Attachment D
Letter of Intent (LOI)

In order to allow for appropriate planning around this component of the ACE Program, the Department is requiring a Letter of Intent (LOI) from each entity that anticipates or is seriously considering submitting a Proposal for providing services under the ACE Program. While submitting a LOI does not commit an entity to actually submit a Proposal, HFS will not accept a Proposal from nor provide data to an entity that has not submitted a LOI by the due date of October 1, 2013.

The Department wants one LOI per entity, irrespective of the number of members within the entity. The organization and person submitting the LOI will be the Department's primary contact unless the contact information is subsequently changed. If an entity determines it is no longer interested in making a Proposal, it should withdraw its LOI.

The LOI must include the following items:

- Section A (Contact Information)
- Section B (Proposal Summary/Self-Assessment Form)
- Section C (HIPAA Data Use Agreement*)

** The Department will provide what HIPAA defines as a 'limited data set'. The data will not contain directly identifiable information, but will have sufficient granularity that HIPAA protections still apply.*

Other than sections marked with < > symbols, you must sign the Data Use Agreement without changes to format or language. We have provided a separate Word document for your use. Remove the < > symbols and content and insert your content as instructed.

The expected high-level timeline of the ACE Program is as follows:

- Last date to submit LOI – October 1, 2013
- Data sharing – As the LOI are received
- Proposals due – January 3, 2014
- Award Announcement – Anticipate February 2014
- Contract Start – Anticipate July 2014

Please send the completed LOI to Amy Harris at Amy.Harris@illinois.gov. If you have questions about the LOI submission, please contact Amy Harris.

Section A: Contact Information

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

Unified Physicians Network ACO, LLC

Primary Contact Information:

Name : Tayebe Shah-Mirany

Title Vice President & General Counsel
Organization: Independent Health Resources, Inc.
Address: 5215 Old Orchard Road, Suite 340, Skokie, IL 60077
Email : tsm@ihr-mso.com
Phone : 847-763-7259
Other information: None

Primary Contact Person for Data (if different):
Name : Jafar Shah-Mirany, Jr.
Title : Systems Analyst
Organization: Independent Health Resources, Inc.
Address : 5215 Old Orchard Road, Suite 340, Skokie, IL 60077
Email : jj1@ihr-mso.com
Phone : 847-763-7223
Other information: None

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.

Please See attached narrative.

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?

Please See attached narrative.

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.

Please see attached narrative.

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

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.

Please See attached narrative.

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.

Please see attached narrative.

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

Section C: HIPAA Limited Data Set Agreement

Please see attached executed HIPAA Limited Data Set Agreement

Section B Question 1: Geography and Population

Our service area is Cook County, Northern Will County, and Eastern Dupage County. We would anticipate a minimum of 25,000 enrollees and a maximum of 100,000. Our efforts to recruit enrollees include, but are not limited to: 1) the enrollees already existing relationships with our 103 primary care physicians; 2) Thirty years of positive brand recognition of Unified Physicians Network; 3) Website; 4) Community outreach such as health fairs to include preventative screenings and immunizations; and 5) Well mom and baby campaigns.

Section B Question 2: Organization and Governance

Unified Physicians Network ACO, LLC ("Unified ACO") was formed by Primary Care Physicians ("PCPs") and Independent Health Resources, Inc. ("IHR"), a managed care management company. The majority of the participating PCPs and specialists are members of Unified Physicians Network, Inc., an independent physicians association. ("Unified IPA"). Unified IPA was founded in 1984 to enable independent physicians to participate in and contract with health maintenance organizations ("HMOs"). Unified IPA is also managed by IHR. Through years of participation and experience working with area managed care payers such as Harmony Health Plan/WellCare, BlueCross/BlueShield of Illinois and Humana, the PCPs of Unified IPA and their management team have learned to: 1) practice evidence based medicine; 2) improve quality and outcomes; 3) ensure appropriate utilization of healthcare resources and pharmacy; 4) develop successful care management programs and; 5) develop strategies to more fully engage patients in their care. Moreover, Unified IPA has developed strong fiscal policies and procedures that ensure the financial integrity of the organization and the provision of adequate resources to support the required IT infrastructure and management services. Therefore, we are confident that the PCPs and specialists of Unified ACO and their management team are well equipped and prepared to succeed as an ACE. More importantly, the management team and PCPs have worked together for a number of years. Consequently, there is mutual respect, trust and understanding in working together for the betterment of the patient.

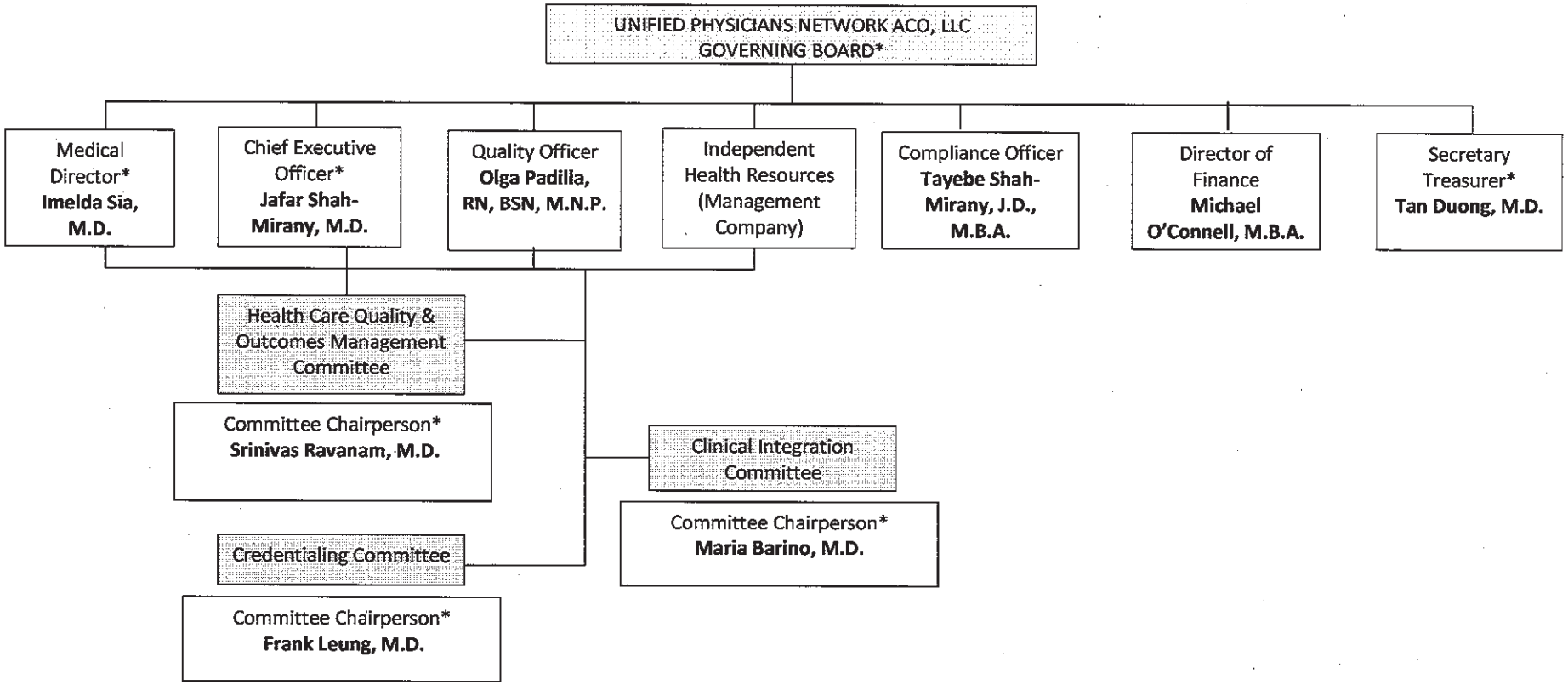
Unified ACO is a separate and distinct legal entity from Unified IPA. The company was formed as a Limited Liability Company under Illinois law. The governing board consists of five primary care physicians (PCPs), a management company representative and a Medicare beneficiary. The PCPs control seventy-five percent (75%) of the governance. There is a Chairman of the Board, CEO, and Secretary/Treasurer. Additional leadership includes a Medical Director, Quality Officer, Compliance Officer and Director of Finance. There are three committees, a Quality Committee, Clinical Integration Committee and Credentialing Committee. All Committees are chaired by PCPs. ACO Providers are requested to participate and contribute to the ACO in a meaningful way by serving in a leadership role, on a committee or by acting as a physician advisor. Please see the attached organization chart for the names of those in key leadership positions and their roles. The ACO intends to establish a Consumer Advisory Board to meet the requirements of the ACE solicitation. We also are considering adding a Medicaid recipient to our Governing Board.

Agreements are in place with PCPs, specialists, hospitals and a behavioral health organization, which will require amendments to allow participation in the ACE program. Similarly, there may be amendments required to our existing management agreement with Independent Health Resources, Inc. It is anticipated that all amendments will be completed prior to the ACE solicitation deadline.

The mission of Unified ACO and the governing board is to improve: 1) healthcare delivery, quality, utilization and outcomes for individual patients and populations of patients through the application of evidence based medicine, quality initiatives, care coordination and patient engagement. This will be achieved through the cultivation of a PCP driven medical home model

supported by the governing board, management team and IHR IT infrastructure and analytical reporting capabilities.

Unified Physicians Network ACO, LLC
Organizational Chart 2013-2014



***Members of the Unified Physicians Network ACO, LLC Governing Board**

Section B Question 3: Network

The providers who have agreed to participate in the ACE are 106 primary care physicians and 504 specialists (includes 30 obstetricians), twelve hospitals and a behavioral health network. The majority of these healthcare providers have long standing contractual relationships with Unified Physicians Network. Additionally, contracts exist with hospital based physicians, free standing diagnostic centers, physical therapy vendors, a reference laboratory, a national pharmacy, ambulatory surgery centers and other ancillary providers. The majority of the healthcare providers are located throughout Cook County, Northern Will County and Eastern Dupage County. We will only recruit additional providers to the extent that we identify gaps in coverage for certain areas of specialty practice.

Section B Question 4: The primary source of funding for the ACE operations and up front expenses will be the management company of Unified Physicians Network ACO, LLC, Independent Health Resources, Inc. ("IHR"). We believe the upfront expenses will be minimal given the fact that IHR already has in place an IT Infrastructure and currently provides: quality management, care management, case management, utilization management, claims management, contract management, provider management, customer service, capitation & enrollment management and financial management services to ACE like entities. IHR has access to six million dollars in capital.

Section B Question 5 Care Model

a. ACO Methods to coordinate care through an episode of care and during care transitions, inside and outside the ACO

Unified ACO's goals for care coordination are to reduce fragmentation in the delivery of health care and improve quality of referrals and transitions by establishing accountability for each aspect of a patients overall care and promote the transfer of information from one participant in a patient's care to another.

Unified ACO's participant primary care physicians (PCP) have an established role in the coordination of patient care and accountability for their patients across many payers. A PCP identification process ensures that patients undergoing care transitions have an identified and responsible practitioner at all times. Unified ACO's participant primary care physicians collaborate with Unified ACO's clinical care coordination team to determine and update care coordination needs for ACO patients.

Patients with high risk diagnosis or complex care coordination needs are identified through data or may be referred by a provider to Unified ACO's clinical care coordination team. Unified ACO's Clinical Care Coordinators and Case Managers are Registered Nurses and Advanced Practice Nurses that assume proactive responsibility for coordinating care between health care providers and services across the continuum of care transitions for ACO patients. The care coordination team provides condition specific health coaching throughout a patient's care transitions to empower patients and caregivers to self-manage their own health.

The ACO's care coordination team establishes an individualized plan of care that identifies care coordination needs, short and long term goals and addresses any potential gaps as well as accountability for implementation of each part of the patient's care plan. The patient's primary care physician along with the care coordination team assess a patient's health care needs and collaborate with the patients and their families to develop an individualized care plan that incorporates patient goals and preferences. The care coordination Team communicates progress to goals and updates care needs via electronic fax, secure email and through the patient's electronic health record.

EHRs within physician practices allow communication of care and medical history, care goals, quality benchmarks and patient preferences. Unified ACO participants forge collaborative relationships with trusted providers (i.e. consultants, behavioral health and substance abuse specialists, urgent care centers, hospital and extended care facilities) and other ancillary services (i.e. social work, nutrition, physical and occupational therapy) within and outside the ACO to establish a "Medical neighborhood". Co- management expectations are outlined between providers, such as a visit vs. a handoff of care and the necessity of written reports to referring providers. A patient's PCP and the members of Unifiec ACO's care coordination team track patient referrals to specialist and ancillary services within and outside the ACO via the ACO's electronic portal. An electronic referral/order is sent to a consultant's office with the reason for referral and relevant clinical information. The care coordination team takes an active role in scheduling the patient to see the consultant. The ACO's portal provides each physician's office with a tickler system to follow up with consultants and tc obtain a specialist report.

The ACO has initiatives to decrease the duplication of health care services and improve electronic record communication within and outside the ACO. Many participant's EHR's have electronic capabilities to share care summary information with HIPAA compliant invitations to consultants to view an individual patient's electronic record Unified ACO is in the process of implementing a HIPAA compliant software platform that would allow the establishment of a centralized health information exchange with patient centered record capabilities to allow patients access to their own portable record. A patient portal serves as a vehicle for two way sharing of information so that patients and care givers have the information they need and can provide a record of home monitoring data that can be shared with the care coordination team.

Primary Care physicians at Unified ACO's core facilities have elected to utilize Unified ACO's affiliation with a Hospitalist program for inpatient physician management. A hospitalist is on site at core facilities full time during the day (7 days per week), available 24/7 via pager, and available to assist in acute management of the patients in the emergency department. Hospitalists access a virtual office portal that assists in communication with referring primary care physicians. Admission and discharge information is electronically routed to the patient's primary care physician and the ACO's Clinical Care Coordinator. The Hospitalist is provided with a list of a patient's current medication. On discharge a patient is contacted by the Hospitalist service case manager to assess current health status, queried on medication compliance, other services arranged at discharge, satisfaction with the Hospitalist and forwards the information to the ACO's care coordination team.

The care coordination team is notified whenever an ACO patient is admitted, discharged, or transferred from an ED, Hospital or extended care facility. Unified ACO's R.N. Clinical Care Coordinators play an active role in coordinating a patient's discharge plan with hospital or extended care facility team members. Clinical Care Coordinators communicate with the attending physician, and facility discharge planner to formulate, update and implement an effective discharge plan that facilitates a smooth timely and safe discharge when a patient's condition stabilizes.

The discharge planning process includes an assessment of a patient needs for post hospital follow up care and services. The assessment process includes but is not limited to assessing the patient's functional status, medical status, self-care ability, social support, care giver availability and willingness to provide ongoing care. The plan may include extended care or community based services such as meals on wheels, home health care or a hired care giver if needed. Implementation of the patient's discharge plan includes facilitating the scheduling of follow care appointments with PCP and specialists.

Unified ACO's primary care physicians have electronic access to their patient's electronic medical record and receive copies of the patient's discharge summary at their core hospitals. Discharge instructions includes summaries for the patient and care giver that provides clear guidelines for responding to "red flag" signs and symptoms of a worsening condition, discharge medication instructions and a comprehensive list of scheduled follow up appointments. The ACO's care coordination team notifies the patient's primary care physician of ACO patient admissions that occur outside the ACO's core hospitals or extended care facilities and on discharge assures that the PCP is provided with a copy of the discharge plan and which includes discharge medication.

Patients discharging from inpatient or extended care facilities that are assessed to be High risk due to target diagnosis or complex care needs are referred to Unified ACO's case management services. The Clinical Care Coordinator or the Case Manager (for patient's enrolled in case management services), will contact a ACO patient within 72 hours of discharge to assess follow through with appointments, confirm that necessary discharge services such as home health care have been initiated and may reconcile medications if home services are not indicated.

Collaboration around the patient's care continues as the home health team risk assesses the patient in their home and facilitates a follow up appointment with the primary care physician. For home bound patients a physician home visit may be arranged. As part of the initial home visit an environmental assessment is conducted to identify risk for falls. Medications are reviewed and checked against the list from the hospital discharge and PCP's office. The home care nurse reinforces coaching on medications and education on disease management and lifestyle issues.

b. Individualized Care Program

Unified ACO provides an individualized care program through the provision of case management services to ACO patients. The purpose of the ACO's case management program is to provide a cost-effective, comprehensive method for effectively monitoring and coordinating healthcare services provided to patients identified with complex conditions requiring potentially costly, complicated care. Effective case management of patients with chronic conditions can reduce episode of care costs and promote cost-effective resource utilization such as reduction in the number of home care visits, inappropriate ED visits, hospital length of stay and re-hospitalization rates.

The goals of the ACO's case management program are to help patients regain optimal health; improve coordination of health care delivery and services and/or gain improvement in functional capacity. ACO case managers assure high quality individualized patient-focused services to patients and their families across the continuum of medical care by collaboratively working with treating physicians, other caregivers and health professional to develop, implement and manage care plans that provide efficient and appropriate medical, social and preventive health care services using evidence based medicine guidelines to achieve optimal outcomes.

Unified ACO patients and primary care physicians are made aware of the availability of case management services through communications of the program with printed materials, participant newsletters, and Unified ACO's web site. Unified ACO's case management program utilizes multiple data sources such as claims, encounters, data supplied by practitioners, EHR, predictive modeling software, health appraisals as well as practitioner or care giver referrals to identify patients with multiple or complex conditions that have the potential for long-term, costly or complicated health care needs that may benefit from case management.

The ACO's case manager (CM) assigned to a case conducts an assessment of the patient which includes:
☐ Diagnoses- acute or chronic conditions, co-morbidities, current status of diagnoses, including mental health diagnoses.
☐ Procedures-historical and current.
☐ Clinical and treatment history-including disease onset, history from the onset of the condition(s) leading to the current health status.
☐ Current health status with condition specific information, including current mental status,
☐ Assessment of cognitive function, assessment of ability to perform activities of daily living (ADLs), ability to communicate and understand.
☐ Documentation of hearing or vision limitations,
☐ Medications (including dosage and schedule) and assessment of medication adherence.
☐ Assessment of life planning activities, (living will, advance directives, power of attorney if applicable) and documentation of recommendations or information given. If not appropriate, documentation of why not.
☐ Evaluation of a member's cultural or linguistic needs or preferences.
☐ Documentation of available benefits and limitations and available community resources, needed or not.

☐ Evaluation of care giver resources including availability, level of involvement and understanding of care

☐ Care Coordination needs and potential gaps

☐ The CM will contact the Member's treating physicians and other health care providers involved in the Member's care for additional information to be utilized in developing an individualized care plan.

The CM develops a case management plan in collaboration with the patient and treating physicians that includes the following:

☐ Evidence-based guidelines utilized to manage the case

☐ Goals for care, timeframes for goals to be met and with revision or completion dates, as applicable.

☐ Development of a member self-management plan

☐ The care plan is presented to the enrollee or his/her designated representative with communication of the Member's self-management plan and a follow up schedule.

☐ The care plan takes into consideration the enrollee's short-and long-term goals, healthcare coordination needs, anticipated costs and expected outcome.

The CM contacts the patient or their caregiver in a specified timeframe to assess the patient's progress to goals and self-management, barriers to meeting goals and revision of goals or timeframe to meet goals. The case manager establishes a schedule for follow up and communication with the patient, and physicians including the date for next follow up. The CM is responsible for following-up on the care she/he has arranged, including periodic reviews to assess continued appropriateness, effectiveness and progress to goal achievement. Communications include; assessment of medication adherence, follow-up after hospitalization and documentation of referrals to resources and follow-up to determine if patient acted on referrals(s).

Evidence based guidelines utilized in the complex case management process may include guidelines available from medical or behavioral health specialty societies, Apollo Criteria sets, the National Guideline Clearing House or Unified ACO's clinical pathway guidelines/ algorithms based on researched clinical evidence.

Upon closure of a case a satisfaction survey is provided to the patient and caregiver. The survey be administered telephonically or may be mailed to the patient and care giver. Surveys are reviewed by the Health Care Quality and Outcomes Committee on a quarterly basis. Dissatisfaction is addressed with a corrective action plan and tracked on the complaint log.

An annual assessment of the characteristics and needs of Unified ACO's patient population and relevant subpopulations is utilized to revise and update the complex case management program and resources.

*Sample Care Plan on page 7

c. How individual care plans take into account Community resources.

A patient needs survey /assessment is conducted by Unified ACO's care coordination team of Unified ACO's new enrollees and is updated at any care transition, includes an assessment of current community resources being utilized by the patient and links them with additional services needed that could be provided through various community resources. Case management services assist elderly and disabled adults and their caregivers to decide which community services they need in order to remain living in their home. Case managers assist care givers in finding options for respite care

such as adult day care. In home services such as home health, home maker, care giver or home delivered meals may be arranged for homebound patients. Transportation services can be arranged to assure that a patient can access needed health care services. Referrals may be initiated to local community services that provide assistance in exploring available housing options for seniors that may need to move out of their home.
For seniors, case managers coordinate services with State (i.e. The Illinois Department of Aging) and local resources to facilitate community services for patients. Referrals are made to the patient's Community Care Coordination Units for social worker intervention to assist in facilitating social services and financial resources.
Case managers may assist patients with limited financial resources in the application process to obtain State or pharmaceutical company assistance for paying for prescription medications.
Patients with educational needs are linked to community disease management resources and peer support groups. The ACO care coordination team builds relationships with self-management programs, smoking cessation, exercise programs, weight loss programs and other organizations that provide support groups and educational resources to patients. Unified ACO's clinical pathway protocols and initiatives provide case managers and clinicians with updated lists of locally available resources for disease education, such as the Diabetes resource list outlines contact information local diabetes educational centers as well as contact information for endocrinologists connected to each program.
d. Additional target populations that would benefit from individualized care plans

Intensive claims data analysis is utilized to study inpatient claims by diagnosis, emergency department visits by diagnosis and high cost patients by diagnosis to identify target populations for case management and disease focus quality improvement projects. Customized Health status surveys are administered to ACO patients to measure patient's perceptions of their functional status and are tailored to identify patients who meet high risk criteria.
General characteristics utilized to identify additional high risk target populations for case management screening:
☐ Readmissions within 30 days

☐ Quality indicator outliers (i.e. ischemic heart disease patient with elevated LDL Cholesterol)

☐ Two admission for same condition in a year

☐ Multiple ER visits for same condition in one year, inappropriate use of the emergency room.

☐ Psychosocial situations that place patients at risk (i.e. social isolation, dysfunctional family dynamics, psychological issues)

☐ Multiple medications/ High cost medications

☐ Frequent falls

☐ Frail elderly

☐ Noncompliance with treatment plan/ suboptimal self –management

☐ Poor communication patterns: between healthcare providers and patient, unfamiliarity with healthcare system, language literacy barriers

☐ Chronic pain

Diseases or conditions that place patients in target high risk categories for case management

☐ Dementia

☐ HIV/AIDS

☐ Total Joint Replacement

☐ Diabetes: out of control, hospital admit, renal Insufficiency, CAD with hyperlipidemia.

☐ Asthmatic/ COPD: hospital admission.

☐ Ischemic Vascular Disease – uncontrolled Lipids, uncontrolled hypertension

☐ CAD – Invasive Procedures, Cardiac Rehab, Nutrition counseling , uncontrolled Lipids, uncontrolled HTN

☐ Hypertension- Uncontrolled, Diet and nutrition counseling

☐ Cancer

☐ CHF

☐ High Risk pregnancies, lack of prenatal care

e. How internal assessments of these processes continuously improve your care practices.

A combination of clinical, economic and patient satisfaction outcomes are measured to assess the effectiveness of Unified ACO's care coordination processes and interventions. Measurements of these areas are gauged against the ACO's internal and external data and benchmarks. Quality metrics assessments, patient survey results, and utilization of services statistics are utilized to monitor and evaluate the impact of case management interventions.

Outcome measurement of cost-effectiveness/resource utilization includes practitioner performance such as episode of care cost benchmarks and utilization benchmarking (number of home care visits, inappropriate ED visits, hospital lengtl of stay, re-hospitalization rates, and number of physician encounters). Patient Satisfaction with care coordination personnel, physician encounters, quality of service delivery and access to services is measured by patient and care giver surveys. Clinical outcomes performance measurement includes quality improvement benchmarking on disease management, preventative care benchmarks, and compliance with medications, exercise, diet and smoking cessation. Quality of life outcomes for ACO patients such as improved physical function, perception of general health status, patient safety and social function are measured.

Outcomes are continually evaluated and reported to the ACO's Health Care Quality and Outcomes Committee to ensure evidence-based care guidelines and protocols are being followed and quality is being provided. The Physician Advisory Sub Committee utilizes internal outcomes assessment to identify and intervene with factors in the process of delivering healthcare that contribute to high utilization and poor outcomes such as variations in practice and prescribing, inadequate tracking and follow-up of patients, language and cultural barriers, and noncompliance with treatment guidelines. Ongoing evaluation demonstrates the effectiveness of specific quality and practice interventions, aids in identification of barriers and promotes the development of new interventions to improve the effectiveness of care delivery.

The software technology system of Unified ACO is positioned to incorporate evidence based medical guidelines int UM determinations and report requirements. Risk analysis reporting will stratify beneficiaries with chronic and multipl conditions, accounting for usage and cost of high-risk services, including but not limited to asthma, diabetes hypertension, and cardiovascular disease. Clinical discussion and evaluation by Participant primary and specialty physicians, physician advisors and the Medical director with input from RN case managers will identify outliers an exclusions from the risk pool during regular monthly meetings (special ad-hoc meetings are scheduled based on cas urgency and time constraints). If evidence-based medicine guidelines are not the optimal course to patient health,

variable plan of treatment will be discussed with the Participant providers and shared decision making will involve the beneficiary and/or their representative.

To collectively integrate and ensure information retrieval and reporting capabilities from a geographically dispersed and technologically diverse pool of Participants, our organization created strategies in the following areas: 1) access and sharing of evidence-based literature and sources, including maximizing communication among Participants regarding evidence-based medicine and UM report requirements performed in tandem with direct beneficiary outreach interventions; 2) standardize report submission format; 3) incorporate an IT infrastructure tracking quality assurance by chronic conditions to identify at-risk populations offering assistance and coordination of care from a fully staffed health care team of clinical and community resources; 4) Analytic reporting to Participants on a regular basis that indicates performance feedback on quality, resource consumption, outcomes in association with network benchmarks as well as insights, alternatives, and recommendations to improve performance and patient care.

A health care team approach of RN case managers, executive and financial administrators, privacy compliance staff Participants and physician advisors will assess Unified ACO clinical protocol effectiveness and evidence-based medical guidelines semi-annually; confirmed interventions and changes that show improvement of care practice as well as updates of community resources are discussed and formally transitioned in or out of care management standards Network and resource changes are shared with all management network Participants via newsletter updates.

Unified ACO has established a multi-pronged Participant compliance initiative. First, under contract specifications Unified ACO Participants are required to comply with the Quality Management Program. The success of the organization is based on the effectiveness of the individual Participant in offering and providing appropriate cost effective care. All contracted Participants are given copies of QM Committee approved practice guidelines to promote standardization among the Participants, assist with compliance and prepare them for performance evaluations based on a combination of clinical, claims and administrative data. Second, Unified ACO has established technical reporting mechanisms that compare aggregate network statistics based on national benchmarks with individual physician data (subject to a drill down by patient). This gives the Participant insight into patterns and trends. Such reports are audited by the QM Committee quarterly for outliers and potential risks. Additionally, over and under-utilization is evaluated by analyzing cost per member per month, key diagnostic groups, length of stay, focused studies, and the level of success from beneficiary outreach initiatives. Reporting of quality outcomes are a determining tool for shared savings bonus distribution at the end of the fiscal year. QM program compliance of contracted Participants, both negative and positive is a critical component of the re-credentialing process; peer physicians of the Credentialing Committee are strongly encouraged to assess this value during the re-credentialing process.

The Unified ACO Quality Management Program activities are implemented by the medical staff of the Quality Management Department, managed by the Quality Officer and Medical Director. The Quality Officer is experienced in and is responsible for managing the day-to-day review and reporting activities. The Quality Officer works closely with the Medical Director, supporting and enforcing the QM program processes including: 1) **beneficiary engagement** through access to care, education, development and implementation of preventive/concurrent/retrospective service monitoring and satisfaction surveys; 2) **evidence-based medicine**-analyzing and critically appraising clinical information for validity and usefulness, applying the results to clinical practice guidelines and evaluating performance of the evidence based approach in clinical application; 3) **quality and cost metrics**-strategies aligned with Unified ACO quality, operational and financial objectives through tracking and reporting of quality management results and evaluating the cost and benefit of quality improvement alternatives; and 4) **coordination of care**-utilizing the appropriate infrastructure, clinical manpower, and electronic health records to improve coordination of high quality care to the Medicare patients with consideration of meaningful use requirements and a goal of avoiding unnecessary duplication of services, preventing medical errors, and spending health care dollars more wisely.

Primary Care Physicians, and contracted providers who fail to comply with established protocol and QM requirements including but not limited to policies/procedures, chart documentation, potential risk to quality of patient care complaints, claims inconsistencies, questionable referral and case management processes, and compliance resistanc with quality improvement project participation are subject to Non-Compliance Corrective Action and Sanction Proces Policy. Sanctions range as follows: education, financial penalty, closure of medical practice to new members suspension from participation, termination from Unified ACO.

Quality improvement Programs and standards encompass Unified ACO strategic intentions to monitor, conduct an realize growth in quality performance standards and lower the growth in health care costs. These intentions are bes served by the strength and commitment of the Participant network to form a cohesive relationship between th beneficiary and/or delegated representative, amongst other providers and utilize the resources and coordination of car available in the infrastructure of Unified ACO's internal administration.

The methodology used to establish report feedback to all Participants tracks all 33 required Shared Savings Performanc Standards that assess quality of care using nationally recognized measures and emphasizes the cost of beneficiary healt care within the same quality domains as CMS.

These reporting analytics will provide beneficiary specific actuaries to the primary care Participant along with th respective financial impact of services that will serve to help the primary care Participant better coordinate patient car and improve quality in a way that will reduce cost of care.

Report assessment is conducted at the QM Health Care Quality and Outcomes Committee level with feedback to th Governing Board in a team building approach with recommendations to consider new vendor contracts, optiona community resources, or access to ACO clinical staff to help bridge the relationship of trust and tolerance with th beneficiary, as a representative patient advocate, when indicated or at the request of the Participant office.

Participating in health care delivery requires flexible management standards that evolve with the dynamic changes o the industry, particularly the health needs of the beneficiaries as administrative focus is steered in different directions Thus, Unified ACO has a structured method and schedule of evaluating its performance of the quality managemen program that encompasses the study of traditional cost of care metrics and the cost of quality measures with outcome cost savings, available clinical information, CMS certified surveys, and effective use of patient engagement tools t determine success or failure of protocol and interventions.

Should focus of interventions and initiatives turn in new directions and/or one or more existing shared savings standard no longer require monitoring, detailed newsletters, website updates and direct one-on–one office visits will facilitat notification to Unified ACO Participants of improvements and changes. Participants are always given information o how to contact clinical and administrative staff as well as Physician Advisors who contribute to improve care practice relative to Shared Savings standards.

Each PCP shall receive a distribution of the Shared Savings based upon their meaningful contribution to the operation of the ACE, their adherence to policies and procedures designed to meet the requirements of the ACE Care Model and their ability to meet or exceed quality indicators as defined by the ACE. Each of these areas will be assigned a certain percentage weight as defined by the governing board which together will add up to one hundred percent (100%). The governing board will assign the percentage weights based upon what it deems most important to achieving the intended goals of the ACE. The allocation of the Shared Savings to the PCPs shall be reduced to a per enrollee value by

dividing the Shared Savings earned by the number of enrollees assigned to the ACE. Each Participant will have the opportunity to earn one hundred percent (100%) of the per enrollee value times the number of enrollees with their practice and under their care. To the extent that a PCP does not earn one hundred percent (100%) of his/her share of the Shared Savings pursuant to the aforementioned methodology, the remainder of the savings will be distributed equally to those PCPs who attained one hundred percent compliance with the criteria for receiving Shared Savings.

The management company will receive its distribution based upon meeting performance benchmarks as outlined in the management agreement with the ACE and approved by the governing board. The benchmarks are aligned to ensure the success of the ACE and its providers as well as improving the health of enrollees under their care. The Shared Savings distribution will enable the management company to continue to provide tools, personnel, infrastructure, reporting, analytics and data sharing necessary to meet the goals and expectations of the ACE.

The ACE believes that this model of Shared Savings distribution will highly incentivize PCPs and the management company to meet and exceed the standards established by the ACE which if followed are specifically designed to improve care, health and lower growth in spending.

Section B Question 6-Health Information Technology

The ACE will exchange clinical data through a health information exchange and through a secure provider portal.

The ACE currently has the analytical capability to determine for example, gaps in care, outliers, high utilizers of services such as emergency room and inpatient utilization, readmissions, failure to take medication properly and failure to access preventative and maintenance care as demonstrated by adherence to quality standards. Overall, the data will be analyzed to identify opportunities for savings and quality improvement. The data will also be utilized to determine which beneficiaries are subject to certain quality indicators and which beneficiaries are not accessing care to ensure quality care and improved outcomes. Additionally, the data will be utilized to target specific beneficiaries requiring a higher level of member engagement and intervention to improve their health. Finally, the data will be utilized to benchmark the performance and improvement of ACE providers.

Privacy and confidentiality of beneficiary data is paramount and will be protected and preserved in the following manner. First, the ACE and the providers will have executed Business Associate Agreements that meet the requirements of HIPAA. The management company has also executed a Business Associate Agreement with the ACE. Second, all management company personnel receive regular HIPAA training and guidance and are subject to written HIPPA policies and procedures in place at the company. Third, information sharing with individual providers, ACE governance, leadership, committees and certain management personnel will be limited to the minimum necessary to meet the expectations of the ACE program and ACE goals and objectives. When possible, information will be de-identified for such use. Finally, information systems maintained by the management company meet HITECH and HIPAA standards and are constantly monitored to ensure access by authorized personnel and to prevent unauthorized access to the system whether internal or external.