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The NCQA 2011 ACO Criteria and Implications for ACO Governance



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On Oct. 19, the National Committee for Quality Assurance (NCQA) released for comment its 2011 Draft Accountable Care Organization (ACO) Criteria.¹ This document constitutes a significant contribu-

¹ National Committee for Quality Assurance, 2011 Draft Accountable Care Organization (ACO) Criteria (available at:

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tion to the thinking and the literature about what it will take for a provider organization to function effectively as an ACO, now and in the future.² This article provides

http://ncqa.org/portals/0/publiccomment/ACO/All_ACO_2011_Public_Comment_documents.pdf) (hereinafter *2011 Draft Accountable Care Organization (ACO) Criteria*).

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an overview of these NCQA criteria for ACOs, followed by a discussion of their implications for ACO governance.

The NCQA draft criteria as a whole constitute a comprehensive statement of the wide range of capabilities that will be necessary for an ACO to be operational at the start and effective over time—and thus capable of being accredited by NCQA. The criteria related to governance, and similar provisions likely to come from the Centers for Medicare and Medicaid Services (CMS) as it implements Section 3022 of the Affordable Care Act (ACA), emphasize the importance that health care organizations seeking to become or to participate in ACOs should be placing on ACO board membership and board obligations.

Overview

In the overview section of the document, NCQA usefully sets forth certain overriding concepts related to ACO formation and operation. I highlight several below:³

- 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.
- There is sufficient evidence and emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the core needs of a defined population of patients.
- 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.
- 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.
- Providers that want to become ACOs are in the process of building their capability. Some have leaders who understand core competencies of ACOs and are proceeding accordingly. But most organizations are by no means ready to deliver on the triple aim.
- To support the formation of sustainable accountable organizations, 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 capability.

Categories of Draft Criteria

NCQA organizes its criteria into the following categories:

- **Program Structure Operations**
 - The organization clearly defines its organizational and leadership structure.
 - The organization has the capability to manage its resources effectively.

University; Nicholas Wolter, MD, Billings Clinic; and Mara Youdelman, National Health Law Program.

³ 2011 Draft Accountable Care Organization (ACO) Criteria at 3-11.

- The ACO arranges for pertinent health care services and determines payment arrangements and contracting.
- **Access and Availability**
 - The organization ensures that it has sufficient numbers and types of practitioners who provide primary and specialty care.
- **Primary Care**
 - Primary care practices within the ACO provide patient-centered care.
- **Care Management**
 - The organization collects and integrates data from various sources, including, but not limited to, electronic sources for clinical and administrative purposes.
 - The organization conducts an initial assessment of new patients' health.
 - The organization uses appropriate data to identify population health needs and implements programs as necessary.
 - The organization provides resources for, or supports, the use of patient care registries, electronic prescribing and patient self-management.
- **Care Coordination and Transitions**
 - The organization can facilitate timely information exchange between primary care, specialty care and hospitals for care coordination and transitions.
- **Patient Rights and Responsibilities**
 - 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.
- **Performance Reporting**
 - The organization measures and reports clinical quality of care, patient experience and cost.
 - At least annually, the organization measures and analyzes the areas of performance and takes action to improve effectiveness in key areas.

ACO Eligibility

NCQA states that it is aligning its eligibility requirements for provider organizations wishing to participate as ACOs with those set forth in the ACA.⁴ 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; and
- Hospitals and their employed providers.

NCQA is proposing four levels of scoring for ACOs.⁵ Levels will be agnostic as to organizational structure

⁴ *Id.* at 8.

⁵ *Id.*

(i.e., whether or not it is led by a multispecialty group, hospital or independent practice association) and to reimbursement mechanisms 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** - meets 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** - meets core qualifying criteria and has some advanced features which may include integration of electronic clinical systems and the ability to integrate data for reporting and quality improvement.
- **Level 3** - meets core qualifying criteria, possess advanced features and can report standardized, nationally-accepted clinical quality measures, patient experience and cost measures.
- **Level 4** - meets 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.

Implications for ACO Governance

Each of the categories of ACO criteria listed above is divided into sub-categories to be scored. Under ACO Program Structure and Operations, there are three major sub-categories:

ACO structure, resource stewardship and health services contracting.⁶ The latter two areas address (1) the ACO's responsibilities related to the staffing and infrastructure to effectively manage its resources, including a clinical utilization management plan, and (2) the ACO's arrangements with practitioners and providers to provide the full continuum of care, the payment arrangements it has with its practitioners and certain requirements related to the content of payer contracts.

It is under the ACO structure sub-category that NCQA addresses the role of ACO governing bodies. Overall, it is the intent of this category of criteria, according to NCQA, to determine that an ACO has the infrastructure to coordinate providers and works to increase quality, improve patient experience and effectively manage its financial resources.⁷

With regard to the governing body, NCQA proposes to score ACOs on the effectiveness of the role, structure and functions of the governing body, including how well the governing body provides leadership, establishes accountability and "provides the structure to align the functions of an ACO."⁸ Moreover, the NCQA criteria state that the physician or clinician leader of the ACO "must participate on or advise the board." An ACO also, according to NCQA, will need a documented

process for annually reviewing the ACO's performance, including its social and structural elements critical to achieving high performance, with the governing body.⁹

ACO governing bodies also will need to assure that the following stakeholder groups are involved in its oversight functions: primary care practitioners and specialists who provide care for the ACO's patients, hospitals or other providers that are part of the legal or contracting structure of the ACO and consumers or community representatives.¹⁰ Finally, ACOs and their governing bodies are tasked and will be scored by the NCQA on how well they work with providers, community resources, consumers and payers.¹¹

Whew! Let's step back both in light of these NCQA draft criteria and what we know about evolving fiduciary standards, and assess some of the major issues that directors or trustees of ACOs (and their related provider components) will need to consider in providing oversight:

- Medicare fee-for-service payments are expected to decline steadily in the years ahead.
- Payment changes will further reduce reimbursement to providers with poor scores on quality measures.
- Shifts to pay-for-performance, bundled payments and global payments will require further infrastructure investments and carefully balancing bottom line implications of a mixture of fee-for-service and accountable care-type payment methodologies.
- ACO boards and senior management will need to balance stakeholder representation required by CMS, NCQA or others with perceived community and management representation and the need for independent directors.
- Today's provider-based health systems will need to consider what entity—one that currently exists or one to be formed—will serve as the ACO (including how many ACOs it may want to form or work with) and (1) how to structure such ACO boards to meet legal, fiduciary and mission requirements and (2) how to coordinate such ACO boards with other boards within the system.
- The increasing focus on quality reporting may result in "fraud and abuse" enforcement against providers making claims to public payers for care deemed to be substandard.¹²
- Greater quality data reporting and transparency will require oversight, including assurance that reporting is accurate, thus creating significant additional compliance requirements.¹³
- ACO boards will need to review their oversight structure regarding quality—as it relates both to the ACO and its provider components—and consider the establishment or restructuring of board

⁹ *Id.* at 13.

¹⁰ *Id.* at 14.

¹¹ *Id.* at 15.

¹² See, e.g., Office of the Inspector General, U.S. Department of Health and Human Services and American Health Lawyers Association, *Corporate Responsibility and Health Care Quality* (available at: http://www.healthlawyers.org/Resources/PI/InfoSeries/Documents/OIG_CorpRespHealthcareQuality.pdf).

¹³ *Id.*

⁶ *Id.* at 12-23.

⁷ *Id.* at 12.

⁸ *Id.*

quality committees into “accountable care” committees.

- ACO boards also will need to assure that appropriate and effective management and clinical personnel and protocols are in place to meet CMS, NCQA and other requirements and achieve the ACO’s quality goals.
- ACO boards will need to actively oversee quality reporting and auditing activities in accord with evolving regulatory requirements and fiduciary standards.

Conclusion

The NCQA 2011 Draft ACO Criteria provide a kind of roadmap to NCQA qualification and accreditation for beginning organizations as well as more experienced ones. The breadth of areas addressed helps communicate how much is involved in ACO operations structurally, financially and clinically.

With regard to governance, the last decade has seen great evolution, perhaps it is fair to say a revolution, in the perception and expectation of corporate governance. Directors and trustees, whether for-profit or

non-profit, are expected to be knowledgeable, active overseers of the corporation’s mission, effectiveness and legal compliance, and yet always remaining respectful of the difference between board oversight and executive management. The NCQA Draft 2011 ACO Criteria not only establish a solid and substantive baseline for judging ACO qualification and ongoing performance, but also help lay the groundwork for a better understanding of ACO governance.

ACOs will need to be mindful of the panoply of potential representational needs and requirements for their boards without losing sight of the importance of the fiduciary duties incumbent on each director. Demand for directors who understand the mission of ACOs in the larger payment and delivery reform context, understand something of the financial and clinical issues facing ACOs and understand contemporary thinking about corporate governance will be high. Directors and trustees of ACOs will have challenging responsibilities, but their ability to have a positive impact on the health care system and the health of the populations the ACOs serve will be significant.