SPECIAL SECTION

MEDICAID REFORM

POWER BREAKFAST

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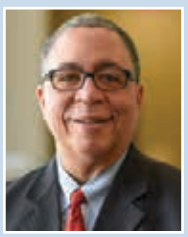
PANELISTS



Al Hammonds
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Millennium Collaborative Care PPS

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Executive Director
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Dr. Jeffrey Rubin
Co-Chief Executive Officer
Elderwood Administrative Services, LLC

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Chief Executive Officer
Greater Buffalo United Accountable Healthcare Network (GBUAHN)

In a discussion at Business First's forum on Medicaid reform,

panelists discussed health care issues facing Western New York residents, businesses and providers. What follows is an edited transcript that highlights points raised in the Q&A session.

JIM COURTNEY

Panelists at the Medicaid reform forum shed light on a range of important health care issues. From left, Al Hammonds, Ricardo Herrera, Dr. Jeffrey Rubin and Dr. Raul Vazquez.

I'm Jack Connors, publisher of Business First. Start off by telling everybody a little bit about your organization and its place in the Medicaid reform effort in Western New York.

AL HAMMONDS: We're Millennium Collaborative Care and our role in health care is we are one of 25 performing provider systems in New York state driving Medicaid reform across the whole state. So what the state has done is they set out these 25 what they call PPSs and it's a very structured initiative with funding — there's combined funding from New York state and from CMS to drive reform. And the primary objective is to transform the system from a volume-driven fee for service type system to a more value-based, performance-driven system. And in a nutshell, that's what we're doing. We are putting systems in place to make sure that that works.

RICARDO HERRERA: I think why we're more important in terms of the Medicaid redesign piece is our critical positive action. One is care coordination. Care coordination helps coordinate all the services, treatment services and the lifestyle development services as they move from institutional care to provide the care and the services in the community and focusing on wellness. It becomes more critical to have to have community-based organizations. We're in an organization that has Article 31 licensure that has been providing care organization services since the late '80s. We've gone through all the revolutions and the redesigns, and so I think we're at a very critical juncture in time where we can deliver a lot of the community-based things they're looking for.

DR. JEFFREY RUBIN: Elderwood is a most acute provider with approximately 17 facilities in Upstate New York, most of them in Western New York. And Elderwood is also going to be a health plan, probably in October or November, the MLTCP Medicaid advantage health plan. And Elderwood also has an institutional pharmacy and transportation company. Elderwood is able to participate in a meaningful way in hospital avoidance. They can do so in two different venues. One is we have approximately 1,500 patients within a system today and the value of hospital avoidance on the new hospitalization side, but more importantly it can play a major role in ER diversion and acute hospitalizations because our company is a company that has the flexibility to deal with higher community patients and lower community patients and has the flexibility to do so almost on a dime. It can really move very quickly and it's a tremendous value proposition because the price point is so much lower than price point that you would see in an acute care setting.

DR. RAUL VAZQUEZ: So I wear three hats. An interesting thing for me is I was actually a Medicaid recipient. I grew up on public assistance, so this to me was a way for my system to be involved. I often see these individuals as second-class citizens in the state, and the fact that you guys are all here is interesting because I don't feel we've had this kind of response with the market for a long time. Design models, that kind of change, we deliver care; it was very difficult because the one thing is as a safety net provider caring for more than 30 percent Medicaid is that you're under a managed-care environment, which it really escalated the dollars that you receive from the population. Not taking into account response and how difficult this market was and, so along came the Affordable Care Act and what it designed, it's been remarkable. So for me, touching people and seeing the impact is remarkable. We joined the only physicians who we had in the ER with what would safely monitor those seven physicians; we formed an idea. We're the largest safety-net IBA in the state. We carry about 35,000 people. No one wants to go into the city, so I think models have to change to make sure we redirect primary care. Primary care is important in everything that you do. Behavior is the core of what we do. It's also broken up into silos. So we're able to

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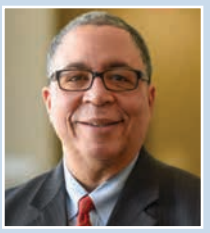
Community Approach to Changing Feel of Healthcare

Millennium Collaborative Care Leading Healthcare Change in WNY

There is a great amount of talk regarding change occurring in healthcare in Western New York. However, most people may not be aware of the ongoing activity because the preliminary work is being done at the foundation level.

A collaborative of healthcare providers (hospitals, primary care physicians, health homes, skilled nursing facilities, clinics and Federal Qualified Health Centers, behavioral health providers and community organizations) are actively engaged in establishing the foundation for a 5 year process that will transform the delivery of healthcare to the Medicaid community. For years, research has shown that there is a need for a comprehensive prevention and primary care plan to properly care for the uninsured and underinsured.

Millennium Collaborative Care, a Performing Provider System (PPS) lead by ECMC, is a major part of implementing this change. To build the new healthcare delivery system there is a focus on obtaining useful data and research about health care delivery in WNY in an effort to target the parts of the healthcare system that are not working properly. Key drivers include quality primary care and coordinated medical care for each patient.



Al Hammonds
Executive Director
Millennium Collaborative Care PPS

MILLENNIUM COLLABORATIVE CARE

"In other words, we're not trying to recreate the wheel, we're just trying to connect the dots so it operates better," stated Al Hammonds, Executive Director of Millennium Collaborative Care.

Under New York State's five-year Medicaid Reform Plan, safety-net providers and other organizations form PPSs to coordinate care for Medicaid patients in a region with a goal of reducing avoidable hospitalizations. The plan requires that each PPS includes both major public hospitals and safety-net heath care providers and a designated lead provider for the group.

Millennium Collaborative Care's primary function is to oversee 11 Delivery System Reform Incentive Payments (DSRIP) projects across 8 WNY counties to fundamentally restructure the healthcare delivery system. They will do so by reinvesting in the Medicaid program with a goal of reducing available hospital use by 25% over 5 years.

Hammonds added, "How are we going to make this happen? Well, it begins with what I refer to as our community health experts. It's the patients, the recipients of the medical services, who must be heard and empowered. Engaging primary care physicians about patient - centered and coordinated care are also important steps to transforming medical delivery."

"Millennium Collaborative Care is creating an integrated delivery model that strives to connect each patient with the right provider at the right time. Through this model we hope to create a best practice for healthcare in the nation that rewards the effectiveness and quality of healthcare versus the volume of healthcare visits," stated Gregory J. Turner, Millennium Collaborative Care Administrative Director.

Millennium Collaborative Care has begun the process of engaging and educating communities about preventive and primary healthcare services and why it is needed to remain healthy. For example on Saturday, September 19, the Millennium Care team were major participants at the WUFO 1080 AM healthcare expo. The team set up interactive workshops led by community healthcare providers such as Preparing for a Meaningful Doctors Visit, How to Eat Healthy on a Budget and Hypertension to Heart Disease: Making Changes for Life. In addition, the change process includes consistent engagement with healthcare providers and primary care physicians with the goal of creating a more patient-centered approach to taking care of patients.

Anthony J. Billittier IV, MD, Millennium Collaborative Care Chief Medical Officer adds "The foundation is important. We hope to put the word care back into healthcare."

"We're excited about leading this challenge; however, it will require that all become dedicated to making both behavioral and system changes. It's not a matter of if it will happen, it's about when the changes will take place," stated Hammonds.

Hammonds adds, "Actually, when we get this right, hopefully the healthcare delivery best practices will impact all patient populations."

To find out more about the 11 patient delivery projects visit www.millenniumcc.org.

From the Sponsor POWER BREAKFAST MEDICAID REFORM

Elderwood prepares for Medicaid reform challenges

WILLIAMSVILLE, NY – The health care industry is gearing up for significant changes as New York State addresses the issue of Medicaid reform. Elderwood has positioned itself to be an important collaborator in this effort, by working internally and with area health care partners to take advantage of funding through New York's DSRIP, or Delivery System Reform Incentive Payment program. Under a state waiver, these funds are being offered to health care organizations who meet performance metrics that demonstrate their progress in improving individual outcomes and reducing unnecessary hospital visits.

The advent of DSRIP was a prime opportunity and catalyst for Elderwood to enhance its use of technology, most specifically implementing an electronic medical records system (EMR) across its spectrum of services. More than two years into this initiative, Elderwood not only has a robust medical records system, but recently partnered with the regional information organization HEALTHeLINK to help streamline the exchange of patient information between health care providers. Similarly, Elderwood's clinical process now includes the use of e-INTERACT, a quality improvement process designed to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.

Dr. Jeffrey Rubin
Co-Chief Executive Officer
Elderwood Administrative Services, LLC

One of the New York State DSRIP program's primary goals is to reduce unnecessary hospital admissions by 25 percent. Elderwood's SMARTS® emergency room divergence program dovetails nicely with this effort. Through the SMARTS program, physicians can direct that their patients bypass the traditional hospital emergency room and go directly to Elderwood for intensive treatment that may include IV therapy, wound care, ventilator care or care for a number of other chronic and debilitating conditions. Patients receive the same tests available in a hospital. Most importantly, medical treatment and rehab begin without the delay and lengthy wait times often experienced in a busy ER setting. All Western New York-area Elderwood skilled nursing communities can accommodate a patient diverted through the SMARTS program. During this past year alone, the SMARTS program has been responsible for successfully managing more than 100 patients, completely by-passing the unnecessary use of any hospitals' valuable space and resources.

In addition, some Elderwood communities are being shaped into "Centers of Excellence." Here, medical professionals and staff with a unique set of clinical skills offer more intensive care for individuals, such as cardiac or oncology patients, who have very specific care needs.

While some changes in health care delivery are the result of reform efforts, others are occurring naturally, as the desire to "age in place" begins to supplant the traditional skilled nursing care model. Health care companies are finding new ways to help seniors remain independent at home for as long as possible, as evidenced by the upswing in the number of managed long-term care programs available to consumers. The majority of these programs are aimed at providing affordable care compatible with Medicaid requirements. Toward this end Elderwood is launching a Managed Long Term Care Health Plan (MLTCP) to address this growing need.

In addition, seniors living in the community, particularly those eligible for Medicaid, often struggle to gain access to adequate care, especially in rural areas. They may no longer be able to drive or use public transportation; they may not live near relatives who can get them to and from doctor appointments. Elderwood Transportation's fleet of oxygen-equipped wheelchair vans aide these individuals by offering safe, reliable, non-emergency transportation throughout Erie and Niagara counties. Van services are often covered by Medicaid.

Health care reform is changing both the way providers are paid and the relationships between acute care providers, post-acute providers and payers. In our community, Elderwood is working toward a collaborative environment of improved clinical capability, supported by the strategic use of technology and investment in physical plants, as a critical piece of its commitment to provide the right place for the right care.

Elderwood provides skilled nursing care, subacute care, rehabilitation, assisted living, independent living and memory care, to more than 5,000 people each year at 17 locations in Western and Central New York. Nine Elderwood skilled nursing facilities and six assisted living communities in Western and Central New York have earned Quality Awards from the American Health Care Association and the National Center for Assisted Living, the most prestigious honor in long-term care. For more information, visit www.elderwood.com.

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MEDICAID TRANSCRIPT, *continued*

kind of bring these things together. You will be able to achieve what we're trying to do, which is cost, quality and patients feeling they're getting great care. Right now, most still don't see it. I think as a Health Home, we came into this not really knowing the work and what was required to change these things, and in our offices we were doing the same thing. We were doing care coordination without being compensated for care coordination, because as a family physician, I am everything. I am the priest, rabbi, I am the doctor, the accountant — they always come to you, asking a lot of questions about what are you going to do. The design really kind of put the doctors on steroids so we can actually reach out and be part of the solution. We're always part of the problem. Doctors are always the problem, we're never the solution. So now doctors are taking part of our teams and being involved and changing the way health care is being delivered. We're already helping them with reducing fear on patient utilization and increasing primary care physician. If you do that, you're able to combine the primary care vehicle to work as one system. It's a $55 billion issue which Medicaid is to the state. So I'm actually enjoying medicine like I've never enjoyed it in my life, and I've been doing this for 25 years. It's not what I thought I was going to do when I grew up, but now I'm doing what I love.

Connors: How does this play into the partnerships that Millennium has to set up to — let's just use that one goal — have 25 percent reduction in avoidable hospitalization for the next five years?

HAMMONDS: We're all partners up here. Our job is to implement an integrative delivery system of care. So what we're trying to do is drive accountable care communities and we're trying to build a population health model. For example, if you look at cardiovascular health, cardiovascular disease, diabetes, hypertension — those are key measurables of population health. And as Dr. Vazquez talked about, the primary care being the center, it's a big part of what we're doing because we're trying to drive everything from people going to the emergency rooms every time they have an issue to going to their primary care provider. We talk about building an integrated delivery system — it's really connecting the dots and you have to have good IT, you have to have good clinical systems, you have to have standards of care. All that is critical. It's not easy. So we're working on all that, putting systems together. I know we're going to get to it, but we have a number of different work groups and projects that are driving the change, and it's a lot of work, it's challenging, it's fun. But it has to work.

Connors: As partners with Millennium, are you doing anything different right now with your clients and your providers to tie in with their goals?

HERRERA: Even starting last year

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Al Hammonds

before Millennium put in its application, there was a lot of work around the table — behavioral health, crisis management, integration of behavioral medical care. So for the first time, I think, community-based providers who did a lot in community work were actually working along with the institutional providers to help start redesigning this system and sometimes it got very interesting. A lot of push, pull; a lot of very strong dynamics. But these work groups worked, so it started then in terms of us having some real say in what was being designed. As it worked out in the community, I think for the first time you're seeing the medical system actually put some teeth into their belief that what drives population health, especially for the poor population, are social determinants of health. And we would say that for decades. It's not a new bit of knowledge that materialized but the medical system was always geared to just treating the diseases. Once you flip the script and you start working on wellness and prevention, I think that's when you started understanding that you did have to do something about poverty; they did have to do something about homelessness. You have to look at all these economic pieces whether you're employed or not. At the end of the day, we're talking about lifestyle changes. You can put all medical things, you can put all the primary health care, but folks are going to learn to make the changes. And if we don't help them change behaviors so that they're living healthy lifestyles, they're not going to get the savings that they're looking for.

RUBIN: I think that the key for Elderwood has been the concept of interoperability. The ability for continuing care to have access to information so that we share medical records with Millennium and physicians and any of the other health care providers and A) that we can get that information for our company, and B) that we can share our information with our health care partners. That has been a large investment for Elderwood health plan. So over the last two years we've gone from a paper-based system to an electronic-based system with the goal of being able to share that information. And HealtheLink's decision is an important component because that's really the portal for everyone to be able to see each other's information. That was a launch initiative for us that was driven by health care reform. There are certain projects that we have now started to implement that will hopefully change metrics regarding immunization. One of them is something called Interact, which is the gold standard of hospital avoidance regarding re-hospitalizations in skilled nursing homes to hospitals. Historically, that was also paper-based; we're now pursuing that on an electronic platform. So we're looking at very different businesses that really are trying to bring value to the system both on the Medicare side and on the Medicaid side.

VAZQUEZ: So looking at it from two sides, at Health Home we're trying to advance. We want you to use Health Home, which is actually an ACO product. And I think that in order for us to really change anything, you have to have access to see where the dollars can be spent and have metrics. I think what we've done now is we have so much information, so much data in hospitals that we don't use. We have people who use paper trails that don't really capture the data that was necessary. I've been capturing data for 18 years; I live in the virtual world. I analyze what makes sense in our groups and what doesn't make sense. At Health Home we do the same thing. I want to make sure the same goes into accountability and keep to it. So if I don't deliver on a product, I'm OK paying some of the dollars back because now you're going to have to change the model of care. Our model is trying to make sure that we're able to survive in that kind of environment, because they don't know what they're going to expect, and managed care is a beast. Preparing the marketing capability, really meeting the challenge, is crucial. I think patients are a key to this whole process where we're actually showing people what they need to do, and physicians are going to be very important. And when I say physicians, I mean the team. It's going to take social workers, it's going to take nurse practitioners, it's going to take primary care. But if we don't develop these types of models and actually measure these out, this is a wasted event. If we get the dollars, one of the biggest problems we had was we had two systems in Buffalo that prefer not to work together and they lose money. I mean, Rochester got $600 million because they worked together; we got half because we wanted to be divided. And the only way to take care of one Buffalo is by having two systems become one, because we don't need to replicate. We replicate services. It's not good for the patient. There's no way to integrate stuff if you're going to have two or three systems. So HealtheLink is a good thing, but if you have too many systems in place, it's not going to be your answer. It's really important for us to look at things. We're all in the same ship. If we're not all careful, we're going to hit something pretty hard.

Connors: You brought up an interesting point. Through the community here is about $335 million, of which $92 million is to Community Partners of Western New York. Are your organizations working with both performing provider systems?

VAZQUEZ: There's a division. We have two places to go, and we align with one entity because we felt that served our market more. If you look at who has been taking care of the Medicaid market in the city, it's been Kaleida and ECMC. I've been doing this for 25 years — I see how the other systems treat our people and I haven't been happy with it.

Connors: Dr. Rubin, not to put you in an awkward position, but maybe the question is: Is there a barrier from your organization from working with both performing provider systems or do you have to choose?

RUBIN: We're taking the Smithsonian approach, and we're happy with both PPSs. We're basically focused internally on building systems and foundations so that we can be an effective partner for either PPS. And obviously it's going to be very specific to clinical programs and patient types. We're very focused on building that expertise so that we can be a meaningful partner and really help the PPSs achieve their targets or their goals.

HERRERA: Dr. Vazquez is correct. It was a shame that the large stakeholders in our community could not find a way to issue and collaborate on one PPS and one application; it would have been in the best interest of our community. They failed on that. We see some of the same patterns showing up in terms of who's on which panel of providers and for which management organization. So you have a client that's referred and you find that this managed care company had a contract with this system so you can't serve the client. Your client has gotten all the rest of their services from the large community organization that you are from. If you're not going to have the kind of conflict-free services that you would when you turn around, this provider system is opening up practices or sites behind your services where you traditionally deliver services. So there's not that coordination, there's not that integration. I don't think that bodes well for clients or community. Unfortunately, at the end of the day I don't see that there's a light at the end of the tunnel on that. Self-insurance will dictate, and these are managers of large corporate systems and they are obligated to make decisions in their best interest. There are some joint projects that PPS decided to work on because they had some shared interest. I think some of the crisis-stabilization work led to a few shared projects. Al can probably delineate those. So there were places where they were able to come together and say, "This makes no sense, us duplicating this set of

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services."

Connors: Let's talk about the district and the PPS. Exactly what are the goals? But also, what's the impact on meeting those goals? If the goals aren't met by everyone, there's an impact on the funding.

HAMMONDS: Correct.

Connors: So how do we get to those goals when we have not only division in our community a bit, but also across the state. If they can't meet their numbers and their goals, what's the impact? And is that fair?

HAMMONDS: Well, the success of the district, we all rise and fall together. To your point, obviously the big, overarching goal is 25 percent reduction in our emergency department visits. In the hospital system, that's the big goal. It's patient-centered, so everything has to be driven to the primary care providers, to the health providers that provide primary care to the physicians. So one of the other bigger goals is helping all of the primary care organizations, all the doctors reach what we call PCMH 2014 Level 3. And what that means is there's a certain standard. Most of the primary care organizations are at a 2011 level. To get to 2014 they have to have open-access schedules in order to have ability to see patients more than just 9 to 5. There's an integration of behavioral health into primary care. That's a component that we

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Ricardo Herrera

need to make sure gets built in. So there's a lot of different complements to make sure that that happens. We have about 250 primary care organizations and 600 physicians and providers that we have to coordinate and make sure that we support through systems and resources, funding people, IT systems to make sure they reach those levels; that's a big deal. Because even when you divert people from the emergency room into primary care, the primary care agencies and organizations have to be able to adequately take care of them. We have to make sure that there's enough primary-care capacity in the region to make that happen. A lot of the efforts are around primary care. There's a huge effort around post-acute care. So we look at the different goals. It's very descriptive so we have quarterly goals. September is where we're at the end of our second quarter, district year one. Quarter two ends Sept. 30, so we have patient-engagement goals. How many folks are we able to effectively help divert away from the emergency room visits? How many people — through this interact project that was brought up — how many folks can avoid getting sent back to the emergency room? We have to equip skilled nursing facilities to handle those situations in the skilled nursing home versus just sending them to the emergency room. So there's a lot involved. There's just a lot involved.

VAZQUEZ: And on the patient center medical home side, there's a lot of integration into it that is key. But there are ways because in funding to kind of help those practices that normally wouldn't be able to do it, I think this is going to be important. That's because every office listing is different and we have to begin to kind of not clone but design a system where care is going to be equal no matter what you look like, where you live; it has to be the same type of care. If you're in Amherst, the care is different. If you're down in the city, the care is different. So this is a good way to start and develop the system that's fair and transparent across the whole area.

HAMMONDS: The big thing here is the way patients are taken care of now is that a lot of focused care is at the hospital level, which is not the way it's supposed to happen. So the way we look at it is we have it broken down into work streams. You have the hospital stream, you have all the skilled nursing facilities and home care agencies. There's all the behavioral health organizations, substance abuse, crisis stabilization organizations. There's the developmentally disabled population that has to be figured into all of that. And there are community-based organizations that are extremely key to making it all happen. So we have systems that we're putting in place that tie all that together. The community-based organizations with the behavioral health crisis stabilization, substance abuse, developmentally disabled. Skilled nursing facilities, home care, hospitals, all the primary care, the safety net — we have all of them on the team and really looking at a team-based approach through the 11 different projects to drive the performance. Our money is guaranteed only for the first two years, so it's paid for reporting, which means putting infrastructure and systems in place year one and two but, starting in year three, it flips. So 60 percent, we got $243 million; 60 percent of that money in year three and up to 80 percent of the money in year four, and five is based on paid for performance. So if the systems

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aren't working, we don't get paid. We can't distribute those funds to the network of providers that are providing the care. We have to put systems in place to make everything work together in concert in order to get the funding that's promised in years four and five. It's a value-based payment system, which means that based on the patients you see and the level of care that you provide, that's how you get paid. That's the way the rest of the world operates; that's the way health care needs to get to.

Connors: So the money that's being provided right now is being used for those funds for the reporting for organizations that couldn't afford it themselves to go out and put together more complicated reporting systems; this is the incentive for them to do that. So at the end we're going to be operating more efficiently, the costs will go down and that's where the incentives will be, based on the success?

HAMMONDS: That's correct. Everything we're doing has to do with patient engagement and leveraging connections. We don't have any cost goals. Although obviously at the end of the day, it's going to save costs because it's extremely expensive for folks to go to the emergency room and get their primary care and get all their needs met there. But the way the system is designed, with the way we have to perform as a performing provider network system, putting it all together, there's no dollars and cents. You have to reduce costs by this much, that kind of thing, or look at the costs of what it takes to take care of — that's not the way we're measured. We're measured on patient engagement, making sure that population health indicators change, which is hard. So if you look at cardiovascular disease or diabetes, if the number of people who have diabetes doesn't get better, three years from now that's how we're going to get paid or how we're going to be incentivized.

Connors: So better engagement really will have an economic impact ultimately.

HAMMONDS: Absolutely.

VAZQUEZ: The other thing is the state's capturing a lot of data. They're going to know how everybody is doing. Eventually NPDs — they are the ones that know exactly what it costs to manage the patient. So you're in Rochester doing this case, you're in Buffalo doing this case, why is it costing more in Buffalo? They're going to basically have to compete, bring the numbers down, so that you're able to kind of attract people. Because if I have to drive to Rochester and the cost is 50 percent less than it's going to eventually affect my budget, I might travel to Rochester. I think that those are the models that are going to be looked at so we have to not only play but play well.

JIM COURTNEY

Dr. Jeffrey Rubin

Connors: Dr. Rubin, with Elderwood, your model is obviously the client base is a little bit different. Not totally different, but how does an organization like Elderwood fit into the PPS, both of them, and drive what needs to be driven to meet those goals?

RUBIN: Obviously the first thing we have to do is cause no harm in the sense that we don't end up with unnecessary hospitalizations from our own patient population that would hurt their numbers, ER numbers and acute care days. But I think the opportunity for Elderwood and the districts is really on hospital diversion. We're doing a lot of hospital diversion today with Medicare product. I think patients that do come to the ER who don't need ER services or don't need acute care services that the primary payer is a Medicaid patient, we could care for those patients at our facilities. And that means us A) having the clinical expertise for certain disease states, whether it's cardiac or diabetic or pulmonary; and then secondly, we have to come up with a payer. So I guess ultimately the district becomes the payer, so in some respect either we are a vendor to the district or provider to the district, or we even possibly look at risk sharing on patient population. I think that we really could make a huge difference specifically for those patients who don't reach that acute care level of care and could be treated in an alternate setting. I think it's just pretty early on in our development with the districts, that we haven't really put those specific programs in place with them with the districts. But I believe that there is a template in place already because we are doing a lot of that on a daily basis with the management care companies.

Connors: Al, have you found that to be true from many of your partners? That they already have managed-care models in place and they're already moving toward what the goals of the PPS and the district are?

HAMMONDS: Yes. A lot of the network of providers are all over the map in terms of maturity level and their depth. Evergreen is pretty deep in terms of what they provide, not only the post-acute but also the primary care, that kind of thing. A lot of our partners have a lot of depth. So all we're trying do is, we're not trying to reinvent the wheel; we're just trying to connect the dots, help put systems in place and connect the dots. I think it was brought up earlier by one of the folks here about electronic medical records and EMRs and being able to connect the EMRs. I mean, one of the rumors that was out there early on was you have to create one EMR for the entire system. And that's not going to work; that's not realistic. But being able to systematically connect the different EMRs. And we're working with HealtheLink to help us do that. One thing I do want to go back to from earlier — you were talking about working with Catholic Medical Partners. We have to work closely with Catholic Medical Partners. Six of our 11 projects have direct overlap with Catholic Medical Partners, so we do have a good working relationship with them. Even though we may have a different strategic approach to how we're doing things than they are, we have to work together or else the funding is not going to get to where it needs to get to in Western New York.

Connors: How many partners do you have that you're working with both performing provider systems, just percentage-wise?

RUBIN: We're in all eight counties of Western New York. We have Medicaid lives that we're responsible for impacting. We have over 250,000 Medicaid lives that we've been assigned by the state that we're responsible for impacting their lives. So there's a lot of overlapping with the Finger Lakes PPS over in Rochester. Catholic Medical Partners is in Chautauqua County, Cattaraugus County and partly in Niagara County, so those counties overlap. So the partners that are up there, the hospitals pretty much choose one PPS or the other. Primary care organizations and the rest of the network — providers are kind of in both camps like we were talking about.

Connors: One of the goals coming up quickly is Sept. 30 reaching 6,000 individuals, and I think 12,200 by the end of December. So how are you engaging Medicaid patients in reform efforts to reach those goals specifically?

HAMMONDS: One of the 11 projects is a patient-activation measures project, and the gist is basically to go out and survey Medicaid patients to figure out where they see themselves in the health care system. There's a series of questions and a survey and there's four different categories — either they're not engaged at all or level four would be they get regularly scheduled physicals and see their doctor at least once a year. And then whenever they have an issue, they go to a primary care physician. We have to engage just on that one project, we have to make sure that we're reaching 6,000 folks. So what we've done is put out a Request for Proposals to community-based organizations and, through that Request for Proposals, process methodology, which is different than a lot of the other PPS the way they're doing it. We selected through a basic criteria four large community-based organizations to help us do that. We've already started funding those organizations, but in addition to those four, because we couldn't get them up fast enough, we set up pilots of other community-based organizations that are doing the work more rapidly to hit our numbers. So we probably have up to eight different organizations that we're working with that we're actually beginning to fund in order to hit that goal.

Connors: Is this engagement serving partners you are using with your organization?

HERRERA: Yes. We went in with one of the partners on grants so we've been up and running in terms of working with them. The design was to utilize all the community organizations that form this particular work group because they already had sites, locations and had existing populations. So it's a matter of getting staff trained in the use, and then starting with your own internal populations and then moving out, especially since most of these organizations already delivered services in those community hot spots. One critical thing that I think sometimes gets overlooked in the discussion is we think as primarily and too often an urban problem in terms of poor health outcomes. That is very true. But the other big population, the poor health outcomes in rural communities and some of the more rural counties. So Buffalo and Niagara Falls share a single dynamic which is a large urban core and then you might see some small, suburban pieces. Then you have these other more rural parts of the counties. When you look at where the hot spots are, you will see them being a big and relatively healthier suburban community. So you're designing systems, you have to work on that duality. So our primary care system for Erie County and Niagara County is going to look very different than the primary care in Orleans County, and it scales up based on that, and the cost is going to be very different based on that, also.

RUBIN: I didn't do justice to our Elderwood health plan and how that could really play into the district or Millennium meeting its goals, and the reason I didn't focus in on it sooner is because the health plan has not gone live as of today. But the MLTCP is going to enroll a few thousand Medicaid lives and the MLTCP starts in Western New York, Niagara County, Erie County and so on and so forth. The MLTCP has all the incentives you need in a district to avoid hospitalization, and I think there's an extraordinary opportunity for the health plan to coordinate services with the Millennium district. And that's the way for us to enroll lives and also to do a better job at care managing those lives. I

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think that's a worthwhile endeavor.

VAZQUEZ: I think it's great that we have a project; I think it's all great we have to use this stuff. So when I'm talking to the patient I can understand the level of understanding of diabetes behavior, depression — all this stuff. So I just hope that as the IT infrastructure matures, that that information is making it back and we're trying to see how effective PAMs work. PAM has been using the Medicaid market for a long time and really shows results. So we're going to have an impact on cost curve — it's going to be utilizing the market, not just going through the process. If you're going to have patients setting up and figuring out just to get through it, it's how you engage. OK, so what we found through the PAM and care coordination is that it does help to kind of pick out and separate A, B and C in terms of patients. I think we do a disservice when we don't separate it because everyone is a little bit different. But overall you get better outcomes if you do that.

Connors: Is there a reason that the Health Home care agencies are not part of this? Or are they?

HAMMONDS: Health Homes are part of the whole district initiative. It started off with Health Homes kind of got separate funding and a separate initiative and the district was a separate path, and we're seeing those more come together now. Dr. Vazquez can probably explain it better but we're working really closely; we're being strongly encouraged to work closely with the Health Home. So that marriage there, it wasn't as defined early on in the planning stages but now, as we're in the implementation phase, in order to accomplish our goals, a lot of our goals, we have to work really closely with the Health Home.

Connors: What role are the HMOs, the Medicare Advantage, Blue Cross Blue Shields, the Univeras, Independent Healths playing in helping to distribute the PPS being involved?

HAMMONDS: They have to be an integral part of the value-based purchasing models that we have to implement in the latter part of year two, definitely in years three, four and five. So we're in conversation with them now, we're in conversations with all of them, meeting with them. We're trying to share information. PHI, we're sharing information with them so we could try to work together in that way. But we're only in the beginning stages of working with them right now. Primarily have them in a wait-and-see mode, so we're pulling them in now.

Connors: Ann Monroe is highly involved in the redesign team that the government put together. Is that a real benefit for us in Western New York, that she is very familiar with the health care system?

AL HAMMONDS: Ann is a a major player in this field and she's been a cheerleader and a leader and a collaborator. She's making sure that Catholic Medical Partners and our PPS Millennium is working together. She's a major broker, a major force in everything that we're doing. She's helping work with her organization with PT to help make sure that all of our efforts are collaborative, that they're transparent, that we're sticking to our core values in what we're supposed to do — that kind of thing. So, yes, she's been a significant player.

Connors: For the community at large, the Medicaid reform with managed care, the goals, the district and PPS: How is it going to bubble through to the larger community?

VAZQUEZ: I have a hard time with that question because when Medicaid markets are out there, no one really cared about it. Now there's an allocation with major dollars for Medicaid. Now we should use those dollars to do this stuff; I totally disagree. I think you have to focus on what the dollars were designed to do, and it was to build the infrastructure that doesn't exist; that's key. My point here is that those dollars need to truly go to the people who are doing the work, who are changing the outcomes, who are going to develop a system that will help the inner city. Out of the 44 counties — and I sit on the Minority Health Council — one of the worst, No. 1, is Buffalo. So we already have an issue where we have two cities. I always wanted to have one Buffalo, and if these dollars are going to be utilized, they need to be applied to what — which is to go and treat these individuals because we have 100,000 people going into the plans now as a result of the Affordable Care Act. If we are not prepared for that infrastructure in these cities, forget it. You know the money is not going to be able to be enough to sustain that model.

HERRERA: From a community-based perspective, Medicaid has always been just one payer source, one source of funding for services. There are other payers, there are grants, there are contracts with county and state and federal. So there are multiple revenue streams that come in to keep my community-based organization open. So if I'm running a senior center and what you'll find is activities programming may be coming out of the county's source of funding, the care coordination that I'm running will either be health care, health senior care coordination or MLTC products based on contractually. But since the house that they're co-located in, whoever walks through our door is going to be entitled. So if you build that infrastructure even for folks who are not on Medicaid, what you will find, especially in our population, is that there's this window there, this huge gap where individuals don't qualify, just make slightly too much to qualify for Medicaid. They still don't have access to all the health resources; Medicare does not cover all the things that they need. The dilemma is: Do I spend the $200 or $300 a month and spend down

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so I can buy into Medicaid so I can get my toes done? We end up having to do these elaborate workups with them and try to help them make the best choices for their lives. That's our business model; it's a community-based organization. We will help you as long as you get paid. If you figure out how to get paid, that's wonderful.

RUBIN: I just would like to take a shot at that question. There's such a tremendous level of excitement for what's going on in Medicaid today, and I think Buffalo has a lot of very smart people and a lot of very caring people. I think there's going to be a lot of interesting innovation coming out of these district Millennium, and I believe there will be some very interesting best practices that will be developed. And those best practices are going to reap the benefit and be applicable to the health care population as a whole. So I do think that even though we're looking at a moment in time and we're seeing funding, specifically for these initiatives, the benefit will be long lasting to the community.

HAMMONDS: The funding is very specific to the Medicaid population so we have to be good sports and make sure that we're taking care of the Medicaid population. Having said that, it's impossible for it not to spill over into the rest of the health care community. Because when a person presents themself, you can't really discriminate. Now, the safety-net primary care providers, the majority of their population is the Medicaid population, safety-net primary care providers. But I think at the hospital level, we talk about ED care triage and emergency department triage and navigating patients into primary care provider, even though we're very focused on the Medicaid population.

Connors: What is your hope and vision for this process for the population of people you serve right now?

VAZQUEZ: I hope we have one Buffalo, that's for sure. Before this process I didn't really know Ricardo, so it's starting to make us work together. We have 90 percent isolation — my census in terms of what goes on in Buffalo. If you're white, you're 90 percent of the time never going to be around a person of color. You have to go to some of these people's houses, you have to see how some of these people live. Then you begin to understand, "I thought this happened elsewhere. It doesn't happen in our community." So if we develop systems and IT infrastructure to kind of learn from each other and come up with best practices and change the model and manage the population, all of us as one, I think that's what I would love to see.

RUBIN: I'm really looking for collaboration, transparency and, hopefully, better outcomes.

HERRERA: I'm looking for a truly community-based system of care. I look at the East Side of Buffalo and it's a complete desert. If you go on Main Street and you go east you can count the number of primary care providers that are available there. There used to be a time that ECMC or the county literally had clinics all through. So as much as we talk about this, the truth of the matter over the last 20 years, what I've seen is this retrenchment. If you're going to do that, we need a community-based workforce and you're going to have to come into the community and build an infrastructure that ties it all together and is considerably more seamless.

HAMMONDS: There are cross-functional and cross-geographical goals that have to happen here or else it fails. So the functional areas that have an integrated delivery system is where you had four silos of hospitals operating in their own world, in their own silo. You had primary care in their own silo. You had post-acute kind of operating in their own silo. Community-based organizations meeting the needs. So those four, they have to connect. And then geographically, we can't forget that the Southern Tier culture is drastically different than Erie County; drastically different than the northern tier with Niagara Falls; Orleans County, drastically different from Genesee and Wyoming County. That's my focus — making sure that total collaborative effort works because we have to make sure that people in organizations and regions don't feel left out. We have to meet the needs of the whole community.