Section A: Contact Information

Name of Accountable Care Entity (ACE) (working name is acceptable)
Sinai Health System Consortium

Primary Contact Information:

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Section B: Proposal Outline/Self-Assessment

The Department is not seeking exhaustive detail on any of the following—that will be the purpose of the Proposal. However, high-level answers will:

- help the State understand who is likely to submit Proposals; and
- help interested entities understand the range of issues that must be addressed in the Proposal, thus giving them a chance to prepare for the eventual submission.

This Section B is simply a list of topic areas that we assume you will address in a separate document. Sections A and C must be completed and returned along with the document in which you answer the questions below.

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.

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?

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.

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

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.

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.

Section B:

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.

   Zip codes within Chicago and proximate areas of Cook County served by Mount Sinai and/or Holy Cross Hospital include (in order of patient use in FY12): 60623, 60632, 60629, 60608, 60804, 60624,60609, 60612, 60651, 60644, 60620, 60636, 60638, 60617, 60637, 60402, 60621, 60653, 60647, 60619, 60652, 60649, 60615, 60628, 60639, 60626, 60616, 60645, 60618, 60641, 60643, 60625, 60607, 60622, 60640, 60659, 60459, 60634, 60453, 60660, 60406, 60827, 60610, 60611, 60680, 60455, 60456, 60637, 60638, 60805, 60629, 60632, 60620. The community areas of west, southwest, and south Chicago and proximate areas of suburban Cook County are the proposed service area.

   Enrollees by the end of year one would range from 25,000 to 42,000 based on enrollment policies and the implementation schedule agreed to by the state.

   Recruitment will be pursued in conjunction with the Medicaid and Marketplace enrollment initiatives. As the state contemplates mandatory enrollment initially to support achievement of ACE enrollment goals, we would cooperate explicitly with state-defined processes.

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?

   Sinai will convene a Governing Committee (GC) monthly, representing all consortium members and targeted community areas. Governance will be implemented through an Executive Committee, a Management Committee, a Training and Compliance Committee, and a Quality and Evaluation Committee. Review of contracting, training, performance, quality, costs, sustainability, and ACE contract compliance will be reviewed by the relevant committees monthly. Project management will staff all committees. MOAs for aligning operations we have developed with other organizations for the CMMI proposal will form the foundation for similar MOAs among the partners. We would target completion of all important organizational MOAs with FHN and FQHCs by January 3, 2014.

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.

   We intend to include FQHCs within the service area in our network, notably Access Community Health Network, Lawndale Christian Health Center, Access Community Health Network, Esperanza Health Center, Alivio Medical Center, Chicago Family Health Center, Friend Family Health Center, Circle Family Healthcare Network, PCC Wellness, & Near North Health Services.

   We also will engage Family Health Network, an MCCN and Voluntary Managed Care Organization (and sponsored by Sinai along with four other hospitals) already serving this Family Health Plan population, extending the provider network outlined above to include FHN's network as relevant to enrollee needs and preferences. Family Health Network's network includes a number of other hospitals within the service area and over 6,000 primary care physicians and mid-level practitioners and physician sub-specialists.

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

   ACE funding for start-up would be developed from within the Sinai Financial Plan budget for 2014 which contemplates a surplus of $6 million. Operating expenses associated clinically within Sinai would be handled

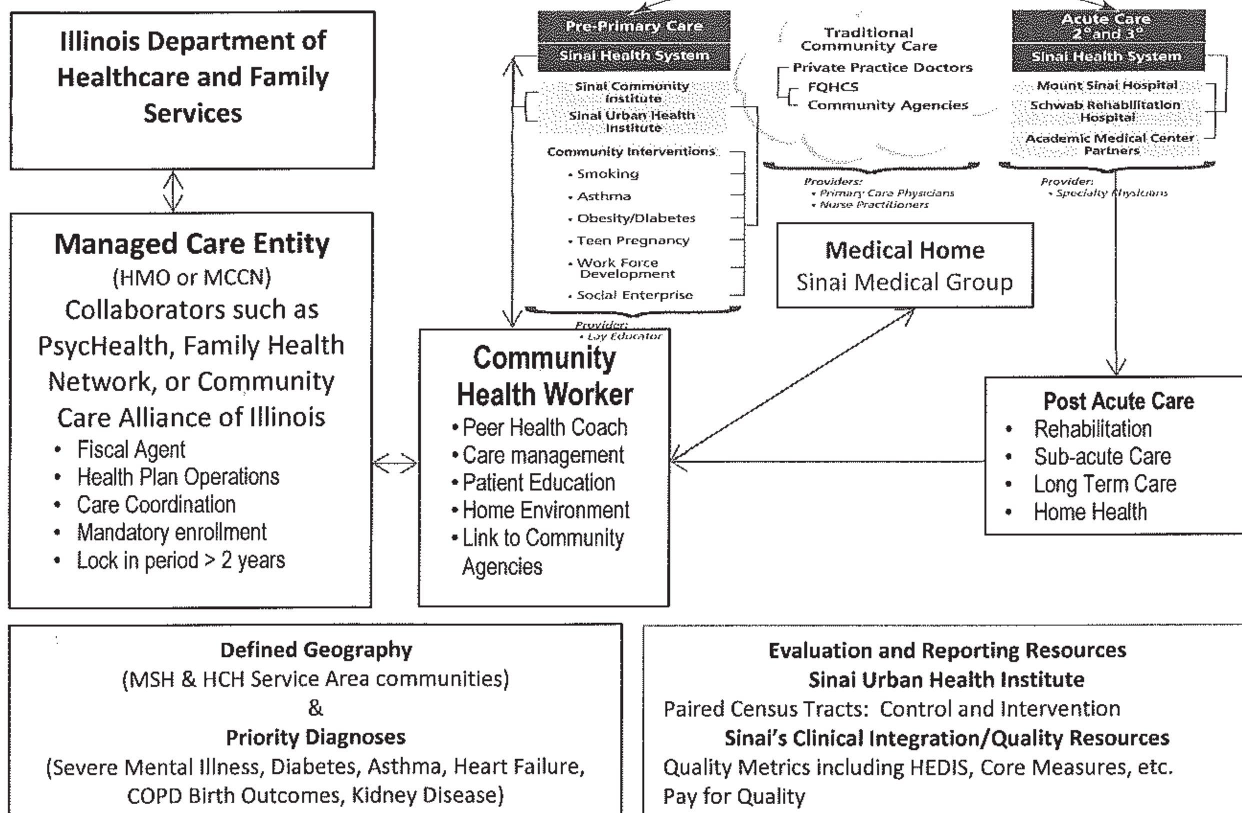
through reimbursement as currently. Our expectation would be to identify PMPM costs associated with patients and the enrolled populations, and use utilization, disease, and care management initiatives to control overall costs and bend the cost curve for HFS, Sinai's Consortium and the enrollees. We may also employ value analysis and actuarial consultants to facilitate identification of cost-saving and revenue enhancing efforts. We submitted a proposal to CMMI this August where we engaged these consultants; we are familiar with each other's resources and capabilities.

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.

Sinai's ACE reflects public and private sector health innovations ushered in by ACA passage in 2010, by Illinois Medicaid and CMS in their Care Coordination Innovation and Medicare-Medicaid Alignment Initiatives and their solicitation for participating private sector health plans in 2011-12, and formation of the Illinois Health Insurance Marketplace and solicitation of QHPs earlier in 2013. Our model integrating population-based and episode-based care delivery strategies embodies six enabling initiatives: practice and service redesign; payment innovation; consumer engagement, education and self-efficacy/management; workforce development and education; and health information technology coordination and inter-operability; and rigorous quality improvement and evaluation. Our payment model can be based on reform in Illinois in Medicaid and MMAI. Combining integrated population-based and episode-based care delivery strategies already pioneered by Sinai in other chronic illnesses will be deployed and will reflect changes in incentives to Sinai and its providers and improving the capabilities and organization of our workforce.

An ACE project team will be composed of a small cohort of managers and varied professionals functionally committed to the various strategies intended to coordinate and integrate health services. Additionally, a large, growing number of community health workers will be employed to facilitate outreach, education, and at-home services and to demonstrate their potential contribution to the delivery model. Their inclusion and the design of the integrated Behavioral Health/Medical Model are a reflection of Sinai's Pre-Primary Care Model below.

Sinai's Vision of Community Based Health Care



Care coordination and management will rely on a combination of elements including: re-education and training of providers within Sinai and providers participating in the network to foster multi-disciplinary and multi-institutional cooperation and teamwork addressing each enrollee holistically; developing seamless and inter-operable electronic medical records; stratifying all enrollees through initial assessment and individualized planning to address their risks and resources and needs for assistance in the home, community, and with providers of their choice; providing care/disease management in conjunction with our health plan partner(s); and assuring quality and clinical integration programs among providers are employing and reporting similar measures and indicators based on federal, state, and commercial sources (AHRQ, NQF, HEDIS, and Illinois Medicaid).

We would expect to negotiate PMPM rates with Illinois Medicaid employing data form Medicaid and regional/national experience available through CMS and commercial data bases.

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.

   Depending on the nature of the data and the providers in question, we will employ different means. Sinai and Holy Cross have Meditech, Next Gen and Askesis Electronic Medical Records, and can coordinate communications, secure record keeping, and billing through these systems. Some aspects of care coordination regarding medical information exchange will be facilitated between entities by the IL HIE and or MCHC's Metro Chicago HIE. It is not clear at this point what legal barriers will persist on the exchange of behavioral health information; we currently anticipate consents in some cases between providers outside Sinai, and for use of common electronic medical records within Sinai which cover medical and behavioral health. With some FQHCs, exchanges of care summaries can be exchanged between EMRs, but with others, the use of faxes may need to be continued for some period of time.

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.

   Concerns all providers and potential ACEs would doubtless express include but are not limited to assuring:

   - Some legitimate means are provided for incentivizing providers;
   - Availability of resources to address the social and environmental determinants shaping health;
   - Simplification at some point of the numbers of delivery/payment model reforms being implemented simultaneously;
   - Legal barriers for exchange of information are consistent with patient rights, privacy, AND care coordination efforts across providers;
   - Licensure and practice rules that enable both oversight and optimal deployment of scare staff and skills in the near term; expansion of persons trained and experienced in needed disciplines consistent with growth in the demand for services;
   - Examination of regulatory processes that limit capital formation and investment in new facilities;
   - Means are available to develop and/or acquire sufficient numbers of trained staff appropriate for employment in this or similar comprehensive models without producing unsustainable salary/fringe inflation.