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NCQA Draft ACO Criteria – A Basis for CMS Accreditation?

On October 19, the National Committee for Quality Assurance ("NCQA"), a private non-profit accrediting organization for healthcare organizations, issued 80 pages of proposed criteria for accrediting accountable care organizations ("ACOs"). NCQA defines ACOs as “provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experience and reducing per capita costs.” NCQA has invited public comment to its proposals by November 19. This paper provides context and an overview of the seven main topics of NCQA’s draft criteria.

Under the 2010 healthcare law, ACOs that meet unspecified criteria will be eligible for unspecified “shared savings” under Medicare for effectively managing care that reduces the cost of healthcare for beneficiaries. The Centers for Medicare and Medicaid Services is charged with designating these criteria for ACOs, but has yet to act. CMS likely will require accreditation for ACOs, which NCQA could provide. Hospitals are more familiar with complex accreditation manuals than many physicians. Each standard would have a score between zero to 100; the actual scoring has yet to emerge.

The NCQA draft criteria indicate that entities seeking ACO accreditation will incur significant start-up costs in their efforts to establish the necessary capabilities. The structural criteria, for instance, would require balancing state corporate law practice with federal and accreditation requirements to develop a governance structure that can succeed. Such costs typically lie outside the concern of accrediting bodies. Organizations considering an ACO approach must assess whether revenue opportunities, when quantified, will cover incremental operational and personnel costs required by compliance. We note it is likely that any ACO would be structured to serve both governmental and commercial payors in order to achieve the necessary mass, but many commercial payors also have looked to NCQA for accreditation standards. Here then are the seven areas of NCQA’s draft ACO criteria.

1. Program Operations

This topic opens with an outline of how an ACO should define its organizational structure. The ACO’s infrastructure must “coordinate providers and . . . increase quality, improve patient experience and effectively manage its financial resources” through three elements:

- Program Structure: Does the ACO have a functioning governing body with primary clinical leadership, defined goals on quality, patient experience and cost, and methods of performance reviews and assessments? The ACO must document the framework within which it operates and how leaders make and execute decisions about resource use. This element requires focus on the “governing body,” including the identification of its members, roles and responsibilities, and how the “board” sets, pursues and evaluates the ACO’s goals and performance toward its objectives.
- Stakeholder Participation: Does the ACO involve its “stakeholder groups” in the oversight of its functions? Stakeholders can be primary care practitioners, consumers (or community representatives), specialists, hospitals and other providers who are part of the legal structure of the ACO or who contract with it to provide care.
- Working with Others: Does the ACO describe how it will work with providers, community resources, consumers and payers? Community resources include all types of caregivers within an area that “provide public health and community-based resources that are essential to maintaining the health of a population.”

2. Access and Availability

The ACO must examine the availability of practitioners to determine if the ACO maintains an “adequate network of primary care and specialty care practitioners (“SCPs”)” and “appropriate access to services.” The criteria focus on these elements:

- Assess Network Needs: Does the ACO have a documented process to assess its defined population of assigned beneficiaries and determine the number of primary and specialty care practitioners and other high volume services/providers needed to serve the ACO’s population?

Availability of Practitioners: Has the ACO established, and does it measure its performance against, quantifiable and measurable standards for (i) the number of primary care practitioners and high volume SCPs, including those practitioners that serve as high volume SCPs; and (ii) the number of practitioners providing primary care services and their distribution in a given geographic region?

- Assessment of Access: Does the ACO collect and annually analyze data to determine access to care during regular and non-typical office hours?
- Ensuring Access: Does the ACO annually analyze if sufficient access to assigned patients is being provided and, if necessary, use such information to improve its access to care during regular and non-typical hours?
- Practitioner and Provider Directory: Does the ACO maintain a web-based physician and hospital directory available to prospective patients?
- Cultural Needs and Preferences: Does the ACO have a process to assess the cultural, ethnic, racial and linguistic needs of its patients and enable practitioners within its network to meet the needs of its defined patients, if necessary?

3. Practice Capabilities

This section addresses whether the ACO has the capabilities to manage patient care. The criteria examine these elements:

- Access During and After Office Hours: Does the ACO have same day appointments, clinical advice over the phone during and after office hours?
- Practice Team: Does the ACO have a process to maintain "team-based care"?
- Guidelines and Management of Care for Important Conditions: Does the ACO use evidence-based guidelines and patient management throughout the care process (e.g., demonstrating pre-appointment planning for 75% of patients)?
- Managing Medications: Does the ACO have a process to manage its patients' medications?
- Self-Care Process: Does the ACO maintain patient self-management for 50% of its patient base?
- Test and Referral Tracking: Does the ACO have a process to track tests and track the status of referrals of the patient?
- Quality Improvement Activity: Does the ACO establish and measure quality improvement activities?
- Identify High Risk Patients: Does the ACO implement systems to identify and properly treat high risk patients?

However, an ACO with a high (as yet undefined) percentage of Primary Care Medical Home ("PCMH") practices[1] may receive automatic credit for each of these elements, allowing such entities to meld the two efforts.

4. Clinical Management

ACOs must use health data systems (i) to manage the salient collective healthcare needs of the population of patients assigned to the ACO and (ii) to integrate the services individual patients receive from the spectrum of providers reimbursed by Medicare. ACOs must demonstrate clinical management through data systems with these capabilities and attributes:

- Data Collection and Integration: Collect and integrate health data from patient-provider claims and encounters, patient EHRs, patient lab and pharmacy data, and health appraisal results.
- Initial Health Assessment: Include an initial health assessment/appraisal for new patients.
- Population Health Management: Identify certain health needs to target and deliver programs to the ACO's population, such as wellness/preventive care, chronic disease management and complex case management.
- Practice Support: Maintain a patient registry that facilitates electronic prescribing, enables patient self-management, generates tickler action lists for care needs/services, and integrates patient history, prescriptions and drug data to avoid conflicts and prompt use of generic substitutes.

5. Clinical Technology

An ACO must be able to facilitate timely information exchanges between primary care providers, specialty care providers and hospitals for care coordination and transitions. The ability to facilitate timely information exchanges between providers must include information exchanges with third-party providers who are not members of the ACO. These information exchange criteria focus on four areas:

- Coordinating Information Exchanges: Does the ACO have a documented process or agreement to exchange health information across care settings, which includes an explanation of the types of information to be exchanged, the timeframes for such exchanges, and the facilitation of referrals?
- Process for Transitions: Does the ACO have a documented process to share information between providers for patients who are in transition between healthcare settings, including the ability to electronically exchange key clinical information, provide follow-up, and track transitions?
- Follow-Up After Transitions: Does the ACO have a documented process to provide annual reviews of transitions to determine if they were performed safely and efficiently?
- Timely Information Exchange: Does the ACO have a documented process to determine if timely information exchange occurs between providers for care coordination and transitions?

6. Patient Rights and Responsibilities

These criteria measure the ACO's ability to treat the patient with respect for privacy and informal patient participation. In evaluating this area, the NCQA would focus on these areas:

- Rights and Responsibilities Statement: Does the ACO have a rights and responsibilities statement? Such a statement would allow the patient to receive information, participate in healthcare decisions, voice complaints and assign the patient responsibility to follow healthcare plans and instructions.
- Privacy and Confidentiality: Does the ACO have a written policy to protect the patients' protected health information ("PHI")? While HIPAA has overlapping requirements, the NCQA criteria expand some areas (e.g., requiring privacy policies for websites).
- Physical and Electronic Access: Does the ACO adequately protect both physical and electronic access to PHI, limiting such access to only those individuals that have a need to access such PHI?
- Complaints: Does the ACO have a policy governing how it receives, documents, investigates, triages, responds to and resolves patient complaints?

7. Performance Reporting

These criteria require rigorous performance reporting measures that the ACO must link to quality improvement efforts and communication with practitioners. The criteria propose that rigorous, constant measurement, reporting and publication of performance and quality improvement efforts will be a virtual way of life for any ACO, and focuses on these elements:

- Performance Measures: Does the ACO report on preventive care, chronic care and acute care clinical measures, including expenditures and resource use? The ACO can use data from outpatient or inpatient claims or encounter data, electronic health records, pharmacy data and laboratory results. The ACO must also distribute performance reports to participating practitioners, with detailed explanations of the measures used in the report.
- Reporting Performance: Does the ACO publicly report its performance? It may choose from one of several methods, including submissions to NCQA, CMS or posting of reports on a website.
- Clinical Quality: Does the ACO, at least annually, take steps to improve the quality of care as indicated by the performance reports, implement at least two interventions and then measure the effectiveness of those interventions?
- Patient Experience: Does the ACO analyze patient experience results and perform interventions to improve selected patient experiences, then measure the effectiveness of those cases?

For a copy of NCQA's Draft ACO Criteria: click **here**.

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[1] NCQA has a separate accreditation program for the medical home, defined as a healthcare setting that "facilitates partnerships between individual patients, and their personal physicians."

Please contact one of these attorneys in Venable's healthcare practice with questions and/or comments:

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