Section A Letter of Intent (LOI)

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Outline and Self-Assessment

Section B of Letter of Intent

Introduction

Overall long term health care savings and improvements in quality of care are achievable for Medicaid beneficiaries in Illinois. In order for this to be achieved, care must be appropriately coordinated, actionable data must be made available in a timely and efficient manner, and payment models must incentivize providers to make value-based decisions. Specifically, this proposal aims to reduce overall costs in the outpatient, hospital, and post-acute setting for Medicaid beneficiaries through an extensive network of providers and hospitals in southern Illinois that will use both a web-based decision support tool and a collaborative system of care coordination and case management. This is achieved through a payment model mechanism that incentivizes physicians to focus on quality rather just quantity of care, including essential preventive measures. These components lead to improved outpatient management that leads to reductions in high-cost radiology and pharmaceuticals, post-acute care, improved preventive services, in addition to savings from initial as well as repeat hospitalizations.

Our proposal brings together six hospitals and their associated physicians, Heartland Women's Health Care, and a large multidisciplinary practice group under the lead organization, St. Mary's-Good Samaritan, Inc. (SMGSI) to form our ACE. The ACE serving primarily nine counties in southern Illinois will partner with Accountable Care Associates, Inc. and Quality Health Ideas, LLC to assist in the aggregation in the data and the development and implementation of our care model, including case management and care coordination. Below we list the key areas of our proposal that outline our location, governance, organization, network, finances, care model, and health information technology capabilities.

1. Geography

    a. Our ACE serves a rural, geographic market spanning 9 counties in southern Illinois with a total population of approximately 230,000 residents.

    b. There are 57,232 total Medicaid recipients in the 9 county service area, and approximately 51,000 of these recipients are non-disabled and would be appropriate candidates for care coordination under our ACE.

County	Child	Disabled Adults	Other Adults	Seniors	Total Comprehensive	Total Partial	Total All Recipients
Clay	1,895	478	1,035	282	3,690	139	3,829
Clinton	2,605	854	1,362	375	5,196	191	5,387
Franklin	6,007	1,427	3,601	735	11,770	454	12,224
Hamilton	983	199	557	199	1,938	77	2,015
Jefferson	6,276	1,193	3,546	697	11,712	501	12,213
Marion	6,115	1,286	3,460	770	11,631	320	11,951
Perry	2,419	515	1,385	259	4,578	167	4,745
Washington	820	158	440	105	1,523	33	1,556
Wayne	1,668	348	968	256	3,240	72	3,312
Total	**28,788**	**6,458**	**16,354**	**3,678**	**55,278**	**1,954**	**57,232**

c. The education level in the service area is lower than national average, and the household income is approximately 25% below national average.

d. The service area is considered to be geographically underserved. The County Health Rankings & Roadmaps, sponsored by the Robert Wood Johnson Foundation in collaboration with the University of Wisconsin Population Health Institute, is updated each year and ranks each county in the US using outcomes, health factors, and behavior indicators. Four of the nine counties in our ACE service area rank among the bottom 12 of 102 Illinois counties.

e. In the Community Health Needs Assessment (CHNA) performed by Good Samaritan Regional Health Center, "Access to Care" emerged as the number one priority in our rural market.

f. All counties within our ACE service area have been designated as a Health Professional Shortage Area (HPSA) for all of part of these categories: mental health, low income primary care, low income dental.

2. Organization

a. The Illinois licensed entity has yet to be developed, but will likely be a business corporation licensed in Illinois. The lead entity within the organization will be St. Mary's -Good Samaritan, Inc. (SMGSI).

b. Management of the entity will be chaired by Philip Gustafson, President and CEO of St. Mary's Good Samaritan, Inc. with strategic planning and coordination activities guided by Julie Long, Vice President, Strategic Business Development, and SMGSI with provider relations coordinated through Lisa Turner, Physician Services & Outreach Manager.

c. The principals of Accountable Care Associates (ACA) will be responsible for IS applications to this project including use of their large data collection system and

proprietary systems that use claims data to direct and coordinate care and provide reports on results with both financial and quality dimensions. We will partner with ACA in the collaboration and development of care coordination and case management protocols and execution of those protocols.

d. The primary responsibility for the participating hospital presidents is to ensure proper direction and coordination of the primary care practitioners in their respective areas.

e. The Medical Director will oversee clinical activities.

f. Michelle Darnell, Vice President of Systems Improvement, SMGSI will direct a Care Coordination Network that will be established to serve each of the practices and hospitals. There will be central control over all aspects of the Care Coordination activities, but individuals will be placed in localities based on the size of the populations to be served.

g. The financial operations will be directed by Dee Evischi, Chief Financial Officer, SMGSI.

h. Each of these members has been involved with the development of a Medicare ACO structure and is familiar with all aspects of a care coordination network.

i. The main agreements that need to be in place are 1) an agreement to join the ACE and 2) an agreement to participate fully in this endeavor which describes how any savings will be shared. This will also identify the participants' responsibilities in all aspects of this effort. This would also include a Business Associate Agreement for data sharing.

j. Much of the development work has been completed as it draws from the same structure of a Medicare Shared Savings Program in which we are participating.

k. Agreements will need to be signed by the end of November.

3. Governance

   a. The Board will consist of 7 to 9 members representing hospitals, primary care providers, obstetrician-gynecologists, specialists, and behavioral health. It will also include two members from the MCO partner, Accountable Care Associates.

   b. "The governing body will be responsible for setting policies, developing and implementing models of care, establishing best practices, setting and monitoring quality goals and assessing performances and efficiencies."

   c. There are a few good candidates for a Medical Director and that will be designated prior to submission of the proposal.

4. Network

   a. Good Samaritan Regional Health Center, Mt. Vernon Illinois

b. St. Mary's Hospital, Centralia, Illinois

c. Cardinal Glennon Hospital

   i. SSM Cardinal Glennon is a sister-hospital to the lead organization, Good Samaritan Regional Health Center, and St. Mary's Hospital

   ii. Good Samaritan is in-process of developing a telemedicine program for neonatology between its nursery and Cardinal Glennon

   iii. A fetal monitoring project could reduce the need to transfer out an estimated 60% of high risk deliveries (safe alternatives for parents which provide better convenience and service, while also reducing overall costs of care)

d. Physician Services Corporation of Southern Illinois is a multidisciplinary group of physicians, nurse practitioners, and physician assistants who serve primarily Marion, Jefferson, Washington, Franklin, and Wayne County. The general specialty categories covered include:

   i. Primary Care Practitioners (internists, family practitioners)

   ii. General Surgery, ENT, thoracic, vascular, and cardiac surgery

   iii. Cardiologists

   iv. Behavioral Health Professionals including physicians and nurse practitioners

e. Franklin County Hospital and associated physicians

f. Washington County Hospital and associated physicians

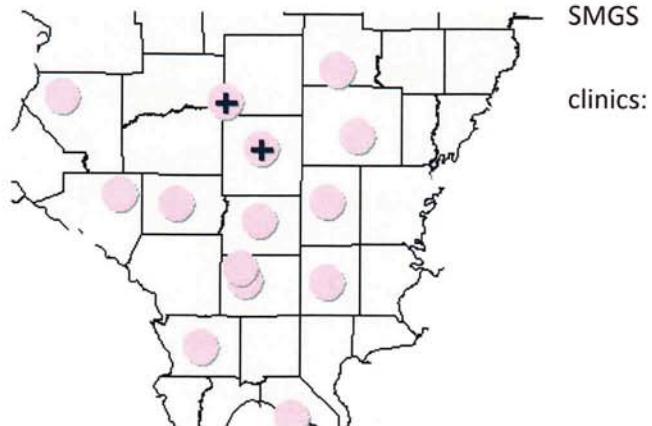
g. Clay County Hospital and associated physicians. Clay County is the only county outside of our nine county service area.

h. Heartland Women's Health Care

   i. 14 OBGYNs.

   ii. Nurse practitioners

   iii. Practicing in the following office locations either independently as Heartland or in partnership with SMGS through a collaborative approach in outreach clinics:



      1. Belleville

2. Mt. Vernon
3. Centralia
4. Marion
5. Flora
6. Benton
7. Pinckneyville
8. McLeansboro
9. Nashville
10. Sparta
11. Harrisburg
12. Fairfield
13. Herrin
14. Metropolis
15. Anna

i. We are currently discussing inclusion of Hamilton Memorial Hospital in Hamilton County, Illinois.

j. There may be additional physicians or hospitals in any of these markets who may choose to join our ACE.

There are approximately 60 physicians and 15 Allied Health Professionals as part of this entity.

5. Financials

Enclosed (Exhibit A) is a description of estimated expenses divided by respective responsibilities of Good Samaritan Regional Health Center and Accountable Care Associates, Inc. It is an estimate of resources needed to produce this Care Model.

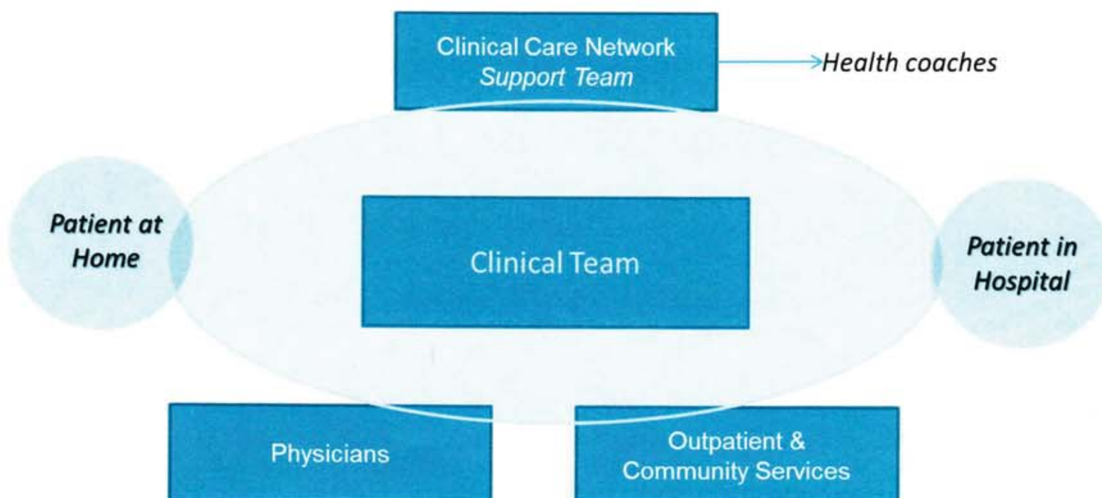
6. Care Model

We propose to enroll ACE participants from the approximate 51,000 non-disabled Medicaid beneficiaries in our region who are potentially cared for by primary care providers, behavior health providers, and other specialists including obstetricians and gynecologists. We expect to serve approximately 30,000 recipients. Small novel incentive payments to providers will encourage them to use a concisely focused web-based tool to address key chronic conditions, particularly in high risk patients, to review essential preventive measures, to focus on costly

medications, and to review actionable data focused on quality based outcomes. Based on prior experience with our subcontractor, Accountable Care Associates Inc., the use of a point of service web-based tool, Care Screen™, by primary care physicians leads to reductions in costs and improvements in health and quality measurements within the first six to twelve months. The tool using EMR, local hospital, and/or HIE data and our care management system helps clinicians to focus on costly and disabling chronic conditions, address preventive care needs, and review for appropriate referral patterns and pharmaceutical options for the most cost-effective care.

Providers participating in ACE are given access to a web-based tool, which through a secure data retrieval mechanism, can aggregate beneficiaries' prior diagnoses, hospitalizations, post-acute stays, high cost radiology usage and medications based on Medicaid claims data and selective data pulled in from an HIE. This data is then filtered and passed on to providers so they can focus on the essential care needs of their beneficiaries. Furthermore, our partner, ACA, has extensive experience in claims retrieval and secure aggregation for over 100,000 Medicare and Medicaid beneficiaries in several states. In addition, key HEDIS and state measures of quality based on age and gender are identified. Providers both at an individual and at a group level are able to see their performance with regards to achieving quality standards for beneficiaries.

Care management components include identification, stratification, and prioritization which are used to identify beneficiaries at highest risk who offer the greatest potential for improvements in health outcomes. The ACE will assure that the goals of care outlined above meet the stated goals of "whole-person" care under the establishment of the Health Home when beneficiaries have met the criteria due to their chronic and/or mental health conditions. Care management programs incorporate clinical and non-clinical sources of information to identify members who will most benefit from care management. We will use previously developed tools to identify high risk individuals which include Health risk assessments, Predictive model (algorithm–driven model that uses multiple inputs to predict high-risk opportunities for care management), Case finding (e.g., chart reviews, surveys), and Referrals (from member, provider, community).



Care Management interventions are tailored to meet beneficiary needs, respecting the role of the patient/caregiver to be a decision maker in the care planning process. Interventions should be designed to best serve the beneficiary, be multi-faceted, improve quality and cost effectiveness, and ensure coordination of care. The Care Manager collaborates with the beneficiary and physician to develop an individualized plan that ensures the beneficiary receives health education, develops skills to self-manage the disease, and receives care in the most cost effective setting. The mission of the program is to improve outcomes for the beneficiary through education, coordination of care and access to services.

Program evaluation includes systematic measurement, testing, and analysis to ensure that tailored interventions improve quality, efficiency, effectiveness and beneficiary satisfaction. Careful and consistent evaluation will build the evidence base in terms of what works for complex and special need populations.

We have with our partner, ACA, access to extensive disease management programs including asthma, diabetes, congestive heart failure, and depression. We will expand on these to develop with our obstetric team special management programs for pregnant women, including those with substance abuse or mental health needs.

7. Health Information Technology

Accountable Care Associates is implementing a private Health Information Exchange (HIE) utilizing the Mirth suite of software including the Mirth Integration Engine, and Mirth Master Patient Index. The HIE will be fully operational by December 31, 2013. ACA's HIE will allow secure data exchange with other HIEs, hospitals and physician practice EMRs, and payors.

The HIE is housed in a state-of-the-art data center that ensures the highest levels of security and redundancy. The ACA servers and network are located in a commercial quality SSAE 16 SOC II, HIPAA compliant, facility in Marlborough MA [primary data center] that allows ACA to have secured servers, with multiple geographically diverse failover points, redundancy and data backup. ACA has secured the area, restricted access to only necessary personnel, via ID. Both data center facilities [MA and CT] have a SSAE 16 SOC II audit report validating compliance with HIPAA and high levels of security.

All data can flow real time if the source systems can accommodate this type of data transfer. Data aggregation and analysis will be performed by ACA and presented to the end user clinician via the QHI proprietary CareScreen™ point of care software tool.