Mini-Summit II: ACOs

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

- **Local Accountability**
  - Foster provider accountability for quality and per capita cost for their patient population

- **Standardized Performance Measurement**
  - Increased accountability on the part of providers should be accompanied by improved incentives and information for consumers

- **Payment Reform**
  - Transition payments from rewarding volume/intensity to increasing value
  - Payments should encourage collaboration and shared responsibility among providers and consistent incentives from payers
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
<table>
<thead>
<tr>
<th>Standards</th>
<th>Core Capability Assessed</th>
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</thead>
<tbody>
<tr>
<td><strong>Program Operations</strong></td>
<td>• Provides the infrastructure and leadership needed to move healthcare systems toward the triple aim</td>
</tr>
<tr>
<td></td>
<td>• Determines provider payment and contracting arrangements</td>
</tr>
<tr>
<td><strong>Access and Availability</strong></td>
<td>• Provides the full range of health care services to its patients (e.g., primary care, tertiary care, community and home-based services)</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>• Provides access to patient-centered care and medical homes</td>
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ACOs can provide valuable resources to support the delivery of patient-centered primary care.
Patient-centered medical homes are ACOs’ foundation, cont.

<table>
<thead>
<tr>
<th>ACO Level Capabilities</th>
<th>Systems for electronic data capture and dissemination</th>
<th>Population Health Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collects Patient and Clinical Information (CM1 C&amp;D)</td>
<td>Electronic Prescribing (CM 4B)</td>
<td>Identify at risk patients and provide programs (CM3 A&amp;C)</td>
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<tr>
<td></td>
<td>Provides access to electronic data - e.g. EHR, registry (CM 1E)</td>
<td>Care Registries (CM 4A)</td>
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<tr>
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<td></td>
<td>Resources for self-management – e.g. PHR (CM 4D)</td>
</tr>
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<tr>
<th>Primary Care Practice Capabilities</th>
<th>Test Tracking (PC 1H)</th>
<th>Manage Medications (PC 1F)</th>
<th>Implements care guidelines (PC 1D)</th>
<th>Identifies at risk patients and manage care (PC1 E &amp; K)</th>
<th>Conducts activities to assist with self care – e.g. document goals (PC1G)</th>
</tr>
</thead>
</table>
37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition

*Includes the District of Columbia
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
<table>
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<tr>
<th>Standards</th>
<th>Core Capability Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>• Provides resources for patients and practitioners to support care management activities</td>
</tr>
<tr>
<td>Care Coordination and Transitions</td>
<td>• Facilitates information exchange across providers and sites of care</td>
</tr>
<tr>
<td>Patient Rights and Responsibilities</td>
<td>• Communicates to patients about the ACO’s performance and is transparent about performance-based payment arrangements with providers</td>
</tr>
<tr>
<td>Performance Reporting &amp; Quality Improvement</td>
<td>• Collects, integrates and disseminates data for various uses, including care management and performance reporting</td>
</tr>
<tr>
<td></td>
<td>• Provides performance reports to providers within the ACO for quality improvement</td>
</tr>
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## 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.

<table>
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<tr>
<th>Level</th>
<th>Points</th>
<th>Must-Pass Elements</th>
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<tr>
<td><strong>Level 1</strong></td>
<td>50 points</td>
<td>None</td>
</tr>
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</table>
| • 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 |
| **Level 2**   | 70 points    | Yes                |
| • For well-established organizations that strongly demonstrate the capabilities outlined in the standards  
  • Length of status: 3 years |
| • 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**   | 70 points and performance against triple aim | Yes |
| • Achieve Level 2 and demonstrate strong performance or improvement across the triple aim  
  • Length of status: 3 years |
| • Same as Level 2 |
ACO Accreditation Early Adopters

The Children's Hospital of Philadelphia
Hope lives here.

Essentia Health

Crystal Run Healthcare
We want you healthy.

Kelsey-Seybold Clinic
Your Doctors for Life

HealthPartners
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: 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
Director, Quality Solutions Group
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
• 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
- March 15 – 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
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
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
• 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