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AGENDA COVER MEMO

Memorandum Date:	February 16, 2011
Order Date:	Discussion only
TO:	Board of County Commissioners
DEPARTMENT:	Health & Human Services
PRESENTED BY:	Karen Gaffney, Bruce Abel
AGENDA ITEM TITLE:	Lane Health Authority

I. MOTION

This packet is for informational purposes only, although the Board may wish to provide future direction as a result of the options discussed in the staff presentation.

II. AGENDA ITEM SUMMARY

Lane County Health & Human Service will present information regarding *Oregon's Action Plan for Health* and the reorganization by the State of Oregon of the physical, behavioral health and public health service delivery system for Medicaid and Medicare individuals in Oregon into regional service delivery areas.

III. DISCUSSION

A. Background

In 2009, the Oregon Legislature created the Oregon Health Authority to consolidate health related programs in the state into one agency. In addition, the Legislature created the Oregon Health Policy Board (OHPB) whose members are appointed by the Governor and confirmed by the Senate. The legislature assigned the OHPB the task of creating a comprehensive health reform plan for the State. *Oregon's Action Plan for Health* was completed in December of 2010 by the OHPB and lays out the strategies and timelines for health reform in Oregon. The goal of this health care reform plan is to "lead Oregon to a more affordable, world-class healthcare system". Recommendations in the plan outline three objectives which are also known as Triple Aim. These objectives are 1) Improve the lifelong health of all Oregonians; 2) Increase the quality, reliability, and availability of care for all Oregonians; and 3) Lower or contain the cost of care so it is affordable for everyone.

Oregon's Action Plan for Health outlines eight foundational strategies to improve/consolidate the health care delivery system. For purposes of this

discussion, Health & Human Services will address Strategy #7 - Involve Everyone in Health System Improvements. A primary component of this strategy is the organization of local health resources through local regions.

Specifically, the OHPB "believes that regions hold great promise for fundamental change through organizing an efficient use of resources and tailoring health improvement initiatives to meet the needs of their residents."

The Establishment of local regional governance structures is to achieve the following:

•Create relationships and contracts with providers in a health system that integrates physical, behavioral, and public health;

•Assume accountability for quality of services delivered and health outcomes;

•Create a collaborative environment in which the local integrated health systems can innovate toward local achievement of Triple Aim goals while staying within the local health budget.

•Create a culture of health in their locality, including programs or initiatives that help people make healthier lifestyle choices;

•Set, measure, and track local progress on Triple Aim goals.

The State of Oregon is requesting that applications be completed by May or June, 2011 (specific time yet to be determined) for the formation of a Regional Health Authority.

B. Analysis

Here in Lane County, discussions have occurred among Lane County's Managed Mental Health Organization (LaneCare), Lane Individual Practice Association (Lipa) the physical health plan for Lane County and Senior and Disabled Services (SDS). The goal of these discussions is to explore the establishment of a Lane Health Authority in conjunction with an Integrated Health Consortium and subsequent Accountable Care Organizations (a provision in the 2010 Patient Protection and Affordable Care Act).

The attachments to this agenda memo outline the major discussion points in the formation of a new health services delivery model.

As stated in *Oregon's Action Plan for Health*, "In many ways, health is most effectively supported and health care most effectively delivered at the local level. Communities and regions are more likely to have a common vision for health and can develop locally relevant solutions based on shared knowledge and context". Health & Human Services believes that the formation of a Lane Health Authority will provide for our citizens the best opportunity and model for integrated health care in Lane County.

IV. ALTERNATIVES/OPTIONS

1. Support Health & Human Services to participate actively in the formation of Lane Health Authority, Lane Integrated Health Consortium and subsequent Accountable Care Organizations.

2. Do not support Health & Human Services to participate actively in the formation of Lane Health Authority, Lane Integrated Health Consortium and subsequent Accountable Care Organizations.

V. RECOMMENDATIONS

Recommend supporting Health & Human Services to participate actively in the formation of Lane Health Authority, Lane Integrated Health Consortium and subsequent Accountable Health Care Organizations.

VI. FOLLOW-UP

As directed by the Board

VII. ATTACHMENTS

Attachment 1: Issues Brief
Attachment 2: Draft Action Plan for Healthcare Reform
Attachment 3: Proposed Organizational Diagram for Lane Health Authority
Attachment 4: Second Proposed Organizational Diagram
Attachment 5: Joint Principles for Accountable Care Organizations

Attachment 1

Issues Brief

Issue: Lane County's participation in health care reform

Should Lane County Health and Human Services develop a public/private partnership with other organizations to establish a Lane Health Authority, a Lane Integrated Health Consortium and a Lane Accountable Care Organization?

Background:

The State of Oregon has announced a plan that will initiate significant change in health care delivery in Oregon. They are calling for coordination and integration of funding, management, and service provision through new entities: Regional Health Authorities and Accountable Care Organizations.

The integration will incorporate organizations that provide Medicaid physical health care, substance abuse treatment, mental health services, public health, and long term care. Health and Human Services, Lipa and Senior and Disabled Services manage these services in Lane County.

The State has said that they will identify the regions to be formed into Regional Health Authorities by July 1, 2011. Lane County is likely to be incorporated with Curry, Douglas, Coos, and perhaps Linn Counties. However, the State is encouraging communities to identify themselves as Regions and submit an organizational proposal to the State by May or June 2011. They have stated that all health care is local and that communities can best develop a successful health care organization.

The Directors of Health and Human Services (HHS), LaneCare, Lipa, and Senior and Disabled Services have had several meetings where collaborative opportunities have been discussed. We believe that together we can organize the public health system in ways to protect and enhance the strong services that currently exist in Lane County.

Recommendation:

Lane County establish itself as a health care Region. The Lane County Board of County Commissioners supports the participation of County staff and programs in the development of a Regional Health Authority, an Integrated Health Consortium, and an Accountable Care Organization.

Risks:

If we do nothing, the State will establish a Regional Health Authority for Lane County. The State has said that they will establish five regions. While they have not said how they would align Counties, it is likely that they would pair Lane County with four or five other Counties that may match Lane County values, programs, and decision-making processes.

Within these new Regions, existing contracts would be terminated and new contracts established with organizations that served all areas of the Region. Lane County government might lose system influence in local health care decisions and have a budget reduction of up to $40,000,000.

Reasons to support this recommendation:

In Lane County there is one Health and Human Services, one OHP Mental Health Organization (LaneCare), one OHP Fully Capitated Health Plan (Lipa) and one Senior and Disabled Services program. Directors have worked together for years, trust each other, and have developed collaborative projects that have benefited residents. All of these programs are recognized as leaders within the state and have set high performance standards.

- LaneCare has 40,000 Oregon Health Plan members. 70% more LaneCare members access mental health care than do members of the other MHOs.
- LaneCare and Senior and Disabled Services have developed a position that in the last 6 months has provided services that prevented 26 of 34 seniors in adult foster care from moving to a nursing eare faeility.

The existing health eare delivery system strengths should be protected and built upon. We can do more within this new structure to improve outeomes, improve services and eontain costs.

Health Care reform is happening and must happen. In Lane County we have initiated planning discussions that include forming the following new community organizations:

The **Lane Health Authority** will bring together health care stakeholders to complete a local needs assessment and develop a strategic health plan. Lane County HHS and LaneCare will be represented on the Health Authority Board.

Lane County Health and Human Services, Senior and Disabled Services and Lipa will form a public/private partnership (the **Lane Integrated Health Consortium**). Each of the partners will maintain existing state contracts and current responsihility for managing funds, serviee contracts and service implementation. Through agreements, this organization will integrate and coordinate by blending and braiding funds, consolidating administrative funetions, developing shared eontracts, developing shared case coordination, and developing medical homes.

Health Care providers in Lane County are meeting and planning the development of an **Accountable Care Organization (ACO)**. An ACO is a group of health care professionals and organizations that aeeept care responsibility for a defined population and are accountable for quality, eost and outeomes. Financial ineentives will be changed as Medicaid purehases outcomes, not individual services. Mental Health providers, including Lane County, are essential providers in an ACO.

Attachment 2

DRAFT

Lane County's
Action Plan for Healthcare Reform

Overview:

The Health Care community of Lane County has come together to plan and design the creation of the Lane Health Authority, the Lane Integrated Health Consortium and the Lane County Accountable Care Organization. These public-private partnerships are designed to promote population health improvements through health care improvements with reduced costs.

The primary focus of system redesign will begin with individuals covered by Medicaid and the safety net population. Typically, 20% of the population enrolled in Medicaid uses 75% of health care resources and services. Yet the health outcomes for this population remain poor. For example, individuals diagnosed with a chronic mental illness have a 25 years shorter life expectancy.

The Lane Integrated Health Consortium will manage Medicaid resources efficiently and effectively by leveraging existing system strengths, management expertise and quality service providers to reduce duplication, braid and blend funds, and integrate services through the expansion of person-centered health homes.

The current health care system is organized around treating illness. Funds and services are organized around identifying and treating medical conditions after people become sick. This results in more intensive and costly services. Health care delivery can be fragmented and siloed. Behavioral health services are sometimes poorly coordinated with physical health services. The Lane Integrated Health Consortium will develop policy and payment reform that reduces system barriers and supports service innovation and integration. The system will move from a fee for service system that pays for volume to a system that pays for quality, value and outcomes.

Lane Integrated Health Consortium:

The Lane Integrated Health Consortium (LIHC) has oversight responsibility for regional health care including public health, physical health, mental health, and long term care. LIHC is responsible for managing the integrated health service system in Lane County, aligning financial incentives to support efficiency and outcomes, and contracting for integrated, community-based primary care, behavioral health care, long term care, and preventative care. The LIHC will develop a regionally integrated health information system to share secure patient information, ensure cost effective, evidence-based services and measure progress toward community health care goals.

Lane Integrated Health Consortium Vision Statement:

Organize the health care delivery system in Lane County by establishing formal inter-organizational operating agreements that establish an integrated management and administrative structure, blend funds, integrate a patient centered care delivery system, and reduce costs while achieving identified community health outcomes.

Lane Integrated Health Consortium Goal Statement:

1. Lane County succeeds with health care reform.
2. Lane County achieves Triple Aim for high-risk, safety-net individuals.
3. Establish a Regional Health Authority (RHA) that will be responsible for setting annual and long term health care goals, for tracking progress, and for making recommendations to the LIHC for administrative and service quality improvements.
4. Administrators, funders and health providers will be accountable for the health of the community.

Lane Integrated Health Consortium Objective Statement:

1. Enhance relationships and develop contracts with providers to establish a health system that integrates physical, behavioral and public health.
2. Establish a quality assurance system that assures identified outcomes are achieved through a high quality provider system.
3. Ensure integrated data sets have capacity to collect, manage, and analyze health performance measures.
4. Support the development of Accountable Care Organizations that are responsible for meeting the unique health needs of individuals living in Lane County.
5. Establish a collaborative health budget that supports innovative efforts to achieve Triple Aim goals.
6. Establish structural and financial systems that support integrated health care:
    a. Enhance community capacity for virtual integration through development of a client health record.
    b. Support physical integration and co-location of behavioral health and physical health providers.
    c. Create a payment structure that:
        i. Covers the cost of essential medical services in a medical health home.
        ii. Funds essential community supports for safety-net clients.
        iii. Provides financial incentives to manage services and to reduce costs.

Lane Integrated Health Consortium Guiding Principles Statement:

The Lane Integrated Health Consortium values:

1. An efficient administrative structure that manages risk with increased provider accountability, monitors quality, uses data in decision-making, and supports a vigorous, community-based treatment approach.
2. Maximizing dollars committed to direct service and minimizing administrative costs while implementing cost effective services that reduce costs.
3. Clinical service system changes that achieve cost containment, provide incentives for providing desired care, implement risk-share approaches, enhance system partnerships, and achieve meaningful outcomes.
4. Treatment that incorporates team-based prevention, pre-treatment, treatment, and aftercare and promotes recovery and independence in clients.
5. Community-based health planning and participation in goal setting, system design, service implementation, and outcome monitoring.

Lane Integrated Health Consortium Participating Organizations:

The LIHC is a collaborative organization created through formal inter-agency agreements between Lipa, LaneCare, Lane County Senior and Disabled Services, and Lane County Public Health. Each of these entities will maintain their existing contracts with the State. Funds will be blended and or braided for Integrated Health Services. Administrative responsibilities for the different components of Integrated Health Services will be assigned by the Executive Committee.

Lane Integrated Health Consortium Policy and Payment Reform:

Lane County recognizes that in order to support the desired system reform, regulations and payment structures must not only allow and support reform, payment structures need to provide financial incentives for contractors to develop and maintain high performing, patient-centered service teams that achieve the outcomes established by the Regional Health Authority.

The LIHC will operate as a public-private partnership to address the levels of integration essential for achieving the Triple Aim goals: Clinical Integration, Structural Integration and Financial Integration. When planning for these three levels of reform the LIHC recognized that moving the system too fast will be disruptive and chaotic and will result in a diminishment of the integrity and quality of the existing system of care. Lane County has many existing health care strengths and reform efforts must be built on and sustain these. The LIHC has planned a phased implementation strategy that has a one-year planning and development phase (2011), a two-year implementation and development phase (2012-2013), and a full implementation phase (2014).

Health care reform should result in better services and outcomes. Structural and financial integration must support clinical integration. Progress in reform at all three levels must progress in unison to achieve meaningful health care system improvements.

Structural Integration will be achieved through the Lane Health Authority (LHA) and the Lane Integrated Health Consortium (LIHC) and Accountable Care Organizations (ACO). The LIHA is a community partnership that includes local government, Medicaid Health plans, physical health care providers, behavioral health care providers, advocates, system partners, and community stakeholders. The LIHC is responsible for conducting community needs assessments, developing community health improvement plans with recommendations, and for advising the LHA.

For the past year Lane County has had a committee that has planned the development of an Accountable Care Organization in Lane County. Most of the discussion has centered on Federal policy and reform and not on Medicaid. The recommendations are equally as relevant to Medicaid reform and the committee will incorporate discussions that include structural and financial integration of Medicaid. All members of the LHA are long term members of this ACO planning committee.

An ACO provides the organizing infrastructure for the clinically-integrated, reformed healthcare delivery system of the future. The ACO will manage new payment models that may include fee for service, bundled payments, carve-outs, and incentive pools.

Financial Integration is achieved through the Lane Integrated Health Consortium (LIHC). In phase 2, the LIHC will establish an integrated budget to support community-wide funding priorities for Medicaid and Safety-net individuals. The Medicaid health plans in Lane County (Lipa and LaneCare) have a performance improvement project that is integrating health care data to identify shared members that are high users of services and resources. Funding will be blended or braided to develop integrated services for the 20% of members that use 75% of resources.

These Medicaid members that are high utilizers of healthcare resources are often impacted by critical needs in other life domains such as housing, social services, and public financial supports. Healthcare improvements and reform must include collaborative arrangements with system partners to provide structural and financial support for comprehensive supports that reduce duplicative services and minimize cost shifts or client dumping.

Financial integration will be achieved through the LIHC development of integrated health services in phase 2. The LIHC will minimize the development of expensive new administrative structures by blending and braiding funds, coordinating administrative functions, and integrating case management activities while preserving the integrity of existing, functional administrative structures. The administrative structural stability will allow maximum focus on the critical and challenging work of health care reform, payment reform, and regulatory reform.

It could be argued that this administrative structure does not achieve reductions in administrative cost. We have considered this. We have come to understand that a forced financial integration at the front end of system reform does not achieve financial savings but is likely to increase the administrative burden as a new administrative system assumes the responsibilities of the existing organizations without having the experience or skills to support the existing system, much less support system improvements.

Clinical Integration must achieve the following as identified as identified by Oregon Standards for Patient Centered Primary Care Homes:

- Better access to care
- Increased accountability
- Comprehensive, whole person care
- Continuity of care over time
- Better coordination and integration of health care services
- Person and family centered care that recognizes the individual is responsible for their health and wellness

Lane Intregrated Health Consortium Executive Committee:

The LIHC Executive Committee is responsible for making operational decisions associated with Integrated Health Services. It is composed of administrative staff from Lipa, LaneCare, SDS, and Public Health. Decisions require committee consensus.

Lipa, LaneCare, SDS and Public Health maintain responsibility for funding decisions, contracting, payment, and system monitoring of health care activities that are not a component of Integrated Health Services.

Planned HealthCare Reform Stages of Lane County:

Phase 1: Organizing the Lane Health Authority and the Lane Integrated Health Consortium.

1. Organize Key Stakeholders

2. Develop a plan for Phase 2 implementation plan for the Integrated Health Services managed by the LIHC.

3. Work with Oregon Health Authority to move health care reform forward in Lane County that is aligned with State reform direction.

4. Develop the administrative structure, financial reform plans, case management coordination plans for LIHC.

5. Execute interagency agreement or memorandums of understanding that support the creation of the public/private operations of the LIHC.

6. A consumer and advocate advisory committee is developed to advise LaneCare and Lipa. This will evolve into the LIHC advisory committee.

Phase 2: Implementing the planned components of the Lane Health Authority and the Lane Integrated Health Consortium.

1. Increase prevention and early intervention efforts and reduce dependence on hospital care and high end, specialty services.

2. Integrate behavioral health and physical health through co-location projects, coordinated care-management decisions, and medical health homes.

3. Develop integrated contracts with LIHC partners that support integrated care.

4. Participate in the planning and development of Accountable Care Organizations that are fully operational and "certified" by Phase 3. Establish pilot projects as appropriate.

5. Support the development and influence of the Lane Health Authority.

6. Develop electronic health records and electronic means of maintaining communication of "virtual care teams" to support collaborative care teams that are not co-located.

Phase 3: Full implementation of the regional health care system reforms

1. The Lane Health Authority is fully operational and meets all standards of federal and State health care reform including Medicaid expansion, development of health information exchanges.
2. Accountable Care Organizations exist and provide a comprehensive continuum of medical and behavioral health services to a defined set of patients in Lane County.

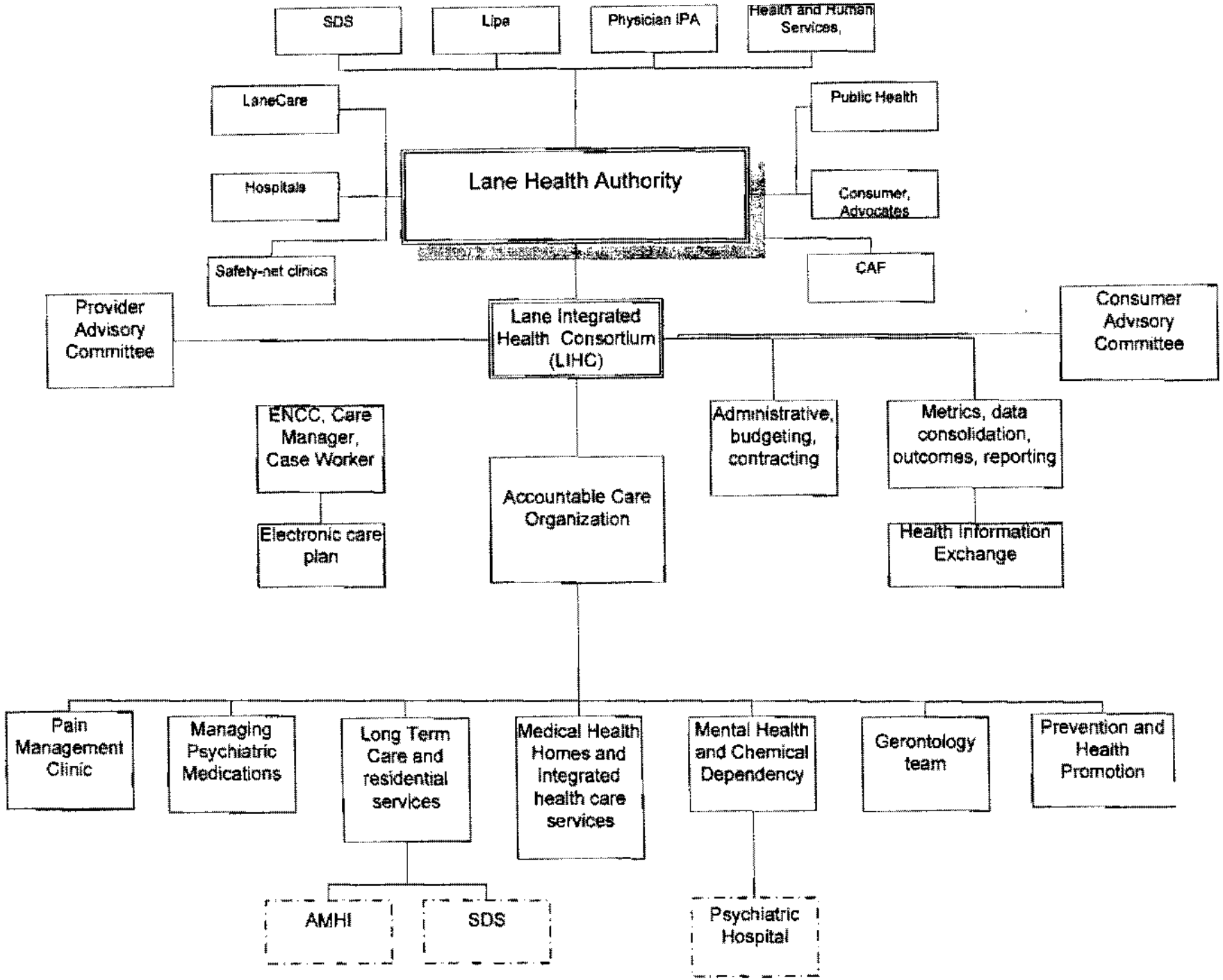
Protecting the Health Care Components in Lane County that are working well:

Lane County is proud of the successful reform initiatives we have implemented and in the performance of the health care system that currently exists in Lane County. Participants in planning system improvements are committed to protecting the existing system and provider strengths while also organizing for system improvements described in this paper.

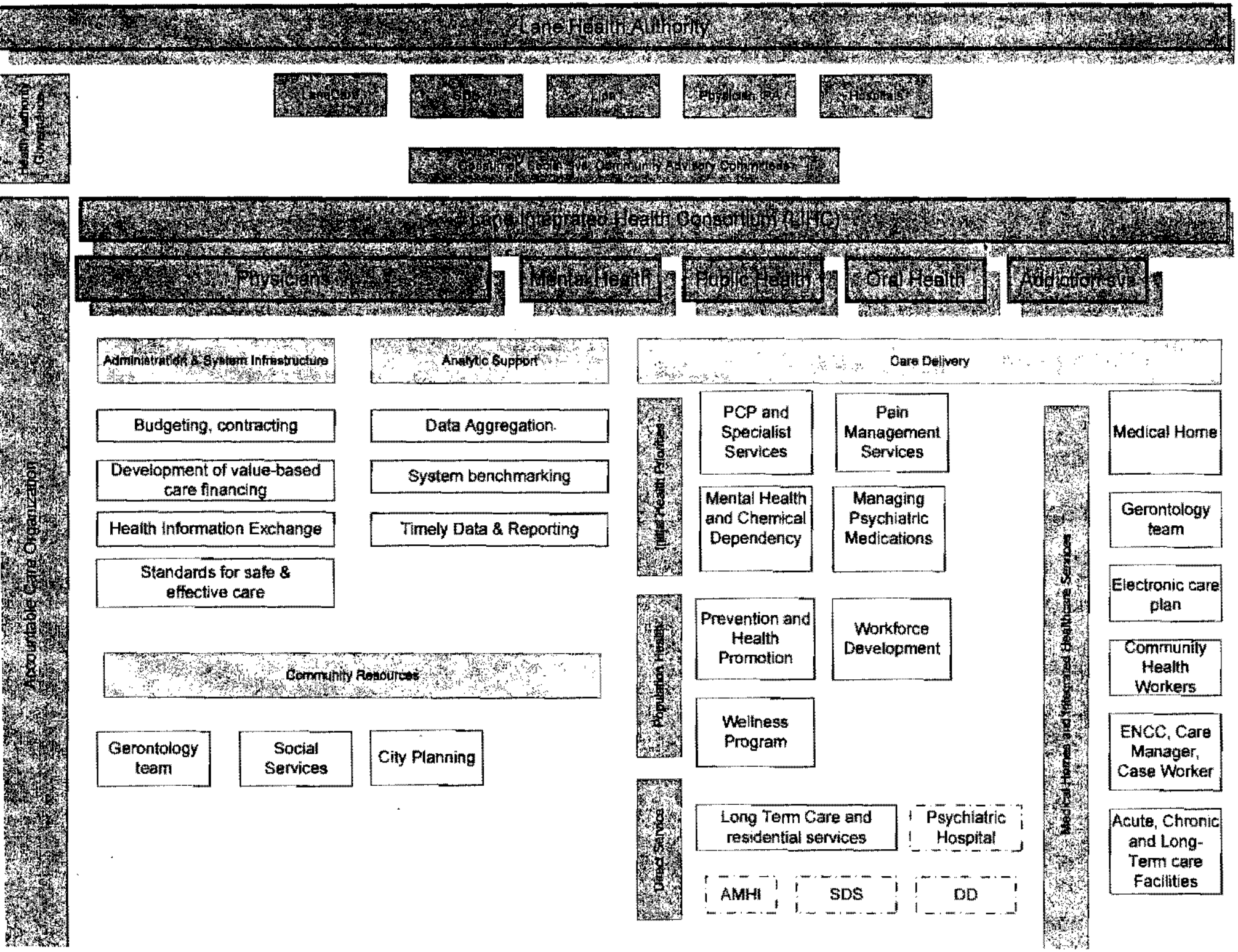
Some of the existing strengths include:

1. Medical homes located at the Lane County Behavioral Health clinic that co-locates primary care at a mental health care facility.
2. Medical homes located at the Lane County Federally Qualified Health Center that co-locates mental health care at a primary care facility.
3. Mental health service integration with Senior and Disabled Services.
4. Integrated mental health and substance abuse treatment programs.
5. High performance level of the lane County Mental Health Organization:
   - LaneCare has a 65% higher participation rate than other MHOs
   - LaneCare provides 67% more outpatient services/1000 members than other MHOs
   - LaneCare provider 65% more value to the health care dollar (R.V.U.) than pother MHOs.
   - LaneCare and Lipa have developed an integrated data set that includes LaneCare, Lipa, and pharmaceutical claims. Data analysis will provide:
     a. Utilization rates
     b. Expenditures
     c. Diagnoses
     d. Services and procedures
     e. Data analysis to develop patient stratification based on Four Quadrants of Medical Care
   - LaneCare and Lipa shared consumer advisory committee

Attachment 3


SDS
Lipa
Physician IPA
Health and Human Services,
LaneCare
Public Health
Lane Health Authority
Hospitals
Consumer, Advocates
Safety-net clinics
CAF
Provider Advisory Committee
Lane Integrated Health Consortium (LIHC)
Consumer Advisory Committee
ENCC, Care Manager, Case Worker
Administrative, budgeting, contracting
Metrics, data consolidation, outcomes, reporting
Accountable Care Organization
Electronic care plan
Health Information Exchange
Pain Management Clinic
Managing Psychiatric Medications
Long Term Care and residential services
Medical Health Homes and integrated health care services
Mental Health and Chemical Dependency
Gerontology team
Prevention and Health Promotion
AMHI
SDS
Psychiatric Hospital

Attachment 4


Care Health Authority
Consumer Board / Community Advisory Committee
Care Integrated Health Consortium (CIHC)
Physicians
Mental Health
Public Health
Oral Health
Addiction Svs
Accountable Care Organization
Administration & System Infrastructure
Analytic Support
Budgeting, contracting
Data Aggregation
Development of value-based care financing
System benchmarking
Health Information Exchange
Timely Data & Reporting
Standards for safe & effective care
Community Resources
Gerontology team
Social Services
City Planning
Care Delivery
Clinical Health Priorities
PCP and Specialist Services
Pain Management Services
Mental Health and Chemical Dependency
Managing Psychiatric Medications
Population Health
Prevention and Health Promotion
Workforce Development
Wellness Program
Direct Services
Long Term Care and residential services
Psychiatric Hospital
AMHI
SDS
DD
Medical Home and Integrated Healthcare Services
Medical Home
Gerontology team
Electronic care plan
Community Health Workers
ENCC, Care Manager, Case Worker
Acute, Chronic and Long-Term care Facilities

Attachment 5

Joint Principles for Accountable Care Organizations

An Accountable Care Organization (ACO) is defined as a group of physicians, other healthcare professionals*, hospitals and other healthcare providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients across the age spectrum and who are held accountable for the quality and cost of care provided through alignment of incentives. These principles state that primary care should be the foundation of any ACO and that the recognized patient and/or family-centered medical home is the model that all ACOs should adopt for building their primary care base. The goals of an ACO structure are to improve the quality and efficiency of care provided and to demonstrate increased value from health care expenditures. The Medicare Payment Advisory Commission (MedPAC) has called for the testing of this care delivery organizational model and the recently passed healthcare reform legislation allows physicians and other healthcare professionals to organize as ACOs under Medicare beginning in 2012. The same legislation also establishes a pediatric demonstration project that allows qualified pediatric providers to choose to be recognized and receive payments as ACOs under Medicaid. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association support the establishment of ACOs within public and private settings that are consistent with the following principles:

Structure

1. The core purpose of an Accountable Care Organization is to provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical Home for the defined population it serves, which includes assurances that care is delivered in a culturally competent and patient and/or family-centered manner.
2. The Accountable Care Organization should demonstrate strong leadership from among physicians and other healthcare professionals, including significant and equitable representation from primary care and specialty physicians, in its administrative structure, policy development, and decision-making processes; clinical integration in the provision of care; and processes to facilitate operation as a true partnership among physicians and all other participants.
3. Organizational relationships and all relevant clinical, legal, and administrative processes within the Accountable Care Organization should be clearly defined and transparent to physicians, other related healthcare professionals, and the public. This includes methods of payment including the application of any risk adjustment strategies for both pediatric and adult patients, quality management processes, and processes to promote efficiency and value in delivery system performance.
4. Accountable Care Organizations should include processes for patient and/or family panel input in relevant policy development and decision-making.
5. Accountable Care Organizations should include a commitment to improving the health of the population served through programs and services that address needs identified by the community including, for example, interfacing with state Title V programs, early intervention programs, Head Start offices, and public education entities.
6. Accountable Care Organizations should provide incentives for patient and/or family engagement in their health and wellness.

* These principles use the term "other healthcare professionals" to represent non-physician direct patient care providers licensed to deliver primary care and other healthcare services (e.g. nurse practitioners, physician assistants, licensed clinical social workers, and clinical psychologists)

7. Participation by physicians, other healthcare professionals, and patients/families in an ACO should be voluntary. However, if patients are assigned to an ACO, they should be encouraged to select a primary care physician.
8. Nationally-accepted, reliable and validated clinical measures focused on ambulatory and inpatient care should be used by Accountable Care Organizations to measure performance and efficiency and evaluate patient experience. These measurement processes should be transparent, and informed by input from primary and specialty care physicians and other healthcare professionals participating in the Accountable Care Organization. .
9. Accountable Care Organizations should implement clinically integrated information systems to provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions and sites of care.
10. The structure and related payment systems of the Accountable Care Organization should be implemented and monitored to prevent " adverse unintended consequences," such as poor access to physicians, denial of needed care, or discrimination against the treatment of the more medically complex or difficult-to-treat patients.
11. Primary care physicians, specialty physicians, and other healthcare professionals should have the option to participate in multiple Accountable Care Organizations.
12. Barriers to small practice participation within the Accountable Care Organization should be addressed and eliminated. These barriers include the small size of their patient panels and their current limited and future access to capital, health information technology infrastructure needs, and care coordination and management resources.
13. Accountable Care Organizations should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
14. Accountable Care Organizations should promote processes to reduce administrative complexities and related unnecessary burdens that affect participating practices and the patients/families to whom they provide service.

Payment

15. Payment models and incentives implemented by Accountable Care Organizations must align mutual accountability at all levels, fostered by transparency and focused on health promotion and healthy development, disease prevention, care management, and care coordination.
16. Payment models and incentives implemented by Accountable Care Organizations should adequately reflect the relative contributions of participating physicians and other healthcare professionals to increased quality and efficiency and demonstrate value in the delivery of care.
17. Payment models should recognize effort required to involve family, community/educational resources and other pertinent entities and activities related to care management/care coordination of patients with complex conditions.
18. Recognition as an Accountable Care Organization and rewards for its performance should be based on processes that combine achievement relative to set target levels of performanee, achievement relative to other participants, and improvement that have been developed with significant input from primary and specialty care physicians and other healthcare professionals. .
19. Practices participating within the Accountable Care Organization that achieve recognition as medical homes by NCQA, other nationally accepted certification entities,

and/or related processes (e.g. state government recognition) should be provided with additional financial incentives.

20. The structure of the Accountable Care Organization should adequately protect ACO physicians and other healthcare professional participants from "insurance risk," unless clearly agreed as a requirement for participation.
21. Accountable Care Organizations can employ a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while reducing overall costs including but not limited to blended fee-for-service /prospective payment, shared savings, episode/case rates and partial capitation.