Brian Kalis: Welcome to our discussion about “Reimagining Provider Networks and Care Delivery.” Over the past few years, we’ve seen the emergence of new and novel care models that blend people and technology in new ways to provide members with personalized options to manage their health and healthcare. In response, health plans are innovating their networks across preventive, chronic, and catastrophic care with new primary and specialty care models so they can align population risk and address barriers to access and affordability. This panel will explore the emergence of these new high-performance networks and will also examine health plan perspectives on creating closer payer/provider partnerships and alliances as part of these strategies.

My name is Brian Kalis with Accenture’s Health Practice, and I’ll be moderating today’s discussion. Today, I’m honored to be joined by our panelists for the discussion as well. Let’s begin with introductions, starting with Sonal.

Sonal Kathuria: Thank you, Brian. Sonal Kathuria, similar to Brian, I’m a Managing Director in our Accenture Health Strategy Practice, where I lead strategy for health payers.

And Brian, as, you know, I spend a lot of time with my clients working on care delivery innovation, value-based care, and affordability issues. Very excited about the panel, and I’m very excited to be here. So, thank you for having me.

Brian Kalis: Thanks, Sonal. Toyin?

Toyin Ajayi: Hi there, name is Toyin Ajayi, I’m a primary care physician and the Chief Health Officer and the Co-founder of an organization called Cityblock Health. We are a provider organization that delivers integrated primary care, behavioral health, and social services to primarily high risk and rising risk populations of folks who are insured typically under Medicare or Medicaid, or are dually eligible for Medicare and Medicaid. I’m really delighted to be here with you.

Brian Kalis: Great, thanks Toyin, and Mark.

Mark Margiotta: Thanks Brian. Always impossible to follow Toyin, but I’ll do my best here. I’m Mark Margiotta from Tufts Health Plan. I’ll give you just a few quick points that I think will help color some of my comments today. I work at Tufts Health Plan, which is a 1.1-million-member plan, serving
Brian Kalis: Okay, great. Thanks, Mark. Let's begin by looking at the current state of affairs. Sonal, as a starter, how would you describe what the current state is when it comes to reimaging provider networks? And how do you see new primary and specialty care models fitting into those emerging networks?

Sonal Kathuria: Brian, with COVID, many of those reimaging opportunities have been accentuated, like we're seeing across healthcare. When you look at COVID, and you look at typical pair networks, what's being done? Out-of-state needs to be the same as in-state. Access needs to be the same for virtual and face-to-face.

We're in a situation where our medical, behavioral, and pharmacy issues are all bound up in one. What does that network mean? When retail needs to be shifted to mail, and hospitals, when they can't see someone, need to offer virtual care. So, networks need to be thought through with that lens. And some would say, some parts of network are at risk. There's potential volatility with what's going on with the economy and furloughs and this postponement of elective surgeries. It's a very interesting time because as we all know, traditional health plan networks are built upon unit cost negotiations, period, full stop. “Blues” have a better chance of being able to negotiate that unit cost. Nationals are different, and that's sort of how it's been across hospital networks, across specialist networks, across primary care. What's also happening with COVID, and even outside of COVID, is the growing use of health-related digital technologies. Now you have scheduling the applications. There are tools available, and regulatory reasons why you need to convey both the cost and quality transparency of data and services you want to be able to utilize. There are virtual visits, obviously, that have gone up, what? 60% to 80% with physicians. A big proportion of that is mental health and similar care. Could these tools eventually give consumers the ability to create their own hyper-narrow networks? This “atomization” of the provider network is very telling. The challenge for reimaging networks is how do they use networks as a vehicle to right-size and align care where primary care is brought in as this hub to be able to orchestrate that care, and then they can align care across hospitals. I think that's the challenge and the opportunity.
Brian Kalis: Great, thanks, Sonal. So now flipping it a bit, Toyin: more to the new primary care models, and maybe building off what Sonal mentioned, what are you seeing in terms of need and the innovation in new primary care models generally? And specifically, can you share more about the Cityblock model and what led you to creating Cityblock in the first place?

Toyin Ajayi: Yeah, absolutely, thank you. So just maybe a little bit of background into how I got into this work. Prior to co-founding Cityblock, I was the chief medical officer at a health plan also in Massachusetts—Commonwealth Care Alliance—that focused specifically on caring for and ensuring folks who were dually eligible for Medicare and Medicaid across the age spectrum. And from the vantage point of a payer, my experience really, which led to the inspiration for Cityblock. We found, as a payer, that as you contract a network of primary care providers, many have panels of some of your highest risk, most complex, most high-need, highest-utilizing individuals. Typically, that 10% drives up to 60% of spend for across any book of business. What we found was that most primary care providers were not equipped to fully own and deliver across the value proposition for the member and for the plan. And the goal here is to fully align incentives. A lot of providers didn’t have the infrastructure or the technology or the data or the field-based care management capabilities to effectively manage that risk and then effectively integrate care. So, we were essentially creating care management from the health plan perspective and trying our best to wrap around a pretty heterogeneous provider network, where the providers had very different capability sets and lacked the focus necessarily or the orientation to deliver what the members needed. That for me was a huge part of the impetus to found Cityblock.

I'm a primary care provider, and I continue to see patients. I'm deeply passionate about the idea that the primary care physicians and providers in practice, in the community, are best positioned to deliver on what their populations need. They are best positioned to understand not just the physical health, but also the behavioral health and the social drivers of poor outcomes. They can hold and then deliver alongside that longitudinal trusted relationship with that member. If we can equip our primary care providers in the network and in the community with the right tools, data, analytics and infrastructure, we'd actually get the outcomes that we're looking for, especially for those folks who need us the most and who have the highest and most significant needs. And so, that meant creating a business that is built for risk relationships with payers. One that is oriented around populations with the greatest needs that are very frequently not the populations that most venture-backed startups in the health tech space go after. However, they have a huge amount of opportunity that is oriented around delivering primary care, behavioral health and social care. Both as a primary care provider itself, but also in partnership with existing providers within a payer's network, helping to reinforce and bolster the infrastructure around those members with the greatest need. This is part of an ongoing trend. We've seen massive tailwinds in states and CMS creating opportunities for payers to push risk to providers to deliver on what we know works from a field-based care management, care coordination perspective. Our model has been to fund medical, nonmedical and social needs, as well as deliver on the physical health and behavioral health needs of a population, and to bring it all together in one service offering. The genesis of our model is contextualized within a broader impetus to move towards these types of innovations.
**Brian Kalis:** Great. Thanks, Toyn. Now let’s dive into how that’s working and how are you seeing some of those collaborations with other payer partners you have in the network? Mark, we’ll go to you with that. What has Tufts been doing to reimagine its provider networks? And how do new primary and specialty care models fit into those strategies, specifically the Cityblock relationship you mentioned in your intro?

**Mark Margiotta:** Sure. It’s funny listening to hear Toyn talk about the founding of Cityblock because in many ways the challenges that she experienced in her prior role at CCA are the same challenges we were coming up against in our under-65 duals product and led us to the relationship that we have today. I’ll give a little bit more context. These are very similar themes to what Toyn hit on, but from a pure payer perspective. Tufts Health Plan was traditionally a commercial payer. And we’ve since grown into the public plan space through acquisitions and new product launches. At its core, though, as a plan, we view our job as connecting members with the providers that are most appropriately resourced to serve them. Trying to create those connections and, as we move more toward specialized product lines and specialized communities within our markets, trying to match them together brings more challenges. I think the hyper-narrow network, Sonal, that you’ve mentioned as a concept would be even more challenging for the under-65 duals populations and duals populations in general. Many of those networks are about care pathways and taking a clinical lens.

As we’re trying to solve for these more specialized populations, we’re finding ourselves having to blur the lines between what’s a traditional plan roll, what’s a traditional care management role and what’s a traditional provider role. That’s because we don’t really fit in those silos anymore to actually deliver care or deliver networks for our members that work for them. We’re trying to step back and say, what are the gaps that exist and let’s solve for those gaps. Let’s throw out some of the old norms that exist about what a payer is supposed to do and what a provider is supposed to do. So for Cityblock in particular, for under-65 duals products, our approach was pretty similar to what Toyn mentioned. That is, we have an internal care management staff that is trying to enable members to utilize and connect with our traditional provider network. And this wasn’t just any provider network. It was certainly focused on a Medicaid population. It involved very mission-driven providers. But despite our best efforts, there were still limitations to that model because of the disconnect between the care management relationship and the providers. Regarding the roadblocks, Toyn hit on a couple of them and I’ll add some thoughts.

I think there are no providers in our network who are uninterested in serving this population. Even the most sophisticated will say, “I have not figured out how to do under-65 duals and how to do a risk arrangement.” And so you add that to provider engagement, whether it’s a relatively small population or timely access for acute needs, think of behavioral health, transitions of care. We weren’t able to leverage the network in the way that we wanted. The theory with Cityblock is, if you take an integrated care management and provider partner, they can flex to where the member needs. Is it care management for a member who’s really connected with their own care and in the network? Great. Is it an acute bridge moment, where there’s a transition of care that’s particularly at risk?
And so, you can have a behavioral health visit, you can have a primary care visit, and you’re getting that member back into the network. Or, there are some cases where a member will choose Cityblock as their longitudinal primary care provider. And we’re okay with that because we know that the volume is really going to stay with our network in general. And if that member needs something that Cityblock can deliver, then we want to provide that. It’s a unique model that they have to fill this gap for a specialized population. And when we realized we didn’t have a competitive advantage to fill in this space, Cityblock are the smartest folks in the room on this sort of area, and we wanted to partner with them. But the last thing I’ll say is, I think anytime we’re trying to set up something like this that’s new, their ability to back it up with their balance sheet and take risks when they are providing such a small sliver of the traditional care to members, the provider care went a long way. And I think it really shows the confidence that they have in their own model. And I think that helped us get comfortable internally.

Brian Kalis: Great, thanks, Mark. Mark, maybe to add a different twist on the question, and Toyin you can add in as well. Now that you have the model in place and have been operating, how have you had to adapt in response to COVID-19 to support your members?

Mark Margiotta: Sure. I’ll say for the existing population and the risk arrangement that we have, it’s been a really a great thing to have Cityblock there. They’ve been able to maintain the ability to go into members’ homes with the appropriate PPME, and they have providers on the ground. They combine the virtual capabilities that they already had with their provider mentality, and really haven’t skipped a beat, which is to their credit. And I think we feel great that we have them in the market. But what’s going on with COVID really sharpened our minds and sort of accelerated our thinking. We thought about this for the under-65 duals population, but there are at least some elements of Cityblock’s model that make a lot of sense for other populations potentially or higher risk subpopulations within other product lines. And so we’ve stood up a fee-for-service model, really a pilot where Cityblock is leveraging some of their capabilities to still be in the home during this time, as well as their virtual capabilities. We’re proactively outreaching based on both data reviews on risk levels and on referrals to members within our Medicaid MCO population, within our individual population, and for our under-65 duals members that weren’t underneath the umbrella of the capitation. It’s really early days, Brian, but we’ve seen examples where we can intervene and bring in a provider like Cityblock, to deliver a differentiated network experience for our members.

Brian Kalis: Great, thanks, Mark. Toyin, are there any additional things you would add related to how you’ve had to modify and kind of adapt the model on the fly, to respond to members’ needs?

Toyin Ajayi: Yes, absolutely. And just thanks to Mark, it’s no surprise that this has been a collaborative and very enjoyable partnership to work with someone who understands the value proposition and the opportunity to improve the outcomes for their members collectively. Even before we knew COVID was on the horizon, our model has been tailored to populations that have historically been the hardest to reach, folks who have significant mistrust of the healthcare system, and also who have significant access barriers to healthcare.
These tend to be the individuals who don’t see their PCP frequently, who have struggles with transportation or with meeting their other social needs that create barriers to them accessing traditional fee-for-service clinic-based healthcare on a regular basis and with the efficacy that they need. We’ve built our model to be a sort of omni channel, to meet people where they are. We talk about that from a philosophical perspective in terms of building trust, but also very practically, our care teams and our model are predicated on the idea that we go to our members. In pre-COVID times, that often meant going in-person to their homes and to the community. Most of our care was delivered, most of our care coordination was delivered in-person, in the field, in people’s homes, in community centers, accompanying them to their PCP visits and other visits within the network. It also meant staying in touch as much as possible through every modality. And we have deployed technology largely to allow us to stay in touch with our members through SMS, through telephone, through video visiting to some extent, before COVID. And so it was pretty natural for us when COVID hit to ask the same question we’d asked before, which is, “What do we need to do in order to be there for our members and meet them where they’re at?” At a time when, you know, it was really increasingly more dangerous for people to leave their homes. At a time when people were increasingly more frightened and mistrustful about going to the hospital. When people were increasingly more isolated, and when we had to safeguard the wellbeing of our care teams. So, we pivoted very quickly, as most providers did, to virtual visits, where in-person care was not required. We scaled up our use of video in particular, and started to prove that, contrary to common belief or lore, low-income, dually eligible, Medicare, Medicaid folks with disabilities can engage with technology if provided with the right supports. We’re able to do a lot of our work virtually.

However, we recognize that no matter what you are able to do virtually, there are some folks, for some needs, who need in-person care. And they need it fast. And they need it from a provider that has access to their entire medical history. They need it contextualized with the ability to meet needs, providing in-person medication reconciliation and education for somebody who struggles with intellectual disability and has problems reading, and also has perhaps 15 medicines that they have to remember. That is an encounter that requires an in-person interaction, usually with a pharmacist or with a clinician on our team. This goes all the way through to folks who were having shortness of breath, had COVID symptoms, and were suffering from exacerbations of their underlying medical needs. We found that a lot of providers and specialists within the network weren’t able to meet people’s needs during the height of COVID. We had folks who hadn’t seen their nephrologists for three months and were struggling with symptoms that may have been due to a worsening of their kidney disease. The ability to go into folks homes right away, to manage them in the home, and then to apply some of the clinical tools that they needed was really important. And so to Mark’s point, we very quickly ensured that we had PPE in place from the very beginning and protocols in place to enable our clinicians to get to people’s homes. And we intensified that during COVID and beyond, so that we’re able now to get a clinician into a member’s home with less than an hour of turnaround time.
They can check labs, put in IVs, give antibiotics, give fluids, communicate with the patient’s primary care doctor, and manage their acute needs in the interest of really keeping them safe and at home. And it has benefited us tremendously in our relationships with payer partners, where we are at risk longitudinally for the total cost of care and for quality outcomes for the population. And it behooves us to make sure that our members are not going to suffer from excess mortality and morbidity as a result of unmet needs during this COVID time. It’s important that we can stabilize and continue to manage people’s acute and chronic needs, ensuring that at a time when COVID has restricted their access to other services, that we’re filling the gap. And that’s always been part of our model and our approach to meeting folks where they’re at and ensuring that we deliver the care that they need when they need it.

**Brian Kalis:** Great. Thanks, Toyin—

**Mark Margiotta:** Brian, can I add one thing there? I want to highlight one thing Toyin said. Toyin just articulated the value proposition for the rapid response during COVID. But she also mentioned how Cityblock has focused on reconnecting the member with their primary care physician and bringing them back into the network. It’s a question I am asked a lot: how do they fit in the traditional network? I think Cityblock is particularly good, but this model in general, and this concept of innovative networks, enables you to fill this gap; you’re solving this problem where there’s an opportunity to extend that primary care so that primary physicians care for this member in some ways. And even in the acute moments like this, it is still possible to bring them back to that network because the member has a longstanding relationship with that provider.

It’s really about extending that network and expanding the capabilities rather than getting in the way, which is not the goal. Even in this intense moment, I think it’s important to flag how Toyin thinks about it. And I think that’s how we at Tufts Health Plan think about it too, because network providers are such an important stakeholder for us.

**Brian Kalis:** Thanks, Mark. Makes sense. To build on that, we’ve talked a fair amount about serving the needs of complex patients, specifically those in both Medicare and Medicaid. Sonal, do you have a perspective of how are we seeing similar types of innovations happening in the commercial sector?

**Sonal Kathuria:** We always say in healthcare that commercial follows Medicare. It’s time that we also think about commercial innovation. And don’t get me wrong: there has been a lot of innovation in commercial networks. We have seen micro-networks in situations where a network is built right around the hospital system. And we’ve seen payer/provider collaborations or joint venture models that really accentuate that and keep everybody whole within that network deliverable market share as well as obviously allowing a “petri dish” of some sort to be able to manage care. We’ve seen pockets of direct-to-provider contracting. Now, the issue and the challenge with direct-to-provider contracting for large employer groups, is you have to have geographic or regional density. Otherwise, it’s hard to orchestrate that. We’ve obviously seen narrow networks with AHCA and the exchange population.

But I think what we’re talking about now, which COVID has accentuated, is a situation where more employees and consumers are foregoing care because they haven’t met the deductible.
And, you know, a big proportion of today’s employer-sponsored insurance is covered under high deductible plans. It’s a very different forum to really think about and reimagine networks. Payers have mostly taken the lens of, you’ve got an HMO network, you’ve got a PPO network, or you’ve got a narrow network. But I think there’s an opportunity to think about a value-added network, which focuses on not just an annual contracting cycle with a purchaser, but on what type of care does the purchaser segment need. And obviously, you and I are part of consulting. Consulting companies and their mobile populations have very different needs in terms of how they access and consume healthcare to somebody who may be in a manufacturing facility or a different kind of industry. So again, bringing in that industry focus and focusing on different cost structures by segments. There are lots of available opportunities. And if I have to frame it: I know we have talked about product innovation that’s required. The question is how can you take network innovation and align the provider side of the equation with how you pay providers and build networks, and the consumer side of the equation with how you align consumer incentives? And I think that type of alignment is required to really manage risk. If there are instances of managing elective care, how do you cover that? Do you have a network that just focuses on elective care? And obviously, with COVID, what got accentuated the most is that we all understood that the large delivery system business models focus on commercially-delivered care and commercially-delivered reimbursements to keep them whole. We believe there’s a massive opportunity to be able to reimagine network.

The other part of reimagining the network obviously has to include lens of value. Are there opportunities now in these times to go and build and look at closer parent/provider collaborations? Are there opportunities to look at closer care provider collaboration with delivery systems or primary care communities in your marketplace that may be at risk? So those are some of the sorts of the emerging themes that we’re seeing. But to me, the most fundamental is whether a payer can really figure out how to align both the provider side of the responsibility with the consumer and really deliver a more innovative network that’s rooted with innovative products that are not built on an annual contracting cycle. I think that’s going to be key. And we’ll see more of that.

**Brian Kalis:** Great, thanks, Sonal. I think a big part of that often comes down to data and what type of data you might need. Mark, please explain how data play into both shaping and executing on these strategies? Also, could you speak to different types of data than we may have seen before?

**Mark Margiotta:** Sure. So much of a what Sonal was saying resonates. So much of building these networks and aligning them—the providers to the members—defines the populations and the appropriate networks. Data are going to be critical pieces of that. For a traditional, commercial or individual market, you’re taking the claims data plus all of the demographic data that you have and trying to build cohorts and come up with real products that are interesting. But for the under-65 duals population, the more specialized population, we have care management, we have encounter-type touchpoints. How do we layer those on, to further refine and specialize?
Intuitively, we understand that and we're working on it. But frankly, and humbly, we're not there. As we get smaller and as we get more specialized the conversations, especially in the complex populations, the conversation quickly sounds more and more like a care pathways conversation and a clinical conversation, which means that you're now constructing networks where you have to have a product specialist in the room, a contracting specialist in the room, and a clinician in the room to try to really think about how do you construct something that even makes sense for a population? That even if it's hyper narrow, it still has to make sense for some group of members. That part we have not cracked yet. I would say that it is something that we're actively working on. Both from a technology standpoint, and I'd say from a human resources standpoint. Making sure that we have the right folks in the room for those kinds of conversations.

As we work on this and try to work through it, I think more about how do we understand at scale and in some sort of analytical way what we're hearing from members? Because we can have a million data points that are, you know, often passive, but our goal is the stuff we've talked about with Cityblock all the time, which is how do we build holistic care plans for members that are member-driven and member-led? We're just trying to enable members to make choices, to use the network that we're providing them. If we're able to pull that in, those are the best data points. It's certainly aspirational. But the challenges we see in trying to have reliable collection and synthesis of the data that we already have, I do find myself wondering a lot about how do we get even better at listening to the members and what they need, and try to structure that?

Because I think if we can do that, that's the best data point that we can have, but it's also the hardest one to collect. It's not a great answer, Brian, because it's a challenge that we have, but we certainly think a lot about it.

**Brian Kalis:** Thanks, Mark. Sonal, you mentioned a lot of these things are not traditional types of data. It isn't all just claims or encounter data or just clinical.

**Sonal Kathuria:** A lot of it involves conversations like, "Well, what do you need in your life that may not be medical?" Whether it's transportation, as you mentioned, Toyin, food needs, or if there are issues with isolation, and how do you identify some of that? Toyin, is there anything you would like to add? How are you grappling with that or trying to do the best you can to build out, getting that information you need to serve those needs?

**Toyin Ajayi:** Yes, absolutely, that's a key component of our model and our approach. And what is so interesting in this conversation from the plan's perspective is you have some of that data and it sits in various parts of the organization, right? At the plan level. You know your actuaries and your med economists, and they know who your high-risk and rising risk populations are. They've already made a business case. They have bought some fancy, predictive modeling software. And they're looking at this data all the time because they need to understand what it means for their claims experience moving forward. Your sales and marketing folks understand the behaviors of sub-segments of the population as they go out to outreach and target and sell products over time. You've got some of it in places. And then adding to Mark's point that key clinical voice, which is the other piece that we can see from the claims that helps us predict and understand, not just
what's going to happen to people, but what we need to do to intervene to change the trajectory for outcomes, to change the value proposition and to change the experience for members. So that's one key piece of it.

As we think about data at Cityblock, it's pulling together all the information we already have from a kind of look-backwards-to-predict-the-future perspective, as well as from the understanding of what your clinical diagnoses are. What do we have in claims? What do we have from pharmacy to help understand what people need? And then we're actually going out and collecting as a first party using our community health partner. This is the key component of our workforce on the ground: folks not clinically trained, who are hired from the communities we serve, who go out and ask questions about social needs, about access, about strengths that individuals have about their history of personal trauma, about transportation and food and loneliness, and exercise, that we then incorporate into this massive dataset that gives us a true 360-degree view of what is going on that person's life and how that ties out to their outcomes over time, and how we then tailor interventions. So, we have, from the plan's perspective, I think you're moving toward atomization. And you also talk about the atomization of networks. It is, "Let's take all of the data sources we have and think not just about segmenting from the perspective of where do we sell our product or what markets do we enter, but also in terms of how do we then understand clinically what populations need from us to deliver the outcomes that we're hoping they can achieve."

And how do we incorporate the lived-experiences of our members, either directly or by proxy, to Mark's point, to help better determine which network provider would be best positioned to meet their needs? That is an important nuance. One other thing that it does tell us and has shown us is that the delivery modalities span lines of business. And so if we take this approach from a network perspective, you will find that there are providers, I would consider us one of them, within a network that can serve a certain type of member across your Medicare book of business, as well as your duals book of business, as well as your Medicaid book of business, as well as your low-income commercial or your exchange population. There are commonalities. If we take this approach, we can begin to meet a minimum threshold for coverage and for populations, and to serve the clinical needs on the ground of the populations that you're covering.

**Sonal Kathuria:** One more thing to what she laid out. I think the issue in all the changes and why this has been so difficult, we're talking about data. But it's also this whole point of when you look at a typical network, you know you have to have panel-density to drive any kind of practice level transformation. Now, if you bring in a network, what they're going to do is take care of that particular patient. You immediately and automatically, on-demand, bring that panel density. But when you look at a general body of a paired network where the same provider is serving Medicare for lives, Medicaid lives and duals, and they also have the commercial lives, you know you need more of this. You have to be able to share this data. And what we have seen in our analysis and working with our payers is it's always the 80/20 rule.
Many times you see those top 20% of the primary care providers driving 80% of traffic to specialty care and other places if you can right-size it. So they end up referring it to the high-providing network. Or they end up focusing on the eConsult for a specialist then going to the specialist and meeting them for X, Y, Z. It could really change the dynamics of affordability and care. And obviously if you can enhance it with data, as Toyin said, to predict hospitalization because you’re always connected with that patient, it starts to become clearer. For these reasons, I think data and technology are definitely going to be the keys.

**Brian Kalis:** Sonal, you mentioned the concept earlier related to alignment. How do you align both providers and consumer incentives around that? We had the discussion around data. A big part of this is, well, can you get enough data across the different silos to actually understand what’s happening and helping with the shaping and so forth? Those were just some key lessons learned. Maybe as we look to wrap up here, I want to ask Mark first, and then Toyin second, are there any other key lessons learned that we haven’t covered, that you would suggest to other health plans?

**Mark Margiotta:** Sure, the quick one I would share is what we’re talking about here, from a theoretical perspective about how you bring in an innovative solution into your network with a partner that is neither a care management vendor nor a traditional provider. There’s a pretty big learning curve because it is new and innovative. And I would not underestimate the amount of time that you’ll spend having these conversations. So that was a little surprising to me, since it makes a ton of sense when we talk about it in this group. But as you go to implement, and as you go to execute, there are a lot of stakeholders where you’ll find yourself really bringing them along on a solution like this and a partner like Cityblock.

**Toyin Ajayi:** I would echo that, Mark. I think making sure that you have the right stakeholders in the room for the conversation is key. And to your point, there are a lot of stakeholders. I think the thing that has always served us well is tying this to clinical experience. Making sure there are clinicians in the room for these conversations to help overlay what we’re talking about from a theoretical and policy perspective, very much to the grounding of what does it actually mean for the humans that you are serving and for the outcomes that you’re trying to achieve? Because it is so critical to recognize that unlike most solutions that one might go to purchase to help manage, this is ultimately about finding human beings, building trust with them, figuring out what each person needs and meeting those needs, and helping to convince them to change their behaviors over time. It is actually that simple. But the people, the stakeholders, they need to buy in where the dollars come from, what success looks like. That stuff takes a ton of time. You must articulate that simple arc, which is, “We have a problem that we’re trying to solve for. We just got a lot of members that we’re financially and morally accountable for, many of whom have needs that are today not being met effectively despite all our best interests and intense hard work. We’ve got to get them to a place where they are effectively managed with great outcomes and wonderful satisfaction.” We have to tell that story. And then you have to figure out which people in your organization, which stakeholders are responsible for what part of that work today who need to get bonded over time. And the importance of storytelling and
the importance of stakeholder buy-in and alignment cannot be understated. That’s why we have to build such great relationships through the process of trying to solve these problems together, because we’ve had lots of conversations to make sure we’re on the same page throughout.

**Brian Kalis:** No, that’s great. The points about, “Remember that this is ‘put-people-first.’ What are those particular needs? How do we solve them? And then work backwards,” are great advice.

Great, in quick recap, Toyin, I liked how you started this. If I could summarize key things, it really starts with, as we said, putting the person first and thinking about the different diversity of needs of all your members. Using that as a starter and then working backward. And with that, we get to what you were mentioning, Sonal, which will naturally drive the atomization of networks and different ways of putting those needs to provide those services. I want to wrap up and thank AHIP for the opportunity for bringing us all together for this discussion. And specifically, a thank you to our panelists for all that you’re doing out there, as well as for joining us to share that with other health plans and others in the network. And then thank you all as well for joining the discussion. Thank you.