOs, one-third of ACOs received shared savings. CMS set a difficult benchmark. Physician-led ACOs outperformed hospital ACOs. This makes sense because physician ACOs don't have to worry about the revenue ramifications of avoided ED or hospital utilization.

**Dr. Jeffrey Hawtof, Beebe**

- ACOs assess costs based on TIN. This would include your cancer centers for instance, and their entire cost falls into the hospital's ACO. This very expensive care falls into the hospital ACO's cost assessment. If that patient was in a primary care only ACO, these costs wouldn't fall into the ACO.

**Dr. Charlie Jose, Graham Center**

- Much of the evidence was positive.
- The negative study looked at the highest quartile risk of MSSP ACOs. These had more ED visits that led to hospitalizations. This study only looked at primary care, not if they received care from a medical home-like system. This highlights the importance of using an advanced primary care model to generate savings.
- We saw more cost savings if patients were more consistent with primary care physicians. We saw mostly cost savings from lower priced sources of care (60%) vs lower volume (40%). Savings came from preventing hospitalizations and imaging procedures.
- One of the studies had a decrease in utilization by 9%. These outcomes varied by the studies too.

**Dr. Jeffrey Hawtof, Beebe**

- The cost avoidance was not necessarily calculated the same across these studies, like how a study defines an avoided ED visit. These differences in the avoided cost might translate into different results in the studies.

**Dr. Charlie Jose, Graham Center**

- That was shown in the MSSP. Previously we were using the benchmarks as counterfactual estimates, which doesn't account for the spending that would have occurred in the absence of this type of program.
- Leadership was responsible for ACO success. We actually did a qualitative study of what makes a PCMH or ACO successful. It came down to accessibility, high value, coordinated services, and collaboration.
- All these are features of the LAN category 3 and 4 forms of delivery.

**Dr. Jim Gill, MSD**

- There is room for improvement in all types of systems.
- It is actually not true that MSSP biases against hospital systems. You only get shared savings if you decrease your costs, so if your costs are already high you can generate savings easier. Already efficient practices that spend less have a more difficult time generating savings.
- The methodology is changing a bit and moving to include regional cost comparison, not just historical costs.

**Dr. Fan**

- This tees us up for the APMs LAN category 3 and 4.
- Jessica and Kelly from JHU provided some follow up on the care coordination payments. This document provides further research and drills down a bit in response to some of the questions they received last week.
- If we are going to talk about upfront investment that can fall under LAN category 2. Highmark, your models currently incorporate LAN category 2 elements, correct?

**Kevin O'Hara, Highmark**

- Yes

**Dr. Fan**

- How do we get to LAN categories 3 and 4?
- This fall we discussed that Delaware has significantly less uptake of APMs than other states. What are some of the barriers to moving from LAN category 1 to LAN categories 3 or 4?

**Dr. Jim Gill, MSD**

- We are actually in a LAN category 3 model with our Aledade ACO – type B for Medicare and type A for Highmark and Aetna. We wouldn't have been able to do this without Aledade, they have a fantastic data system and great support. I think we can move to a LAN category 4 model.
- We are the first and only in Delaware to achieve Medicare shared savings.
- There are a lot of barriers to advancing payment models. There is insufficient payment for care coordination. Medicare is the best for care coordination payments, but require a lot of documentation because the payments are paid through chronic care management. The level of administrative work negates the value of the high care coordination

payments. They also apply copays and deductibles that makes no sense to patients or the provider.

- Highmark and Aetna provide lower care coordination payments that don't require much documentation. These care coordination payments cover about 10-15% of the cost to the practice of paying for care coordination. You cannot hire any staff with that level of investment. These payments are also at risk based on quality metrics, which is inappropriate because you cannot take payments back for care coordination.
- One thing recommended is an adequate care coordination fee that is $15-20 pmpm. That is what is recommended by the most definitive studies from Commonwealth and AHRQ. Also supported some calculations of the costs of having nurses and others to do care coordination. That is the only way you can do care coordination in a sustainable way.

**Dr. Fan**

- Is one of your barriers data analytics at a provider level?

**Dr. Jim Gill, MSD**

- The provider needs its own data system. All need the basics, to track the patients and utilization. You need to have that data within the practice in addition to a system level investment.

**Dr. Fan**

- Beebe and Christiana you have put in the investment yourself at the system level for your practices

**Dr. Jeffrey Hawtof, Beebe**

- Yes, the systems need to be in place at the practice level, so they can truly impact the health care of the individual. Your EHR typically holds the key to that. The other side of the data is claims-level data.
- If you are going to assume the total cost of care of a patient you are responsible for them no matter where they go, which means we need their claims-level data. We get that pretty well from Medicare already, but getting that same data from insurers quickly is important to allowing me to help my patients.

**Jennifer Schwartz, Christiana Care**

- What is more challenging that providing data, is providing a meaningful dashboard that resonates with the provider. That is the data that is actionable to a provider. A lot of ACOs and other organizations have worked hard to get to that point.
- At Trinity (NJ), we were a NextGen ACO with downside and upside risk. We were successful all three years I was with Trinity. We assessed our budget and found that we spent $22 pmpm on the infrastructure to manage the population effectively with downside risk.

**Dr. Fan**

- Can the payers speak to that? What have you seen in other markets that have put that kind of infrastructure in place? What strategy we could use to advance practices' infrastructure?

**Chris Morris, Aetna**

- We have seen that in other areas, especially with larger systems with the infrastructure in place.
- With the infrastructure, they were ready to move to the next stage. It is certainly heading to that direction in Delaware, but in other markets in Pennsylvania are ready.

**Kevin O'Hara, Highmark**

- We have examples of LAN category 3 APMs in Pennsylvania with providers that were already equipped with the ability to manage risk. We have progressed to LAN category 4 with some of those practices.
- The glidepath here in Delaware is all over the place. Some practices have no capabilities and the larger systems are better prepared.
- We have an assessment tool that we use to talk about LAN categories 3 and 4 with providers who are interested. We go through enough data with those practices to evaluate their capabilities and their data needs.

**Sen. Townsend**

- We understand that different providers are at different stages of readiness, but it sounds like the amounts being payed are still below what the data suggests are needed.
- Regarding the care coordination efforts of payers, are there studies that talk about payers' care coordination efforts?
- Do you do care coordination internally as payers, and if so, what is that investment look like?

**Kevin O'Hara, Highmark**

- In LAN category 3 and 4 deals, there are other funding streams, beyond care coordination, that allow the provider some contribution for these infrastructure costs, but we do have a standard approach to care coordination for a couple bucks for more well members up to $15 pmpm for sicker patients. We pay the chronic care codes at Medicare levels.
- We are not just paying care coordination, but we also provide other incentives where we see quality gains and cost savings.

**Dr. Fan**

- How do you plan to use what you have in place to move providers from LAN category 1 to at least category 2, and from LAN category 2 to 3 when we have people saying they need more to build the infrastructure?

**Kevin O'Hara, Highmark**

- From a global sense we don't have that strategy in place.

**Chris Morris, Aetna**

- The goal is to move as many as we can above and beyond, but we don't have a strategy in the place if they don't have the infrastructure already.
- When we are talking about the infrastructure to take on risk, that is beyond the care coordination payment.

**Dr. Fan**

- The early enablers of PCMH are still struggling and I am trying to figure out why if they really want to move up to LAN categories 3 or 4.

**Kevin O'Hara, Highmark**

- We are fully able to advance providers that are ready.

**Dr. Fan**

- How are you helping them get ready?

**Steven Costantino, DHSS**

- I think there needs to be a realism test. A small practice is not going to take on a lot of risk, and that expectation that a small practice in LAN category 1 or 2 is going to go up to LAN categories 3 or 4 is unrealistic. Any practice can do care coordination, but the expectation that they will take on risk is not realistic.
- I think we need to set some achievable goals. For health systems and ACOs that is where you talk about the continuum of going from LAN category 1 to LAN category 4 or an all-inclusive population-based payment.
- Providing and standardizing that care management payment and tying it to performance is important. But expecting for a small practice to take on this level of risk is not realistic.

**Dr. Fan**

- For the majority of providers maybe the goal is moving them from a LAN category 1 to 2, and for larger practices, moving to a LAN category 3 or 4.

**Steven Costantino, DHSS**

- Maybe there are some practices that have matured in the PCMH and can continue on the glidepath.
- Both physicians and hospitals have been in the ACO world for 6 years, and CMS is pushing for more risk. A lot of investments have been made early on in care management, technology, why hasn't there been the ability to piggyback that model into Medicaid and take on an attributed population in Medicaid or in the commercial world?
- What are the barriers to moving to what Vermont did starting with Medicaid when adopted in Medicare and commercial?

**Dr. Jeffrey Hawtof, Beebe**

- I disagree that a single one or two practice can take on risk. As a practicing family physician, at one point, I had a two-provider practice and grew it to an eight person.
- Two years into our Medicare ACO, we went to Blue Cross for a contract, but they wouldn't give us an ACO contract. Recently things have changed.
- We have four ACOs throughout the state. Joining up with ACO, a small provider can be part of a clinically integrated network (CIN) and can use these tools already built into the ACO.

**Steven Costantino, DHSS**

- I was talking about a small practice not in an ACO.

**Dr. Jeffrey Hawtof, Beebe**

- But they could join.

**Chris Morris, Aetna**

- You want a stable and sizable population in an ACO to mitigate some of the risk and volatility. There is a reason we require a certain attribution level.

**Nick Biasotto, MSD**

- We recently joined an MSSP. I am happy with the data collection. Why can't the insurers provide a data collection system?

**Dr. Jim Gill, MSD**

- Just to get back to the model proposed from AAFP this is a LAN category 4 model, it is full risk.
- This model is the capitation covering all your primary care work: preventive care, chronic condition management, care coordination, and also some quality and utilization bonuses.
- This model would work best if practices integrate, but it can still apply to small or large practices. You cannot hold primary care providers responsible for oncologist or other services they do not control.

**Nick Biasotto, MSD**

- As a PCMH, once a patient became part of an oncologist group, that person became their attributed patient, not mine.

**Emmilyn Lawson, AmeriHealth Caritas**

- I think there was some discussion last week of Medicaid, which is a little different. A lot of the care management is prescribed by the Medicaid contract. We are required to do a lot of the care coordination tasks mentioned last week.
- As we have discussions with providers, we are using that list to inform what those care coordination fees should look like. We know what we use in terms of resources to provide that care coordination. We stratify the member population and depending on their risk we cover that list with the level of appropriate staff to keep the costs down.

**Dr. Fan**

- And that is part of the reason I asked Charlie what the team composition was. I know we are using more and more non-physician professionals to drive the teams because we don't have enough physicians.
- We would like to be able to have a consensus that we need to invest more and which tools we will use to do that. Care coordination fees are one tool. We have good data analytics that are not working efficiently for us.
- If you don't have a strategy moving practices out of FFS to build the infrastructure, then what kind of investments can you make?
- The plan sponsors are the ones paying for it. There are some self-funded systems here at the table. We need them to recognize that part of this is the community benefit.
- How to we move practices out of LAN categories 1 and 2? We have already discussed adequate care coordination payments.

**Kevin O'Hara, Highmark**

- I think I heard that that primary care couldn't have an impact on care they do not control.

**Dr. Jim Gill, MSD**

- No, we can have an impact, but we cannot get not paid based on the decisions of other providers

**Kevin O'Hara, Highmark**

- Are we divorcing this conversation from how we paid for it? If I was a plan sponsor I would be concerned that everything you are talking about is increasing my costs.

**Jennifer Schwartz, Christiana Care**

- There is duplication in the care coordination efforts. The payers are required to do certain tasks, and providers duplicate some of those and want to get paid for the duplication. We have to have a meaningful discussion about which entities are best suited to doing care coordination.
- Some payers are inefficient in the outreach because patients don't want to talk to the payer.
- There are only so many dollars in the system. It is unrealistic to think we can add dollars so that everyone can do these tasks. The provider must balance the risk and opportunity with the infrastructure payment they are going to get. The providers have to believe there is a return on investment possible. I have the experience where we saw returns and we could bring checks to providers.

**Kevin O'Hara, Highmark**

- I have seen this success too, and I agree. The other Delaware reality is that the total cost of care is the third highest in the country.

**Sen. Townsend**

- That is precisely the reason we need to do this. We all agree this is an issue, and there are some solutions. Then let's do it. It is a complicated conversation and we need to acknowledge the delicate balance that is there.
- We need to make the structural changes in order to get there. We need to have ongoing integrative dialogue to get it right. We don't want to be too strict and stifle innovation. We need to set a framework that people can operate within.
- We need to note when we are identifying problems that we can fix or problems we can do nothing about. I think high cost of care is a reminder of how much money is in the system. Delaware has got the money, it just needs to restructure where it is going.
- If we could agree on the different elements, then let's formalize the process to ensure progress continues.

**Dr. Fan**

- If we want to talk about a model that would incorporate total cost of care. The total cost of care is being tracked in the state's benchmarking process. In the individual provider context, there is a total cost of care for each patient that is your responsibility. There are systems and ACOs that might be able to reach that level of accountability.

- To answer Kevin's question, where does that money come from, without making the client pay for it?

**Rep. Bentz**

- The criticism we had over the fall is that we didn't being a group together to discuss. We need your answers.

**Dr. Jim Gill, MSD**

- All these studies show that every dollar we invest in primary care you save $3-5. Savings occurs in months following the investment, so we need money up front.
- We need someone like the payers to up that money up front for a few months or a year.
- We need to be on that same page.
- In New York, providers were getting a $15 care coordination and got a 5:1 ROI. The return on investment doesn't take 10 years. The Rhode Island initiative saved 4.5% in the first year by increasing primary care up front.

**Chris Morris, Aetna**

- Did they have targets that they had to meet upfront?

**Dr. Jim Gill, MSD**

- No, not as far I know.

**Tom Stephens, Westside Family Healthcare**

- As an FQHC, we play by different rules. We cannot engage in downside risk.
- We have been involved in a lot of initiatives at the state. We have been involved in the SIM grant transformation. On the Clinical Committee, one of the things we recognized with SIM initiative was that we need to pay for care management and care coordination upfront. Practices need this infrastructure and need some upfront payment to get there. Those conversations never happened for whatever reason. We didn't get those payments done and care coordination never happened through the SIM grant.
- Westside had an interaction with UHC when they were a Medicaid MCO. We wanted to do care coordination but couldn't fund it. We got UHC to give us a larger pmpm, sufficient enough that we felt we could begin to build the infrastructure and we hired three care managers. When UHC lost their place in the market, we couldn't follow through to see if there was going to be a benefit. Built into that agreement was that they provided the pmpm as seed money and after a period of time it would face some risk.
- I think there is some middle ground in providing this upfront money. The practices don't have the money. The health systems have money. The payers are the only ones who can make this happen.
- Upfront investment is necessary to move practices ahead. The other requirement is knowledge. We have been able to work with Art Jones recently, and our understanding of APMs has advanced significantly. There are a lot of folks that don't have the ability to make informed decisions or to enter into arrangements.

**Steven Costantino, DHSS**

- We know the investment works but where does it come from. Is it additive or does it come from within the existing spending?
- If its additive, you are adding to the denominator and you will never get to 12% primary care spending.
- In Rhode Island, they made sure they weren't adding to the denominator. They moved money within the premium to primary care.

**Rep. Bentz**

- And if you understand that there will be savings?

**Steven Costantino, DHSS**

- You would have to tie the investment to the savings. That could be the compromise. Then you have to figure out what are the penalties or withholds for not meeting that criteria.

**Rep. Bentz**

- In the report, we express that we want to do it within the existing spending, obviously that ruffled some feathers, but we are trying to be conscious of investing without raising premiums.
- What is that middle ground there? We don't want to see a rachet up of total cost.

**Dr. Jeffrey Hawtof, Beebe**

- We created two different care coordination models and one worked better. One was centralized model and one was a practice-based model. We found very clearly that a centralized model doesn't work. At the provider level, there are different ways of practicing and different support that they are asking for and were able to reduce the cost of care.
- If you take the money already being used on the insurance side and let care coordination being done by the provider, that would be a more efficient use of spending.

**Steve Groff, DMMA Director**

- When we talk about the payers, we attribute some more autonomy to their decision-making than we should. Regarding the Medicaid payers, we are talking about the state of Delaware tax payers making that investment. That passes through our organization to the MCOs.
- The state of Delaware is also a major payer though self-employed plans for employees. We need to consider the impacts of our decisions on the state budget and tax payers.
- In 2015, we prioritized care coordination in the MCO contracts, which meant building in very strict requirements for MCOs around levels of staffing and what they have to do to care of the 200,000 members.
- Now we realize that to get where we want to be, we need to push care coordination out to the practice level. We have stuck a lot of requirements and invested heavily and it may not be in the right place. How do we make that transition? It is not just moving the money, because I still have to hold the MCO accountable for the member and they cannot

do that if they will not have levers to pull with the providers. Without that accountability I don't think we will see the savings or even see improved care.

**Sen. Townsend**

- No one is looking at this as an easy fix, but I think that the key is figuring out the timetable to get this right. We need to have a structure of dialogue and oversight to get this right.
- The two broad topics we need to figure out are provider capacity, including data, and if it is new spending or comes from within the current spending.
- What would be a reasonable timetable? It cannot be a prohibitive challenge that care is expensive.
- I understand the cashflow challenge, but when the savings are proven to be possible, you can identify which patient profiles are the ones most likely to generate immediate cost savings. So why aren't we doing that?

**Emmilyn Lawson, AmeriHealth Caritas**

- There is a certain level of maturity practices need to achieve those savings. I think the conversation needs to be how do we accelerate that process so that those savings are not two or five years out.
- We can share learning on how to get to those savings. From a payer perspective what is scary is that we cannot simply turn the investment loose with providers. It requires a very careful partnership by all involved to ensure that that timeline to get to savings is short and realized.
- How do we make sure that the savings are realized?

**Nick Biasotto, MSD**

- Change can be made with the stroke of the pen can be done, as with SB227. We are now being brought up in reimbursement.
- The primary goal is keeping primary care physicians in Delaware.

**Dr. Fan**

- The preference is not to make this additive.
- I don't like punitive measures, but I do like accountability. To payers, the accountability is cost savings from providers.

**Kevin O'Hara, Highmark**

- I don't have anyone in the marketplace paying for this. If it isn't additive, then what are the guardrails we are willing to work within.
- We don't know that our payment model is not working yet. It is not yet 3 years old.

**Chris Morris, Aetna**

- We have to deliver value, and we do have that in some programs. Not all primary care providers are in those programs though.

**Dr. Jeffrey Hawtof, Beebe**

- Part of the problem is the more successful practices are, the more mature they are. Nothing we can do today will speed that up, unless you pull more into the successful models. If you think of it less like ACO and think of it as a CIN, the payers will contract with the CIN. Now practices have the ability to leverage the experience and readiness of the network.
- We work well with our Aledade doctors; it doesn't matter if they are in our ACO or not. If we all do it right, then we are all happier.
- So I do think we have models where this can be done. The key factor is if we can capture the money already being used for care coordination and move it down to the practice level.

**Sen. Townsend**

- I understand the payers have their programs, but they are not working.
- Moving forward there needs to be a different approach. Are we talking about broad guidelines with requirements, or are we talking about an approach with specifics?
- We are not on a trajectory to get where we need to be.

**Jennifer Schwartz, Christiana Care**

- There is not meaningful risk right now for the providers. It changes how you plan, the systems you set up, and how you staff a practice.
- There needs to be some broad parameters on what the levels of risk are meaningful for practices.

**Rep. Bentz**

- Can we talk about what meaningful risk means?

**Jennifer Schwartz, Christiana Care**

- That will look different based on the organization.
- The risk that Christiana is willing to take on is different. And that number might be different for Medicare and Medicaid.

**Dr. Jim Gill, MSD**

- Maybe you guys are coming up with a solution.
- Someone needs to be at risk down the road. You have to be in an integrated entity to be successful. In the future, practices will either be in an independent network, in a system, or they will be concierge. Maybe we can put the money up front, but the ACOs take the risk and part of the payment goes to building the infrastructure.
- Use the money spent on care coordination by payers as upfront spending in the form of $15 pmpm care coordination fees starting July 1, and hold practices accountable through ACOs. To play you need to be an ACO.
- Solo private practices are not going to take risk.

**Dr. Fan**

- It doesn't matter what kind of practice you are in to join ACO. You could be PCMH or not.

- In this model is there still room for a smaller practice who doesn't want to join an ACO to get a pmpm, but less than an ACO?

**Steve Groff, DMMA Director**

- I do take offense that the care coordination from our MCOs does no good. I don't think that's true.
- We do have special populations and I want to know how we protect them if we just ship this out providers. Are providers equipped to handle home modifications for individuals with very specialized needs? We could carve that out.

**Dr. Fan**

- This conversation is not ended. Next week we will continue this discussion and talk about an implementation entity. The entity is about monitoring and enforcement.
- You should be prepared to discuss what sort of entity you can live with.

**Dr. Tom Stephens, Westside Family Healthcare**

- The care coordination cannot be done all at the provider level, in particular for a vulnerable population. On the flip side, there are a lot of patients that only want to speak to the provider.
- We need to have these conversations and the flexibility so that it is not one-size-fits-all and automatically all at the practice or payer level.

**Dr. Jeffrey Hawtof, Beebe**

- Similarly, with MSSP they segmented accountability into four populations with different health needs.
- You can absolutely figure out the most appropriate place to do the care coordination for specific populations.

**Public Comment:**

**Dr. Andrew Dahlke, President of MSD and Beebe Board Member**

- I think we have one problem to address and that its data collection. You cannot change bad behavior without it. With MEDnet we don't get the data from AmeriHealth Caritas that we need. We use Health EC to mine the data.
- We will have trouble collecting the data for the APCD.
- I see this as a three-year plan, but until we can get the data to the physicians in a timely manner we cannot change outcomes.

**Tyler Blanchard, Aledade**

- We work with independent physicians only. We are in the first Medicare ACO in the state to achieve shared savings and we are going to two-sided risk. We collaborate with the other ACOs.
- This problem is urgent. We had a practice that we got to hand a big savings check to, but they moved to a concierge model the next month.
- We have immediate challenges and savings may not enough. And practices just starting today are years away from having a payoff.

- There is technical infrastructure needed. We spend a million dollars each year to operate our infrastructure in Delaware. We are VC backed, so we have a long time horizon to achieve returns.
- We work with those willing to take on risk. We are bankrolling most of the downside risk, and reaching realistic agreements with practices for downside risk they can tolerate.

**Rep. Bentz**

- You may have noticed we are pushing a bit more at this meeting. We just need to move forward. We were spending more time talking about the problem at the last meeting. We are appreciative of everyone's time.

**Dr. Fan**

- We are trying to answer a need. We heard that there needs to be more discussion among the stakeholders. We need to invest in primary are. We are getting to the hard questions of where does that money come from.
- If you have information you want to push out that supports your point, please send it to Jules and Read. If you feel there is information that needs some research, let us know that as well.
- For homework for next week, come prepared to continue the discussion from today and to discuss the implementation entity.

**Meeting was adjourned at 8:00 p.m.**