NCQA Criteria for Accountable Care Organizations

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NCQA
Measuring quality.
Improving health care.

What Are ACOs?

- Provider-based organizations that are accountable for both quality and costs of care for a defined population
  - Arrange for the total continuum of care
- Align incentives and reward providers based on performance (quality and financial)
  - Incentivized through payment mechanisms such as shared savings or partial/full-risk contracts
- Goal is to meet the "triple aim"
  - Improve people's experience of care
  - Improve population health
  - Reduce overall cost of care

What Types of Organizations Might Qualify as ACOs?

- ACOs are fundamentally "care delivery" organizations
- Eligible entities could include:
  - Providers in group practice arrangements
  - Networks of individual practices
  - Hospital/provider partnerships or joint ventures
  - Hospitals and their employed or contracted providers
  - Publicly governed entities that work with providers to arrange care*
  - Provider-health plan partnerships*
- Must serve at least 5,000 patients

*Not included in the CMS Shared Savings Program

Core ACO Functions

1. Provide infrastructure and leadership needed to move health care systems toward the triple aim
2. Provide full range of health care services to patients (e.g., primary care, tertiary care, community and home-based services)
3. Determine provider payment and contracting arrangements
4. Provide access to patient-centered care and medical homes
5. Collect, integrate and disseminate data for various uses, including care management and performance reporting

Core ACO Functions

6. Provide resources for patients and practitioners to support care management activities
7. Facilitate information exchange across providers and sites of care
8. Communicate to patients about ACO performance and is transparent about performance-based payment arrangements with providers
9. Publicly report overall ACO performance
10. Provide performance reports to providers in the ACO for quality improvement

Evaluating ACOs

- **Start by measuring capabilities to identify ACOs that have the infrastructure needed to achieve the triple aim**
- **Performance measures must be part of the evaluation, but it will take time before ACOs can be qualified only on outcomes**

NCQA ACO Criteria Development

- **Criteria development informed by:**
  - **Evidence** on best practices, where it existed, on expert **consensus,** where it did not
  - Input from NCQA's ACO **Task Force**
  - **Insight** gained from organizations seeking to become ACOs

NCQA ACO Task Force

- **Chair: Robert J. Margolis, MD**
  HealthCare Partners Medical Group
- **Lawrence P. Casalino, MD, PhD**
  Weill Cornell Medical College
- **Kirsten Sloan**
  National Partnership for Women & Families
- **Jay Crosson, MD**
  The Permanente Federation
- **Nicole G. DeVita, RPh, MHP**
  Blue Cross Blue Shield of MA
- **Duane E. Davis, MD, FACP, FACR**
  Geisinger Health Plan
- **Joseph Francis MD, MPH**
  Veterans Affairs
- **George Isham, MD, MS**
  HealthPartners
- **Phil Madvig, MD**
  Permanente Medical Group
- **Dolores Mitchell**
  Group Insurance Commission
- **Edward Murphy, MD**
  Carilion Clinic
- **Gordon Norman, MD**
  Alere Medical Inc.
- **Cathy Schoen, MS**
  Commonwealth Fund
- **Jeff Stensland, PhD**
  MedPAC
- **Susan S. Stuard, MBA**
  THINC, Inc.
- **John Toussaint, MD**
  ThedaCare
- **Woody Warburton, MD**
  Duke University Medical Center
- **Nicholas Wolter, MD**
  Billings Clinic
- **Mara Youdelman**
  National Health Law Program

Public Comment: An Important Step in Criteria Development

Partial List of Participants

- AHIP
- ACP
- AAFP
- UPMC
- PBGH, et al
- Families USA
- National Partnership for Women & Families, et al
- HRSA
- State agencies (OR, ME, AZ)
- Premier
- CAPG
- Aetna
- BCBS Association

- Held Public Comment October–November 2010
- Collected input from all interested parties
- Received 2,200 comments from approximately 200 individuals and groups
- Considered input carefully
- Recommendations inform final version of criteria

NCQA Evaluates Capabilities in 7 Key Areas

1. ACO Structure and Operations
2. Access to Needed Providers
3. Patient-Centered Primary Care
4. Care Management
5. Care Coordination and Transitions
6. Patient Rights and Responsibilities
7. Performance Reporting and Quality Improvement

ACO Structure & Operations

- Clearly defines its organizational and leadership structure:
  - Identifies organization responsible for managing clinical and administrative functions
  - Identifies organization's governing body
  - Identifies clinician leaders
- Collaborates with providers and community partners (e.g., consumers, purchasers) to work toward the triple aim
- Has information systems to support population health management, real-time connectivity to clinical information, analysis and provider reporting

ACO Structure & Operations

- Monitors resource utilization for appropriateness and waste
- Provides clinicians with reports on variances, coupled with training and education
- Has mechanisms to reward practitioners based on performance

Access to Needed Providers

- Has sufficient numbers and types of practitioners who provide:
  - Primary care
  - Specialty care
  - Urgent/Emergency/Inpatient care
  - Community and home-based services
  - Long-term care
- Evaluates provider sites to ensure adequate access during and after typical office hours
- Assesses and adjusts to meet patients' cultural needs and preferences

Patient-Centered Primary Care

Primary care practitioners in the ACO:

- Act as medical homes
- Have prepared, proactive care teams that:
  - Are the first point of contact for patients
  - Coordinate patient care across providers
  - Proactively identify and manage high-risk patients
  - Manage medications
  - Track test results and follow up appropriately

Care Management

- Conducts initial assessments of patient health
- Identifies patients for population health programs (e.g., wellness, case management) and alerts primary care providers to care needs
- Provides resources to patients and practitioners to support care management activities
  - Patient education materials, classes
  - Wellness programs (e.g., Tobacco Use Cessation)
  - Decision aids for preference-sensitive conditions to practitioners

Care Coordination and Transitions

- **Facilitates timely information exchange between providers and care settings**
- **Proactively identifies patients at risk of transitioning (e.g., inpatient to long-term care) and ensures timely exchange of information between providers, patients and caregivers**

Patient Rights & Responsibilities

- Informs patients about the role of the ACO and services it provides
- Protects the confidentiality of personal health information
- Is transparent about how patients are attributed to the ACO and about any performance-based financial incentive offered to practitioners

Performance Reporting and Quality Improvement

- Measures clinical quality of care, patient experience and cost
  - Publicly reports performance
  - Provides comparative reports to providers in the ACO
- Identifies opportunities for improvement and works with providers and other stakeholders to improve

Potential Measures Required for Accreditation
Work in Progress

Clinical Performance	Patient Experience	Efficiency/Utilization
Staying Healthy	***Satisfaction***	***Resource Use with Standardized Cost***
Breast Cancer Screening Influenza Immunization Care for Older Adults Immunization Status Tobacco Cessation Cervical Cancer Screening Chlamydia Screening	Adult or Pediatric Clinician Group CAHPS Survey *HCAHPS*[1]	Relative Resource Use (RRU) Measures: Diabetes Asthma Low Back Pain COPD Cardiovascular Conditions Hypertension
Getting Better	***Coordination of Care***	***Utilization***
Appropriate Testing for Children with Pharyngitis Appropriate Treatment for Children with Upper Respiratory Infection Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis Use of Imaging Studies for Low Back Pain	Provider visit w/in 7 days of pt discharge *Post-acute, LTC, end-of-life measures*[1]	Inpatient Utilization—Acute Care Discharges (IPU) Inpatient Utilization—Bed Days (IPBD) Outpatient Surgeries Utilization—Percentage Done in ASC (OSU) Emergency Department Visits (EDV)
Living with Illness	***Safety & Avoidable Events***	***Safety & Avoidable Events***
Controlling High Blood Pressure Behavioral Health (AMM) Diabetes Measure Suite CV Measure Suite Respiratory Measure Suite	Medication Reconciliation *Measures of mortality, hospital error*[1]	Inpatient Readmissions Within 30 Days (IRN) Preventable Hospitalizations

[1] *Non-HEDIS/Future Measures*

Issues Outside the Scope of NCQA's Accreditation Program

- Attribution
- Payment mechanism
- Concentration of market power
- Legal barriers to integration
- Risk of financial insolvency

Pilot Testing: The Next Step in Developing Criteria

- April–May 2011
- Test the feasibility and applicability of criteria with potential ACOs that have these structures:
  - Multispecialty group practices
  - Hospital-provider partnerships
  - Networks of individual practices (IPAs)
- Findings will help further refine criteria for final product launch in July 2011

Questions?