

November 19, 2010

Margaret E. O’Kane  
President  
National Committee for Quality Assurance  
1100 13th Street, NW, Suite 1000  
Washington, DC 20005

RE: Comments on NCQA’s Accountable Care Organizations (ACO) Draft 2011 Criteria

Dear Peggy:

The Consumer-Purchaser Disclosure Project is a collaboration of leading national and local consumer, labor, and employer organizations committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. We support NCQA’s effort to establish standards for assessing the capabilities of Accountable Care Organizations (ACOs). ACOs, if done “right,” can be a tool that increases quality and affordability of care. We believe, however, that the proposed NCQA standards should go further in assuring that ACOs will deliver on the goals of improving care and reducing costs.

Given the current climate – both market and political – it is imperative that NCQA hold ACOs to a standard that makes certain they can deliver on the triple aim of improving health, improving patient experience, and reducing costs. Consumers and purchasers want an affordable health care system that works for them and the country can no longer sustain in its current form. Accountable Care Organizations are one of the first new models of care that is being implemented from the Patient Protection and Affordable Care Act to address these very issues. We believe these standards will also set the stage for assessment of other new models of care.

Below we offer general comments on the standards and address design issues and global questions posed by NCQA. Additionally we provide specific recommendations on the standards in Appendix A, possible measures to include in a core set in Appendix B, and the Consumer-Purchaser Disclosure Project Principles on ACOs in Appendix C. These principles served as a guide post for all our comments.

### **General Comments**

The guiding principles upon which the NCQA criteria are built – a strong foundation of primary care, reliable measures and a commitment to support quality improvement and cost reduction, working cooperatively with stakeholder groups, and support for a sustainable workforce – are essential building blocks of a new care delivery system.

We support flexibility in how providers can organize themselves as ACOs. But what is more important is ensuring only those models that simultaneously improve health, improve patient experience and reduce costs are designated as ACOs. Thus, we emphatically support NCQA's statement that performance measurement must be part of an ACO's evaluation but are extremely concerned by NCQA's finding that it will take time before ACOs can be judged on outcomes. We are also deeply concerned performance reporting is not a core qualifying criteria for all ACOs. We do not believe that providers should receive rewards for providing marginally effective care or care that is already routinely furnished.

The standards are very weak on addressing costs, and in particular monitoring and reporting performance. More emphasis needs to be placed on cost containment to meet all objectives of the triple aim. This can be done through improving cost measurement such as managing trend at CPI plus 1%, maintenance of sound fiscal policies and financial management practice that assure oversight of risk-based contracts, and expectations for resource stewardship and reduction of waste.

ACO certification should be withdrawn if no gains are demonstrated on each element of the triple aim within 24 months after initial certification.

NCQA should commit to making public the summary scores of the ACO 2011 Criteria, not just pass/fail status, and the information on which the scores are based. This underlying data that forms the basis for ACO certification should be made public in a user-friendly way, similar to what was developed for the Physician Hospital Quality (PHQ) standards. This will allow consumers and purchasers to differentiate high-performing ACOs and provide best in class information to providers.

In response to the number of instances where NCQA invites comment on whether having a high percentage of Patient-Centered Medical Home (PCMH) recognized practices within an ACO should be deemed automatic credit for certain requirements, we believe only those ACOs who have more than 80% of Level 3 PCMH recognized practices should be given such credit.

Finally the ACO criteria should reflect the national movement toward the use of electronic health information and systems. While many providers belonging to ACO networks may not have such systems in the early years, it is important for NCQA to signal that its criteria will evolve over time in such a way as to rely primarily or exclusively on information from electronic systems that are capable of secure information exchange.

### **Design Issues**

In addition to feedback on the individual standards and elements, we appreciate NCQA seeking input on key design issues:

- **ACO Levels:** NCQA should eliminate the current Level 1 and maintain three levels. We appreciate the need to encourage the formation of ACOs, but feel Level 1 is too low of a bar for entry.

- **Eligibility for Participation:** Because an adequate provider network is critical to attract and retain patients, we believe that criteria should be linked to a needs assessment for the location population and include guidance on the categories of specialists that an ACO is required to include in its network. Specialists to have in the guidance could include: specialists that treat the ten most common chronic conditions, reproductive health specialists, mental health specialists, pediatricians, essential community providers, and access to rehabilitation centers, skilled nursing facilities, and home health agencies. We also support the acceptability of narrow, highly selective ACO specialist networks.
- **Measures:** We strongly believe that NCQA should not wait to require demonstrated ability to integrate data for reporting and quality improvement; it should be a core capability from the start. NCQA should require all ACOs to report on a set of core measures that includes measures of clinical quality (including outcomes), patient experience, and cost. For a recommended set of measures, see Appendix B. Additionally, it is important to make use of performance reporting programs already in place to reduce the data collection burden. For example, many organizations are already submitting data for regional collaborative reporting and Medicare programs.

### **Global Questions**

NCQA also includes “global” questions about the overall design of the criteria:

**Do the criteria align with stakeholder expectations for ACOs?** ACOs are being touted as a new model of care to fix current quality and affordability problems with health care, yet it remains to be seen if ACOs will deliver. The Disclosure Project has developed principles that should be adhered to in order to have a successful ACO (see Attachment C). There are some key places in the NCQA standards that need to be strengthened to align with the expectations of consumers and purchasers; we have detailed these in our general comments, response to questions, and specific recommendations to the standards.

### **Are there critical functions not included in the current draft standards?**

- Shared decision-making for preference sensitive conditions
- Patient access to comprehensive, portable health information
- ACO attribution and patient notification
- Transparency of ACO patient attribution methods, as well as the design of financial incentives

**Closing**

We believe the proposed standards are a start to defining a national understanding of Accountable Care Organizations while recognizing there are multiple models that have the potential to be successful. We also recognize that these standards should evolve over time as our understanding and evidence in this arena advances.

Thank you for the opportunity to comment on this important initiative. If you have any questions, please contact either of the Disclosure Project's co-chairs, Debra Ness, President of the National Partnership for Women & Families or David Lansky, PhD President & CEO for the Pacific Business Group on Health.

Sincerely,



Debra L. Ness  
President  
National Partnership for Women & Families



David Lansky  
President & CEO  
Pacific Business Group on Health

Enclosures

cc: Don Berwick, MD, Administrator, Centers for Medicare & Medicaid Services  
Jonathan Blum, Director, Center for Medicare Management, Centers for Medicare & Medicaid Services  
Richard Gilfillan, MD, Acting Director, Center for Medicare & Medicaid Innovation  
Peter V. Lee, Director of Delivery System Reform, US Department of Health & Human Services

## **Attachment A: Specific Comments by Section**

### **Program Operations 1: ACO Structure**

**Overall:** The definition of ACO should be broadened to include physicians with a strong primary care base and sufficient other “providers with knowledge of social and community supports”. Creating a strong foundation of primary care is not just about physicians but also other health and social service providers that keep patients well and living in the community.

#### ***Element A: Program Structure***

**Factor 2:** Consumer and purchaser representatives should be designated members of the ACO governing body.

**Factor 3:** We strongly support the recommendation ACOs must define goals for clinical quality, patient experience and cost. We propose additional specifications that performance goals should take into account community AND national benchmarks and make explicit the improvement targets.

While cost goals are defined by example, we recommend the addition of appropriate use as distinct from resource use. We also recommend defining clinical quality and patient experience as follows.

Clinical quality goals may include those addressing:

- Health status
- Clinical processes
- Clinical outcomes
- Functional outcomes
- Care coordination and care transitions.

No more than 50 percent credit should be permitted for clinical process measures.

Patient experience goals may include those addressing:

- Access
- Treatment option decision support
- Self-care
- Provider communications

No more than 50 percent credit should be permitted for organization-level measurement of patient experience, with the remaining credit subject to physician or practice-level measurement.

**Additional Factors:** We recommend the inclusion of three additional factors: 1) Information about the organization’s financial arrangements with its providers, 2) .Defined infrastructure and performance criteria for provider credentialing and program participation and 3) Defined fiscal policies commensurate with financial risk-bearing level of the organization.

**New Factor:** We recommend the inclusion of the following additional factors: information about the organizations financial arrangements with its providers; defined infrastructure and performance criteria for provider credentialing and program participation; and defined fiscal policies commensurate with financial risk-bearing level of the organization.

***Element B: Stakeholder Participation***

**Factor 2:** We agree that consumers or community representatives should be one of the stakeholder groups involved in the oversight of ACO functions. We also believe that purchasers should be included. Consumer and purchaser participation on boards and subcommittees should be proportional to other stakeholders.

**Program Operations 2: Resource Stewardship**

***Element A: Clinical Utilization Management***

Factor 3: Modify to specify risk assessment and adjustment to ensure the inclusion of appropriate analytics to support the process.

**New Factor:** We recommend the inclusion of an additional factor: Process for review of resource use and appropriateness of care (e.g., clinical complications, readmissions, emergency room utilization, facility type and level).

***Element B: Resource Stewardship***

**Factor 3:** To recognize the complexities of patients with multiple chronic conditions, the written policies for applying criteria based on individual need, particularly those for length of hospital stay, should also include availability of an informal caregiver and community service and supports.

**New Factor:** All the factors are retrospectively focused and there should be more of an emphasis on prospective analysis. We recommend the inclusion of an additional factor to help address this issue: Use of decision support tools at the point of care to support evidence based care.

**Program Operations 3: Health Services Contracting**

***Element A: Arranging for Services***

**Overall:** We agree that this is not a comprehensive list. Skilled nursing facilities, rehabilitation services, and hospice should be added. If an organization is responsible for managing transitions of care, they need to demonstrate the ability to manage and support the continuum of care, even if the provider relationship is on a referral basis.

***Element B: Practitioner Payment Arrangements***

**Factor 1:** We strongly support basing a portion of practitioners' compensation on performance. To ensure a delivery system based on value, this should be at least 20% of compensation. Practitioner performance incentives should be based more on outcome and population health measures than process measures. All physicians in the ACO network (including physicians that are part of a leased network) should be subject to accountable care terms. In the case of a leased network, it is acceptable for the leasing organization to commit to these terms and to "cause" their contracted physicians to adhere to the terms.

**New Factor:** Structures its compensation to promote accountability for the total cost of episodes of care.

***Element C: Payer Contracts***

**New Factor:** We recommend the inclusion of an additional factor: Provisions that allow for transparency of financial and performance information for providers, including hospitals and physician-level.

**Access and Availability 1: Availability of Practitioners**

***Element A: Assessing Network Needs***

**Factor 1:** Geriatricians should be included as a primary care practitioner.

***Element C: Assessment of Access***

**Overall:** We recommend that the explanation be revised to: "The organization performs an analysis to determine whether it provides sufficient access to its patients, *taking into account seasonal variation.*"

***Element E: Practitioner Directory***

**Overall:** Since not all patients have access to the internet, ACOs must find other ways of providing these patients with the complete practitioner directory. Other options include: making hard copy versions of the directory available to federal repository libraries, senior centers, and current and prospective patients upon request. We strongly support including "languages spoken by the physician or clinical staff" in the directory.

**New Factors:** We recommend the inclusion of additional factors: office hours, quality indicators, web visits and HIT capabilities as well as email and IP addresses so that external parties can locate address information to send electronic messages to provider organizations and individual practitioners. The standards should better align with the current HIE efforts that are underway.

***Element F: Provider Directory***

**Overall:** Since not all patients have access to the internet ACOs must find other ways of providing these patients with the complete provider (hospital) directory. Other options include: making hard copy versions of the directly available to federal repository libraries, senior centers and current and prospective patients upon request.

**New Factor:** We recommend the inclusion of an additional factor: quality indicators.

***Element G: Cultural Needs and Preferences***

**Factor 2:** It will not always be possible to adjust practitioners within its network to meet consumers' cultural needs and preferences because of the current demographics and supply of

practitioners. Organizations should therefore provide cultural competency training to its practitioners based on the assessment of cultural, ethnic, racial and linguistic needs of their patients. We also recommend including examples of some best practices or reference to NCQA's Standards and Guidelines for Distinction in Multicultural Health Care to provide a better explanation for how RELG, health status and disability data should be collected and how ACOs should explain to patients why the information is being collected.

### **Primary Care 1: Practice Capabilities**

#### ***Element E: Managing Care:***

**Factor 1:** Pre-visit planning should be conducted for 100 percent of appropriate patients – not the at least 75 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately, then a 3-year staged move to 100 percent coverage should be allowed.

**Factor 2:** The individualized care plan that the ACO team is required to develop should include *health status and quality of life* goals in addition to *treatment* goals. It should also provide for the opportunity to engage in advance care planning as under the Medicare wellness visit. Some patients may not want treatment per se, preferring palliative care.

**Factor 3:** Care plans should be conducted for 100 percent of appropriate patients – not the at least 75 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately then a 3-year staged move to 100 percent coverage should be allowed.

**Factor 4:** The barriers to treatment and care goals should also include lack of: support for family caregivers, resources, and community services and supports.

**Factor 5:** Clinical summaries should be conducted for 100 percent of appropriate patients – not the at least 50 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately, then a 3-year staged move to 100 percent coverage should be allowed. Clinical summaries must be written in easy to understand, consumer friendly language. NCQA should consider defining the key elements of the clinical summary based on the definition in Stage 1 of Meaningful Use, and that definition should evolve to be consistent with Stage 2 of Meaningful Use once it is finalized.

**Factor 6:** Referrals should be a routine practice for older patients with multiple chronic conditions especially dementia. Referrals should also include culturally appropriate local social service providers and community supports.

**Factor 7:** Follow-ups with patients who have not kept important appointments should be conducted for 100 percent of appropriate patients – not the at least 50 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately, then a 3-year staged move to 100 percent coverage should be allowed.

**New Factor:** Uses standardized tools for assessment of health status, functional outcomes and behavioral health screening (e.g., SF12, PHQ9, etc.) for 100% of appropriate patients.

**New Factor:** Addressing attention to patients that are not scheduled for a needed visit. Non-adherent patients that do not schedule visits are the ones likely to be discovered after an adverse event has occurred. There should be a comprehensive scan of all patients applying clinical scanning technology to systematically identify patients with gaps in care, according to clinical guidelines for their respective circumstances (e.g. age, gender and diagnostic appropriate cancer screenings, diabetic tests, Rx adherence). Scans should also cover safety

considerations (e.g. Rx conflicts) and suboptimal care (e.g. dosing problems or prescriptions that should be considered). These scans should result in follow-up alerts and outbound contact, regardless of whether the patient has scheduled a visit.

***Element F: Manage Medications***

**Factor 2:** The ACO should provide patients/families with clear information about new prescriptions in language they understand.

**New Factor:** Need an additional factor specifying the requirement of a medical record feed and alert system for absence of a fill for a critical drug that is to be taken over time for a chronic condition.

***Element G: Self Care Process***

**Overall:** The ACO should conduct self-management activities with 100 percent of patients/families – not the 50 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately, then a 3-year staged move to 100 percent coverage should be allowed.

**New Factor:** Require the ACO captures the specific services available to each patient (smoking cessation, weight loss, etc.) so that the patient's wellness program and other resources external to the ACO may become part of the referral resources.

***Element H: Test Tracking and Follow-Up***

**Factor 4:** In addition to notification of normal and abnormal test results, the ACO must also ensure that patients receive help in understanding the results, the appropriate follow-up care, and treatment recommendations. Missing test results should also trigger a notification. All these should be done in an appropriately timely manner.

***Element I: Referral Tracking and Follow-Up***

**Factor 3:** Once the practice receives the report from the specialist the information is shared with the patient in a timely fashion.

***Element J: Quality Improvement Activity***

**Overall:** This element seems to overlap with PR 2: Quality Improvement. We recommend using the elements in PR 2: Quality Improvement with the addition of Factor 3. All quality data should be collected and stratified by race, ethnicity, language, gender, health status, and disability status. We also believe that ACOs, even in Level 1, should be required to collect and analyze quality data to establish a baseline and begin to improve. (See our earlier comments recommending that the proposed Level 1 be eliminated.)

***Element K: Identify High Risk Patients***

**Factor 1:** Dementia should be added to the list of criteria for identifying high risk patients.

**Explanation:** Strengthen language to say “must include” rather than “may include” a combination of the following.

**CM 1: Data Collection and Integration**

**Overall:** This should be a “must pass” standard for ACOs.

***Element A: Process for Data Collection and Integration***

**Overall:** ACOs should be required to document the percent of providers who will be “covered” by their data sources and integration efforts. In other words, once all data is integrated, how comprehensive is that data in terms of the number of providers that contribute to it? For Levels 3 and 4 ACOs, they should meet specific requirements regarding data sources that cover at least 80 percent of providers in their network, preferably using electronic data. (See our earlier comments recommending that the proposed Level 1 be eliminated.)

**New Factors:** We recommend the inclusion of additional factors: Patient experience and patient reported outcomes should be included as data sources.

***Element B: Data Collection and Integration***

**New Factors:** We recommend the inclusion of additional factors: Patient experience and patient reported outcomes should be included as data sources.

***Element C: Patient Information***

**Factors 1, 2, 3, 4, 5:** Date of birth, gender, race, ethnicity, and preferred language should be collected for 100 percent of patients – not the at least 50 percent included in the element. ACOs should be held to a much higher standard than that set by the meaningful use requirements that were designed to permit solo practices to qualify.

***Element D: Clinical Data***

**Factors 3, 4, 5, 6, 7, 8:** Blood pressure, height, weight, BMI, length/height, weight, head circumference and pediatric BMI, tobacco use, OTC drugs, and herbal products should be recorded and chart changes for 80 percent of patients – not the at least 50 percent included in the element.

**CM 2: Initial Health Assessment**

***Element A: Health Assessment***

**Overall:** ACOs should follow up with patients who could not be reached or did not participate in the initial health assessment. They should also reach out to family caregivers where appropriate – particularly for patients with dementia.

#### **CM4: Practice Support**

##### ***Element A: Patient Care Registries***

**Overall:** ACOs should maintain registries for at least five chronic conditions to advance patient care and allow for data collection that provides a longitudinal analysis of global patient outcomes. If this can be done via HIT, a separate registry is not needed. For instance, advanced technology systems can be programmed to conduct frequent scans with clinical logic to detect gaps in care and other alert-worthy findings across the entire caseload. For patients with multiple conditions, there needs to be a way to assess quality of care across their conditions.

##### ***Element B: Electronic Prescribing***

**New Factor:** There should be mention of refill tracking as an element of e-prescribing that comes either from the pharmacy, in the case of a pharmacy with that capability, or from other sources like a PBM that can quickly provide refill histories that can be fed electronically into EMRs.

##### ***Element D: Self-Management Support***

**Overall:** All self management materials must be written in clear, consumer-friendly language. Self-management support must be integrated into the care process at point of care.

#### **CT1: Information Exchange for Care Coordination and Transitions**

**Overall:** Care providers may include, but are not limited to, primary care practices, specialists, and hospitals. Other providers may include pediatricians, home health, nursing homes, and hospice. The ACO should also have processes in place for timely information exchange with other professionals that the patient determines to be on their care team.

##### ***Element B: Process for Transitions:***

**Overall:** All factors must be done in a timely manner. During transitions of care, timely information can make a significant difference in the quality, safety and efficiency of care. NCQA should consider whether ACOs should also develop a system of alerts so that, at a minimum, they are notified and can take action whenever a patient transitions across settings and, potentially, whenever a patient transitions across providers within the same setting.

**Factor 5:** The ACO should, when appropriate, follow-up with the caregiver to evaluate the patient's status and any required follow-up appointments.

#### **RR1: Patient Rights and Responsibilities**

##### ***Element A: Rights and Responsibilities Statement***

**Factor 1:** In plain language, patients should be informed of their assignment to an ACO and are given an opportunity to opt out. Patients should be notified of ACO financial rewards/payment, so that they understand the potential incentives for providers to reduce costs and the

importance that the ACO places on improving quality at the same time. It must be clear to patients that this is both about reducing costs and improving health outcomes.

**Factor 4:** Patients should be informed that they have access to an external appeals process. ACOs should specify their planned response timelines based on the processes they establish for receiving, documenting, and resolving complaints. ACOs should respond to complaints in less than 30 days or sooner if the circumstances warrant. A patient should always be notified in writing that an investigation was conducted, the findings of the investigation, and any action taken by the ACO to address the patient's complaint. The ACO can communicate this information to the patient by phone, but a phone call should not replace written notification. Additionally, if the ACO is unable, for legal reasons, to notify the patient of the specific action taken, the ACO must still advise the patient that action was taken to address their complaint.

***Element D: Policies and Procedures for Complaints***

**Overall:** Patients should be informed that they have access to an external appeals process.

**PR1: Performance Reporting**

**Overall:** ACOs take responsibility for simultaneously improving health, improving patient experience and reducing costs. This is reflected in Program Operations 1, Element A, Factor 5 and other areas throughout the standards. Performance reporting should reflect this as well. The intent should be revised to: "...to improve the quality of its services *and reduce costs* by measuring performance..."

***Element A: Core Performance Measures***

**Overall:** While we strongly support patient experience surveys being a required measure, we are very disappointed only eleven other measures are required. To be able to better assess and compare across ACOs, NCQA should require a core set of at least thirty-five measures by all ACOs. The core set should capture preventive care and a portfolio of measures that address the breadth of care for three chronic conditions. Additionally, there should be a greater focus on outcomes, resource use, and cost. Missing from the Appendix A: ACO Measure Grid are more measures related to patient engagement, patient safety, care coordination, outcomes, functional status, episodes of care, resource use, and hospital patient experience. See Appendix B for examples.

**Factor 4:** ACOs must report on resource use and cost. The factor should not be constructed so that reporting on these elements this can be avoided (e.g., allowing ACOs to only report on appropriateness).

***Element B: Performance Measure Data Sources***

**Overall:** How the data is handles is more important than the access issue, since access to this information should be a given. Rather ACO's should be assessed on: a) ensuring data is valid and complete, b) ensuring that "like data" that comes from different sources (claims, lab, EMR) is truly the same data, and c) provide the definitions/specifications for measures in each of these data source settings to ensure they are the same. If NCQA chooses to list these as examples in the explanation, patient surveys should be included.

### ***Element C: Practitioner Performance Reporting***

**Overall:** Quality data should be publicly reported and stratified by race, ethnicity, language, and gender. Practitioner performance reporting should include the following information: a) baseline vs. change over time, b) reliability/variation properties of the metrics, and c) absolute vs. relative performance comparisons.

**Factors 2 and 3:** The organization should distribute reports both at the practice-level and individual practitioner-level. Since there is a lot of variation that is masked at the practice level, to effectively stimulate quality improvement it is necessary to include results on individual performance. This should be a “must pass” element.

### ***Element D: Reporting Performance Publicly***

**Overall:** The information for patients should be clearly written, with explanations for how to interpret the information. Materials should be provided electronically and hard copies should be made easily available to patients/caregivers without access to the internet. Performance should be reported at the individual provider/physician level wherever possible. Quality data should be publicly reported and stratified by race, ethnicity, language, and gender.

**Factor 4:** ACOs must report on resource use and cost. The factor should not be constructed so this can be avoided (e.g., only report on appropriateness).

**New Factor:** We recommend the inclusion of an additional factor: ACOs should participate in larger regional collaboratives in order to obtain regional benchmarks for comparative purposes.

### **PR2: Quality Improvement**

**Overall:** The standard should be renamed Quality and Cost Improvement.

### ***Element A: Clinical Quality and Cost Performance Improvement***

**Factor 5:** This factor should require ACOs to both measure and report the effectiveness of interventions to improve each measure. This facilitates both accountability and the ability for others to learn what works and what does not in improving performance on quality and cost.

**New Factor:** The ACO must demonstrate improvement in clinical quality and cost/efficiency.

### ***Element B: Patient Experience Improvement***

**Overall:** We strongly support this element. In the Explanation section, the first sentence describes the CAHPS CG survey as “qualitative.” We believe this is an error. These criteria, which call for both quantitative and qualitative, must be maintained, and NCQA should consider weighting them heavily. In addition, ACOs should examine patient experience data by race, ethnicity, gender, and preferred language. This will move ACOs forward in the drive to reduce and eliminate health disparities.

There should be a process for collecting information on the family caregiver's experience, especially if the patient has cognitive impairment or dementia. In addition, a focus should be on the experiences/needs of chronically ill, high risk, complex patients. This would include domains of self-care management, care coordination, shared decision making and care system integration.

## **Attachment B: Possible Measures for Core Set**

In addition to measures listed in Appendix A: ACO Measure Grid, the following are possible measures that could be included in a standard core set for all ACOs.

Measures from current ACO programs:

- Blue Cross Blue Shield of MA Alternative Quality Contract
- Brookings-Dartmouth ACO Learning Collaborative
- Premier ACO Collaboratives

Measures from National Quality Forum Projects:

- National Voluntary Consensus Standards For Ambulatory Care Using Clinically Enriched Administrative Data
- National Voluntary Consensus Standards for Ambulatory Care: Additional Outpatient Measures 2010
- National Voluntary Consensus Standards For Hospital Care: Outcomes and Efficiency Phase I & II
- National Voluntary Consensus Standards for Medication Management
- National Voluntary Consensus Standards for Patient Outcomes
- National Voluntary Consensus Standards for Patient Safety Measures
- Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination
- National Voluntary Consensus Standards for Serious Reportable Events in Healthcare

Measures from PROMETHEUS Evidence-Based Case Rates™ (ECRs™)

## **Attachment C: Consumer-Purchaser Disclosure Project Principles for Accountable Care Organizations**

In order to be successful, ACOs should:

- **Result in significant improvements in quality and care coordination and decreased cost.** This will require creating a robust dashboard of measures that reflect areas that matter to consumers, including clinical outcomes, functional status, appropriateness, patient experience, care coordination, cost and resource use and setting minimum benchmarks that providers must meet in order to reach performance goals. We do not believe that providers should receive rewards for providing marginally effective care or care that is already routinely furnished.
- **Realize meaningful cost savings.** This can be accomplished by 1) starting with having meaningful measures of cost, efficiency, and resource use; 2) setting minimum benchmarks that encourage innovations in care; and 3) once shared savings programs have demonstrated success, moving to models of shared risk and capitation.
- **Align the public and private payers.** To represent a substantial cross-section of the market, ACO/shared-savings models should include public and private sector payers, including Medicare, Medicaid, and private payers. Medicare should consider multi-payer initiatives as an important criterion for assessing which pilots to select.
- **Return a majority of the savings to beneficiaries and purchasers of care.** A target would be for 66% of the savings to be passed on to beneficiaries and the purchasers, with 33% going to providers.
- **Risk adjust payments to reflect the complexity of patients.** This is necessary in order to achieve appropriate levels of care coordination and transition activity, as well as for ensuring proper care around rare events (e.g., organ transplants and other very high-cost procedures).
- **Continually monitor the health care marketplace** to ensure that ACOs are not resulting in market consolidation and higher costs. As we learn more, there may be specific regulations that we need to help assure access to high-quality and affordable care through ACOs.
- **Reduce disparities in care.** High quality care should, by definition, reduce disparities. To achieve this data on race, ethnicity, language and gender (RELG) must be collected for all patients, and performance measures must be stratified according to this data so that disparities can be identified and addressed.
- **Protect consumers in the “attribution” process.** Attribution policies must allow patients the choice of going outside of their ACO for care, provide for adequate access to specialists, and make transparent the financial incentives available to providers.