

**For Public Comment**

October 19 – November 19, 2010

Comments due 5:00 pm EST

# **Accountable Care Organizations (ACO) Draft 2011 Criteria**

## **Overview**

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# Overview

## **NCQA Seeks Input on Draft 2011 ACO Criteria**

Public comment is integral to the development of NCQA standards and measures. NCQA actively seeks input from all interested parties during the development process and integrates recommendations in the final version of its programs.

We welcome your suggestions and encourage you to comment on the overall structure, the standards (e.g. PO 2: Program Operations) and elements (e.g. Element A: Staffing). Suggestions for ACO 2011 will be considered as we finalize the criteria scheduled for release in mid-2011.

## **Background**

### **National Committee for Quality Assurance's (NCQA) Mission: Improve the Quality of Health Care**

For 20 years, NCQA has been driving improvement throughout the health care system and helping to raise the issue of health care quality to the top of the national agenda. NCQA accredits and certifies a wide range of health care organizations. It also recognizes clinicians and practices in key areas of performance. NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used performance measurement tool in health care. NCQA is committed to providing health care quality information for consumers, purchasers, health care providers and researchers.

### **Accountable Care Organizations (ACOs): Definition**

Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the health care needs of a defined population with the goal of simultaneously improving health, improving patient experience and reducing per capita costs.

How providers organize themselves as accountable entities is expected to vary based on existing practice structures in a region, population needs or local environmental factors. Within the ACO structure itself (i.e. subject to the direct authority of the ACO's governance) ACOs are likely to vary widely with respect to the components of care delivery directly included. Some may include a full range of services including a variety of sub-specialists, hospitals, home care agencies, insurance products, etc. Others will be more narrowly constructed but maintain active relationships and formal contracts with providers across the spectrum of care necessary to meet the needs of their patients.

While there is room for much innovation and experimentation, there is sufficient evidence and emerging consensus that ACO's must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers. Providers will need to be clinically integrated and work together to seamlessly coordinate care for assigned patients. Given evidence that alignment of clinical and financial incentives is desirable, ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals. By coordinating and integrating care, ACOs have the potential to simplify the care process for patients, enhance quality, and reduce costs.

## **Philosophy: Qualifying Organizations to Act as ACOs**

The Patient Protection and Affordable Care Act (ACA) makes provisions for provider groups who voluntarily meet certain criteria, including quality measurement and reporting, to share in the cost savings they achieve for public insurance programs such as Medicare. There is widespread agreement that performance measurement across the triple aim domains of cost, quality and patient experience must be a key element in the evaluation of ACOs. That said there is a growing realization of the complexities involved in organizations producing sufficient directly comparable measures to adequately characterize performance on the triple aims. NCQA's position is that it is possible and desirable to define evidence-based structure and process measures that can identify with reasonable accuracy which ACOs have the infrastructure necessary to achieve the triple aim. NCQA believes performance measurement must be a growing part of ACO evaluation but that for a variety of reasons it will take some time before organizations can be primarily judged on the outcomes they achieve.

NCQA's conviction about the importance of structure and process measures comes from years of experience with measurement and evaluation of health care organizations. Providers that want to become ACOs are in the process of building their capability. Some have leaders who understand the core competencies of ACOs and are proceeding accordingly. But most organizations are by no means ready to deliver on the triple aim. Capabilities such as aligned organizational leadership, care coordination, patient engagement and financial analysis of use patterns are essential to the financial success of ACOs. Care management techniques that ensure that patients are receiving the care they need to optimize their health are critical to ACO quality. Mechanisms to evaluate the experience of members and meet their needs are critical to public acceptance.

To support the formation of sustainable accountable organizations, NCQA believes that we must have clear standards that assess capabilities that improve the likelihood of a potential ACO's success and that provide a blueprint and a pathway (with clear stages) to full ACO capability. NCQA has convened national experts to develop a parsimonious set of standards that in our judgment assess the core capabilities that increase the probability of ACO success.

## **ACO Criteria Development**

In April 2010 we convened an ACO Task Force to provide insight on the current state of ACO development, its relationship to the medical home model and to obtain input on developing potential qualifying and monitoring criteria.

### **NCQA ACO Task Force**

**Chair: Robert J. Margolis, MD**, HealthCare Partners Medical Group

**Lawrence P. Casalino, MD, PhD**, Weill Cornell Medical College

**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**, Department of Veterans Affairs

**George Isham, MD**, 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  
**Kirsten Sloan**, National Partnership for Women & Families  
**Jeff Stensland, PhD**, MedPAC  
**Susan S. Stuard, MBA**, THINC, Inc.  
**John Toussaint, MD**, ThedaCare  
**Woody Warburton, MD**, Duke University  
**Nicholas Wolter, MD**, Billings Clinic  
**Mara Youdelman**, National Health Law Program

**Qualifying criteria** are a set of core capabilities that an ACO should demonstrate to be recognized as an accountable entity. Organizations would meet these criteria at the outset and be reviewed against them at intervals of every 2 to 3 years.

**Monitoring criteria** are areas of focus for performance reporting and benchmarking. They include clinical quality, patient experience and cost measures. Organizations would be required to collect and publically report these measures at least annually.

NCQA sought to build on concepts of the patient-centered medical home and create criteria that were sufficiently flexible to accommodate the various ACO models emerging. Development of draft criteria was informed by:

- Evidence on best practices where it existed; expert consensus where it did not
- Input from the ACO Task Force, and
- Insight gained from organizations seeking to become ACOs.

### Guiding Principles

The ACO Task Force set forward the following principles to guide the development of qualifying and monitoring criteria. They are aligned with core aims in the ACO principles developed by the American College of Physicians (ACP), American Association of Family Practice (AAFP), and American Medical Group Association (AMGA).

1. **ACOs have a strong foundation of primary care.** A core of primary care providers with medical home capabilities provides the foundation for the ACO to deliver comprehensive, coordinated, patient-centered care.<sup>i,iii</sup>
2. **ACOs report reliable measures to support quality improvement and eliminate waste and inefficiencies to reduce cost.** ACOs should measure and report overall performance using nationally-accepted, validated clinical measures focused on ambulatory and inpatient care as well as measure their performance related to patient experience and costs. Valid measurement of the quality of care provided through ACOs will be essential to both ensuring that cost savings are not the result of limiting necessary care and promoting higher-quality care.<sup>ii</sup>
3. **ACOs are committed to improving quality, improving patient experience and reducing per capita costs.** ACOs should established shared goals for improvement across providers in the organizations. They should continually strive to improve patient care by monitoring and analyzing clinical quality, patient experience and cost data and apply their findings to improve these measures through tools such as benchmarking, best practices, and peer review.<sup>iii</sup>

4. **ACOs work cooperatively towards these goals with stakeholders in a community or region.** Linking providers in the ACO with other components in the delivery system such as hospitals, social services and county health departments can help organizations effectively manage the full continuum of patients' care, from preventive services to hospital-based and nursing-home care.<sup>iv</sup>
5. **ACOs create and support a sustainable workforce.** The demand for primary care will increase as the new federal health reform law expands insurance coverage to more people. This demand combined with the shrinking supply of primary care providers signals the need to create a system that supports providers and patients.

### **Program Design Features**

It is NCQA's goal to have criteria that are within reach of the range of ACO configurations (e.g. "virtual" ACOs created by independent practice associations, multispecialty practices, integrated delivery systems, etc.) Criteria must simultaneously provide a blueprint and a pathway (with clear stages) to full ACO capability and promote evidence-base practices that increase the likelihood of the organization's success.

#### **What's in the Draft Criteria?**

The overall structure of the ACO draft criteria follows NCQA's standard style. Criteria are arranged into "standards" with individual elements and factors that are scored. Related "standards" are grouped into categories. (See below for "How to Read a Standard.")

Draft ACO criteria have been organized into seven categories reflecting the core capabilities accountable organizations should possess. The table below provides a high-level summary of the criteria.

Category	Summary of Criteria (Standard/Element)
1. <b>Program Structure Operations (PO)</b>	<ul style="list-style-type: none"> <li>• The organization clearly defines its organizational and leadership structure. (PO1)</li> <li>• The organization has the capability to manage its resources effectively. (PO 2)</li> <li>• The ACO arranges for pertinent health care services and determines payment arrangements and contracting. (PO3)</li> </ul>
2. <b>Access and Availability (AA)</b>	<ul style="list-style-type: none"> <li>• The organization ensures that it has sufficient numbers and types of practitioners who provide primary and specialty care.(AA1)</li> </ul>
3. <b>Primary Care (PC)</b>	<ul style="list-style-type: none"> <li>• Primary care practices within the ACO provide patient-centered care.</li> </ul>
4. <b>Care Management (CM)</b>	<ul style="list-style-type: none"> <li>• The organization collects and integrates data from various sources, including, but not limited to electronic sources for clinical and administrative purposes. (CM1)</li> <li>• The organization conducts an initial assessment of new</li> </ul>

Category	Summary of Criteria (Standard/Element)
	patients' health. (CM2) <ul style="list-style-type: none"> <li>• The organization uses appropriate data to identify population health needs and implements programs as necessary. (CM3)</li> <li>• The organization provides resources for, or supports, the use of patient care registries, electronic prescribing and patient self-management. (CM4)</li> </ul>
5. <b>Care Coordination and Transitions (CT)</b>	<ul style="list-style-type: none"> <li>• The organization can facilitate timely information exchange between primary care, specialty care and hospitals for care coordination and transitions. (CT 1)</li> </ul>
6. <b>Patient Rights and Responsibilities (RR)</b>	<ul style="list-style-type: none"> <li>• The organization has a policy that states its commitment to treating patients in a manner that respects their rights, its expectations of patients' responsibilities, and privacy. A method is provided to handle complaints and to maintain privacy of sensitive information. (RR1)</li> </ul>
7. <b>Performance Reporting (PR)</b>	<ul style="list-style-type: none"> <li>• The organization measures and reports clinical quality of care, patient experience and cost. (PR 1)</li> <li>• At least annually, the organization measures and analyzes the areas of performance and takes action to improve effectiveness in key areas. (PR2)</li> </ul>

NCQA anticipates that most criteria will be reviewed at the organization level. For example, we would review an ACO's overall process to manage patient transitions from an inpatient setting to home health care. However, criteria evaluating the capabilities of provider groups within the ACO, such as those in the Primary Care (PC) standards, may be reviewed for a sample of the organization's practices or may have scores that vary based on the percentage of the population with access to the functionality.

We encourage you to comment on the individual standards and elements. We are specifically interested in your feedback on whether each requirement reflects a core capability that all ACOs should possess. Individual items may seem ambitious for some organizations. However, it is not expected that organizations will need to meet all requirements in order to achieve qualification.

### How will organizations be surveyed?

NCQA will utilize its Web-based ISS Survey Tool™. The Survey Tool guides the organization through documenting performance against the standards and enables electronic submission of information, streamlining the survey process. Organizations can use the Survey Tool to perform a readiness evaluation before the NCQA Survey and determine the information it needs to demonstrate how it meets NCQA standards. The survey may consist of both an offsite review of documentation submitted through the ISS and onsite review of patient files (if applicable). The final survey process will be determined when final ACO criteria are published.

### Design Questions

We would like your thoughts on some key design issues we are considering:

**ACO Levels:** NCQA is proposing four levels of scoring for ACOs. Levels will be agnostic to organization structure (i.e. whether or not it is led by a multispecialty group, hospital or independent

practice association) and to reimbursement mechanism used (e.g. shared savings, global payment). Levels would be based on the organization's demonstrated capability to function as an accountable entity and achieve the triple aim (improved quality, increased patient satisfaction, lower per capita costs).

- **Level 1** – meet the core qualifying criteria which include standards for infrastructure (e.g. legal entity, leadership team, available primary care and specialty providers, etc.) and processes that promote good patient care and quality improvement (e.g. care coordination and managing patient transitions).
- **Level 2** – meet core qualifying criteria and have some advanced features which may include integration of electronic clinical systems and the ability to integrate data for reporting and quality improvement.
- **Level 3** – meet core qualifying criteria, possess advanced features and can report standardized, nationally-accepted clinical quality measures, patient experience and cost measures.
- **Level 4** – meet core and advanced criteria and demonstrate excellence or improvement in the metrics.

The goal of the scoring levels is to provide a reasonable, evidence-based set of expectations for organizations that can be used to qualify them as ACOs as well as provide them with a roadmap for achieving higher levels of capability. We would like your feedback on the capabilities you would expect to see for each ACO level.

**Eligibility for Participation:** NCQA is aligning its eligibility requirements for provider organizations wishing to participate as ACOs with those set forth in the ACA. To undergo survey for qualification, an organization must be the legal entity that accepts contracts for a defined population to provide health care and must include primary care physicians. Organizations that include hospitals, specialists and other health care providers are also eligible. NCQA does not restrict nor evaluate the mechanism(s) organizations use to come together to form ACOs. Following are examples of organizations that would be eligible to apply for an ACO survey.

- Providers in group practice arrangements (includes multispecialty practices)
- Networks of individual practices
- Partnerships or joint venture arrangements between hospitals and providers
- Hospitals and their employed providers.

We are seeking your feedback on the following questions related to eligibility and provider participation in ACOs:

1. Does the eligibility criteria capture the organization types that have the capability to act as ACOs (i.e. provide the full continuum of services, coordinate care, manage resources effectively, report performance)? Should additional arrangements be considered?
2. Should the types of specialists that should be included in the ACO be specified in the criteria? If so, must they be part of the organization's legal structure (i.e. subject to the direct authority of the ACOs governance)?

**Measures:** While ACOs will ultimately be judged based on performance, most potential ACOs do not yet have sufficiently complete data to produce a reasonable number of standardized, reliable, valid measures for comparison and benchmarking. NCQA believes that until meaningful, comparative performance reports are available, ACOs should demonstrate core capabilities critical to improving

quality and reducing costs. As ACO measures are being developed, NCQA is interested in exploring mechanisms organizations may use immediately to begin to report performance. A list of available standardized measures for clinical quality and patient experience is included (Appendix A). We are interested in your feedback on how these measures may be used immediately by organizations to demonstrate performance. (Because there are no national data sources for benchmarking performance on these measures for ACOs, we would not report results publicly or score organizations on the results at program inception.)

**Global questions:** In addition to questions related to specific issues above, we encourage you to provide thoughts and insight on certain global issues related to the ACO criteria:

1. Do the criteria align with stakeholder expectations for ACOs? Are there gaps or areas not addressed but should be?
2. For organizations seeking to become ACOs: Does your organization have materials/documents, etc. to demonstrate compliance with the criteria? If not, which areas are challenging?
3. Are there critical functions not included in the current draft standards?

## **How to Read the Standards**

Draft criteria follow NCQA's typical standards style and are organized into elements with factors and explanations. For public comment, we have included elements with factors, explanations and examples where possible. We have not included scoring or look-back periods as these will be determined once standards are finalized. Following is a summary of a standard's structure.

Each standard includes the following information.

<b>Standard statement</b>	A statement about acceptable performance or results.
<b>Intent statement</b>	Describes the importance of the standard.
<b>Element</b>	The component of a standard that is scored and provides details about performance expectations. NCQA evaluates each element within a standard to determine the degree to which the organization has met the requirements within the standard.
<b>Factor</b>	A scored item in an element. For example, an element may require the organization to demonstrate that its policies and procedures include four specific items; each item is a factor.
<b>Scoring</b>	<b><i>DETERMINED AFTER PUBLIC COMMENT:</i></b> The level of performance the organization must demonstrate to receive a specified percentage of element points. Each element has up to five possible scoring levels (100%, 80%, 50%, 20%, 0%).
<b>Data source</b>	Types of documentation or evidence that the organization uses to demonstrate performance on an element. NCQA defines four types of data sources. <ol style="list-style-type: none"> <li>1. <b>Documented process</b>—Policies and procedures, process flow charts, protocols and other mechanisms that describe an actual</li> </ol>

process used by the organization

2. **Reports**—Aggregated sources of evidence of action or compliance with an element, including, program evaluation management reports; key indicator reports; summary reports from member reviews; system output giving information like number of member appeals; minutes; and other documentation of actions that the organization has taken
3. **Materials**—Prepared information that the organization provides to its members, practitioners and delegates, including contracts, agreements, written and electronic communication, Web sites, scripts, brochures, reviews and clinical guidelines; contracts or agreements with practitioners, delegates and vendors.
4. **Records or files**—History of cases, proceedings, verification of actions involving members or practitioners, such as documentation of completion of denial, appeal, complex case management or credentialing activities

The organization must submit evidence to NCQA either when it submits its survey or during the onsite survey, when specified. Although an element may list multiple data sources, the organization can meet the requirement with one data source, or any combination of data sources, unless otherwise specified in the explanation.

**Scope of review**

**DETERMINED AFTER PUBLIC COMMENT:** The extent of the organization's services evaluated during an NCQA Survey. The scope of review depends on the elements and how the program is administered.

**Look-back period**

**DETERMINED AFTER PUBLIC COMMENT:** The period for which the organization must demonstrate performance against NCQA requirements (or standards). NCQA measures the look-back period from the point of the organization's submission of the completed Survey Tool. Unless otherwise noted, the organization must meet requirements *throughout* the look-back period. Under certain circumstances, NCQA may expand the look-back period.

**Explanation**

Specific requirements that the organization must meet, and guidance for demonstrating performance against the element.

**Examples**

Descriptive information illustrating performance against an element's requirements. Examples are for guidance only and are not specifically required or all-inclusive.

## **Public Comment Documents**

Interested parties should review and provide feedback on information in this overview document as well as the draft criteria and draft measure list.

## **Submitting Comments**

### **Due Date**

Comments must be received by **Friday, November 19, 2010, 5 p.m. ET**, to be considered.

### **How to Submit Comments**

Submit all comments through NCQA's Public Comment Website <http://publiccomments.ncqa.org>.  
**NCQA does not accept comments via mail, e-mail or fax.**

To enter comments:

1. Go to the Public Comment database
2. Enter your e-mail address and contact information.
3. Select **Accountable Care Organizations (ACO) 2011**
4. Select the **Topic, Standard and Element** you would like to comment on.
5. Select your support option (e.g., Support, Do not support, Support with modifications, Other).

If you choose Do not support, include your rationale in the text box. If you choose Support with modifications, enter the suggested modification in the text box.

**There is a 1,800 character limit for each comment.** If you exceed this limit, your comment will be cut off at 1,800 characters. Please try to be brief and to the point in your feedback.

We suggest that you develop your comments in Word, in order to check your character limit and save a copy for reference. Use the "cut and paste" function to copy your comment into the text box.

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<sup>i</sup> ACP. Policy Statement Pertaining to the Development of the Accountable Care Organization Model. April 2010

<sup>ii</sup> Brookings-Dartmouth. Reforming Provider Payment: Moving Toward Accountability for Quality and Value. Issue Brief. March 2009.

<sup>iii</sup> AMGA. Accountable Care Organization Principles.

<sup>iv</sup> The Henry J. Kaiser Family Foundation. The Kaiser Commission on Medicaid and the uninsured: Community Care of North Carolina: putting health reform ideas into practice in Medicaid. Washington, DC: The Henry J. Kaiser Foundation Family; 2009. Publication no. 7899.