NCQA Draft 2011 ACO Criteria

On October 19, 2010, the National Committee for Quality Assurance (NCQA) released its draft 2011 Accountable Care Organizations (ACO) criteria for public comment. NCQA’s mission is to improve health care quality through its activities, such as accrediting and certifying health care organizations and recognizing clinicians and practices in key areas of performance. The following advisory provides a summary of the draft ACO criteria, as well as a list of issues on which NCQA requests feedback.

I. NCQA Definition of ACO

NCQA defines ACOs as “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.” NCQA notes that while providers will differ in how they organize themselves as ACOs and what components of care delivery they include in their organization, they all “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.” Also, clinical and financial incentives should be aligned for providers; this requires an administrative infrastructure to perform functions including managing budgets, collecting data, reporting performance, making payments related to performance and organizing providers around shared goals.

II. Draft ACO Criteria

There are seven proposed categories of reflecting core ACO capabilities: (1) program structure operations; (2) access and availability; (3) primary care; (4) care management; (5) care coordination and transitions; (6) patients rights and responsibilities; and (7) performance reporting. Within each of the criteria are a number of standards consisting of elements and factors that are scored. Attached to this memorandum is a table outlining the categories, standards and elements included in the draft ACO criteria.
The draft criteria are geared toward assessing whether an ACO has the infrastructure needed to reduce costs, improve health care quality and improve patient experience. In the draft ACO criteria, greater focus is placed on the organization’s capabilities rather than performance. Noting that it will be some time before organizations can be judged primarily on performance measurement, NCQA believes that there must be “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 capacity.”

III. Comments Requested for Specific Issues

In addition to comments on the individual standards and elements in the draft criteria, NCQA is requesting feedback on the following issues concerning the criteria:

1. Should certain individual standards or elements reflect a core capability that all ACOs should possess?

2. NCQA is proposing four levels of scoring for ACOs, and the levels would be based on the organization’s demonstrated capability to function as an ACO and improve quality, increase patient satisfaction and lower per capita costs. NCQA is requesting feedback on what should be the expected capabilities for each ACO level.

3. 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)? Also, should additional arrangements or structures be considered?

4. Should the types of specialists 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)?

5. NCQA provides a list of available standardized measures for clinical quality and patient experience in an appendix. These measures come from NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare & Medicaid Services Requirements of Meaningful Use of Electronic Health Records, the Dartmouth Atlas and the Integrated Healthcare Association California Pay for Performance Program. Not all of these measures have been endorsed by the National Quality Forum. NCQA requests feedback on how these currently available measures might be used immediately to report performance.
(6) Do the criteria align with stakeholder expectations for ACOs? Are there gaps or areas not addressed but should be?

(7) For organizations seeking to become ACOs, does the organization have materials or documents to demonstrate compliance with the criteria? If not, which areas are challenging?

(8) Are there critical functions not included in the current draft standards?

IV. Next Steps

Public comments to the draft criteria are due by November 19, 2010. The comments will be considered as the criteria are finalized for release in mid-2011.
## NCQA ACO Draft 2011 Criteria

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<thead>
<tr>
<th>Category</th>
<th>Standard</th>
<th>Intent</th>
<th>Element</th>
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</table>
| Program Structure Operations (PO) | PO 1: ACO Structure | The organization has the infrastructure to coordinate providers and works to increase quality, improve patient experience and effectively manage its financial resources. | Element A: Program Structure  
Element B: Stakeholder Participation  
Element C: Working with Others |
| PO 2: Resource Stewardship | The organization has the staffing and infrastructure to effectively manage its resources. | Element A: Clinical Utilization Management  
Element B: Resource Stewardship |
| PO 3: Health Services Contracting | The organization contracts with practitioners and providers to provide the full continuum of care and foster open communication and cooperation with quality improvement (QI) activities. | Element A: Arranging for Services  
Element B: Practitioner Payment Arrangements  
Element C: Payer Contracts |
| Access and Availability (AA) | AA 1: Availability of Practitioners | The organization maintains an adequate network of primary care and specialty care practitioners and maintains appropriate access to services. | Element A: Assessing Network Needs  
Element B: Availability of Practitioners  
Element C: Assessment of Access  
Element D: Ensuring Access  
Element E: Practitioner Directory  
Element F: Provider Directory  
Element G: Cultural Needs and Preferences |
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<tbody>
<tr>
<td>Primary Care (PC)</td>
<td>PC 1: Practice Capabilities</td>
<td>The practice provides patients/families with access to appropriate routine and urgent care.</td>
<td>Element A: Access During Office Hours Element B: Access After Hours Element C: Practice Team Element D: Guidelines for Important Conditions Element E: Managing Care Element F: Manage Medications Element G: Self-Care Process Element H: Test Tracking and Follow-Up Element I: Referral Tracking and Follow-Up Element J: Quality Improvement Activity Element K: Identify High Risk Patients</td>
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<td>Care Management (CM)</td>
<td>CM 1: Data Collection and Integration</td>
<td>The use of multiple modalities for data collection and integration ensures that the organization collects data that meet the needs of clinical care and administrative purposes.</td>
<td>Element A: Process for Data Collection and Integration Element B: Data Collection and Integration Element C: Patient Information Element D: Clinical Data Element E: Practice Access to Electronic Data</td>
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<tr>
<td>Category and Transitions (CT)</td>
<td>Standard</td>
<td>Intent</td>
<td>Element</td>
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<td>CM 2: Initial Health Assessment</td>
<td>Assessment of patient health is relevant to the management of clinical needs.</td>
<td>Element A: Health Assessment</td>
<td></td>
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<td>CM 3: Population Health Management</td>
<td>Accurate identification of care needs and the provision of population health management programs enables organizations to provide quality patient-centric care.</td>
<td>Element A: Identifying Care Needs Element B: Data Sources for Identification Element C: Providing Population Health Management</td>
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<td>Care Coordination and Transitions (CT)</td>
<td>CT 1: Information Exchange for Care Coordination and Transitions</td>
<td>The organization has a coordinated system of care between multiple providers to offer integrated, timely and effective care.</td>
<td>Element A: Coordinating Information Exchange Element B: Process for Transitions Element C: Follow-Up After Transitions Element D: Timely Information Exchange</td>
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| Patient Rights and Responsibilities (RR) | RR 1: Patient Rights and Responsibilities | The organization recognizes the specific needs of and maintains a mutually respectful relationship with patients. | Element A: Rights and Responsibilities Statement  
Element B: Written Policies for Privacy and Confidentiality  
Element C: Physical and Electronic Access  
Element D: Policies and Procedures for Complaints |
| Performance Reporting (PR)   | PR 1: Performance Reporting       | The organization strives to improve the quality of its services by measuring its performance using valid measures and making results available to the public and participating providers. | Element A: Core Performance Measures  
Element B: Performance Measure Data Sources  
Element C: Practitioner Performance Reporting  
Element D: Reporting Performance Publically |
|                              | PR 2: Quality Improvement         | Sound, quantitative measurement and analysis establish a basis for quality improvement and tracking results. | Element A: Clinical Quality and Cost Performance Improvement  
Element B: Patient Experience Improvement |
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For further guidance please contact one of the attorneys or advisors listed below:

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### Atlanta Office

Donna P. Bergeson  
404.881.7278  
donna.bergeson@alston.com

Angela T. Burnette  
404.881.7665  
angie.burnette@alston.com

Robert C. Lower  
404.881.7455  
bob.lower@alston.com

Dawnmarie R. Matlock  
404.881.4253  
dawnmarie.matlock@alston.com

Robert D. Stone  
404.881.7270  
robert.stone@alston.com

Michelle A. Williams  
404.881.7594  
michelle.williams@alston.com

### Washington Office

Kimberly L. Brandt  
202.239.3647  
kimberly.brandt@alston.com

Jennifer L. Butler  
202.239.3328  
jennifer.butler@alston.com

Elinor A. Hiller  
202.239.3401  
elinor.hiller@alston.com

Laura E. Holland  
202.239.3980  
laura.holland@alston.com

Peter M. Kazon  
202.239.3334  
peter.kazon@alston.com

Stephanie A. Kennan  
Senior Public Policy Advisor  
202.239.3159  
stephanie.kennan@alston.com

Keavney F. Klein  
202.239.3981  
keavney.klein@alston.com

Rudy S. Missmar  
202.239.3034  
rudy.missmar@alston.com

Michael H. Park  
202.239.3630  
michael.park@alston.com

Mark Rayder  
Senior Public Policy Advisor  
202.239.3562  
mark.rayder@alston.com

Colin T. Roskey  
202.239.3436  
colin.roscopy@alston.com

Thomas A. Scully  
202.239.3459  
thomas.scully@alston.com

Tamara R. Tenney  
202.239.3489  
tamara.tenney@alston.com

Timothy P. Tyslla  
202.239.3420  
tim.tyslla@alston.com

Marilyn Yager  
Senior Public Policy Advisor  
202.239.3341  
marilyn.yager@alston.com

Colin T. Roskey  
202.239.3436  
colin.roscopy@alston.com

Timothy P. Tyslla  
202.239.3420  
tim.tyslla@alston.com

Marilyn Yager  
Senior Public Policy Advisor  
202.239.3341  
marilyn.yager@alston.com

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