WHITE PAPER

NCQA Accreditation of Accountable Care Organizations

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INTRODUCTION

Accountable Care Organizations (ACO) have the potential to get better quality at lower cost by aligning incentives to promote coordination and transform health care delivery. However, not every group of providers that wants to call itself an ACO has what it takes to accomplish this vital mission.

That is why NCQA, working with a broad array of expert stakeholders, has developed clear criteria and standards for guiding ACOs to success. NCQA's ACO Accreditation provides independent evaluation of organizations' abilities to coordinate and be accountable for the high-quality, efficient, patient-centered care expected from ACOs. Like the highly successful NCQA Patient-Centered Medical Home (PCMH) program that transforms primary care into what patients want it to be, our ACO accreditation provides a roadmap to help providers make the challenging and much-needed transformation into ACOs. The program aligns with many of the expectations that the Centers for Medicare & Medicaid Services (CMS) has for the Medicare Shared Savings Program, as well as with common expectations of private purchasers.

WHAT ARE ACOS, AND WHAT DO WE WANT THEM TO ACHIEVE?

ACOs are provider-based entities that have come together with the shared goal of taking the responsibility for improving quality of care and reducing cost growth for a group of people. Today, most health care is organized around a site of care and the services provided there. ACOs should transcend the boundaries of particular sites to care for populations over time and across settings. The key tools needed for this approach will be excellent analysis of patterns of care to identify high-risk populations and opportunities for improvement and targeted resources devoted to care management. These will help drive out waste and unnecessary care by identifying and addressing unwarranted variation. Successful organizations will have committed leaders who set aligned goals and incentives across the diverse providers who care for patients.

ACOs are fundamentally care delivery organizations. Entities eligible for NCQA Accreditation include:

- 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

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- Provider-health plan partnerships

NCQA's ACO Accreditation program will help organizations meet the needs of multiple payers, both public and private. Most of these types of entities also participate in the Medicare Shared Savings Program, but we have included the two last types to broaden the alignment across state and private initiatives. Also, in order to have sufficient patients for quality reporting and managing financial risk, ACOs will need to serve at least 5,000 patients.

BUILDING FROM PATIENT-CENTERED MEDICAL HOMES

NCQA's approach to developing the ACO Accreditation program started with lessons learned from the successful development of its PCMH program. We used many elements of that program, recognizing that excellent primary care is the foundation of good health care. One lesson was that a program that starts with structure and process measures can be extremely useful for clarifying key steps and ingredients needed for organizations to make a successful transformation—the measures provide a roadmap of successful integration of care. PCMH also taught us that levels of recognition can be valuable to purchasers, for identifying organizations and practices that are ready to partner with purchasers and deliver results. Another lesson was that using the same framework of structures and outcomes across many collaboratives and pilots can help bring diverse stakeholders to the table and simplify participation for organizations already challenged by the change in how they provide care.

Primary care as the base. From the outset, we viewed ACOs as built from the capabilities we expect from the patient-centered medical home—that is, care organized around the patient's needs, coordinated over time and supported by meaningful use of health information technology. The ACO broadens the services that an organization can be accountable for—beyond primary care and specialist referrals—to include inpatient, post-acute and other care.

Primary care practitioners in the ACO act as medical homes and have prepared, proactive care teams that:

- Are the first point of contact for patients
- Coordinate patient care across providers
- Proactively identify and manage high-risk patients
- Manage medications
- Track test results and follow-up appropriately

The value of structure and process measures. There is widespread agreement that performance measurement across the "triple aim" goals of cost, quality and patient experience must be a key element in evaluation. NCQA has always been a strong supporter of performance-based evaluation where measurement is feasible; indeed, NCQA pioneered

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requiring health plans to report performance information, and NCQA uses that information for accreditation scoring.

NCQA believes that although performance measurement is critical, it is necessary and desirable to also evaluate ACOs against evidence-based structure and process measures that can identify, with reasonable accuracy, organizations that have the infrastructure needed to achieve the triple aim. Performance measurement must be a growing part of ACO evaluation, but for a variety of reasons, it will take some time before organizations can be judged primarily on the outcomes they achieve.

In the market, interested providers are building their capability for transformation into ACOs. Some have leaders who understand the core competencies of ACOs and are proceeding accordingly. A number of primary care and multi-specialty groups have functioned like ACOs for some time. But many organizations are not ready to deliver on the triple aim. Aligned organizational leadership, care coordination, patient engagement and analysis of use patterns are essential to an ACO's success. Care management techniques that ensure patients receive the care they need for optimal health are critical to ACO quality. Mechanisms to evaluate the experience of members and meet their needs are essential to public acceptance. These key components are reflected in our ACO accreditation standards, which give providers a clear description of the abilities they need to succeed.

Demonstrating readiness. NCQA's ACO evaluation product will serve as a roadmap and a vehicle for provider-led organizations to demonstrate their ability to function as ACOs. Around the country, private purchasers are launching many innovative approaches to shared savings and value-based purchasing with provider organizations that want to participate. In some communities, health plans are already contracting with integrated delivery systems that they know well. However, we expect that larger plans covering multiple communities, and large employers, will be challenged to understand if organizations are capable of participating in these initiatives. NCQA's ACO Accreditation program provides different levels to signal different degrees of readiness—to share savings and financial risk and to report and improve on quality. The program can also be used by state and federal purchasers to create a common platform of understanding whether an organization is an ACO. Organizations going through this program will provide assurance to consumers that they have met requirements for transparency, disclosure and accountability.

The program will have three levels of scoring, to allow organizations with varying levels of capability the opportunity to be accredited.

- **Level 1:** This level is for organizations that are in the formation/transformation stage but have not yet reached full ACO capability. They have the basic infrastructure and possess some of the capabilities outlined in standards. Level 1 status lasts for two years. The reevaluation period is shorter than for levels 2 and 3, requiring organizations to improve capabilities more quickly.

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- **Level 2**: This level is for organizations with the best chance of achieving the triple aim. At this level, entities strongly demonstrate a broad range of ACO capabilities. Level 2 status lasts for three years.
- **Level 3:** This level is for organizations that not only meet level 2 points and must-pass requirements, but also demonstrate strong performance or significant improvement in measures across the triple aim. Organizations may demonstrate this through performance in state/regional measurement collaboratives in the short term, and through national performance benchmarking in the longer term. Level 3 status lasts for three years and requires annual reporting and evaluation of performance to maintain the status.

Aligning purchasers with common expectations. NCQA offers our evaluation program for ACOs with the goal of aligning health plan, employer, state and federal purchaser initiatives to create the most leverage possible to prompt organizations to take on the challenging task of changing how they provide care. Commercial health plans and self insured employers are beginning to sponsor demonstrations of accountable care across the country (Higgins 2011). At the same time, multipayer groups and Medicaid agencies are looking at the ACO as a new model of care. The Medicare program is also sponsoring ACO pilots—"Pioneers"—and has released the final regulations for the permanent ACO program to start next year.

While different payers may want to negotiate with organizations about reimbursement and attribution and assignment of patients, the NCQA ACO Accreditation program clarifies expectations for these new entities. It builds on our success with the PCMH program, which allows all types of purchasers—commercial health plans, Medicaid programs, the Military Health Service and the agency sponsoring Federally Qualified Health Centers—to be able to recognize practices that are interested in participating in pilots and broader programs, and to ascertain how well they have organized their practices to deliver on the promise of the PCMH program.

PROGRAM ELEMENTS

The ACO program contains 7 categories, broken into 65 elements; element-level point allocation is based on 100 points; there are 4 must-pass elements. Conceptually, these fall into several important areas.

Standards for the organization of the entity—leadership and scope. This group of standards require organizations to provide the infrastructure and leadership needed to move health care systems toward the triple aim, and to provide the full range of health care services to patients. We expect ACO leadership to establish payment mechanisms and other contracting provisions that encourage providers composing the ACO to work toward shared goals across settings.

NCQA expects ACOs to report and eventually be scored based on measures, in addition to standards. We require ACOs to measure their performance and act to improve on the triple

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aim, to be a learning organization effective at making changes, to act on all improvement opportunities towards the triple aim.

Because we expect ACOs to deliver on a full range of care and provide excellent access, we call for them to have sufficient numbers and types of practitioners who provide:

- Primary care
- Specialty care
- Urgent/emergency/inpatient care
- Community and home-based services
- Long-term care.

Note: *ACOs need to arrange for care provided by these providers, not necessarily hire them.* We expect ACOs to evaluate their providers to ensure adequate access during and after typical office hours, and to assess and adjust the care they provide to meet patients' cultural needs and preferences. Access standards are also a feature that resonates with patients and consumers. We have found that providing access to care has been a fundamental part of the patient-centered medical home, one we believe has led to reduced use of emergency room care and hospital admissions. Recent articles in peer-reviewed literature confirm the success of several medical home pilots in reducing emergency room use (Takach 2011). NCQA's ACO program calls for organizations to provide access to patient-centered care and medical homes.

Primary care as a foundation. Primary care is a very important part of the health care system, and the patient-centered medical home standards that the ACO program builds on reflect many of the same elements that make primary care successful. Primary care clinicians are often the first point of contact for an individual, so access to care is a critical issue. Clinicians need to have a broad knowledge of many health care conditions because they often follow their patients over years, so the quality of the relationship and the clinician's ability to track care over time are important. Because many primary care clinicians refer their patients to specialists, communication among providers is an important—yet often challenging—issue.

Providing information and shared resources to manage population health. Essential to managing a population of patients are analyzing data and providing targeted resources for care coordination and management. Individual practices can adapt the practice of care to include a team-based approach, but for some patients, health care staff with expertise in supporting patients between visits and connecting them with external resources can provide needed care that practices cannot afford on their own. NCQA calls for organizations to collect, integrate and disseminate data for various uses, including care management and performance reporting. Organizations should provide resources for patients and practitioners to support care management activities. And organizations should invest in technology and practices that will allow real-time patient information to flow across settings and providers.

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Transparency and aligning incentives to improve quality across providers. Given the concerns some consumers may have about changes they see in a practice, and concerns they might have about the implications for access and quality, ACOs must communicate performance information to patients and be transparent about performance-based payment arrangements with providers. We call for ACOs to publicly report and provide performance reports to their providers for quality improvement. Not only is transparency important in and of itself, but it is also the foundation for aligning focus on improvement on the measures.

Resource stewardship. Standards for resource stewardship require organizations to provide decision support tools to practitioners and decision aids to patients, to encourage them to understand the trade-offs associated with different treatment options and to more actively participate in their care. NCQA expects organizations to analyze patterns of health care service use for appropriateness and overutilization; to provide reports to individual clinicians that detail variation from expected care; and to educate providers about ways to reduce variation.

NCQA PROCESS FOR DEVELOPING CONSENSUS

NCQA used a comprehensive approach in developing the NCQA Accreditation program. Starting with an evidence review and convening a group of experts and stakeholders, we used a consensus-driven process that was informed by public comment and a pilot test of the results. We wanted to develop a program that is rigorous, yet feasible, to reflect readiness levels in the delivery system in markets across the country. The goal was to create consensus around the core elements of a program that is responsive to the needs of patients and consumers, and private and public purchasers. Following NCQA's normal process, program standards were brought to the Clinical Programs Committee and to NCQA's Board of Directors for discussion and approval. Staff also shared information and sought input on the program with several NCQA advisory boards: the Consumer Advisory Committee, the Public Sector Advisory Committee and the Purchaser Advisory Committee.

Evidence review. At the start of the ACO Accreditation program development process, NCQA staff performed a comprehensive review of the research literature, to isolate the organizational attributes that seemed highly correlated with strong performance. This review included peer-reviewed literature, as well as other documents, including the statutory language in the Medicare Shared Savings Program included as a part of the Affordable Care Act. Although there are no provisions in law for Medicare to deem requirements satisfied through review from a private accreditation entity, our goal was to create alignment across payers. In drafting ACO criteria, NCQA conducted informational interviews with organizations that are redesigning into accountable entities, to further our understanding about how ACOs can be structured and to identify activities that lead to increased quality, improved patient experience and better cost containment. At a task force meeting, we presented a case study of one of these organizations and highlighted findings from the remaining organizations.

Task force. NCQA's ACO Task Force is made up of experts from leading health organizations, researchers, purchasers and consumers. The group met over a two-year period

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to shape the standards and to decide on scoring and performance levels and the content of measures to be collected. In addition to debate over these issues, NCQA conducted a structured survey of task force members to elicit additional input.

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