



MIDWEST INDEPENDENT PRACTICE ASSOCIATION'S ACCOUNTABLE CARE ORGANIZATION (MIPA'S ACO)

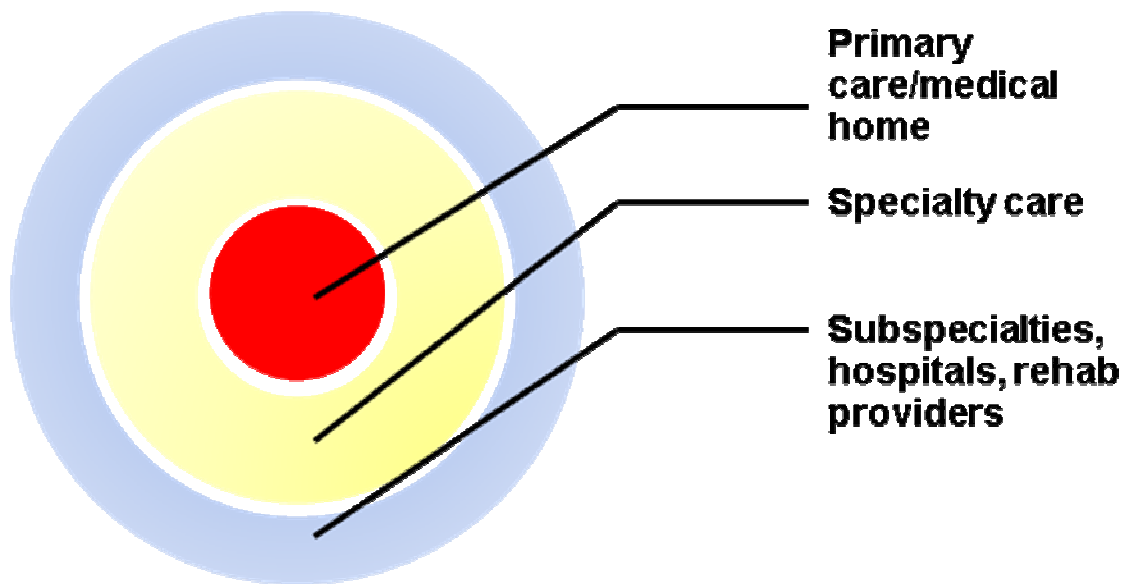
Mission:

The mission of MIPA's ACO is to accelerate the provision of the highest quality of health care to our patients in a cost-effective and efficient manner while supporting the independent medical practices so that they may not only survive but thrive.

Goals:

Aligned with IOM's triple aim outcomes

1. Develop an interdependent, collaborative network of independent physicians and health care providers focused on improving the quality of care delivered while decreasing the total cost of care.
2. Provide an electronic information system to all participating clinics for the purpose of transmitting focused clinical information, communicating with participating partners and collecting data for quality and cost analysis.
3. Demonstrate that the value (quality + access + satisfaction/cost) of medical care provided by independent practices is the best care available for the consumer.
4. Collectively contract with governmental and commercial payers for this "value" product on a fee-for-service plus cost savings basis.
5. Establish a program to evaluate quality outcomes and appropriate utilization of services and modify practice patterns by the physician participants.
6. Transparent sharing of total cost, quality and patient experience data.



Structure

1. The core of the MIPA ACO is the primary care medical home. The medical homes will provide:
 - a. Patient tracking systems & patient registries
 - b. Care coordination
 - c. Patient education and self-management
 - d. Performance reporting
 - e. Electronic transmission of information
2. The core clinics are surrounded by those specialists commonly utilized by the primary care clinics and who have agreed to the quality and utilization standards of the MIPA ACO.
3. Hospitals, subspecialists and others will be utilized on a vendor basis.

Competitive Effects

1. Position in the market: eligible physicians:
 - a. Primary care 30% of the market
 - b. Specialty care 70% of the market
2. Non-exclusive: MIPA will not force payers to contract with it. If MIPA and a payer cannot reach an agreement MIPA physicians will be free to independently negotiate with the payer.
3. Primary care members are free to independently contract with payers or with another care organization and they have no obligation to contract only through MIPA unless MIPA has contracted with the payer in question for a specific product marketed by the payer.
4. Specialty care members may contract with any care organization as long as the payer is able to identify which payment contract should be applied to their services.

Governance

1. The MIPA ACO will operate as a subsidiary of Minnesota Primary Care Physicians LLC (MPPC), dba Minnesota Healthcare Network LLC (MHN) which is non-profit taxable corporation established sixteen years ago.
2. The MHN operating company is the administrator of the MIPA ACO. The operating company will be paid for its efforts out of the shared savings funds.
3. Representation on the MIPA ACO Board shall include administrators and physicians from the member clinics. An individual clinic may have only one representative on the Board.
4. Votes shall be based on a per member per month basis determined by the clinics member enrollment in the MIPA ACO contracted health plans.
5. The MHN Board will have the final veto power over the MIPA ACO Boards' decisions.
6. At least one member of the MHN operating company will be allowed to attend the MIPA ACO Board meetings in a non-voting position.

MIPA ACO Board of Directors Responsibilities

1. At least annually evaluate the performance of the ACO
2. Recommend a budget to the MHN Board
3. Approve payer contracts
4. Approve providers and clinics for admission into the ACO
5. Approve discharge of providers and clinics from the ACO
6. Approve the clinical integration program and its goals
7. Approve the distribution of incentive funds
8. Recommend operating plans and financial development plans to the MHN Board

Membership Requirements

The MIPA ACO will allow membership for physicians entering the MIPA-ACO through an established network who agree to comply with the following standards:

1. Participates in the clinical integration program and medical director attends clinical integration committee meetings.
2. Agrees with the mission and goals of the organization.
3. Physicians are board-certified or board-eligible.
4. Actively participates in the quality improvement and clinical performance program.
5. Delegates contracting to the MIPA ACO.
6. Has high speed internet connections at all practice sites.
7. Agrees to share claims data for patients covered by the MIPA ACO contracts
8. Agrees to refer patients to MIPA-ACO providers whenever it is in good medical judgment to do so.
9. Agrees to comply with the MIPA ACO utilization review plan and suggestions for improvement.
10. Agrees to work toward certification as a medical home.

11. Agrees to designate a care coordinator for their clinic and provide needed education for that care coordinator.
12. Agrees to follow ICSI guidelines in the provision of care unless medically contraindicated.
13. Agrees to submit appropriate quality data to Minnesota Community Measurement.

Operating Company Functions

1. Manages payer relations and contracting
2. Manages provider relations and contracting
3. Provides training to physicians and clinic staff regarding ACO functions
4. Network development
5. Manages clinical integration development and programming
6. Provides clinical performance measurement, analysis and recommendations for improvement on an individual physician and aggregate basis.
7. Administers the distribution of incentive payments based on clinics' patient population.
8. Provides training to clinics regarding care coordination functions
9. Markets the services of the ACO
10. Communicates market changes to the providers and clinics

Committees

1. Clinical Performance
 - a. Establishes all clinical performance initiatives
 - b. Establishes all clinical performance goals and measurements
 - c. Approves clinical performance reporting
 - d. Designs the clinical incentive plan
 - e. Oversees the care coordination program
 - f. Ensures that clinical information technology is available to the membersAdvises Board regarding members failing to meet clinical goals
2. Finance/Payer Contracting
 - a. Develops payer contracting strategy and policy guidelines
 - b. Reviews cost analysis and proposed fee schedules
 - c. Recommends division of shared savings to the Board
 - d. Recommends approval/disapproval of contracts to the Board

Data Models Required

Population-health data models

Total Cost of Care: facility inpatient and outpatient, pharmacy, lab, radiology, professional, and ancillary
Performance tracking adjusted for illness burden using ACGs.

Quality reporting by provider, by clinic and by ACO.

Prevention and promotion education to patients.

Referral system with secure email and single sign-on/look up capacity.

Metrics for Measurement of Success

Quality Outcomes - as per MNCM and State of MN statutes – MIPA ACO clinics must reach the 25th percentile within one year of joining, direct data submission to MNCM

1. Optimal Diabetes Care
 - a. HbA1c less than 8
 - b. LDL less than 100
 - c. Blood pressure less than 140/90
 - d. Non-tobacco user
2. Optimal Vascular Care
 - a. LDL less than 100
 - b. Blood pressure less than 130/80
 - c. Non-tobacco user
 - d. Aspirin Rx. If 40 years or older and no contraindications
3. Depression Care
 - a. Six month remission rate
 - b. Utilization of PHQ-9
 - c. Twelve month remission rate
4. Preventive Services
 - a. Colonoscopy screening
 - b. Mammogram screening
 - c. PAP screening
5. Other initiatives to be developed

Overuse Measures – administrative data from health plans, goal above the 25th % from MNCM

1. Appropriate testing for children with pharyngitis
2. Avoidance of antibiotic treatment in adults with acute bronchitis
3. Asthma management

Patient Experience

TBD

Cost Measures – comparison TBD

Total cost of care

Generic drug use

Inpatient care

Outpatient care

Costs by specialty

Efficiency Measures – comparison TBD, methodology based on episode groupers

Avoidable hospital readmission rate

Hospital length of stay rate

Hospital admissions per 1000

Emergency department admissions per 1000

Payment Methodology

Negotiated fee-for-service + shared cost savings + quality awards