SB 227: Primary Care Collaborative Meeting

Monday, March 4th, 2019
6:00pm-8:00pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance:

Present:	**Email:**	
Senator Bryan Townsend	Bryan.Townsend@delaware.gov	
Dr. Nancy Fan	nfanssmith@yahoo.com	
Representative David Bentz	David.Bentz@delaware.gov	
Staff:		
Read Scott	Read.Scott@delaware.gov	
Juliann Emory	Juliann.Emory@delaware.gov	
Attendees:		
Katherine Impellizzeri		Aetna
Kevin O'Hara		Highmark
Wayne Smith		Delaware Healthcare Association
Vince Ryan		Department of Insurance
Representative Ray Seigfried		House of Representatives
Kathy Collison		Division of Public Health
Andrew Dahlke		Medical Society of Delaware
Kim Gomes		Byrd Group
Kathleen Willey		Quality Family Physicians
Mike Wornt		Aetna
Margaret Defeo		AmeriHealth Caritas
Rosa Rivera		La Red Health Center
Susan Conaty		Delaware Coalition of Nurse Practitioners
Kristina Thompson		AmeriHealth Caritas
Gary Kirchhof		Highmark,
Anthony Onugu		UMACO
Kiki Evinger		Department of Health and Social Services
Dr. Karen Feeney		DCS
Sylvia Canteen-Brown		Delaware Pediatrics
Jennifer Mossman		Highmark
Liz Stabler		Aetna
Chris Morris		Aetna
Steven Costantino		Department of Health and Social Services
Gary Seigelman		Bayhealth
Dr. Christine Donohue-Henry		Christiana Care Health Systems
Karyn Scout		AmeriHealth Caritas
Lizzie Lewis Zubaca		Hamilton Goodman Partners
		Christiana Care Health System

Faith Rentz	DHR
Lisa Zimmerman	DMMA
Pam Price	Highmark
Jamie Clarke	Nemours
Steve Groff	DMMA
Geoff Heath	Christiana Care Health Systems

The meeting was brought to order at 6:00 p.m.

Dr. Fan

- The Collaborative doesn't feel we will come to consensus on everything. The point is to take a deeper dive on these topics. Whatever we can take back as consensus would be useful.

Dr. Art Jones, HMA

- We have agreed that in addition to fee-for-service, we need value-based payment revenue sources
- We talked about three different areas: care management, shared savings to shared risk, and pay for performance
- These models reinforce each other. You can choose to do one of these alone, but we want to move towards an accountable delivery system that includes all three.
- There may be primary care physicians in the market that are not integrated and cannot do shared savings.
- There has to be some possibility for independent physicians to move to value-based payments.

Tom Fitzpatrick, Highmark

- If they are all interrelated isn't there another category of FFS? In that FFS category, I would include the chronic condition and care management fees.

Dr. Art Jones, HMA

- Agreed. This was focused as VBP, but this could be FFS too though.

Steve Costantino, DHSS

- Does it assume everything is under an ACO?

Dr. Art Jones, HMA

- The handout says clinically integrated network; the slide says ACO.
- The assumption is that some integration among providers is necessary to be prepared to take on shared savings or risk effectively.
- Not too many groups have enough attributed population to do shared savings or shared risk within an acceptable degree of impact of statistical variation.

Steve Costantino, DHSS

- If a provider wanted to be a PCMH and not an ACO?

Dr. Art Jones, HMA

- If they had enough attributed lives they could do this alone as a PCMH. Whatever the entity is, they must be big enough to have sufficient attributed lives and the capabilities to manage the total cost of care.

Gary Seigelman, Bayhealth

- Payment is not the only thing that impacts the ability of providers to be successful.
- I have some thoughts on payment models, but there are other burdens like administrative burden.

Dr. Art Jones, HMA

- The administrative burden has come up in other meetings and we recognize that there are also other ways of investing in primary care such as tuition payback programs and support for investment in HIT.

Gary Seigelman, Bayhealth

- Standardizing the quality goals and simplifying the administrative goals.

Dr. Art Jones, HMA

- I think where we do not have total consensus but have agreed on some aspects.
- We will not be able to talk about individual contracts, but what we are trying to do is to agree on some principles so that whether you are the payer or provider group you understand where the other side is coming from and where there is agreement or not.
- Under care management fees, there is an upfront pmpm with task accountability. We have discussed that we do not want duplication of services with clear hand-offs in roles and responsibilities. Whatever the amount, the pmpm should be paid up front and there should be clear accountability.

Dr. Christine Donohue-Henry, Christiana Hospital

- Would there be legislation on the delegation of care management to this entity?

Dr. Nancy Fan

- We don’t want to be too prescriptive.
- What we are looking at is what principles you want to agree on to sustain primary care.
- We want to increase primary care spending. And the follow up recommendation is to move to value-based payment models.

Dr. Christine Donohue-Henry, Christiana

- Would the payers also maintain their care management function, in addition to the CIN level?

Dr. Art Jones, HMA

- I think what it comes down to is laying out the tasks and having a conversation about who is most suited to accomplish those tasks.
- Part of that has to do with the population and the entity's capability to do care coordination and care management.
- We would not be prescriptive here, but we would encourage a clear discussion on the tasks.

Karyn Scout, AmeriHealth Caritas

- We are in the Medicaid space and our requirements may look different than those for other populations.
- We might require a higher level of care coordination based on our contracts with the state.

Tom Fitzpatrick, Highmark

- What do you mean by "related to a percent of the premium"?

Dr. Art Jones, HMA

- Before we get to that second bullet, the first bullet means that if it is really a care management fee, the dollars must be used for that particular purpose whether in staffing or other resources for care management.

Tom Fitzpatrick, Highmark

- How is that different from the chronic are management fees?

Dr. Jim Gill, MSD

- Chronic care management is only for a small subset of the population.
- Care management fees would be for everyone, around $15-20 per month.
- Chronic care management applies only to individuals with at least 2 chronic conditions and who require the practice to spend 20 minutes in a month on care coordination.

Dr. Art Jones, HMA

- The value has to be taken from two perspectives. It has to be an amount that can reduce total cost of care even after incorporating the cost of the CM fee but also support the cost of doing the service.
- This group is not supposed to dictate a specific value.

Tom Fitzpatrick, Highmark

- The JHU folks had a presentation previously, which showed that the pmpm that generated savings was not $15-20 dollars.

Dr. Nancy Fan

- That presentation was just an example from other states. They were not prescriptive for Delaware and what works in other states might not work here.
- The number that Dr. Gill is throwing out is his own proposal.
- We want to hear what everyone can do to get to the increased spending in primary care.
- If there is point where the cost of the pmpm cannot support an ROI, then we need to do consider that evidence.
- Tonight we also need to discuss a funding proposal, an oversight body, and other sorts of primary care investments.
- We should all agree that the care management fee is for staffing and infrastructure and not just for chronic care management.
- The pmpm must support the service and provide an ROI.
- We are not going to legislate what the right number is. We will legislate how to increase primary care spending.

Dr. Art Jones, HMA

- For a CPC+ Medicare population, they pay $15 on a blended rate, but on an average $800 per month premium. That is 1.8% of premium.
- You have to understand your population and what you are spending. The savings potential depends on the premium costs as well. The care management fee must be proportionate to the health care costs and savings potential.
- If you are going to provide a pmpm, what is the accountability to contain the total cost of care? Develop the shared savings arrangement accounts for the medical and care management costs. The expense for care management is included in the share savings arrangement. The MLR might get adjusted as the administrative cost to the payer changes.
- With pay for performance, we want to choose key metrics. Align the metrics to the provider with the financial incentive of the payer and also align metrics for similar populations across payers as much as possible.

Gary Seigelman, Bayhealth

- This is not a trivial issue. It took us a year and a half to build the CMS metrics in to the EHR with high usability and accuracy and consistently.

Chris Morris, Aetna

- We have standard clinical criteria we use, we just want to ensure that the metrics have enough value to be meaningful.

Kevin O'Hara, Highmark

- We tried to stay as close to the Common Scorecard as possible. For all the measures we have in our program, we can tell you where they came from and we have a 80% compliance with Common Scorecard.

Dr. Fan

- All payers have about 80% compliance with the Scorecard. The difficulty is trying to meet the specifications of each specific plan. That would be a technical discussion on how to make it easier for providers to data mine the metrics and demonstrate that they are meeting the metrics.
- When we are talking about pay for performance, agreeing on the standardization to reduce the administrative burden is an area of savings for the practice.
- That would help enhance pay for performance and uptake.

Dr. Art Jones, HMA

- You have 80% overlap in metrics; can you have a discussion of the 20% other metrics?
- We are not suggesting that there is a certain number of metrics. The total number of metrics needs to be limited to a number that is reasonable for a provider. Metrics will vary by population.
- Providers start their baseline performance at very different places. The providers will look at their benchmark performance and decide they will or will not participate based on if they think they can succeed.
- One strategy is to provide some reward for improvement over baseline and then provide additional rewards for making the goal.

Chris Morris, Aetna

- It is a quality improvement program; if they are hitting a metric and best in class we won't look for improvement.
- The program is very collaborative. We review the metrics with the provider each year.

Dr. Art Jones, HMA

- Does anyone have a problem with the principle?

Tom Fitzpatrick, Highmark

- Is it practice improvement or improvement over the market?
- We believe it should be improvement over the market. If you have a low performing practice, we should not be paying for marginal improvements.

Dr. Art Jones, HMA

- The problem with that approach is that you will not engage them in quality improvements.

Jamie Clarke, Nemours

- Performance has to be measured at the practice level. On appropriate risk adjustment to compare with the market.

- With a unique patient population, we do not always have an appropriate market comparison. We are open to similar children's health systems in other areas, but comparison to the market is difficult in a small state like Delaware.

Dr. Christine Donohue-Henry, Christiana

- Struggling with the clinically integrated network vs the provider level performance.
- The decision of whether you are going to incentivize someone to improve is a discussion for the CIN level that will be implementing the strategy. The CIN would take on the risk and decide how to implement quality improvement.

Margaret Defeo, AmeriHealth Caritas

- It does sometimes take an investment to get a practice back to the median performance.
- It might be worthwhile giving consideration to the practices not getting any incentive and assessing if they would improve with an investment rather than letting them fall out of the program.

Dr. Art Jones, HMA

- The idea is continuous quality improvement. The experience shows that providers assess how likely they will be to succeed. They will not participate if they don't think they can hit the target.

Chris Morris, Aetna

- This is why we have different models.
- We do measure practices against their historic performance. In some models, like in pay for performance, we have greater expectations.

Tom Fitzpatrick, Highmark

- We are having a hard time having a client pay for this program if we are paying out for improvement in a practice that doesn't correlate to cost savings for client.
- How do we square that for agreement?

Dr. Art Jones, HMA

- Sounds like we do not have agreement

Gary Seigelman, Bayhealth

- It is a process. Not sure the details can be worked out. Some of it is selling it to the client. If you want an employer to have a long term strategy, they need to understand that we need to improve the system overall.

Dr. Fan

- If we are going to talk about consensus, we need to be flexible. If we are talking about small practices, the metrics should be against the practice level. For an ACO or ICN, then incentivizing to beat the market might be a better strategy.
- At some point there needs to be a trigger for the payers to say that we have given you a timeline to meet a benchmark and you haven't' met that. I think providers are comfortable talking about that.

Steve Costantino, DHSS

- There is a gate and ladder approach. To create a true benchmark with a higher incentive, with smaller incentives for continuous improvements.
- Usually the more you improve the harder it is to improve. You might have a hybrid approach to accommodate both issues.

Dr. Art Jones, HMA

- For the minutes, should we say there is some disagreement on how we reward for improvements?

Tom Fitzpatrick, Highmark

- I think we would like it marked as reward based on practice improvement or market improvement.

Dr. Art Jones, HMA

- If the market improved, and a provider showed some improvement, but didn't get to the market level, should that provider be rewarded?

Tom Fitzpatrick, Highmark

- That is not where we are in agreement
- We would not provide a reward in that case. If the practice didn't move over and above what the market did, either that practice's starting point is too high from a cost perspective or too low from a quality perspective.

Dr. Art Jones, HMA

- Moving onto shared savings to shared risk.
- First, if savings are created, they would be between the CIN and the plan.

Kevin O'Hara, Highmark

- Would the split be 50/50?

Dr. Art Jones, HMA

- The split varies by provider and by year in an agreement. This means that you as a plan will enter into a shared savings moving to shared risk. This is saying that you think it is important to enter into these arrangements.

Gary Seigelman, Bayhealth

- At some point there have to be some parameters. Is it based on amount of risk or the amount of investment?

Dr. Art Jones

- That is part of the negotiation between the plan and provider.
- There are details of a shared savings arrangement that we will not be prescriptive on such as target medical loss ratio.
- There will be an agreement that there is a transition to shared risk over time.

Tom Fitzpatrick, Highmark

- It will depend on the definition of time.
- We have set forward a transition to risk over a 3-5 year period. We have said that for a long time. We cannot afford to have providers in upside only plans forever.

Dr. Art Jones, HMA

- Does the group feel OK on a time of 3-5 years from shared savings to shared risk?

Chris Morris, Aetna

- As long as the risk is within that frame. That really depends on the provider.

Dr. Jim Gill, MSD

- I am mostly just agreeing, assuming that a provider is made whole with the various aspects by paying for these other things. The timeline of 3-5 years is fine.

Tom Fitzpatrick, Highmark

- Doesn't that run counter to the care management expenses as part of the risk pool?
- Those costs would be part of the total cost of care in the shared savings program.

Dr. Jim Gill, MSD

- I am not disagreeing on that. Once you pay for care coordination, it becomes part of the total cost of care. The mechanism by which you pay for care coordination is not though the shared savings.

Dr. Art Jones

- The care management needs to be paid prospectively pmpm. In calculating the shared savings, the care management cost is accounted within the total cost.

Tom Fitzpatrick, Highmark

- Looking at the worst-case scenario, assume we paid $100k in care management fees but the ACO lost $100k. When we do the shared savings calculation. Assuming we are in

50/50 arrangement, they will have to pay back $50k, which is 50% of the care coordination fees.
- We are agreeing to pay care management up front, but we will recoup with losses.

Dr. Art Jones

- Yes, if you are in a shared risk arrangement.

Dr. Fan

- What we are trying to say is that the transition to shared risk is exclusive of the care management fee.
- With a 3-5 year timeline, are you talking about a total cost of care or what level of risk? I think there are areas we could use greater definition.
- You don't have to have all three elements in this slide to do this.
- Your care management fees do not mean you are in a shared savings to shared risk model.

Tom Fitzpatrick, Highmark

- I think we would disagree with that. We cannot pay care coordination fees without realizing savings. We wouldn't agree to pay care management fees on top of chronic condition management codes if there wasn't shared savings and shared risk.

Dr. Christine Donohue-Henry, Christiana

- I think 3 to 5 years is too passive and will not transform care.
- I think we need total cost of care at the CIN level. The money the payers already spend on care management would be provided to CIN in a delegated model. That spending should cover the care management costs.

Dr. Jim Gill, MSD

- I think we are losing the premise. The path is not total cost of care. Shared savings is not the answer.
- Poor primary care in Delaware is the problem. The way to get better primary care is not total cost of care or shared savings. The answer is better care through care coordination and PCMH.
- The current solutions the payers have come up with will not work.

Dr. Christine Donohue-Henry, Christiana

- There is a way to do that and support the primary care physicians and protect them against that risk. The CIN is larger and has the capacity to help support them.

Dr. Jim Gill

- Any model cannot include total cost of care or shared savings up front.
- The pmpm must come first, followed by pay for performance, then shared savings.

Sen. Townsend

- There are things that we need to do, we are missing the point if we are getting distracted by secondary concerns.
- I think your point was this has nothing to do with value-based care necessarily. There are things we need to do to deliver good primary care.
- I hear you say that we are so skeptical that this framework is going to work if that framework is not acknowledging the fundamentals of what we need to provide before we get into measurements, risk, and attribution

Dr. Jim Gill, MSD

- Primary care is valuable. You need to pay for the fundamentals, which includes care coordination, if you want to move to an even better system.

Sen. Townsend

- Risk sharing isn't inappropriate, but the care management piece needs to be considered fundamental and central to good primary care.

Chris Morris, Aetna

- This is why we have a glide path. We look at the care coordination as an investment in year one. We expect to have value though, so they will be at risk eventually.

Dr. Fan

- I don't think there is a lot of disagreement.
- I think the disparate starting points of practices is the difficulty. There are some practices or systems that can do all of this, as long as their care management fee is sufficient.
- We need to have consensus that we need a greater upfront investment in primary care.

Margaret Defeo, AmeriHealth Caritas

- I think I heard from the payers that if they were going to do provide pmpms, by year 3 you need to claw back the care coordination fees for performing worse than the market.
- If we were all investing in care coordination, taking away that little bit of investment away wouldn't be helpful.

Dr. Fan

- I want to hear from Tom and his team about the previous discussions, anything you want to bring forth.

Tom Fitzpatrick, Highmark

- A little bit on my heels hearing that total cost of care cannot be a driver here. That is the whole reason we have been participating and that is the only way it will be sustainable. Otherwise you might as well just go to the clients and ask to increase spending.

- We looked at the savings created through our program. What if we pulled those dollars forward into the next year and set aside for care coordination for the following year.
- The cost savings associated with the program is about $4 pmpm in the True Performance program. We would look on a pilot basis to add that savings to our existing care coordination fees as an upfront investment to get these practices invested and stabilized in an effort to move to risk. In essence for the first year or two, we would front end load and socialize the savings across all the practices. That is the best way for us to jump start that glide path to risk. This is counter to what we have historically done and what we do in other markets.
- But to not acknowledge total cost of care is not something we can sign up for. We need to reduce total cost of care or we will have a problem.
- We want all practices involved. Hopefully the Collaborative will mandate participation in these programs. We would be willing to do this for all practices. We believe in that middle box of shared savings and risk. We do have parameters for practices to participate currently. The ACO or CIN could help a practice meet the minimum attribution to participate.

Gary Seigelman, Bayhealth

- I think one of the things that is important is that there has been a tremendous amount of investment in population health. That includes investment in people: population health nurses, data analysts, etc
- That infrastructure of the ACO has shown some real improvements; the quality metrics have been high. The ACO has come under the benchmark set by Medicare meaning that Medicare is saving money relative to what they are doing nationally.
- We can leverage this existing infrastructure, not necessarily in a mandated way, but allow practices to participate in the CIN. The CIN can help with the technical challenges of contracting.
- Having a network that you are working in can be a great benefit. This is a model that would provide a great number of benefits.
- You could design how much risk falls to the providers. Most of the risk in the ACO falls to the health system, not the primary care providers.
- This uses an existing infrastructure to address quality and outcomes.
- The assumption is that if you are improving the quality of care, you are flattening the cost curve. If you can do that there are dollars to pay for what the primary care doctor needs to do.
- The payers will save money because the providers will be taking on more risk.
- If there are reductions in utilization per capita there will be savings.

Dr. Fan

- Current ACOs are all Medicare and you are talking about expanding to commercial.
- The incentive to support primary care comes from the infrastructure and cost is already built in a network.

Dr. Jim Gill, MSD

- Current ACOs are not just Medicare. We work with Highmark commercial.

Steve Cosantino, DHSS

- The ACO penetration outside Medicare is minimal. Hence the Medicaid RFI.

Chris Morris, Aetna

- We have two commercial ACOs in Delaware.

Dr. Jim Gill, MSD

- Generally I am in agreement. It probably will work better if clinicians are in CINs.
- The caveat would be that there are some practices that want to do it on their own. We might end up where we need to figure out what to do with the providers who cannot join a CIN. We need every primary care provider in the state, so we cannot ignore anyone.
- As for the funding part – there is money in the system now. Probably need some up-front fees, then the risk would come later. How much later is up for debate.
- The funding is not contingent on risk up front.

Dr. Fan

- NPs as independents should have parity.
- If they have an independent practice within the CIN they do not currently have parity. They assume the same risk and same funding stream and same reimbursement parity with physicians.

Gary Seigelman, Bayhealth

- I personally wouldn't want to speak to that.
- The APRNs are providers and we want them working toward these goals. They also need resources. I'm not sure that parity is an assumption.

Dr. Christine Donohue-Henry, Christiana

- There are structures within that track and measure providers for that clinician's panel. We assume that APRN would be an equal provider in that assessment.

Dr. Fan

- I think a lot of this could dovetail together.

Dr. Jim Gill, MSD

- The medical society also put together a proposal. I have a summary version.
- This is built around the AAFP advanced primary care alternative payment model. This has been approved by PTAC.
- It puts costs into the four quadrants.

1) Payment for preventive acute and chronic care
2) Care coordination fees
3) Performance based payments
4) Fee for services items that just don't fit elsewhere

- This is not a total cost of care model .
- The most important points are what level of spending goes into primary care. We need to standardize how we measure that. There is a good report from Milbank that talks about that.
- Right away start the care coordination. The $15-20 pmpm is supported by studies from Commonwealth and AHRQ. We are happy to discuss the appropriate level and the balance between what it costs to provide and what is feasible.
- In a year or so, build in performance-based measures. We need to move away from HEDIS to other primary care measures, like how much do you do coordination of care, continuity of care.
- Then the risk would be introduced. If you agree to a basic level of risk, you get the basic payment. You cannot take risk if there is no upside. You can be eligible to be at risk if you have an opportunity to get higher measures.
- The shared savings would be the same idea. You should be eligible to get additional money if you share costs. You should be responsible for the cost if you lose money.
- Putting everything into capitation would be a stepwise approach. What gets left over would be high cost.
- We have a lot more details where with how we came up with these numbers.
- The whole thing could be in place January 2022.

Tom Fitzpatrick, Highmark

- Difficult to follow on the phone. We would like to reserve our comments until we have a minute to digest.

Dr. Fan

- We are definitely talking about pay for value, care coordination, shared savings and shared risk.
- These were in all three models.

Kristina Thompson, AmeriHealth Caritas

- Offered to pull together our care coordination model so we have that.

Dr. Art Jones, HMA

- Some of the details we can agree to the principles and the details need to be negotiated between payers and providers.

Steve Costantino, DHSS

- Care coordination can in part be put at risk?

Dr. Jim Gill, MSD

- They can be put at risk based on measurements. It is really important that these metrics are transparent. The data to measure these things need to be available to the provider.

Steve Costantino, DHSS

- What is at risk? Let's say you didn't meet the measures.

Dr. Jim Gill, MSD

- Let's say the basic care coordination fee is $17 pmpm. Part of that would be at risk if you didn't meet these measures. And you could get more than that as a performance incentive.

Steve Costantino, DHSS

- The only thing at risk is the 15-20? What is not at risk is total cost of care or any of the potential savings?

Dr. Jim Gill, MSD

- That would be part of the shared savings risk. The eventual goal is to get to capitation.

Chris Morris, Aetna

- If you don't deliver value, the entire care management fee is at risk?

Dr. Jim Gill, MSD

- The concept would be that the incentive has to be as great as the risk.
- The care coordination fee isn't something extra. It is a basic payment.

Chris Morris, Aetna

- You could have other cost savings and risks

Tom Fitzpatrick, Highmark

- They really are extra dollars. You don't need care coordination for you low risk patients.
- We are already paying chronic care management fees for your high risk patients. To have a flat dollar amount for everyone is adding extra dollars.

Dr. Jim Gill, MSD

- Everyone needs care coordination. Someone without any health problems still needs care coordination.
- Chronic care management fees don't kick in unless you spend more than 20 mins per month and the patient has 2 chronic conditions.
- There is a misunderstanding that this is something else. We are not getting paid for we have to do and the infrastructure to get this work done.

Dr. Fan

- When we talk about total health care spending, care management is not additive to the total health care dollars already being spent.
- Care coordination fees are a foundational investment. It might seem like additional dollars, but we need to make it not additive. The answer to leveraging primary care investment without making it additive.

Chris Morris, Aetna

- We are not supportive of an additional fee, but we do have care coordination in place where it is an upfront investment. It does become at risk, but not in year one.

Sen. Townsend

- There needs to be some level of agreement of what it takes to get it right.
- What does it take to provide the services we are trying to provide here? If you have the data to back that up, great. Those examples from the last meeting are from states that have different primary care situations, with less crisis.
- So much of the tone of tonight doesn't seem to involve the kind of agreement I thought we would have.
- You have to provide in a primary care context a certain level of service. The initial payments need to be up front and come from somewhere, but the amount can come from savings elsewhere.
- If you agree on a set of services that are needed for different populations, there is a lot of savings available in the system by doing it right. I don't see from the payers a philosophical commitment to the shared incentives and achieving this.

Tom Fitzpatrick, Highmark

- I think your comments are misdirected. We have participated from the beginning. We have talked about our programs' care coordination fees. We are objecting to the amount and the level of these fees. We have shared data to support this. We simply referenced the only piece of data from the JHU. We are happy to look at the evidence supporting higher pmpms. We haven't seen that level of pmpm anywhere.
- We put together a proposal to front load care coordination fees, but we cannot do it without savings associated because otherwise we are just increasing total costs. We shared in the first meeting that 70% of our members are attributed to a primary care provider, that is the highest across all our markets. There are engagement issues in all of our footprints.
- The comments are misdirected because we haven't been an impediment to this.

Chris Morris, Aetna

- We want to get primary care providers all involved in one of our models.
- What I am trying to explain that there are complexities. Some of the smaller providers get smaller fees because they cannot take as much risk.

Dr. Kathy Willey, Quality Family Physicians/MSD

- I am a family doctor. I am an NCQA Level 3 medical home. I have 2 years left on my lease and we are closing. I have made it though 20 years of capitation, meaningful use, HIPAA, and the number one reason I am closing is because I cannot tell you what my cost of care is.
- I do great on the quality metrics. Care coordination is done without the physician involved.
- The problem is when I sit down I cannot get an answer for how I can control the external costs. There is not one report that comes in and tells me how to address those costs.
- The care coordination is taking care of the patient when they are not in front of you.
- We cannot get this to work. If we don't invest in this you are going to have a state without primary care doctors.

Rep. Bentz

- That is why we are here. Because we are talking about a business, we loose sight of the customers who are looking to access primary care.
- This was always going to get harder before we have a breakthrough. Some amount of consternation is the sign of a good compromise.

Dr. Fan

- We have not set any more meetings. There is lots of room for discussion.
- My vote is that the three of us will discuss the next direction and where the meeting should be. I want it to include everyone at the roundtable right now. Having your input is very valuable.
- I think you need to think about the original recommendations that we will be building off.
- Oregon and Rhode Island have great ideas, but we need to hear what you are comfortable with in terms of authority and accountability.
- The next steps will be the Collaborative discussing what we have heard so far.

Wayne Smith, DHA

- Talking about giving the authority to cap hospital rates is detrimental to what we are trying to achieve.
- Everyone involved in hospital based primary care knows that they lose millions of dollars. We are the back stop; our primary care providers are in areas where there aren't independent primary care providers.
- The idea of taking money from hospitals is counter to the goals.

The meeting was adjourned at 8:00 p.m.