Heritage Provider Network

October 1, 2013

Ms. Amy Harris-Roberts
Illinois Department of Healthcare and Family Services
Email: Amy.Harris-Roberts@illinois.gov

Re: Submission of Letter of Intent – Accountable Care Entities (ACE)

Dear Ms. Harris-Roberts:

I would like to take this opportunity to submit a Letter of Intent for Heritage Provider Network to participate in the State of Illinois ACE Program. Heritage Provider Network (HPN) will create a new separate legal entity licensed and based in Illinois to operate the ACE.

HPN has been managing and improving patient care since 1979 when founded by Dr. Richard Merkin, MD. Using an interdisciplinary team of health care professionals and patient care enhancement programs, HPN is able to improve the quality of patient care while enhancing the efficiency and lowering the cost of delivering health care services. Demonstrating a proven model of growth and success, HPN and its affiliates manage the health care of approximately 1 million individuals in California, New York and Arizona.

HPN operates on a full/global risk basis for health care services provided to its members. Insurance companies delegate the provision and coordination of care and the administration of benefits to HPN. HPN and its affiliates then employ and/or contract with doctors, hospitals, and other care providers for the provision of care. HPN is licensed by the State of California and is required to meet the same financial, administrative, quality, and access standards as all managed care health plans.

In addition, HPN currently operates the Nation's largest CMS Pioneer ACO providing care coordination to 85,000 Medicare Fee-for-Service (FFS) beneficiaries. We also operate CMS Shared Savings ACOs in both New York and Arizona providing care to a combined 40,000 additional Medicare FFS beneficiaries.

Attached are Section A (Contact Information), Section B (Proposal Summary/Self Assessment Form) and Section C (HIPAA Data Use Agreement) as required to be submitted with this LOI. HPN looks forward to submitting a Proposal for the ACE Program. If you have any questions please do not hesitate to contact me.

Best Regards,

RICHARD MARTIN, Vice President
Direct Dial: (916) 295-4069
Email: rmartin@heritagemed.com

Attachments

Section A: Contact Information

Name of Accountable Care Entity (ACE) (working name is acceptable)

Heritage Provider Network

Primary Contact Information:
Name - **Richard Martin**
Title - **Vice President**
Organization – **Heritage Provider Network**
Address – **621 East Carnegie Drive, Ste. 140, San Bernardino, CA 92408**
Email – **rmartin@heritagemed.com**
Phone – **916.295.4069**
Other information (e.g., assistant)

Primary Contact Person for Data (if different):
Name – **Jaya Kurian**
Title - **CFO**
Organization – **Heritage Provider Network**
Address – **8510 Balboa Blvd., Ste. 285, Northridge, CA 91325**
Email – **jkurian@heritagemed.com**
Phone – **818.654.3455**
Other information (e.g., assistant)

Section B: Proposal Outline/Self-Assessment – Heritage Provider Network

1. **Geography and Population.** Define your service area by county or zip code. Describe, at a high level, the anticipated number of Enrollees (i.e. minimum and maximum) and your plan for recruiting Potential Enrollees. If different than your expected service area, specify the county(ies) or zip codes for which you are requesting data.

Heritage Provider Network (HPN) will create a new separate legal entity licensed and based in Illinois to operate the ACE The goal would be to service as many as of the mandatory managed care regions below through collaborative partnerships with medical groups, specialty care groups, hospitals and health systems such as Presence Health Systems, Loyola/ Trinity Health Systems and the Cook County Health Systems among others.

- **Cook and the Collars:** Cook, Lake, Kane, DuPage, Will, and Kankakee counties;
- **Rockford:** Winnebago, Boone, and McHenry counties;
- **Quad Cities:** Rock Island, Henry, and Mercer counties;
- **Central Illinois:** Knox, Stark, Peoria, Tazewell, McLean, Ford, Champaign, Vermilion, Piatt, DeWitt, Macon, Logan, Menard, Sangamon, and Christian counties; and
- **Metro East:** Madison, St. Clair, and Clinton counties

HPN ACE will be prepared to provide services to as many beneficiaries as necessary in each region approved.

2. **Organization/Governance.** List and describe the background of any primary members of the ACE and their responsibilities. Provide a high-level description of your expected governance structure including who will participate on the governing board and the responsibilities of the governing board. What are the main operating agreements that will have to be developed with the primary members? To what extent has work started on developing these arrangements? When will the remaining work be completed?

HPN ACE will be a newly formed legal entity based in Illinois. The ACE will develop an integrated senior management that includes executives who have clinical, operational, and administrative experience in managing integrated systems and are committed to assuring HPN ACE's success. The integrated management team will consist of at least a Chief Executive Officer, Chief Medical Officer and an ACE Executive Director/Operations Officer and will be accountable for overseeing all aspects of the ACE and will operate within the established governance structure.

In partnership with HPN ACE management team and ACE providers and participants, the HPN ACE governing board will set the overall strategic direction of the ACE. It is responsible for all shared savings-related aspects of the ACE, including developing and implementing policies and procedures. The ACE governing board will also provide oversight on issues such as care delivery, evidence-based medicine, patient engagement, quality and cost reporting, care coordination, distribution of shared savings, establishing clinical and administrative systems, etc. This will be achieved through, but not limited to:

- ✓ Commitment to the ACE Program principles
- ✓ Implement a robust Quality of Care Program that improves clinical processes as well as meeting clinical outcome goals
- ✓ Holding management accountable for meeting the goals of the ACE
- ✓ Establishing a culture of collaboration and integration that enhances the provision of evidence-based patient care, improves patient experience, provides a safe employee and patient care environment, and supports innovation and creativity
- ✓ Overseeing strong provider network development through recruitment and retention, ensuring provider satisfaction and engagement, and embracing diversity as a strategic advantage

- ✓ Maximizing operational efficiencies to provide the highest quality of safe and appropriate patient care
- ✓ Ensuring regulatory and other compliance
- ✓ Achieving and maintaining strong financial health
- ✓ Establishing an effective means to communicate throughout the organization
- ✓ Participating as needed in provider participant recruitment efforts
- ✓ Continuing leadership in community engagement and the formation of community partners

To reflect HPN ACE's commitment to providing a strong provider network, better care for individuals, and quality assurance and improvement, separate committees focusing on primary care, specialty care, hospital care, Behavioral Health care, and quality will be formed and operate under the established ACE governance structure. A brief description of the structure of each committee is provided below:

Primary Care Physicians (PCP) Advisory Committee:
The PCP Advisory Committee will consist of primary care physicians representing the varying geographies served. The Chairperson will sit on the governing board and provide two-way communication between the governing board and the PCP advisory committee.

Specialty Care Provider (SCP) Advisory Committee
The SPC Advisory Committee will consist of primary care physicians representing the varying geographies served. The Chairperson will sit on the governing board and provide two-way communication between the governing board and the SCP advisory committee.

Hospital Advisory Committee:
The Hospital Advisory Committee will consist of network Hospital representatives. The Chairperson will sit on the governing board and provide two-way communication between the governing board and the committee.

Behavioral Health Advisory Committee:
The Behavioral Health Advisory Committee will consist of behavioral health providers representing the various geographies served as well as primary care providers to establish cutting edge collaborative care centers that treat patients with integrated medical, behavioral, and social interventions. The Chairperson will sit on the governing board and provide two-way communication between the governing board and the committee.

Quality Improvement Committee (QIC):
This Committee will be comprised of representatives from HPN ACE senior management and medical staff as well as representatives from the ACE's participating primary care providers, specialty care providers, hospitals and include a designated Behavioral Health Care representative. Ad Hoc members may be selected where quality review requires a specific body of knowledge and expertise (i.e., the review of a complex medical specialty or related quality concern).

The duties of the committees above include, but are not limited to: 1) reviewing new medical policies adopted by HPN ACE; 2) making recommendations to the HPN ACE governing board on issues brought to the committee pursuant to quality management and patient care issues; 3) serving in an educational role, as needed or requested, regarding provider/patient perception of care and services; 4) Quality Improvement and Clinical Outcomes and 5) serving as advocates for patients and providers in order to assist HPN ACE in becoming and maintaining itself as quality leader in health care.

A **Consumer Advisory Board** will be created and consist of HPN ACE beneficiaries representing the various geographies and cultural diversity of the ACE service area population. The Chairperson will sit on the governing board and provide two-way communication between the governing board and the Consumer Advisory Board. This board will represent the beneficiary's interest and act as a sounding board for ACE initiatives. Members of the board may be called upon to act as spokespersons for the ACE and to act as moderators for community meetings and functions. The board will advise on ACE policies

and programs, review quality indicators and patient experience survey results and recommend quality improvements from the beneficiary perspective.

3. **Network.** Provide a high-level summary of the Providers who have agreed to participate in your network and a summary of other Providers that the ACE plans on recruiting to participate in their network.

HPN ACE intends to enter into collaborative partnerships with medical groups, specialty care groups, hospitals and health systems such as Presence Health Systems, Loyola/ Trinity Health Systems and the Cook County Health Systems among others. Discussions are currently active and HPN ACE will recruit providers where needed to adequately service the population in the regions approved.

4. **Financial.** Please provide a description of the financial resources available to the ACE including the sources of funding for upfront expenses.

Heritage Provider Network is licensed and regulated as a limited health care service plan by the State of California Department of Managed Health Care and must comply with minimum tangible net equity requirements to comply with regulatory financial standards. As of quarter ended June 2013, HPN had $27 million in excess tangible net equity.

5. **Care Model.** Give an outline of your care model, including your plan for care coordination and care management and how your governance structure and financial reimbursement structure support your care model. At this point, we are not expecting a full description of your care model, just a high-level summary of the major components of your expected Proposal.

HPN has a very robust and integrated Model of Care that achieves coordinated management for our beneficiaries. The Model of Care facilitates collaborative coordinated primary care to our ACO population through a clinical team working in partnership with the beneficiary's Aligned Provider (AP), the beneficiary, and the identified support structure, and other key parties.

The Model of Care includes expert, timely recognition and management of health care needs with special emphasis on: coordination of care through a central point of contact; preventative health services; seamless service delivery that meets the expressed needs and preferences of the beneficiary; collaborative practice by interdependent professionals; paraprofessionals and ancillary personnel; implementation of clinical guidelines promoting best practices in the care of the beneficiary; integration and coordination of medical, behavioral, social and home and community based services for patients and their families throughout the entire continuum of care and, continuous quality improvement processes.

The medical care goals of our Model of Care include:

- Reducing unwarranted hospitalizations and skilled nursing facility utilization;
- Improving and/or stabilizing the beneficiary's self-management and independence;
- Improving and/or maximizing function and beneficiary satisfaction by focusing on achievable outcomes which present more benefits than burdens for the beneficiary; and,
- Stabilizing and delaying, if possible, progression of chronic illness to maximize the quality of life;
- Improve quality of care and outcomes
- Improve patient experience and patient and family satisfaction
- Improve physician and provider satisfaction

The cornerstone of the HPN Model of Care is the interdisciplinary care team (ICT). Since these beneficiaries can be one of the highest risk populations with at least one acute or chronic health condition and potentially other co-morbid conditions, the team assigned to the beneficiary may consist of clinicians and allied professionals with specialized expertise providing care through the life continuum.

HPNs approach to delivering care is beneficiary-centered. By putting individuals first, HPN assures every beneficiary has access to the highest quality of life as defined by individual preferences. HPN supports each beneficiary's right to self-determination, which includes the right to agree and opt in to our program, which will result in an individualized care plan with an advanced directive program resulting in the clear communication of the beneficiary's goals for ongoing care and the end-of-life experience. Where supported, the ICT has access to the beneficiary's health information electronically, with beneficiary approval, to facilitate care and documentation in the provision of seamless care.

The care coordination care planning process is very robust and addresses all facets of the beneficiary's health, functional, mental and spiritual needs through a comprehensive initial health risk assessment tool. The care plan is a living document which includes results of case rounds discussion and actions to be taken, that include beneficiary preferences, goals, and participation. HPN believes that it is important that a collaborative environment is established in working with the beneficiary and their aligned provider, to develop a care plan that is appropriate to the beneficiary's needs.

The HPN Model of Care emphasizes the value of providing preventative care through collaboration, coordination and communication with our ACO beneficiaries and their Aligned Providers. To reinforce this model's philosophy, robust training is provided both initially at hire, or contract, and at least annually thereafter throughout all levels of the care delivery system.

6. **Health Information Technology**. How will clinical data be exchanged? ACEs must have the capacity to securely pass clinical information among its network of Providers, and to aggregate and analyze data to coordinate care, both to make clinical decisions and to provide feedback to Providers.

HPN has an internally developed wholly priority Population Health Tool (qUBE) employed by the HPN to identify, stratify and coordination care throughout the healthcare continuum. qUBE is an encrypted web based enterprise tool that is both integrated into electronic medical records but also available exclusively via a web portal. Information and data is refreshed in 15 minute increments and available in an asynchronous environment which allows 24/7 review and updated entry. qUBE aggregates claims data, pharmacy data, personal or nurse directed health risk assessment data, utilization data and other relevant health and social data in turn it runs a risk algorithm to identify the best Population Health Program match for the selected patient.

Care coordination is performed throughout the care continuum with special focus on the transition between inpatient to lower levels of care. Clinical decisions are supported by access to the library of tools which include coding, clinical guidelines and health education materials.

Communication and feedback is supported by dashboard reports and satisfaction surveys.

7. **Other Information.** Please provide any other information that you think will better enable the Department to understand and meet your needs or the general needs of potential ACEs.

None at this time