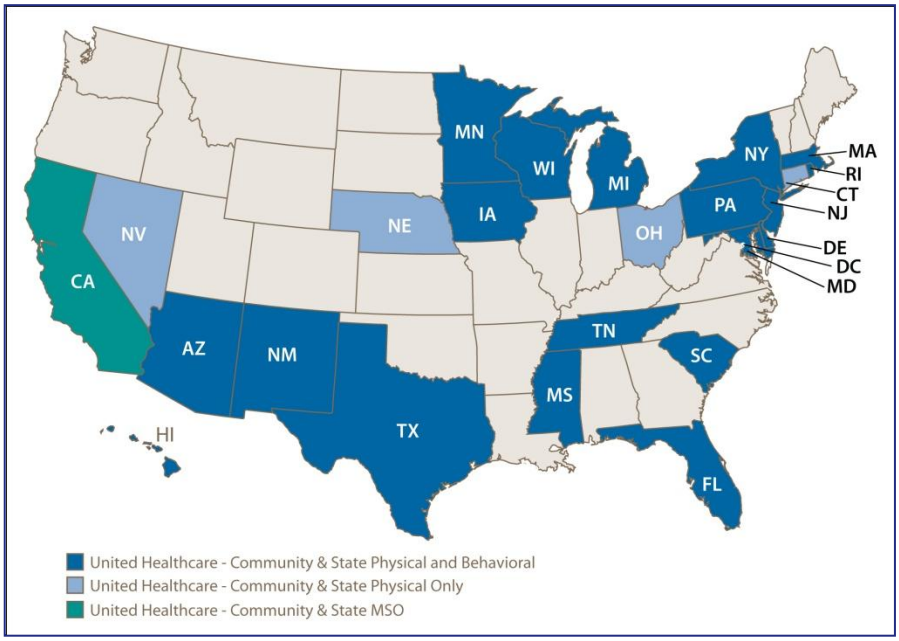
Company Overview

UnitedHealthcare of Illinois, Inc. (UnitedHealthcare) is a subsidiary of UnitedHealthcare Group, a diversified health and well-being company that provides a broad spectrum of resources and services to help people achieve improved health and well-being through all stages of life. UnitedHealthcare of Illinois serves the commercial and Medicare markets with 2,100 employees based in the state. **Our contracted network of 23,276 physicians and 187 hospitals serves over 850,000 Illinoisans, including 121,399 senior and 731,714 commercial members.**

UnitedHealthcare Community & State is the business unit of UnitedHealth Group that focuses on serving individuals eligible for Medicaid, CHIP and other publicly funded programs for financially vulnerable populations. We bring over **29 years of experience working with Medicaid populations**. UnitedHealthcare Community & State currently serves Medicaid (TANF, ABD and LTC) and CHIP clients through full-risk capitated and fee-for-service arrangements in **24 states, covering over 3.4 million members**. The following map illustrates our broad national experience:

As part of UnitedHealth Group, UnitedHealthcare Community & State has access to the expertise and resources of one of the nation's leaders in health care services. Collectively, through our work with other UnitedHealth Group companies, we have access to over 80,000 talented individuals, who believe in ***helping over 80 million people live healthier lives,*** in both the public and private sectors. This positioning allows UnitedHealth Group to seamlessly support additional growth and respond to Illinois' need for innovative solutions to support new initiatives through the following segments:



UnitedHealthcare Community & State: Medicaid, long-term care, CHIP and uninsured programs

UnitedHealthcare Medicare & Retirement: Medicare and retirement plans

UnitedHealthcare Employer & Individual: Commercial group and individual plans

UnitedHealthcare Military & Veterans: Armed services members, veterans and their families

OptumHealth: Includes United Behavioral Health, disease management, wellness programs, Nurse Line and other specialty services

OptumInsight (formerly known as Ingenix): Provides consulting, health information systems and data management services, including Lewin Group, Impact Pro™, CareTracker EHR solution and Axolotl's Health Information exchange products.

Optum Rx (formerly known as Prescription Solutions): UnitedHealthcare's pharmacy benefits manager.

Response to Questions

UnitedHealthcare Community & State appreciates the opportunity to provide the Illinois Department of Healthcare and Family Services (HFS) suggestions for innovative coordinated care models and strategies for the delivery of quality, coordinated and comprehensive care for Medicaid beneficiaries pursuant to P.A. 96-1501. The questions posed in the *Key Policy Issues* paper get to the heart of the major policy choices that must be addressed to meet the legislation's ambitious goals and timeline. Our response to Illinois' request for comments outlines key tenets of a model that is based on the best practices that we have implemented or observed in state Medicaid programs across the country. The proposed model includes the following elements, which are discussed in more detail in the body of this response:

- A broad set of Medicaid covered benefits and services -- including primary and preventive care, specialty care, diagnostic and treatment services, hospital services, behavioral health and long term care -- that are provided through comprehensive managed care plans;
- A broad service area that includes both rural and urban regions and that includes sufficiently large population to enable coordinated (managed) care organizations to have sufficient enrollment to support the risk;
- Mandatory enrollment of all Medicaid populations in the covered regions;
- Contractual incentives and/or requirements that support the development of ACOs, patient-centered medical homes and other components of an accountable delivery system with appropriate "wrap-around" services from the managed care plans to ensure care coordination across the full continuum.
- Risk-based financing that shifts risk from the State to third-party entities, consistent with the requirements of P.A. 96-1501;
- The assignment of each Medicaid beneficiary to a medical home that provides or ensures the provision of all aspects of care across the continuum of care;
- Identifying and stratifying the population in need or at risk, using predictive modeling and other tools to anticipate needs and target appropriate levels of intervention to match need;

- Care coordination to tailor a care management plan and integrate and coordinate services within a network of providers;
- Disease management (DM) and chronic care management for targeted sub-populations, across all co-morbid conditions including behavioral health that is integrated with the medical home and leverages available resources;
- Consumer education and engagement activities, including self-care management;
- Outreach with consumers, family caregivers and providers to facilitate more effective utilization of services and improved health outcomes;
- Data management services and information exchange;
- Provider engagement strategies; and
- Quality and performance measurement, reporting and accountability.

1. How comprehensive must coordinated care be?

Questions for Comment

a. Do you think that coordinated care should require contracts with specific entities that arrange care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration?

UnitedHealthcare Community & State believes that a model that coordinates care across the broadest range of services possible will provide maximum benefit for enrollees, providers and HFS. When selected services are carved-out, no organization is focused on managing the overall costs and health status of the whole person. Having multiple entities manage only "their bucket" is prone to outcomes that are not, overall, as cost-effective as a fully integrated model with a single accountable organization. From an administrative perspective, a model that includes multiple carve-out options or that allows entities to contract for less than the full range of available services is extremely complex, requiring State staff to manage numerous contracts with variable terms.

Optimally cost-effective care coordination demands a capability to assist members across the entire continuum of care – but also demands a program design model that does not create silos of different components of an individual's care. Through a comprehensive benefit design, Illinois can develop a delivery model that allows for flexibility to ensure that an individual's needs are met without the confusion of which system is responsible. For a variety of reasons, but particularly in consideration of the State's fiscal situation, we encourage that the State opt for the carve-in model to the fullest possible extent, paying particular attention to the inclusion of behavioral health, home and community based long term care and skilled nursing facility benefits. We note, however, that the State may want to consider phasing in long-term care benefits. Based on experience in Tennessee and other markets, it takes time to build provider relationships and establish the delivery system for long-term care services.

Illinois' Medicaid beneficiaries may be better served by incorporating long-term care services on a slightly slower timeline to allow time for market development and stakeholder support and buy-in. If the State wants to have a meaningful impact on healthcare cost growth, it must look at long-term care costs, but this must be done in a manner and timeframe that is sensitive to providers and enrollees.

Under our proposed model, managed care plans and other care coordination entities would assume full risk and would be financially responsible for providing the following set of Medicaid covered benefits and services that include, but would not be limited to:

- Inpatient and outpatient services
- Physician services
- Family planning services and supplies
- Laboratory, radiology and other diagnostic services
- Preventive care services provided by local health departments
- Home health services
- Pharmacy/prescription drug services
- Dental services
- EPSDT services
- Mental/Behavioral health services
- Skilled nursing facility services
- Waiver services

A model that integrates the full range of acute, mental/behavioral health and long-term care services under a single capitated payment offers both near and longer-term benefits for Illinois. A comprehensive model creates near-term budget predictability and opportunities for budget savings because there are incentives to manage risk, and there is a corresponding aggregation of clinical information that enables timely and proactive management of each member's care. By creating a system that encourages early identification of individuals who are at risk of nursing home placement, comprehensive community options can be designed to maintain individuals in the least restrictive setting possible. Inclusion of long term care and behavioral health services in the proposed model offers Illinois a systemic solution to address the issues facing the State in caring for their most complex and costly Medicaid beneficiaries.

Through a comprehensive and integrated program design, individuals who have co-morbidities and co-occurring conditions or who may be at risk of deterioration and, thereby, placement in nursing homes or institutions can be identified and maintained in a community setting. A comprehensive and integrated design also maximizes the ability of managed care plans to utilize data from across the full range of services to produce powerful analytics, coordinate care and target interventions. Illinois has the opportunity with the passage of P.A. 96-1501 to shape a program that improves care provided to Medicaid beneficiaries while creating a sustainable Medicaid program and reduced tax payer burden.

The model should encourage the development of coordinated care entities, such as ACOs, that fall outside the traditional definition of managed care that are willing and able to accept risk for a range of services for a given population. This can be achieved by providing financial or other incentives for plans to contract with ACOs or other coordinated care entities where they exist to assume responsibility for the majority of care for a segment of the enrolled population. However, the model must recognize that the ACO marketplace has not yet evolved, and is unlikely to do so within the State's timeframe, to the point where it can provide truly comprehensive, integrated care for a meaningful segment of the population. For example:

- *Wrap-around services.* Under a model where HFS contracts with comprehensive managed care plans, the plans can provide an array of "wrap-around" services that the ACO may be unable to provide, at least in the near term. These services include coordination of out-of-network services and a range of care management and patient support services, including data analytics, disease management programs and health promotion and education activities. They may also include long-term care and/or behavioral health services that an ACO may be unable to provide.

- *Infrastructure development.* ACOs, like organizations and their participants will require significant capital investment to develop the governance structure, care management, claims payment, utilization management, information technology and contracting infrastructure to effectively manage services across the full continuum on a risk basis. Given the current fiscal climate, it will likely take years to develop the necessary infrastructure and capacity.

- *Development of regulatory framework.* Similarly, it will take time for the State to develop the regulatory infrastructure to support ACO development and to ensure that ACO members are subject to adequate regulatory protections. Key areas that must be assessed include regulations governing the assumption of financial risk, fraud and abuse, antitrust, timely claims payment and consumer protection.

b. *Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?*

As discussed above, the requirements of P.A. 96-1501 can be met most efficiently through a program that contracts directly with managed care plans to coordinate the full continuum of Medicaid services across settings and various funding sources. We have recommended that the contract between HFS and the managed care plans include requirements and/or incentives for the plans to contract with ACOs or other coordinated care entities to the degree that they exist in various regions. The contract between the managed care plans and the coordinated care entities can be customized to meet the unique characteristics of small, medium and large entities based on the services they are able to provide, the degree to which they will utilize the plan's wrap-around services, and the degree to which they are

willing and able to accept two-sided risk. The requirement to contract with coordinated care entities could be gradually increased or strengthened over time to encourage the development of accountable delivery systems. Additionally, we would envision that patient centered medical homes would also be a core part of the ACO delivery model under the proposed Medicaid managed care structure.

c. Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized? Would existence of a medical home require NCQA certification? Would all primary care physicians be required to be in practices that meet these requirements? What requirements are essential for every practice? Presumably it would be possible to increase requirements over time. What progression would make most sense?

The cornerstone of a coordinated care program is **a patient centered medical home** designed to provide coordinated comprehensive care that results in increased efficiencies, patient safety and improved health outcomes. Although definitions of what constitutes a medical home vary and continue to evolve, most medical home initiatives and efforts (including those of UnitedHealthcare Community & State) have been based on the joint principles of the patient centered medical home (PCMH) developed and supported by the four primary care specialty physician societies- the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association as well as the National Committee for Quality Assurance (NCQA).

According to these principles, patient centered medical homes encompass the following key characteristics:

Personal Physician: each Member has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice: the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of Members.

Whole Person Orientation: the personal physician is responsible for providing for all the Member's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services and end of life care.

Care is Coordinated and/or Integrated: across all elements of the complex health care system (for example, subspecialty care, hospitals, home health agencies, nursing homes) and the Member's community (for example, family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that Members get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and Safety: Hallmarks of the Medical Home:

- Practices advocate for their Members to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, care coordinators, Members and the Member's family
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement
- Members actively participate in decision-making and feedback is sought to ensure Members' expectations are being met
- Information technology is utilized appropriately to support optimal Member care, performance measurement, Member education and enhanced communication
- Members and families participate in quality improvement activities at the practice level.

Enhanced Access: Care is available through systems such as open scheduling, expanded hours and new options for communication between Members, their personal physician and practice staff.

Payment: Appropriately recognizes the added value provided to Members who have a patient centered medical home.

Under UnitedHealthcare Community & State's proposed model, each Medicaid member would be assigned to a primary care provider/medical home provider. With additional supports and services provided by participating managed care plans such as through the support of care managers, care can be coordinated and integrated across all elements of the delivery systems (i.e. specialty, home health, hospital, residential care settings; skilled nursing homes). Ideally improved access to primary care and more coordinated care will result in enhanced quality and efficiency of care for Medicaid beneficiaries.

While the patient-centered medical home is a key component of a coordinated care program, we caution against setting a specific timetable for certifying practices as medical homes without a thorough understanding of the existing primary care provider marketplace and the barriers to patient-centered medical home certification. Such policies could have the unintended effect of reducing access to care. While many large, more sophisticated practices are steadily advancing toward certification (or have already achieved it), many smaller practices are moving more slowly. These smaller practices comprise a significant segment of the Medicaid provider base. These practices should be encouraged to pursue certification and supported along the way, but the overarching goal must be to ensure access to high-quality primary care for all Members in all regions. Whatever approach Illinois takes with respect to patient-centered medical homes, it should be standardized across regions and programs to minimize confusion and barriers to participation.

We encourage the State to look toward existing examples of programs that are helping to transform primary care practices into patient-centered medical homes. For example, the Washington State Patient-Centered Medical Home Collaborative is working with 32 practices to transform them into

accountable medical homes.[1] Participants include small (five or fewer providers), medium and large (20+ providers) practices, and rural, suburban and urban practices. Participant teams attend regular learning sessions, participate in monthly webinars, work with a quality improvement coach, test and measures practice innovations, and collect and analyze data on their performance.

d. How explicit should requirements be about how an entity achieves coordinated care? For instance, should the care coordination entity be required to assign an integrator or care coordinator to each enrollee?

UnitedHealthcare Community & State recommends that each Medicaid beneficiary receive a health risk assessment upon enrollment into the coordinated care entity. The results of the health risk assessment would be used to determine the health care needs of each individual member as well as members that may benefit from additional intervention and services such as care coordination and disease management services. For those with the greatest needs, such as individuals requiring long-term care or waiver services or those with special health care needs, the coordinated care entity would be required to conduct a comprehensive assessment of each individual's physical, behavioral and social needs; develop a personalized plan of care that details strategies for addressing the full range of services required including the promotion of the medical home and coordination of services. In addition to mandatory health risk assessments, we recommend that HFS require risk stratification based on claims data, where available, with the top 15-20% of patients being mandatorily assigned to a care coordinator.

We discourage the State from placing highly specific and prescriptive care coordination requirements on managed care plans. As an example, in a recent procurement in another state, respondent health plans were to be required to have four face-to-face visits per year with all enrolled SSI children. For some enrollees, four visits would be the "right" amount of face-to-face interaction, but for most enrollees a different level of this kind of outreach would probably be most appropriate. Requirements of this nature force the managed care plans to focus more on "meeting a contract requirement" than on providing the best, tailored interventions to its enrollees. Ensuring that managed care plans have the latitude to develop individualized care plans and interventions is likely to be more effective in producing improved health outcomes and ultimately savings for the State.

e. Where, if at all, should HFS provide some kind of umbrella coverage for entities, e.g. negotiate a master pharmaceutical contract that would be available to all coordinated care entities?

As articulated above, UnitedHealthcare Community & State believes that the maximum value and benefit can be achieved by a coordinated care program that is as broad and comprehensive as possible. Under such a model, we don't believe umbrella coverage or master contract services are necessary and may be counterproductive. We believe that allowing the managed care plans to contract independently for the full range of services will foster competition and innovation, which ultimately benefits the members, the State and taxpayers alike.

[1] Washington Patient-Centered Medical Home Collaborative fact sheet (DOH 345-284). February, 2011.

f. What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?

Under the coordinated care model articulated above, Illinois has the ability to and, indeed, is required to, go beyond traditional fee-for-service payment methodologies, which provides an opportunity to create incentives for provider participation. There must be great transparency in how financial incentives are designed and implemented, but the State, through managed care plans, can encourage provider participation through a wide range of incentives that reward both participation and outcomes. For example, managed care plans have the flexibility to reimburse providers for services that may fall outside of covered fee-for-service services. Managed care plans can also offer a range of non-financial incentives to encourage provider participation, including care coordination, data analytics, care management support in the field, disease management programs, cultural and linguistic services, and health promotion and education programs.

In addition, several components of the overall coordinated care program design can create incentives for a wide range of providers to join coordinated care networks. These include:

- *Mandatory enrollment.* UnitedHealthcare Community & State recommends that a **mandatory enrollment** approach be employed for the coordinated care program. Mandatory enrollment is an effective model to address populations from a comprehensive perspective. Under mandatory enrollment, beneficiaries would have a choice of at least two State-approved managed care plans within their region. In regions that are designated as rural, there may be a need for the State to implement a rural exception policy that would allow HFS to require mandatory enrollment of Medicaid beneficiaries into a single care coordination entity where only one is available. A mandatory program gives providers the assurance they need that there will sufficient patient volumes in the program to support the delivery system changes under a coordinated care program. Providers are far less likely to make necessary investments in IT, quality and care coordination if enrollment in the program is voluntary.

  In addition to the benefits described above, a managed care program that includes mandatory enrollment of all covered populations on provides the following advantages to the State:

  - Budget predictability and certainty
  - Greater potential for cost containment and cost savings
  - More accountable program for the State
  - Makes rate setting more predictable
  - Can offset ramp up or start up costs for managed care plans, making it a more sustainable and viable program
  - Facilitates the investment in the necessary infrastructure (i.e. case management staff, systems, robust provider networks) to administer the model
  - Encourages providers to participate in the Medicaid program thereby increasing access
  - Facilitates Medical Home practices to invest in required and necessary infrastructure

- Return on investment more likely in terms of improved access, quality and cost effectiveness over the long term

In our experience serving 3 million lives in 24 states, voluntary enrollment is the least likely to achieve the 50% statutory goal or to have a meaningful impact on savings and quality outcomes. In addition to increased costs and unnecessary distraction for managed care plans in order to recruit new members, voluntary programs have demonstrated limited ability to attract providers and members and, in some cases, drive to adverse selection.

- *Rural and urban service areas.* UnitedHealthcare Community & State recommends that the State include both rural and urban areas in a mandatory coordinated care program. We strongly recommend that the State include rural areas so that these populations can benefit from coordinated care and to support the development of integrated care delivery systems in these areas.

- *Contractual requirements and/or incentives for plans to contract with coordinated care entities.* As described in our response to Question 1A, we recommend that the State include a requirement and/or incentives in its managed care contracts for plans to contract with coordinated care entities, including ACOs. This will spur the growth and development of these entities to assume a larger role over time.

2. What should be appropriate measures for health care outcomes and evidence-based practices?

Questions for Comment

a. What are the most important quality measures that should be considered?

Performance measurement is a critical element of any coordinated care program, giving states, providers, consumers and managed care plans valuable information about the quality and utilization of care provided, as well as access to care and consumer satisfaction. The information can be used to track performance over time, identify areas for improvement, facilitate comparisons across plans and determine priorities for special initiatives.

To comply with federal requirements, HFS must require its Medicaid health plans to operate a quality assurance and performance improvement program to ensure the delivery of quality health care by all managed care entities. Typically, a Medicaid health plan's quality assurance and quality improvement program uses a variety of mechanisms to objectively and systematically measure, evaluate and improve the services provided to health plan members. All are founded on continuous quality improvement (CQI) principles which focus on implementing the PDSA (Plan, Do, Study and Act) cycle as a means to meet or exceed the minimum performance standards established by the Medicaid Program.

UnitedHealthcare Community & State recommends that the State align its quality requirements with the National Committee for Quality Assurance (NCQA) requirements for performance improvement and measurement. NCQA's standardized quality and performance indicators such as HEDIS and CAHPS are structured to allow for benchmarking of health plan performance from year to year and comparison with other health plans providing similar benefits to members.

HEDIS is considered the gold standard in health care performance measurement and has been widely adopted by the health care industry and by most states. HEDIS® is a registered trademark of NCQA and includes performance measures covering key domains such as effectiveness of care; access/availability of care; satisfaction with the experience of care; use of services and cost of care. Included for each HEDIS performance measure is a set of technical specifications that define how plans should calculate a "rate" for a particular metric. Selected HEDIS measures include, but are not limited to:

- Advising smokers to quit
- Antidepressant medication management
- Breast cancer screening
- Cervical cancer screening
- Children and adolescent access to primary care physician
- Children and adolescent immunization status
- Comprehensive diabetes care
- Controlling high blood pressure
- Prenatal and postpartum care
- Fall risk management
- Pneumonia vaccination status for older adults

The adoption of HEDIS measures can serve as the set of baseline data for the coordinated care program and can allow the State to determine and report on the outcome and quality of care for the program and objectively compare managed care plans in terms of performance. CAHPS measures can supplement the HEDIS measures by assessing overall access to care and consumer satisfaction with their health plan and providers.

b. Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients--for instance, children versus adults or disabled versus non-disabled?

UnitedHealthcare Community & State recommends that the State utilize sets of measures that are customized for different kinds of clients. Most HEDIS measures are applicable primarily to specific subsets of the overall population, such as children, the elderly or women of childbearing age. Certain measures of access are also particularly applicable to subsets of the population. For example, timely access to high-quality specialty care and admission rates for ambulatory care sensitive conditions are particularly germane to populations with multiple chronic conditions.

c. How should the Department think about client risk adjustment in order to level the playing field as providers deal with patients across a wide range of situations?

Medicaid coordinated care models work and have proven to be sustainable when states work in collaboration with managed care plans to develop rate setting methodologies that recognize and reflect the key components and objectives of the model. We believe it is critically important that the State's rate setting methodology include risk adjusted rates that accurately reflect the complexity of the patient population. There are several states that use risk adjustment as a mechanism to match payment to the risk of members; help control payment escalation and encourage efficiency. Risk adjusted payments also creates an incentive for new managed care plans to enter the market and stay in Medicaid. Most importantly, we believe that it is critically important that the reimbursement model for the coordinated care program align and support the State's overall policy and program objectives. As the State more clearly defines the key components of the proposed managed care delivery model and cost savings targets that it desires to achieve, we offer and welcome the opportunity to work collaboratively with the State and other key stakeholders to assist with estimating and modeling the expected cost-savings opportunities.

In addition, a coordinated care program creates opportunities to move beyond traditional fee-for-service payments to providers as well. As plans develop alternative payment models for providers (i.e., pay-for-performance), the acuity of the provider patient panel must be taken into consideration. For example, if a plan pays a PMPM amount to a patient-centered medical home for case management, the PMPM may be adjusted based on eligibility category (e.g., TANF versus ABD) or other factors.

d. What kind of guidance is available concerning the number of measures that would make sense, especially since coordinated care covers a broad spectrum of care?

Performance measures should be reflective of the population(s) served and the delivery models being offered. Ideally, the State should identify measures that are actionable and align with the policy priorities of the State. For example, childhood immunizations, prenatal care, rapid development and maintenance of care plans for chronic care members, reduced ER use, and reductions in hospital and nursing facility admission rates are possible measures that could serve as a foundation.

e. What percentage of total payment should be specifically tied to quality measures?

Any risk-taking care coordination plan will face aligned incentives, as quality and cost-effectiveness are linked goals. However, we note that the specific percentage of total payment tied to quality measures should vary based on a number of factors, including the underlying health (and supporting health informatics) of the population. We also note several important issues for consideration in setting a percentage:

- Quality-related payments must be meaningful, but should not inadvertently create access barriers. Base rates must be actuarially sound and sufficient to ensure access to the full range of

services. For example, a 1 percent incentive payment can represent 25 to 33 percent of total profits if net income is in the 3 to 4 percent range. This would be a very strong incentive.

- Quality-related payments to providers should reward both strong performers (i.e., those who consistently achieve good outcomes) as well as those who demonstrate continuous improvement (i.e. process measurements).

- There should be substantial flexibility allowed in how providers are rewarded for quality. Some providers are willing and able to place a larger share of their reimbursement "at risk" to achieve quality goals, while other providers may need to ramp up this capacity over time.

f. How can the Department most effectively work with other payors to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

There are several examples nationally -- including Arizona, Pennsylvania and Tennessee -- of effective collaboration among payors to define and adopt quality measures. In some instances, the major provider organizations, including the state primary care association, the American Academy of Pediatrics and the American Academy of Family Physicians also actively participate. In these states the Medicaid program often serves as the platform for bringing together a wide range of payors. Through regular meetings the payors develop and adopt measures, and review them regularly to adapt to changing public health and policy issues.

g. How will we know when we have achieved care coordination, i.e. how should we measure success?

Success in care coordination will ideally be measured by a combination of factors:

- Improved access to primary and preventive care, as demonstrated by a decline in unnecessary ED visits and admissions for ambulatory care sensitive conditions and growth in the percentage of enrollees with access to a patient-centered medical home.

- Quality and outcomes as measured by population-appropriate NCQA HEDIS measures.

- Member satisfaction, as measured by annual CAHPS surveys, and provider satisfaction.

3. To what extent should electronic information capabilities be required?

Questions for Comment

a. What type of communication related to the clinical care of a Medicaid client should be required among providers until electronic medical records and health exchanges become ubiquitous?

More than 50 percent of physician practices in Illinois currently have an electronic medical record (EMR) system in place. While this is a significant increase over just a few years ago, we are far from reaching the point where electronic medical records are "ubiquitous." In general, those practices that have not yet implemented an EMR are more likely to be smaller and have fewer financial and human resources available to undertake the substantial investment required. Additional financial incentives beyond the ARRA incentives will undoubtedly spur additional adoption, but they will likely not be enough to reach universal or near-universal adoption. We encourage the State to find ways to better understand the barriers faced by these remaining paper-based practices and to identify technical assistance models and other mechanisms that can support their transition. We would caution against setting absolute requirements that all practices be electronically enabled, however, as such a requirement could inadvertently discourage participation by high-quality providers.

b. Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

Please see our response to Question 3a.

c. If additional incentives were going to be added for being electronically enabled, that would inevitably mean less reimbursement somewhere else. How important are incentives above and beyond the ARRA incentives to induce electronic connectivity? What trade-offs would be appropriate to support such incentives? (For instance, should the amount of money available for outcome incentives be reduced to increase these incentives? Or should there be a lower base rate with specific incentives for increasing connectivity?)

Please see our response to Question 3a.

d. On what time frame should we expect all practices to be electronically enabled? How would we operationalize the requirements? Is tying them to the official "meaningful use" requirements sufficient?

Please see our response to Question 3a.

4. What are the risk-based payment arrangements that should be included in care coordination?

Questions for Comment

a. How much risk should be necessary to qualify as risk-based?

UnitedHealthcare Community & State supports the core tenets of P.A. 96-1501, which require the State to shift full financial risk for at least 50% of Medicaid enrollees to other entities. We believe a comprehensive coordinated model like the one outlined in this response minimizes the level of risk assumed by the State and provides maximum stability and predictability for State budgets. A model that includes large or multiple "carve outs" shifts risk back to the State, further fragments care

delivery for the consumer, and is inconsistent with the intent of P.A. 96-1501 to provide care via "integrated delivery systems". Similarly, a model that directly contracts with care coordination entities other than managed care plans may inadvertently introduce additional risk for the State, providers and Medicaid beneficiaries due to the lack of regulatory infrastructure currently in place for such entities. Health plans are subject to an array of regulations promulgated by HFS and the State Department of Insurance governing financial solvency, prompt payment of providers, consumer grievances and appeals and other key protections. While Illinois and other states are in the process of developing the necessary regulatory structure for other risk-bearing entities, it will take time to develop an effective framework that affords adequate protections for beneficiaries, providers, the State and taxpayers.

A central component of the coordinated care program should be a financing model and reimbursement structure that supports the policy goals and key tenets of the program and better aligns incentives for prevention of illness, chronic care management and comprehensive coordinated care for the Medicaid population. The reimbursement model should recognize the added value of a medical home and the management of the enrollee's health care needs across the entire continuum of care and create a sustainable and viable program for the State.

b. Could "risk-based arrangements" include models with only up-side risk, such as pay-for-performance or a shared savings model? But if it's only up-side risk, is there any "skin in the game", without something to be lost by bad performance?

UnitedHealthcare Community & State supports a model under which the State contracts with managed care plans on a full-risk basis for the full range of Medicaid-covered services. This model ensures "skin in the game" and provides multiple other benefits, including the following:

- *Potential for immediate budget savings.* A full-risk managed care delivery model provides greater potential for immediate, predictable savings while improving access to care and enhancing quality and health outcomes. Numerous studies have documented the positive impact of managed care on State budget savings, access and quality.[2]

- *Transfer of risk*. A comprehensive coordinated care model like the one described in this response transfers financial risk from the State to participating health plans. If health plans do not perform up to the minimum standards specified in the contract, the State will see liquidated damages. Such a transfer will require a commitment to actuarially sound rate-setting processes. In our experience, these processes work better where there is greater transparency and data sharing between health plans and state rate-setting staff.

[2] See, for example: *Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies,* The Lewin Group, Prepared for America's Health Insurance Plans, July 2004, updated March 2009, which found that nearly all studies demonstrated managed care savings (ranging from 1 percent to 20 percent).

- *Administrative simplicity*. Multiple risk-based arrangements, including one-sided and two-sided arrangements or shared savings models will be administratively complex for the State to administer. UnitedHealthcare Community & State recommends contracting with managed care plans on a full risk basis but allowing plans to contract with providers and coordinated care entities (e.g. ACOs) based on the individual provider's willingness and ability to accept varying degrees of risk.

c. If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?

Please see our response to Question 4b.

d. What should be the relative size of potential payments conditioned on whether a provider is accepting full risk as compared to a shared savings model?

Please see our response to Question 4b.

e. In the case of either a capitated or a shared-savings model, what should be the maximum amount of "bonus"? Stated differently, what is the minimum Medical Loss Ratio for a provider?

In developing the parameters for the proposed shared savings payment, it will be important to be mindful of regulatory issues associated with P4P programs under Medicaid. In both Medicaid managed care and PCCM delivery models, incentive payments may not increase total payments above 105 percent of the approved capitation rate.[3] It is our understanding that CMS will not consider payment rates to be actuarially sound if incentive arrangements provide for payment in excess of 105 percent of the approved capitation rate. This may limit the amount of savings health plans and the State can share from the proposed incentive arrangement.

f. Who should be at risk? Is it sufficient that the coordinated care entity accepts risk, or must there be a model for sharing that risk with direct providers?

UnitedHealthcare Community & State recommends a model that places managed care plans at full financial risk for the Medicaid covered benefits and services outlined in the response to Question #1. The capitation payment would prospectively reimburse managed care plans for a defined set of Medicaid benefits, administrative costs, risk and contingencies, and case management activities. The managed care capitation payment would be an actuarially sound rate established and certified by Illinois HFS and accepted by CMS. Rates should be risk adjusted to ensure that rates are commensurate with the complexity of the population(s) being served.

[3] Jean D. Moody-Williams, RN, MPP, Center for Medicare and Medicaid Services, Center for Medicaid and State Operations, Division of Quality, Evaluation and Health Outcomes, "Provider Level Value-Based Purchasing PPT presentation," July 9, 2009.

The capitation payment paid to the coordinated care entity provides the entity with flexibility and latitude to provide necessary services to meet the needs of the Medicaid population. A component of the capitation payment should include a care management PMPM payment to support care management activities for individuals with special health care needs and medical home provider responsibilities and care coordination management services and processes at the medical home provider practice level. We recommend providing flexibility in how the plan contracts with its provider network, permitting but not requiring providers to share any downside risk. Many providers aren't prepared to share risk, and a requirement to do so may have an unintended negative impact on provider access.

g. How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?

Please see our response to Question 4f. We recommend that HFS consider financing arrangements that include risk corridors or other stop-loss mechanisms, particularly in the first few years of the program, to encourage participation and mitigate up-front risks.

h. How can the state assure that capitated rates or other risk-based payments are not used to limit appropriate care or serve as a disincentive to diagnose and treat complex (i.e. expensive) conditions?

The State can assure that risk-based payments are not used to limit appropriate care through monitoring and enforcing the quality assurance/quality improvement and utilization requirements in its contracts with managed care plans. Contractual provisions should include:

- regular reporting of HEDIS quality and access measures (see our response to Question 2 for specific recommendations on measuring quality and outcomes)
- a requirement that each plan develop an evidence-based utilization management plan, which is reviewed on an annual basis by the State; and
- regular reporting of over- and under-utilization pursuant to the plan's utilization management plan.

5. We also recommend that the State implement a rigorous audit program to ensure that plans are meeting their contractual obligations to the State and Medicaid beneficiaries, including the contractual obligations proposed here. What structural characteristics should be required for new models of coordinated care?

Questions for Comment

a. Should Medicaid lead or follow the market? Should we contract only with entities with operational, proven models or should we be willing to be an entity's first or first significant client?

The passage of P.A. 96-1501 provides a tremendous opportunity for Medicaid to lead the market in developing and implementing coordinated care models that are financially sustainable and predictable and that provide evidence-based, integrated care for a wide range of populations. Given the aggressive timeframe required by ACA, however, we encourage the State to build off the existing risk-based managed care infrastructure to nurture the development of ACOs and patient-centered medical homes and grow the capacity within the provider delivery system and supporting regulatory structure to assume responsibility for a segment of the population. As outlined in our response to Question 1, ACOs,, like organizations and their participants will require significant capital investment to develop the care management, information technology and contracting infrastructure to effectively manage services across the full continuum on a risk basis. It will likely take years to develop the necessary infrastructure and capacity. Similarly, it will take time for the State to develop the regulatory infrastructure to support ACO development and to ensure that ACO members are subject to adequate regulatory protections. Key areas that must be assessed include regulations governing the assumption of financial risk, fraud and abuse, antitrust, and consumer protection.

b. What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements? How should the determination of "minimal financial base" be different for one and two-sided risk arrangements? Should Department of Insurance certification be required?

See response to Question 5c.

c. Should there be a minimum number of enrollees required in an entity for it to be financially stable and worth the administrative resources necessary to accommodate it and monitor it? Should that amount differ by types of client? Can it be different for entities taking one-sided as opposed to two-sided risk?

As a general rule, an entity that accepts full risk will likely need to cover a minimum of 25,000 members in a single geographic area (50,000 in a larger regional or statewide area) in order to be financially viable and re-coup up-front development expenses. This scale is also necessary to be able to have the ability to have an impact on the community's delivery system. If one-sided risk is permitted in the final program design, a slightly smaller entity could be financially viable. To protect the interests of enrollees, providers, the State and the taxpayer, we believe Department of Insurance certification (or equivalent) should be required.

d. What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?

An integrated service delivery network is a key component of a coordinated care delivery model. Under the model we've outlined, contracted managed care plans would be required to develop a contracted service delivery network that includes primary, specialty, inpatient, behavioral health, home and community based and long term care providers for the provision and delivery of all covered services for the target population. They would also be required and/or incentivized to contract with entities, such as ACOs, that are able to accept responsibility for a significant portion of the care continuum for a segment of the population.

The service delivery network of providers for the proposed coordinated care model should:

- Include a sufficient number and type of providers to ensure adequate access to all covered services under the proposed Partnership model;
- Meet the needs of the anticipated number of Medicaid enrollees including their expected utilization of services taking into consideration the characteristics and health care needs of the target population;
- Comply with all network adequacy standards in terms of geographic location and distance as well as appointment availability standards for both urban and rural areas of the State, and
- Provide physical access for the disabled and linguistic and cultural appropriate services.

Additionally, continued support of the State's safety net system is integral and participating managed care plans should be encouraged to contract with Federally Qualified Health Centers (FQHC) Rural Health Clinics (RHC), Community Mental Health Centers (CMHCs), local health departments and other community health centers, particularly in underserved communities.

We also recognize the rural nature of the State and recognize some of the challenges that may be present in developing a provider network in traditionally underserved and rural environments. If providers do not exist in the community, managed care plans may need to creatively assess how to build the local capacity, such as training or incenting providers, developing telemedicine solutions, engaging regional or national provider chains to fill the gap or negotiate single case agreements for highly specialized services. UnitedHealthcare Community & State strongly supports the inclusion of rural areas in the coordinated care program as a means to spur the development of integrated care models in these communities and "lead the market."

e. Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

Consistent with the overall coordinated care model we've outlined in this response, we would discourage the State from carving out specific populations (e.g., individuals with HIV/AIDS, children with special healthcare needs). Separating these populations would further segment the marketplace, increase the administrative complexity of the program and, in all likelihood, limit the ability of these populations to benefit from the comprehensive coordinated care model described here. Instead, we would encourage the State to care for special needs populations within the comprehensive coordinated

care model. This can be achieved by ensuring that capitation rates are actuarially sound and appropriately risk-adjusted.

6. What should be the requirements for client assignment?

Questions for Comment

a. The Medicaid reform law requires that clients have choices of plans, as do federal regulations. Would it make sense to limit the choices of clients by underlying medical conditions? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?

We would discourage the State from limiting plan choices based on underlying medical conditions. Separating populations by underlying condition would further segment the marketplace, increase the administrative complexity of the program and, in all likelihood, limit the ability of these populations to benefit from the comprehensive coordinated care model described here. Instead, we would encourage the State to care for special needs populations within the comprehensive coordinated care model. We believe the State can assure the needs of individuals with special health care needs are met under the proposed model by including care management requirements specific to individuals with special health care needs in a health plan's contract. Further, the health plans should be required to foster the development of patient centered medical homes to effectively serve Medicaid clients with chronic conditions and co-occurring conditions, supported by care coordination and disease management services provided by the health plan. This can be achieved by ensuring that capitation rates are actuarially sound and appropriately risk-adjusted.

b. How much should the Department stratify choice areas by geography? Considered alternatively, would a provider need to have network coverage throughout a major area, such as Chicago? Or could a coordinated care entity limit its offerings to a particular neighborhood?

UnitedHealthcare Community & State recommends that enrollees have a choice of least two State-approved managed care plans within each region that is included in the coordinated care program. In regions that are designated as rural, there may be a need for the State to implement a rural exception policy that would allow HFS to require mandatory enrollment of Medicaid beneficiaries into a single care coordination entity where only one is available. Provider network coverage requirements should be at a regional level (e.g., northern collar counties, southern collar counties) rather than a local or county level, as enrollees frequently live and work in different localities and often have establish provider relationships that cross local borders. Service areas should be large enough and include enough enrollees to ensure the financial viability and sustainability of the program and participating plans. Service areas should also take into account the local referral and care delivery patterns to the extent possible.

c. Can entities limit the eligible population they serve, and how narrowly can they limit their population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?

Please see our response to Question 6a.

d. On what basis should assignment of clients who have not self-assigned be made in the first year?

UnitedHealthcare Community & State recommends that a mandatory enrollment approach be employed for the coordinated care program. Mandatory enrollment is an effective model to address populations from a comprehensive perspective. Under mandatory enrollment, beneficiaries would have a choice of at least two State-approved managed care plans within their region. For clients who do not voluntarily select a health plan, it is our position that the State should automatically assign that client to a health plan. Based upon our experience in other states with mandatory Medicaid managed care programs, we recommend that the State's approach for auto-assignment should be made based on at least three factors:

- *Plan capacity/geographic access.* Does the plan have the capacity within its existing provider network and within the client's geographic area to accept the new client?
- *Claims history/existing provider relationships*. For existing fee-for-service clients, assignment should be based on a review of the patient's claim history, maintaining existing provider relationships wherever possible.
- *Plan quality and performance*. In addition to provider continuity, the auto-assignment algorithm should favor plans with the strongest performance on a designated set of quality and performance measures.

e. One approach would be to make auto-assignment to capacity in proportion to the self-assigning choices. Another approach would be to allow providers to bid on slots, with lower rates getting a larger proportion of the auto-assignees. What are the strengths and weaknesses of these approaches? Are there other approaches?

Please see our response to Question 6d. We recommend an approach that favors and incentivizes quality and continuity of care, which are key tenets of a coordinated care program. An auto-assignment policy that assigns patients in proportion to self-assigning clients may have the unintended effect of reducing enrollment in newer entrants to the market that may have less "name recognition" but deliver high-quality care and services.

f. Over time, the auto-assignment bases could change: one approach would be to make auto-assignment in relation to outcomes. Cost could also be a factor. How long a period should be allowed before switching to a more experienced-based formula?

A quality-based auto-assignment policy could be implemented as soon as all participating plans have sufficient experience in the program to produce a reliable set of quality indicators. We estimate that this would take about one year. In the interim, we recommend that auto-assignment be based on health plan "scores" under a competitive RFP process.

g. Whether for self or auto-assignment, should there be a client lock-in period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?

UnitedHealthcare Community & State believes the client lock-in period should provide significant flexibility and protection of client choice. We recommend that enrollees be allowed to change plans within the first 30 days, with a one-year lock-in period after that initial 30-day period. Once enrolled in a health plan, however, we recommend that clients be allowed to change their primary care provider/medical home at any time. We recommend that the State establish an expedited appeals process to allow changes outside of the lock-in period in cases where enforcement would be detrimental. Such cases might include a change in the enrollee's residence, a significant change in their health status, or other factors that might necessitate a change in health plan.

h. If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?

Regardless of the care coordination delivery model that is implemented, enrollee choice must be maintained pursuant to federal law if enrollment is mandatory. We have recommended a model that includes mandatory enrollment of all eligibility groups that are required to be included in the coordinated care program pursuant to P.A. 96-1501. Under the proposed model, participating health plans may also play a significant role in facilitating enrollment into the program through a range of value-added services including consumer education and outreach to consumers, family caregivers, community stakeholders and providers.

i. How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?

This is a critical issue, as P.A. 96-1501 requires that dual-eligibles be included in the care coordination program. Although they comprise 15 percent of Medicaid enrollment, dual eligibles account for 39 percent of Medicaid spending for medical services.[4] This presents a tremendous challenge for states but also a tremendous opportunity to improve the quality of care and make more efficient use of limited resources. Under the Illinois Coordinated Care program, health plans should be required to coordinate care for Medicare fee-for-service covered services and, where applicable, to coordinate with a client's Medicare Advantage plan. Approximately 70 percent of dual-eligible costs are for long-term care

[4] Kaiser Commission on Medicaid and the Uninsured. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007*. December 2010.

services.[5] Short of a model that fully integrates Medicare and Medicaid funding streams, the comprehensive coordinated care model outlined here -- which includes acute care services, long-term care and behavioral health -- represents the strongest option for achieving savings, better care coordination and better outcomes for this population.

7. How should consumer rights and continuity of care be protected?

Questions for Comment

a. How do we assume continuity of care as entities come and go or change contractual status? (This issue could be particularly acute if HFS "leads" the market by allowing contracting with entities for whom Medicaid is their only coordinated care contact.)

The coordinated care model described here would minimize the disruption of care issues noted in the question. As outlined in our response to Question 1a, a model that coordinates care across the broadest range of services possible will provide maximum benefit for enrollees, providers and HFS. From an administrative perspective, a model that includes multiple carve-out options or that allows entities to contract for less than the full range of available services is extremely complex, requiring State staff to manage numerous contracts with variable terms that are likely to change frequently as entities change or leave the market. From the perspective of participating providers and enrollees, a comprehensive coordinated care model like the one we've described provides maximum stability and protection against frequent changes in contractual status. Managed care plans participating in the coordinated care program would be subject to the terms and conditions of their contract with the State and would also be subject to the full array of Department of Insurance regulations governing financial stability and risk-based capital, prompt payment of providers, and consumer grievances and appeals.

b. Although not strictly a coordinated care issue, how can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance programs--such as will be provided by the Health Benefits Exchange under the ACA? In that respect, how important to continuity is a Basic Health Plan (a provision in the ACA that allows States to create a plan for clients with incomes between Medicaid eligibility and 200% of the Federal Poverty Level)?

UnitedHealthcare Community & State supports the coverage expansions that will be implemented under ACA and is committed to participating in the Health Benefits Exchanges that are being established in the states. We are also supportive of efforts to ensure continuity and transparency for enrollees that may transition back and forth between Medicaid and Exchange-based private coverage. The standardization of data exchange requirements and data flows will be absolutely critical, and we welcome the opportunity to work closely with the State to resolve these issues.

[5] Ibid

c. Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if client income or circumstances change?

We believe that most health plans that participate in the Medicaid program will want to participate in the Exchange to maximize continuity of care for their enrollees. We also note that the health plan-based coordinated care model we've outlined in this response will maximize the opportunity for coordination and transparency across public and subsidized private coverage. In contrast, a coordinated care model that is based on direct contracts between the State and other care coordination entities (e.g., ACOs) may result in additional fragmentation, as ACOs will be unlikely to play a meaningful role in Exchanges in the near future.

d. What rights, if any, should the client have to continue a medical home relationship in changing circumstances?

UnitedHealthcare Community & State supports – and most Medicaid managed care programs allow for – a 90-day transition period to ensure continuity of care for clients in changing circumstances. We also recommend that the State consider the development of all-payer medical home models so that, as an individual's income or payer changes, there is a greater likelihood that they can stay with their medical home.

e. What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?

UnitedHealthcare Community & State recommends that the State implement a uniform, State-administered quality assessment survey through CAHPS. This will provide another valuable source of comparative plan data for the State and enrollees.

8. What is your organization's preliminary anticipation of how it might participate in coordinated care?

a. How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure how your organization would participate, what would be some of the factors impacting your choice?

UnitedHealthcare Community & State is prepared to participate in the Illinois coordinated care plan as a full-risk managed care plan under contract with HFS to provide the full range of Medicaid-covered services. We are also committed to working in partnership with the State, providers and other key stakeholders in the community to develop innovative care delivery models, such as patient centered medical homes that include alternative reimbursement models that more appropriately align clinical and financial incentives as part of our managed care program. Additionally, we are prepared to contract

with and work with a wide range of coordinated care entities, including ACOs and patient-centered medical homes, to provide the necessary wrap-around services and to help develop and deploy accountable care delivery models in the State.

b. Do you have some model in mind that you think would work to meet the terms of the law and also work well for you and the patients you serve? If so, please share it.

We believe the model outlined in this response (see, in particular, our responses to Question and Question 5) is the most efficient and prudent way to meet the terms of the law within the required timeframe. Consistent with the requirements of P.A. 96-1501, the proposed model includes risk-based financing that shifts risk from the State to third-party entities and maximizes budget predictability. The proposed model also includes the following elements:

- A broad set of Medicaid covered benefits and services -- including a patient centered medical home, specialty care, diagnostic and treatment services, hospital services, behavioral health and long term care -- that are provided through comprehensive managed care plans;
- A broad service area that includes both rural and urban regions;
- Mandatory enrollment of all Medicaid populations in the covered regions;
- Contractual incentives and/or requirements that support the development of ACOs, patient-centered medical homes and other components of an accountable delivery system with appropriate "wrap-around" services from the managed care plans to ensure care coordination across the full continuum.
- The assignment of each Medicaid beneficiary to a medical home that provides or ensures the provision of all aspects of care across the continuum of care;
- Identifying and stratifying the population in need or at risk, using predictive modeling and other tools to anticipate needs and target appropriate levels of intervention to match need;
- Care coordination to tailor a care management plan and integrate and coordinate services within a network of providers;
- Disease management (DM) and chronic care management for targeted sub-populations, across all co-morbid conditions including behavioral health that is integrated with the medical home and leverages available resources;
- Consumer education and engagement activities, including self-care management;
- Outreach with consumers, family caregivers and providers to facilitate more effective utilization of services and improved health outcomes;
- Data management services and information exchange;
- Provider engagement strategies; and
- Quality and performance measurement, reporting and accountability;

By building on existing managed care infrastructure, the proposed model:

- Coordinates the broadest range of services under a single responsible entity, thereby maximizing the potential for savings and the clinical benefits that can be achieved through truly integrated care across the entire spectrum.
- Reduces administrative complexity for the State by consolidating responsibility for the population within a limited number of health plans per region that are subject to the same core terms and conditions, rather than dozens (perhaps hundreds) of direct contracts with coordinated care entities.
- Ensures that the enrollees, providers, the State and taxpayers are protected via the current regulatory structure governing health plans that covers such important areas as prompt payment, financial stability and consumer grievances and appeals.
- Provides an opportunity for the Medicaid program to "lead the market" by requiring and/or incentivizing health plans to contract with ACOs and other coordinated care entities where they are available.

c. Is your organization considering developing a Medicare ACO? Do you see opportunities for entities like ACOs in the private market? How do you see yourself involved in either Medicare or other forms of ACOs?

UnitedHealthcare is building on our significant experience in collaborating and contracting with accountable provider delivery systems by actively engaging in development and maturation of Accountable Care Organizations (ACOs) through our collaboration with the Dartmouth/Brooking ACO Learning Network and other activities with care delivery systems. UnitedHealthcare is involved in the development of several Medicare ACOs, and we see growing opportunities for ACOs and similar entities in both the public and private market. We are an industry leader in the Medicare market and have extensive experience with providing innovative models of care for targeted populations, such as those in the institutional setting and beneficiaries living with chronic diseases, that have proven to decrease costs and yield improved outcomes for patients. Our Evercare plan is a comprehensive care model for those who have long-term or advanced illness, are older, or have disabilities living in a variety of settings including their homes, nursing homes and long-term care facilities, or assisted living.

We see the role of UnitedHealthcare as an entity that can help develop and deploy a range of accountable delivery system models while providing the necessary wrap-around services to help these models succeed within the Medicare, Medicaid and private markets.

d. If your organization is considering participating in Medicaid coordinated care in some way beyond contracting with coordinated care entities, do you think you will be ready to do so by mid-2013? If not, when?

Not applicable.

e. For how many Medicaid clients could you anticipate taking coordinated care responsibility? Is there a particular group of clients for whom you believe your organization is particularly suited or for whom it has developed particular expertise?

UnitedHealthcare Community & State believes that larger populations are more easily managed than smaller populations as a larger size allows for the implementation of more specialized care teams to address specific client health care needs. It is also important that populations be aggregated in adjacent or contiguous geographies for a particular health plan to that the local presence is maximized compared to a dispersed approach. We note that we bring over 29 years of experience working with Medicaid populations and currently serve Medicaid and CHIP clients through full-risk capitated and fee-for-service arrangements in 24 markets, covering over 3 million members. This experience encompasses all eligibility groups and the full range of Medicaid-covered benefits. Currently, UnitedHealthcare of Illinois serves the commercial and Medicare markets with 2,100 employees based in the State. Our contracted network of 23,276 physicians and 187 hospitals serves over 850,000 Illinoisans, including 121,399 senior and 731,714 commercial members. The combination of our current footprint in Illinois and our broad Medicaid experience nationally places us in an excellent position to begin serving urban and rural Medicaid enrollees in Illinois within the timeline required by P.A. 96-1501.