Mini-Summit II: ACOs

- NCQA ACO Accreditation
- ACO HEDIS Performance Measures
- ACO Perspective from HealthPartners
- Question & Answer

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Using Accreditation to Build a Sustainable Accountability Model

Tricia Marine Barrett
VP Product Development
February 20, 2013

Overview

- About NCQA
- What are ACOs and why do they matter?
- NCQA Standards
  - Assessing Core Capabilities
  - Medical Homes as the Foundation
- NCQA ACO HEDIS Measures

About NCQA

Private, independent non-profit health care quality oversight organization founded in 1990

Our Mission

- To improve the quality of health care

Our Method

- Measurement

  We can't improve what we don't measure

- Transparency

  We show how we measure so measurement will be accepted

- Accountability

  Once we measure, we can expect and track progress

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NCQA Evaluation Programs

- NCQA Accreditation/Certification Programs:
  - Health Plans
  - Accountable Care Organizations
  - Wellness & Health Promotion
  - Recognizing Innovation in Multicultural Health Care
  - Managed Behavioral Healthcare Organizations
  - Disease Management Organizations
  - Case Management
  - Physician Organizations
  - Credentials Verification Organizations
  - HEDIS Auditors and Software Vendors
  - Utilization Management and Credentialing Services

NCQA Recognition Programs

- NCQA Recognition Programs for Clinicians & Practices
- Releasing a NEW Patient Centered Specialty Practice 3/25/13
- Just launched: PCMH Content Expert Certification

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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

The types of provider-led groups that serve as ACOs will vary.

- 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

Why ACOs Matter:
Targeting the Triple Aim

GOAL: Reduce and/or control growth of healthcare costs while maintaining or improving the quality of care patients receive (clinical quality, patient experience and satisfaction)

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Why ACOs Matter:
A Reason for all Stakeholders

- For patients, ACOs mean "care the way you want it to be."
- For providers, ACOs mean alignment of financial incentives
- For plans, purchasers and consumers, ACOs mean more health for the health care dollar.

Why Accreditation Matters

- Variation in capabilities and readiness make ACOs risky for payers, patients.
- Accreditation:
  - Assures patients their ACO focuses on them and their care
  - Aligns purchasers with common expectations.
  - Identifies which ACOs are likely to be good partners.
  - Can serve as a roadmap & vehicle for provider-led groups to show their abilities
    - Levels of accreditation demonstrate varying levels of readiness to be ACOs.

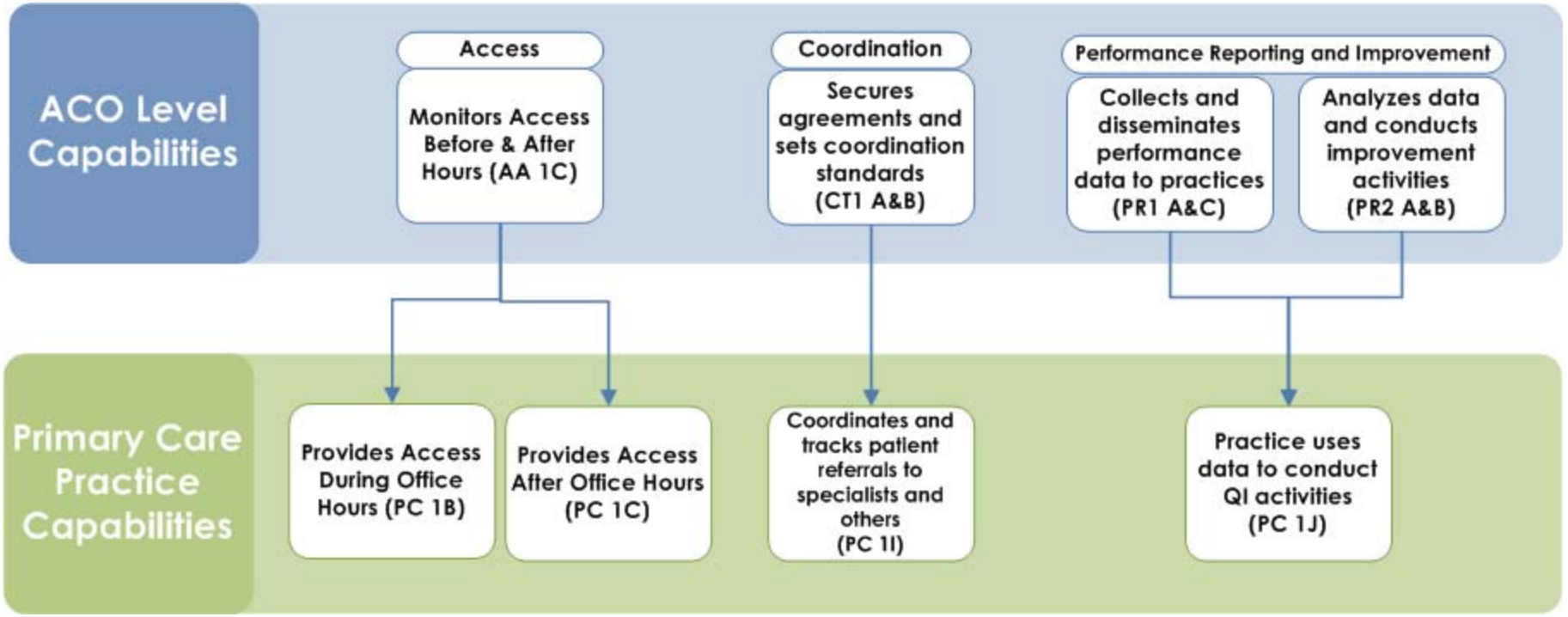
NCQA Accreditation: Aims

- Provide a strong evidence base for action:
  - Provide a roadmap and vehicle for organizations to transform into accountable entities
- Be flexible
  - Accommodate the range of ACO structures and promote innovation
- Identify with reasonable accuracy organizations that have the infrastructure to achieve the triple aim

NCQA ACO Standards:
Assessing Core ACO Capabilities

Standards	Core Capability Assessed
Program Operations	•Provides the infrastructure and leadership needed to move healthcare systems toward the triple aim •Determines provider payment and contracting arrangements
Access and Availability	•Provides the full range of health care services to its patients (e.g., primary care, tertiary care, community and home-based services)
Primary Care	•Provides access to patient-centered care and medical homes

Patient-centered medical homes are ACOs' foundation.



ACOs can provide valuable resources to support the delivery of patient-centered primary care.

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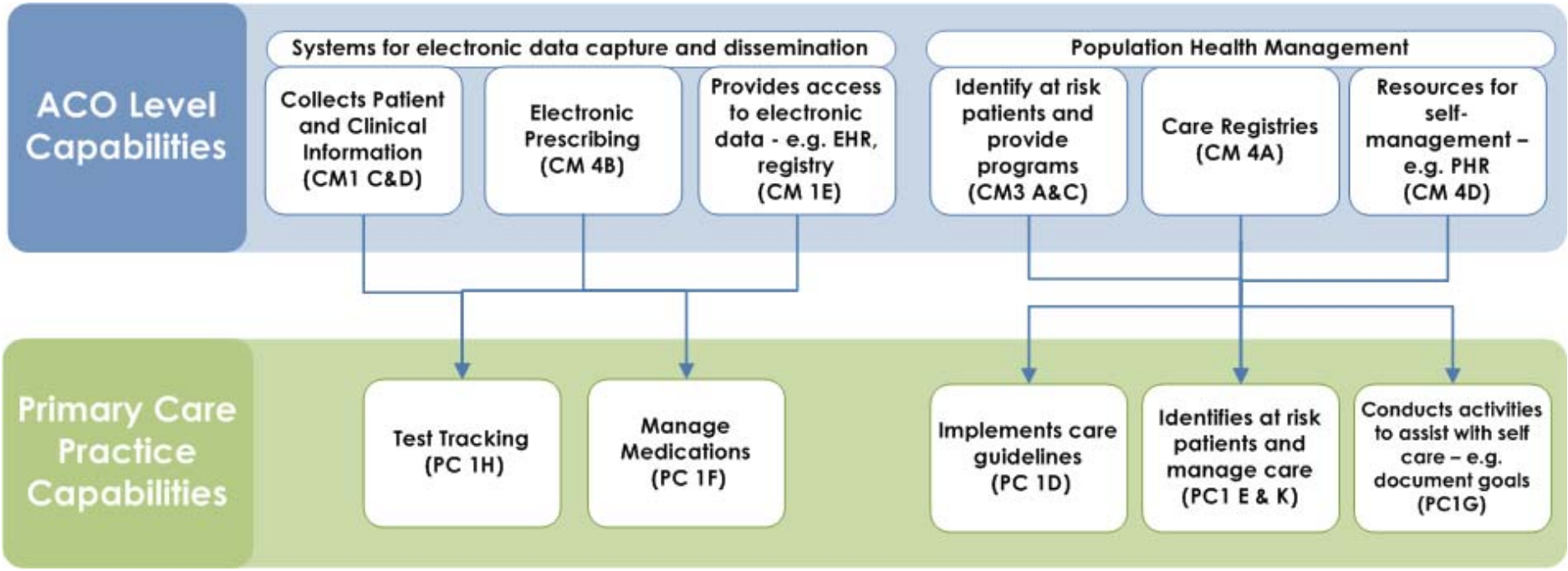
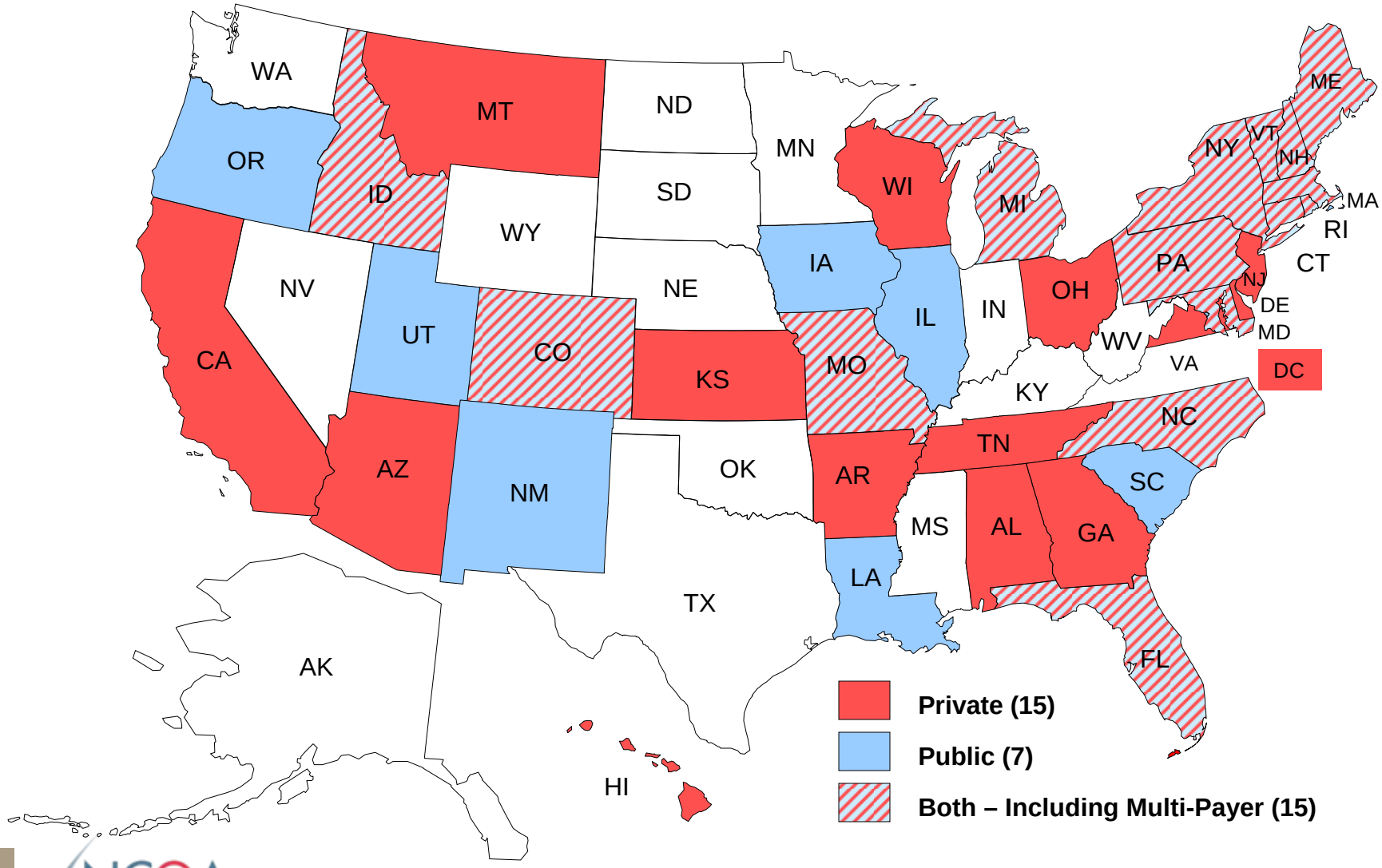
Patient-centered medical homes are ACOs' foundation, cont.



37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition



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Growing Evidence on PCMH

- Benefits of Implementing the PCMH – Improved Quality and Patient Satisfaction, Lower Costs Patient Centered Primary Care Collaborative, September 2012

- Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits & Demonstrated Plan ROI Harbrecht, Health Affairs, September 2012

- PCMH Improves Low-income Access, Reduces Inequities Berenson, Commonwealth Fund, May 2012

- Community Care of North Carolina $1B Savings Milliman, January 2012

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NCQA ACO Standards:
Assessing Core ACO Capabilities, cont.

Standards	Core Capability Assessed
Care Management	•Provides resources for patients and practitioners to support care management activities
Care Coordination and Transitions	•Facilitates information exchange across providers and sites of care
Patient Rights and Responsibilities	•Communicates to patients about the ACO's performance and is transparent about performance-based payment arrangements with providers
Performance Reporting & Quality Improvement	•Collects, integrates and disseminates data for various uses, including care management and performance reporting •Provides performance reports to providers within the ACO for quality improvement

Accreditation Measures

NCQA ACO Performance Measures		
Clinical Quality		
• Body Mass Index (BMI) 2–18 Years of Age • Adult BMI Assessment • Colorectal Cancer Screening • Breast Cancer Screening • Cervical Cancer Screening • Chlamydia Screening in Women • Childhood Immunization Status Immunizations for Adolescents • Follow-Up Care for Children Prescribed ADHD Medication • Appropriate Treatment for Children With Upper Respiratory Infection • Appropriate Testing for Children With Pharyngitis	• Controlling High Blood Pressure • Diabetes Measure Suite • Cholesterol Management for Patients With Cardiovascular Conditions • Use of Spirometry Testing in the Assessment and Diagnosis of COPD • Appropriate Medications for People With Asthma • Follow-Up After Hospitalization for Mental Illness • Antidepressant Medication Management • Initiation and Engagement for Substance Abuse Treatment	• Annual Therapeutic Monitoring for Patients On Persistent Medications • Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis • DMARD Use for Rheumatoid Arthritis • Osteoporosis Management • Care for Older Adults • Monitoring Harmful Drug-Disease Interactions in the Elderly • Use of High-Risk Medications in the Elderly • Medication reconciliation post discharge
Patient Experience		
• CG-CAHPS	• H-CAHPS (if applicable)	
Efficiency/Utilization		
• Use of Imaging Studies: Low Back Pain • Plan All-Cause Readmissions	**Relative Resource Use (RRU) Measures:** • People With Asthma • People With Cardiovascular Conditions • People With COPD • People With Diabetes • People With Hypertension	

Levels of accreditation reflect varying levels of readiness to be ACOs.

Level	Points	Must-Pass Elements
Level 1 • For organizations in the formation or transformation stage; have not reached full ACO capability. • Organizations have basic infrastructure and some capabilities outlined in standards. • Length of status: 2 years	**50 points**	**None**
Level 2 • For well-established organizations that strongly demonstrate the capabilities outlined in the standards • Length of status: 3 years	**70 points**	**Yes** • Report core performance measures and patient experience • Evaluate and improve patient-centered primary care • Have complete data on a minimum threshold of patients
Level 3 •Achieve Level 2 and demonstrate strong performance or improvement across the triple aim • Length of status: 3 years	**70 points and performance** against triple aim	**Yes** • Same as Level 2

ACO Accreditation Early Adopters

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Remaining Challenges

- Adequate employer involvement
- IT capabilities to integrate services
- Quality, cost and patient experience measures
- Transparency commitments
- Consumer and employer awareness
- Aligning incentives
- Full-service integration
- Collaboration between health plans, providers and the community

Medicare Shared Savings & Accreditation

Medicare Shared Savings: Aligned Expectations

- Great deal of alignment in structural requirements and expectations for quality systems:
  - Evidence-based medicine
  - Patient-centeredness
  - Care Coordination
  - EHR adoption
  - Eligible Entities
  - Governance*
- Major differences related to requirements necessary for CMS to administer the program:
  - Financing and incentive payments
  - Measures – applicable to the 65 years + population

**Some differences in the details*

ACO HEDIS Performance Measures

Karen Onstad
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February 20, 2013

Overview

- What is ACO HEDIS?
- How were the *Technical Specifications for ACO Measures* developed?
- What are the differences between ACO HEDIS and…
  - Health plan HEDIS?
  - CMS MSSP measures?
- Next steps

ACO HEDIS

- Technical specifications for core performance measures from NCQA's *ACO Standards and Guidelines*
- Adaptation of HEDIS for ACOs from:
  - Health plan HEDIS
  - Physician HEDIS
- Released in Sept 2012

What is in ACO HEDIS?

- Overview
- General Guidelines
  - Defining the population for measurement
  - Reporting to NCQA
  - Data collection methods, sampling, etc…
- Technical Specifications for Core Measures
  - 23 clinical quality measures
  - 5 efficiency/overuse/utilization measures

Clinical Quality Measures

- Prevention (9 *measures*)
  - Body Mass Index (BMI) 2–18 Years of Age
  - Adult BMI Assessment
  - Colorectal Cancer Screening
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Chlamydia Screening in Women
  - Childhood Immunization Status
  - Immunizations for Adolescents
  - Care for Older Adults- Medication Review

Clinical Quality Measures

- Respiratory Conditions (2 measures)
  - Use of Spirometry Testing in the Assessment and Diagnosis of COPD
  - Use of Appropriate Medications for People with Asthma
- Cardiovascular Conditions (2 measures)
  - Cholesterol Management for Patients with Cardiovascular Conditions
  - Controlling High Blood Pressure

Clinical Quality Measures

- Diabetes (7 measures)
  - LDL-C Control in Diabetes Mellitus
  - Blood Pressure Management
  - Urine Screening for Microalbumin or Medical Attention for Nephropathy
  - Eye exam
  - Foot Exam
  - HbA1c Control <8.0%
  - HbA1C Control >9%

Clinical Quality Measures

- Musculoskeletal Conditions (2 measures)
  - Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
  - Osteoporosis Management in Women Who Had a Fracture
- Behavioral Health (3 measures)
  - Antidepressant Medication Management
  - Follow-up Care for Children Prescribed ADHD Medication
  - Follow-up After Hospitalization for Mental Illness

Clinical Quality Measures

- Medication Management (4 measures)
  - Annual Monitoring for Patients On Persistent Medications
  - Medication Reconciliation Post-Discharge
  - Potentially Harmful Drug-Disease Interactions in the Elderly
  - Use of High-Risk Medications in the Elderly

Clinical Quality Measures

- Access
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Efficiency/Overuse/Utilization Measures

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Imaging Studies for Low Back Pain
- All-Cause Readmissions
- Relative Resource Use (RRU) Measures for Asthma, Cardiovascular Conditions, COPD, Diabetes, Hypertension (*Future*)

Principles for ACO Measurement

- Align with health plan and physician HEDIS
- Leverage NCQA's experience with Integrated Healthcare Association P4P
- Align with CMS MSSP where possible
- Meet ACOs where they are in terms of ability to measure and allow for evolution
- Encourage consistency across ACOs to achieve future benchmarking

Timeline for ACO Specifications

- December 2011: Developed Draft General Guidelines
- January 2012: Convened ACO Measures Advisory Panel
- February 2012: CPM WebEx Meeting
- March15 – April 6, 2012: Public comment
- April/May 2012: Revise specifications
- July 2012: Align with HEDIS 2013 specifications
- September 2012: Release HEDIS 2013 Technical Specifications for ACO Measurement

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Public Comment

- NCQA sought feedback on key policy areas. Provided:
  - An overview which describes background and rationale for NCQA's approach
  - The first two sections of the HEDIS 2013 Technical Specifications for ACO Measurement
  - Revised specifications for five selected measures

Key Policy Areas

- Defining the population for measurement
- Measure reporting to NCQA
- Methods and definitions for data collection and sampling

Defining the Population for Measurement

- ACO contracts and measurement
  - If ACO has at least one contract, two options:
    - Report on the aggregate ACO population as defined in the contract
    - Report on the aggregate ACO contract population plus the population identified using NCQA recommended attribution method
  - If no contract, use NCQA recommended attribution method

Defining the Population for Measurement

- Attributing Patients to ACOs
  - Use the CMS' MSSP patient attribution model, with the following modifications:
    - Have at least 1 primary care service within a 24 month period, rather than the CMS 12-month period
    - Apply the plurality of primary care visits, rather than the CMS plurality of primary care allowed charges
  - Retrospective attribution for measurement – same as CMS
  - Minimum population for measurement
  - Eliminate continuous enrollment criteria

Measure Reporting to NCQA

- Population stratification option for Medicaid
- ACOs and Payer or Collaborative reporting
- Data submission to NCQA
  - Annual in June, beginning in 2013
  - Initial Data Submission Tool that may expand over time
- Audit requirement
  - Phase in; not before June 2014

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Methods

- Choice of Electronic or Hybrid method for all measures
- Systematic sampling and sample size requirements align with HEDIS
- Require exclusions (as in Physician HEDIS)
- Pharmacy data
  - Allow pharmacy claims or prescriptions initially; may move to pharmacy claims over time

ACO and Health Plan HEDIS

- Differences
  - Defining the population
    - Assignment or attribution vs. enrollment
    - No continuous enrollment in ACO
  - Report on patient population with an option to separately report Medicaid
  - Audit not yet required for ACO HEDIS
  - ACO allows hybrid method for most measures
  - Exclusions are required for ACOs
  - ACOs use pharmacy claims or prescription data to identify medication use

ACO and Health Plan HEDIS (*cont.*)

- Similarities
  - Measurement year
  - Coding conventions
  - Code tables
  - Sampling method
  - Sample size requirements
  - Annual data submission in June

ACO HEDIS

- Implications:
  - Results are not directly comparable
  - ACO HEDIS will evolve
  - Goal is to establish ACO measurement consistency to support future benchmarking

CMS ACO Measures

- 33 total measures across four domains
  - Patient/caregiver experience (7 measures)
  - Care coordination/patient safety (6 measures)
  - Preventive health (8 measures)
  - At-risk populations (12 measures)
    - Includes measures of diabetes, hypertension, ischemic heart vascular disease, heart failure, coronary artery disease

Care Coordination

- No measure overlap
- Content overlap
  - Medication reconciliation after discharge
  - Readmission measures

Preventive Health

- Measure overlap
  - Colorectal Cancer Screening
  - Breast Cancer Screening
- Content overlap
  - Adult BMI/Weight Assessment

At Risk Populations

- Measure overlap
  - Diabetes HbA1c Poor Control (>9%)
  - Controlling High Blood Pressure
- Content overlap
  - Diabetes
  - Coronary Artery Disease

Next Steps

- Gain experience with ACO HEDIS
  - Provide technical assistance to ACOs on core performance measures
  - Begin collecting ACO HEDIS results in June 2013
- Develop an ACO HEDIS Audit
- Long Term
  - Audited results for scoring and benchmarking
  - Evolve ACO HEDIS

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