NCQA Draft Standards for Accountable Care Organizations Outline a Pathway to Integrated Care

The concept of Accountable Care Organizations ("ACOs") began to take a more defined shape last week as the National Committee for Quality Assurance ("NCQA") released for public comment draft ACO standards and guidelines. This guidance has implications not only for providers interested in participating in the upcoming Medicare Shared Savings program or forming ACOs for the commercial payer or Medicaid markets, but also for all other providers looking to improve coordination and quality in order to succeed in a reformed health care delivery system.

NCQA's goal in these draft criteria is to identify core capabilities that increase an ACO's likelihood of success in achieving the "Triple Aim" of improving health, improving patient experience, and reducing per capita costs. These core criteria fall into the following seven defined categories:

- Program Structure and Operations
- Access and Availability
- Primary Care
- Care Management
- Care Coordination and Transitions
- Patient Rights and Responsibilities
- Performance Reporting

Recognizing that ACOs will seek continuous assessment and improvement, NCQA also furnishes guidance on how organizations can continue to enhance their performance even after meeting the threshold criteria for recognition as an ACO by Medicare. To this end, NCQA proposes to implement four scoring levels that apply regardless of organization structure, with Level 1 ACOs meeting core quality criteria, and Level 4 ACOs meeting advanced criteria and demonstrating excellence or improvement in outcomes. At a minimum, to qualify as an ACO, an organization must be the legal entity that accepts contracts to deliver health care to a defined population and must include primary care physicians. Beyond these requirements, NCQA leaves flexibility for providers to organize themselves in ways that best address the needs of their communities, including but not limited to group practice arrangements, networks of individual practices, partnerships or joint ventures between hospitals and providers, or hospitals and their employed providers. ACOs are also free to develop various reimbursement mechanisms.

Implications for the Medicare ACO Program

NCQA intentionally aligned its eligibility requirements with the requirements in the Affordable Care Act, and thus its standards are likely to appear in the Medicare shared savings program regulations that the Centers for Medicare and Medicaid Services ("CMS") is currently developing. CMS may explicitly include some or all of the NCQA criteria as standards for participating in the Medicare program, or it may permit ACOs meeting these criteria to be deemed to meet CMS requirements. NCQA's selected indicators on clinical integration

and coordination may also influence the antitrust and fraud and abuse safe harbors or waivers that are currently under consideration. If adopted by Medicare, the NCQA standards will no doubt also play a significant role in how ACOs develop in the private markets.

Broader Implications for Provider Success in a Reformed Delivery System

While intended as a blueprint for the creation and ongoing improvement of ACOs, the NCQA guidance can serve more broadly as a roadmap to integration for those providers not currently embarked on developing ACOs. NCQA methodically reviews the structure and processes necessary to achieve coordination across the components of a health system, from best practices on contracting for services to processes for fostering patient-centered care. Providers seeking to develop or participate in a more integrated system of care would do well to review the NCQA guidelines, treating them as a checklist of steps that would help accomplish that goal.

In addition, these criteria highlight that the ACO model is but one of many overlapping components of successful delivery system reform that are supported or incentivized in the Affordable Care Act. For example, NCQA explicitly built its ACO criteria from its existing requirements for medical homes, and NCQA deems ACOs with a high percentage of recognized medical home practices to meet many of the requirements. The medical home model is mentioned throughout the Affordable Care Act and is included among the models to be tested in the new CMS Innovation Center. NCQA expects that at least a portion of provider compensation will be based on performance, and the Affordable Care Act promotes value-based purchasing under Medicare for a range of providers. Many of the reporting, assessment, and accountability standards included in the NCQA criteria assume use of health information technology for which capital funding may come from the Recovery Act Medicare and Medicaid incentive payment programs. And much of the savings that accrue to ACOs will be from efforts to reduce admissions and readmissions—goals that are further encouraged by Medicare and Medicaid payment policies in the Affordable Care Act.

Challenges in Meeting NCQA Criteria

As you begin to analyze how your organizations measure against NCQA's criteria and the steps you can take along its proposed pathway to integration, keep in mind the potential legal pitfalls. NCQA neither purports nor has the legal authority to address the antitrust, anti-kickback, or self-referral challenges raised during the recent ACO workshop sponsored by CMS, the Federal Trade Commission, and the Department of Health and Human Services Office of the Inspector General. NCQA expects that providers will align to negotiate with payers, will distribute organization payments among the participating providers, will base compensation on performance criteria that include cost as well as quality, and will facilitate referrals of patients to participating and non-participating providers, among many other activities, in ways that are otherwise consistent with state and federal law. Providers will have to navigate other requirements, such as patient privacy, while meeting requirements to share patient information collected in systems accessible to each of the organization's participating providers.

Finally, providers will have to contend with the reality that building the infrastructure described in the NCQA documents will require significant investment of time and resources. ACOs will need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals.

How Ropes & Gray Can Help

As you and your organization assess the challenges and opportunities presented by ACOs, Ropes & Gray is here to help you with strategic and legal advice from an experienced team of attorneys with relevant backgrounds in all aspects of ACO formation. In addition, we are setting aside a new area of our Health Reform Matters website specifically geared to delivery system reform in general and to ACOs in particular. Visit frequently for the latest federal developments in the drive toward accountable care. For more information, contact your usual Ropes & Gray attorney.

Comments on NCQA's draft criteria may be submitted until 5pm on November 19 through the NCQA's public comment website.