AFTERNOON SESSION

(1:20 p.m.)

MS. WARNER: I think we can get started for the next session, which is actually going to be lead by Tom Romeo from IBM. He is going to take over for the next session.

MR. ROMEO: Thanks, Michelle. My main speaking partner left the room. There she is. (Laughter.)

MR. ROMEO: I agreed to facilitate the session here. I struggled a little bit with the topic. The idea was to bring up some state examples of program implementations. So I did some research and found some. I'm going to take those as the context of some of the return on investment and business case and business value that comes from some of those programs, but Rhonda is first going to talk about her experience in Georgia and the efforts that are underway there.

DR. MEDOWS: I thought I would start off with a disclaimer. We know that we've got lots of room for improvement and opportunity, and I'm more than interested in hearing some feedback and some discussion about some of the things that Georgia has proposed to do and some of the things that Georgia is doing. We also know that we are not the end all/be all. And I think coming into this discussion with that type of an attitude and acknowledgement helps.
Georgia, unlike some of the states represented here, is a little bit newer to the HIT world and the HIE world. What we tried to do is play catch up in some areas and also to try to lead in others. When we look at the world of HIE, we looked at it in terms both of the state, in terms of the community health leaders, so stakeholders, so the health plans, the commercial health plans, the payers, providers, et cetera, what they can do for HIE in terms of expansion and adoption across the state and then what the state government can do as well. So I want to speak to that and I want to talk about two different bodies of work that interconnected, but at the same time you realize that there are two tracks that come along at the same time.

One of the first things that we did and some of the things some of you have already done, and that is engaging in state leadership. That meant not only have legislation passed, but having executive orders, having governors submit basically to set the tone. A lot of states have already done that. The next thing we had them do other than just participate and was in support of the state itself, not just the government, was not just to start the adoption of HIA, but also to go ahead and create an advisory panel, which would be step two, which is the
inclusion of the state leaders. And again, a lot of states have already done something similar where we've actually brought in payers, providers, doctors, labs, diagnostic centers, hospitals, nursing homes, pharmacies, et cetera, come in.

Some of the states have managed to go to step three, the establishment of a not-for-profit entity to govern that. We haven't gotten to that point yet. That's where our next goal would be. And then what we did with the advisory council—all of these stakeholders from across the state actually create the community-based HIE grant program.

There's a big debate about whether these grants are true pilots as opposed to the funding of the huge, statewide one-time allowed, which is more effective? For us it wasn't much of a question. There is always so much money that we had, so we went with the pilot.

What we did have was have the actual advisory council create the criteria. In order for them to create the criteria for the grant, we had to actually understand both the common language, the common goals and guiding principles that we could actually create the criteria. That meant that people who didn't already understand and know the value of HIE as well as the challenges and barriers had to understand it. They also had to speak the same language as you can probably read.

In Florida, doing this kind of work we...
We had to have the same language. We were in our second year of the community-based HIE grants and part of the key stipulation was that the grants had to be awarded to partnerships. Partnerships had to be public and private. They had to include payers and providers. It could be any provider type and they had to actually exchange information from one entity to another, not just an exchange within an entity. So if the hospital wanted to have its connected clinic, they couldn't. They had to have an outside entity. There had to be an actual exchange, getting them to actually first develop and then to actually build it and then be able to actually measure it—each success. That's kind of where we are with that. Then, perhaps because we thought this would just be way to easy and comfortable for us, we added a couple of other things to this advisory council. We made them responsible for actually coming up with a way to develop a transparent website. It's not controversial enough just to exchange information. It has to be transparent to use it, too. So those people on the advisory council...
are at the end of their second year or about to look at deployments going forward. But that was our first major step. And again, a big step a lot of other states had done a couple of years ago for some and some are just now starting to do.

That was kind of our most basic way of doing the first wave of awareness, education, support, and promotion of HIE. Then while all of this was going on, we also had some folks over in the state government itself actually come together and be responsible for actually what the state would do as a leader and a partner in the HIE world. So the same poor staff, the staff of the advisory council had to have another job and that job was to look within state government health programs and say what's our responsibility? What are we supposed to be putting on the table? We can't go out and continue to say a commercial health plan—two doctors, two hospitals. That's all we need to get up to speed with HIE. What are we going to do for our part?

In Georgia, I'm lucky as well as at times challenged to have the three major health plans in one agency and one department. That helps tremendously. I think as somebody mentioned earlier before—I think it was you. If you don't have state health plans at the table, how do you leverage that? We have Medicaid. We have SCHIP. We have the state
health plan in one department. They have one crazy commissioner, namely, me who basically says don't make me go nuts. Have one strategy.

One of the things that we know that we can do on a consistent basis across the board is we are outsourced out to the max. In Medicaid, we have three GMOs. In our benefit plan, we have 17 different health plan partners. We're narrowing down that range, but as we do procurement and as we do contract renewals, we are putting in stipulations. You have to do health information exchanges. It's the standard order of business and we have to define for them the basic elements of the HIE that we wanted--the interoperability requirements, the ability for them to work on the Medicaid side, EDS, Applause. Then we have to basically tell them, listen, this is what we're going to do and you have to have it done by such and such a date. And by the way, when we do the evaluation at the end of the year, we're not evaluating the providers. We're also evaluating the health plans on meeting the benchmarks that we set.

By next month, we will award two new statewide health plans--state health benefit plans. There are 17 plan options. There will be two. Those two will provide HMO, PPO. In each of those product lines, they have to do health information exchange that allows the health plan members to move from plan
to plan and take their information with them as they move around the state. So that's on that side.

On the Medicaid side, we have a proportionate fee for service--Medicaid, DH1 disabled, and those individuals are primarily locked into disease management programs. Guess what, when they renew their annual contracts, they have HIE requirements as well. We have three CMOs that take care of the low-income Medicaid children. For our state there's three of them. One of them has already come in with their proposal. They're required to come in under the renewal contract with their HIE plan. One of them actually basically heard what we said about E-H-R, the Medicare and have already pledged to pay their providers who are E-H-R-capable and above on a 3 to 5 percent higher reimbursement rate and to negotiate a discount for them when they go out to purchase. And ECHIP certified system. They're coming in with their ideas already.

MS. WARNER: I'm sorry. Are you saying there was a bonus?

DR. MEDOWS: A 3 to 5 percent higher reimbursement rate if they're using E-H-R in their practice to provide patient care. That's kind of setting the standard for some of the other to match that or improve upon that. We're not trying to dictate to them how they provide the incentive, but...
that's one way. I'll talk to you about some of the incentives. Some of the physicians have actually proposed to us include on the table for other health plans to consider. Yes, sir?

MR. PLOUCK: Are your rates then that you would propose to pay to that provider will they go up 3 to 5 percent as well or is that coming to you at the state?

DR. MEDOWS: Are they going to try? Probably. Are we offering to pay for that? No. We're actually telling them we already know, actuarially, what the sound range is. And you have to come to us with that proposal and this is not an add-on. We've been looking at their rates a little bit and we're going to bill as medical. What we're going to basically do is try to tie it to actual quality improvement in years two and three. Right now, we just want the adoption. So we're kind of mimicking a little bit the Medicare stuff for the adoption is the focus of the first year and then the different functionalities are being rewarded to a different degree than first year, then the second year the actual data in compliance with the actual reporting; and then year three to five. There's the actual meeting and exceeding actual performance measures, clinical performance measures. Those are the key things we have with
SCHIP and Medicaid fee-for-service and managed care. Then we went a little bit beyond the scope of the department itself and went into other departments. It's just way too easy and we need more challenge. One of the things that came up on our list were concerns about mental health drugs. Probably a lot of you have heard that too. One of the key complaints that we've heard from providers, patients, advocates, and people who pay their way was when a patient, a beneficiary--whatever we want to call them--is in a Medicaid program, but moved out of the Medicaid program to another state health funded program, particularly, mental health drugs as well moved from one state agency to another they have to go through a different PDL or perhaps something along those lines. Wasn't there a way we could provide some kind of continuity of care going across? So the commissioners for the Department of Juvenile Justice, the Department of Corrections, Medicaid Program, the SCHIP Program, then we have the Department of Human Resources, the Foster Care, people who are in state mental hospitals, public health, the county health departments--that kind of thing--were actually going to put together a prescription drug exchange so that people who are treated in those programs can actually
have an common exchange of information as people move from one program to another. That information can be accessed by the prescribing physician who is taking care of them so that if somebody moved from SCHIP and then the child goes into DJJ and then into the Medicaid Program, the physician in each of those places—sometimes it's the same. Sometimes it's not—can actually figure out what they've been on, how long they've been on it. This exchange of information and then they look to keep them on it. If they were on any anti-psychotic—something along those lines, they would not have to retrial. They would remain on the same medication.

MS. EVANS: How are you developing that?

DR. MEDOWS: We're busy in Georgia right now trying to figure it out.

MS. EVANS: The state's procuring it?

DR. MEDOWS: Absolutely. It's across the four state agencies. We house the Office of Health Information Technology within my department. We're going to take lead in coordinating effort. We're starting off with first the community grants. We're still developing people in the community to be up to speed.

MS. EVANS: Is public health outside of your department?

DR. MEDOWS: Today it is.

(Laughter.)
DR. MEDOWS: Today it is. You know how the states go through these things were we have a huge mega agency. The administration comes down and they break it all out and then another administration comes in. They put it all together and they kind of break it back out again and they twist it around and turn it upside and flip it around and then move it again. We're in the flip it around, move it again. We'll see where it lands. So we just include them in the conversation and in the planning because we never know the charge. Our efforts change is truly an exchange across the agency and the state agencies are also--just because that's way too easy and we need more of a challenge, we're trying to basically contract out the best it can for the prescribing component to feed into.

Most of you are aware that the different departments are funded in different ways. Some of it is state appropriation. Some of it is from separate federal dollars. So each of us has to figure out a way to do the e-Prescribing. We can actually use common knowledge when we do those procurements.

That's kind of in a nutshell some of the bigger pieces that we're trying to achieve and we're trying to bring ourselves into the 21st Century. One of the things that we wanted to do as well was to figure out if we could bring the health plan to the table, we can invite employers, other payer sources
to come in and work with us on these things. What we need to do is actually get our physician community engaged and then the Medicaid demonstration project came out to focus on physician practices and we realized we'd have some discussion and work on that, and there was an opportunity for us to use it as the way to actually have conversations with the physician and that physicians in general would do the procuring. They've done a little bit of their own work by themselves when they come to the table, so this is what we did, took a bunch of physicians, we put them in a room and we locked the door. They put up a big white board. What would it take for you and your colleagues to join the new E-H-R? How could we possibly incent you?

I said I'm going to put the first two things on the board. Number one, give us all the money. Number two, don't over regulate us. Put those two up on the board. Now, you have to go from there and work your way down. I thought, if I could, I could share with you a couple of things they said. This is the way that it helps me to remember them. Maybe it will help you remember what they said, too. I'll break it down to you in four basic groups, sets---drugs, money and rock and roll. Okay.

For all of you who thought I said sex, get your minds out of the gutter. The money part they talked about how can you help us with our startup
4-23 12-45pm.txt

costs? We want to participate, but this is a lot of money. We're small physicians, practices. I said I can't buy you your computers. I cannot buy that for you. That's not in the Medicaid budget. What I can do is do some things that help you have less costly startup costs. How would you like me to help you do that? One, how to negotiate a discounted pricing on E-H-R? I, and a physician practice, with one or two I don't have any kind of leverage.

Number two, can you bring together all of E-H-R vendors who have a web-based system? We don't have to just keep re-engineering and building. We don't have to do all that. We just basically turn on the computer and it's there. If something goes wrong, there's a phone call we can make and they service it. We kind of like that. Can you help us do that?

Number three, we have all figured out that it's not just a matter of you putting or we putting a computer in our office and having software. Somebody has to figure out workflow. Can you help us negotiate a contract, as a group, that will allow these consultants to come in at a reasonable rate and help us figure out how do we actually do this in a meaningful way that makes sense? A lot of us have
these really huge paperweights in our office that we call computer terminals. We have no clue how to do it and they're out of date before we can turn them on. That's kind of the money piece.

In addition, they talked about can you pay me at a higher reimbursement rate? Are you willing to do it for me in the beginning as a P4, little "p"-pay-for-participation first year or the second year?

Then later can you do a fee for big "P"--pay-for-performance because then I'm pretty confident I can take care of my patients. I've been doing it all along. I'll be very much into this technology. I don't know how to demonstrate to you that I've actually provided it to you. And then they said, okay, we're willing to do that. And then this is where I thought that there may have been a plant in the audience. Somebody said, yes, can you do fee-per-fee kind of like those Bridges to Excellence people? I have a strong suspicion--where is that guy?

(Laughter.)

DR. MEDOWS: They talked about can you tie that up because a couple of us in the State of Georgia already--can you do that across-the-board for several different disease states. And by the way, well, this is included in that program. Can you do that for us? That's the money part.
mostly can you do what you did in Florida. Can you actually provide us a new Medicaid Program and then SCHIP and e-Prescribing and can you talk to the PDM vendor? Can you talk to them about getting under a pilot on e-Prescribing? By the way, we don't want just the technology, sending our prescription from the office to the pharmacy, but we want some of the clinical guys. We want to have all of your state-sponsored PDMs loaded in once more. Can you do that for us? That's on their wish list as to drugs.

On the sets side, they basically said, you know what, we like the money. We really, really do. We like the drugs part, too. But one thing that is a nightmare for us every one of your plans--your health plans and the commercial plans come up with a whole new set of metrics to measure us with. And honestly, there can't be that many ways that you measure diabetes. Please, can you help us promote the use of a single set or uniform set? Can you all just decide to do the Medicare one or there's an excellence one. Pick one. Can you fix it to a uniform way?

The Rock and Rollers because I had no other thing to call it there was a ton of little things that actually could add for them. They said, you know, in addition to workflow, assessments and stuff, can you help encourage vendors when they come in to actually be there for two years or more to give the tech support they're supposed to do? Sometimes
they sell us a system and then they leave. Adios.

MR. CULVER: The act of God category.

DR. MEDOWS: What we wanted docs to do was say can you regulate them? Well, no. But if it’s a discount maybe you could purchase it yourself as a health plan and be one of the customers because we know that you’re not going to put up with that crap, so maybe that way. We said, oh, this is an interesting idea. Actually, medical health practitioners they said you know we’d be willing to lower the cost of a premium for malpractice insurance for physicians who actually have E-H-R. Another person in the group said we want tax credits and then somebody said, you know, you can actually get a tax credit now at startup. And they said, no, we want more. We want tax credits. The workflow redesign I put on the table that was actually a big, big piece of the discussion for that group. We don’t need them just to sell us stuff. We need to know actually how to use it.

Here was the last piece. Hold onto your hats. They said, you know, some of us actually are ahead of you. Some of us already have systems in place. We’re using them effectively. It happens to be already the CCHIT certified--whatever that acronym is. We’re already there. We already get it. We’re smarter than you. We’ve been there. We want to serve as mentors or champions. And we think that if
get other physicians on board. But here's the little catch. It's going to cost you a little bit to do that, but we'd be willing to do that because we can get out where you can't.

Then the last one was you guys have these vendor fairs. You have EHRs. People come in and they're showing all the bells and whistles and stuff. Our preference would be to have actual physician customers be with them and actually talk about what the experience was really like because so far we're hearing everything from walk on water to you know solves world peace--the whole nine yards. But we'd like to hear from somebody who actually has been through the implementation and can talk realistically about what it felt like to go through it. That was their wish list and gave this wish list to the next people in the room.

The health plans--eight major health plans, national health plans that operate in the State of Georgia. I also had a couple of large employers in the room as well. We put them in there. We gave them a list. Lo and behold, nobody blinked.
Nobody fainted. Nobody ran out of the room screaming. They actually worked to fine-tune the list. In addition to the evil queen, which would be me---that's in our contract now. You have to do it. They actually worked with us on fine-tuning the list and they're coming back to us with how we could actually do some of these incentives in their own contracts with the providers and their networks. That has been an instructive piece for us. That's pretty much all I have to add.

MR. ROMEO: Questions or comments for Rhonda? I can move on and talk a little bit about some others, but it's a dead match. It combines some of the things that Francois talked about with what Rhonda just talked about. I can probably do that very quickly, and then we can have a discussion from there.

(Slide.)

MR. ROMEO: As I thought through the major roles of state government, Rhonda just touched on all of these. The first is really other convener/coordination catalyst that has to set policies for the exchange of data and things that have come up in the room like how do you get around some of the privacy issues, malpractice. But it's also the technical standards for the exchange of data and usually who's going to have access and at what time. I think actually, over the last few years,
there's been a lot of progress made in that aspect to help coordinate that.

The second is, as an employer and a buyer of services for health plans, Rhonda talked about the leverage that you have there as a big buyer for forcing people who want to participate in that to be part of the equation. I'm going to talk a little bit about the numbers. I think New York State has 6 billion a year in employee health plans. And then, as a payer, which is the Medicaid side, obviously there are billions of dollars there.

(Slide.)

MR. ROMEO: I stole things that were publicly available and the first one was Lori's--the definition of the role I think of the coordinator/convener. So this is from the New York State website that defines the role of Lori's office.

It's a pretty dead match for some of the kind of things that we talked about.

(Slide.)

MR. ROMEO: I also stole one from Michigan. I think they're similar in the convening and the guidance and the direction for the programs. We worked some with North Carolina. Colorado has something similar, I think.

(Slide.)

MR. ROMEO: When I think through those efforts, to me, they are critical but not sufficient.
components of the sharing of information. You can't share information if you don't have the infrastructure to share the information. What's been missing in a lot of the discussion, I think, is why aren't we sharing the information? What's the point? When we've been involved in some of these pilots, it's a fascinating exercise but they don't continue because they don't have the driving business value of their own that keeps them running afterwards. I think the incentives may come from the buyer and payer role of the state—if we could flip to that.

(Slide.)

MR. ROMEO: This really is just some of the things that Francois was talking about. Eighty percent of the costs in the U.S. health care system are on 20 percent of the people who are already in multiple chronic care illnesses. Holly made the point earlier that it's not the point to treat them better. The point is to catch it before it gets to that point.

(Slide.)

MR. ROMEO: This actually is IBM's view of the health care system, but I changed it to say it's the state's view of the health care system, which says that the costs are unsustainable. We work a lot with Medicare. They've been in the news a lot lately about their curve and its unsustainability that there's suspect quality. And you can look at where
the U.S. is ranked. There is a lot of studies about our quality of care and that there's more focus on sick than at the health care. There are some interesting studies right now. I just read in the newspaper yesterday that for the first time the life expectancy of women in the United States has gone backwards. I think it's because of obesity, diabetes and chronic care problems.

(Slide.)

MR. ROMEO: Incentives—to improve performance there's a lot of talk in the room about pay-for-treatment.

(Slide.)

MR. ROMEO: I don't think these are surprises to anyone. It's all results-based transparency and more active treatment.

(Slide.)

MR. ROMEO: This is an IBM strategy, but if you put yourself in here as a state of what the components are of looking at a full value for health care—and I'll talk about what IBM's doing, but only as an example. Would that work in our state? The first thing is patient-centered care. That really is some of this medical home. Potentially, it's the level of consumers that we talked about, but I want to mention it here before I forget. There's a group
called the Patient-Centered Primary Care Collaborative. For those of you in this state who are looking for partners who would bring large employers into plans together that’s a great source to tap into, to pull it in. You can go on the website. It’s got some of the participants, but they promote the ideas of medical home, getting in front of disease treatments, the payment methods for incentives.

We use our purchasing power to drive a lot of the change, list the way Rhonda talked about going to the people who bidding to do your business and you say if you want to do business with us, this is what I’m going to have to see to convince me that that’s the right thing to do. If I looked at that and said, if every state was saying that this primary care initiative or getting in front of wellness is something I’d better see in your bid to me and then the federal government who buys 40 percent of the care started to act that way too and the employers who provide 65 percent of the coverage all started to talk the same talk, it would change. So those who are dug in now, some of the payers, would have to change because their business would depend on that transparency.

We’ve done some other country. We bid Denmark and the transparency is amazing. You can log
onto a portal with your physician. He will say you need this surgery. Here are the hospitals and the rankings that they have for the surgery that you're asking for. Here's the schedule for you to get into that hospital. So let's work on it together. What are you willing to pay to get there? But we push hard on transparency when we leapfrog some of these other efforts to do that. And then the employee-center culture of change, Penny and I were having a conversation. This may be the hardest part--the consumer changing. So IBM does this neat thing where they pay me $150 to do a health assessment on the personal health record. I have that personal health record they pre-populate and I claims data all of my lab tests and any reminders that I need from my health assessment. So for $150 I went and did it, obviously. But I have to say after a year of mucking with it a little bit my physician wasn't interested in it. It becomes sort of a futile exercise. Why am I doing this? What drives my behavior eventually is going to be that I'm paying a lot of the costs and I'm going to get much more involved in paying for it than I am now.

Some of these primary care things, by the way, in Maryland right now I have some friends that have done this. There are VIP medical services. So groups of physicians will say pay me $2,000 at the beginning of the year. I'm going to see a third of
the patient population that I used to see and you'll get 24/7 coverage. Any time you need me I'll be there and I'll manage your full spectrum of care. What worries me with that is it creates a divide for people who can afford that kind of care versus the rest of the population.

(Slide.)

MR. ROMEO: This is just a little bit on our personal health record, but IBM has gone. So I got $150 to do that. I get $150 to sign up for stress management program or a weight loss program or have my children do a health care assessment or populate their personal health records. We do have disease management to offer the employees, but the important pieces of that may be on this.

(Slide.)

MR. ROMEO: We're self-insured. We spent $2 billion annually to insure 500,000. We've invested $20 million a year in the health and wellness programs and have a hard dollar result of $100 million a year. What do I mean by "hard dollars," less visits to ERs, less visits to physicians? This is less missed days of work, which would actually add into the equation. So it's $100 million. Pitney Bowes did a similar program at free clinics fitness programs. The results have been that their growth in health care costs is in single digits. It's not in double.
Microsoft is paying $6,000 per employee and 80 percent of all the costs for employees who are 40 to 50 pounds overweight and they'll say that they have more than reaped the reward back. So there are cases out there that help.

(Slide.)

MR. ROMEO: Partnership for prevention I looked at a broader set of health promotion programs that show the same thing. Then I went through and looked up the states and there are a lot of states that are already doing a lot of this. What I don't see a lot is maybe what Rhonda talked about, bringing that together with on their efforts in the states or on the health IT adoption and the Medicaid plan that the doctors just need more patients that are going to pay for performance. The more people that pay into it the more doctors are going to buy it.

(Slide.)

MR. ROMEO: On the Medicaid side, probably a lot of you heard about the North Carolina work. They focused on chronic illness for their Medicaid patients. They hired an outside consultant to come in and do an audit for them for the financials, and they say with $20 million spent they saved $235 million. When you look at how do you fund the infrastructure, if you can bring it altogether, you could probably build a pretty strong business case.
that says, well, I saved money here and I've paid for the infrastructure to get the work done. When I drive that behavior, the physicians need the electronic information and do the pay-for-performance, so it starts to drive the whole thing.

(Slide.)

MR. ROMEO: My conclusions on all of this, and I'd like to open it up for discussion, it's very easy for me because I don't have to drive any of these states to do any of this is that the role of the state employee health care plan and mitigate really can add a lot of dollars into the equation if you can get them. And I realize that in most states those are separate organizations, but you could sick like the PCPCC on your state employees health plan to go have them work it for you. The medical home models require information, so if you're paying for that behavior the electronic health record piece is going to come because they have to have them to be part of the model to get the reimbursement.

The state employee health care program can use their buying power to help that and to leverage what's already been done. There was an article in the paper last week that Medicaid discontinued their pilot care project because they were spending more
than they were getting. How does that add up to what we're talking about? One of the things IBM has done for a long time is have someone in the disease management role separately—one of those companies that will call your employees and try to make sure that they're participating in case management. It hasn't worked. You need the primary care physician to be the one driving the behavior. That's where the trusted relationship is. If somebody calls you up out of the blue and says, gee Tom, we really think you should do these things. You're like yeah, yeah, yeah, go away. But if you're physician's doing it and he's looking at your data—and Holly talks about electronic monitoring that's a different scenario.

I don't believe that it's the chronic care program didn't work. It's that the implementation of it wasn't an effective implementation. They are doing some medical home pilots of their own.

MR. LEVINE: Most of the successful chronic care programs work collaboratively with the physician. Were all the ones in the Medicare program not doing that?

MR. ROMEO: They were disease management.

MS. THOMPSON: Normally, they're engagement models with call for interaction with the physician exactly the same participation generated from the physician, but there was a lot of criticism of how patients were selected for participation in
the chronic care demonstration. This point that Holly raised earlier about where are you in the life cycle. The intervention point has to be earlier enough to make a difference in the course of treatment. The feeling was, well, at least from the diseased management company perspective that the patients that they were given were too late in the life cycle for their intervention and engagement model to make a difference.

MR. LEVINE: Right.

MR. ROMEO: That's really what the North Carolina thing was. They got in front of the problems before they happened. So they're expanding now and tomorrow the medical home model, trying to engage more on the prevention.