NCQA Accreditation Launches for ACOs

BY MARY ELLEN SCHNEIDER

FROM THE NATIONAL COMMITTEE ON QUALITY ASSURANCE

Starting Nov. 21, the National Committee on Quality Assurance will begin to accredit accountable care organizations.

The program offers three levels of accreditation based on the readiness of the ACO. As with the NCQA's recognition program for patient-centered medical homes, achieving accreditation at each level will be based on accruing a certain number of points by meeting standards and fulfilling some "must-pass" criteria.

NCQA officials said that they decided to establish the new program while ACOs are still in their infancy in order to provide payers and patients with some assurance about the model. The idea is to let everyone know that if a group of providers calls themselves an ACO, then they have adhered to a set of principles and are doing the right things for patients, Margaret E. O'Kane, NCQA president, said during a press briefing to announce the program.

Accreditation also offers a "roadmap" for groups that aspire to be ACOs, Ms. O'Kane said, by outlining the elements needed to qualify as an ACO. "If you can meet these standards, you can be an ACO."

The NCQA is launching its accreditation program as many physicians and hospitals are still trying to figure out if they could operate as an ACO. On Oct. 20, the Centers for Medicare and Medicaid Services released its final rule spelling out how an ACO should be structured and how providers in the organization would be paid by Medicare. Ms. O'Kane said that NCQA officials tried to align their accreditation standards with the Medicare rules as much as possible.

NCQA will offer accreditation to 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, and partnerships with providers and health plans. ACOs will need to serve at least 5,000 patients to quality for the NCQA program.

ACOs that seek accreditation will be evaluated on 65 elements, including 4 "must-pass" items. The elements fall into the following seven broad categories:

► **Program operations.** ACOs must have the infrastructure necessary to coordinate providers.

► **Access and availability.** ACOs must have sufficient numbers and types of providers, as well as timely access to care. NCQA said that the range of providers should include primary care, specialty care, urgent/emergency/inpatient care, community- and home-based services, and long-term care.

► **Primary care as the foundation.** The NCQA accreditation program builds on the standards in its patient-centered medical home recognition program.

► **Care management.** This requirement includes providing population health programs.

► **Care coordination and transitions.** The ACO must have a coordinated system for timely information exchange across multiple providers.

► **Patient rights and responsibilities.** ACOs must have a process for patient complaints, and a way for patients to restrict access to their data.

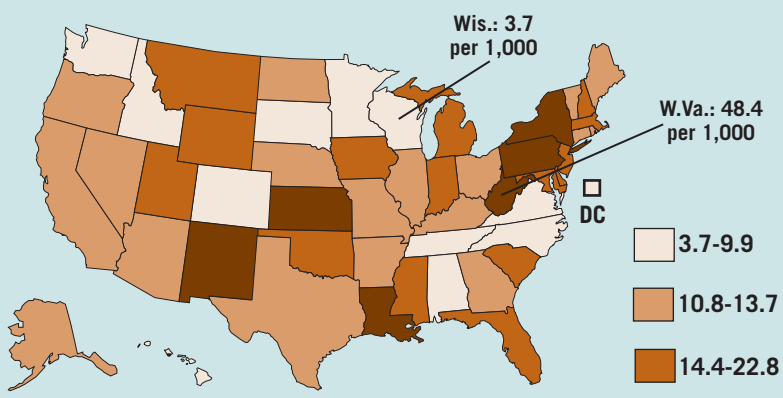
► **Performance reporting.** ACOs must measure their performance and publicly report the results.

ACOs that seek NCQA accreditation will also be evaluated using 40 measures of clinical quality, patient experience, and efficiency and utilization.

The program is the product of 2 years of discussions by the NCQA's ACO Task Force, which includes patients, policy experts, representatives from integrated health systems, and physicians. NCQA also evaluated 2,200 public comments and pilot tested the standards among integrated delivery systems, multispecialty practice groups, and independent practice associations. ■

DATA WATCH

States Varied Widely in 2010 Paid Malpractice Claims
(per 1,000 physicians)



Note: Based on an analysis of data from the National Practitioner Data Bank.
Sources: Kaiser Family Foundation, Lewin Group/American Medical Association

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Personhood Act Gets a No Vote

Voters in Mississippi rejected a ballot initiative that would have granted legal rights to embryos, starting at fertilization. Opponents of the measure had said that the state-constitution change not only would ban abortion in all but rare cases, but also would make forms of birth control and fertility treatment unavailable. Dr. Douglas Laube, the board chair of Physicians for Reproductive Choice and Health, said that the "personhood" amendment would have disallowed birth control options that prevent implantation of an embryo, such as emergency contraception and the use of intrauterine devices. The amendment's ban on destroying human embryos would have curtailed in vitro fertilization, he said. Dr. Jennifer Mason, a spokeswoman for Personhood USA, which is promoting similar constitutional amendments around the country, said that personhood amendments shouldn't make fertility services any less available. Nearly 60% of Mississippi voters rejected the ballot measure.

Court Blocks Ultrasound Mandate

A federal judge held up North Carolina's requirement that women seeking an abortion view an ultrasound image of their fetuses. Passed in July over Gov. Bev Perdue's veto, the law requires abortion providers to place the ultrasound images in the woman's line of sight and describe the images. The law includes other abortion restrictions, such as a 24-hour waiting period. In October, U.S. District Judge Catherine Eagles temporarily blocked enforcement of the ultrasound provision but let other provisions go into effect. Bebe Anderson, senior counsel at the Center for Reproductive Rights, a group challenging the law's constitutionality, said the ultrasound provision "forces doctors to go against their medical judgment to deliver an ideological message to their patients."

Medicare Starts New Coverage

Medicare is now paying to screen beneficiaries for chlamydia, gonorrhea, syphilis, and hepatitis B. A decision memo in November also started coverage for behavioral counseling aimed at preventing sexually transmitted infections. Screening for chlamydia and gonorrhea is covered for the small Medicare populations made up of pregnant women aged 24 or younger, pregnant women who are at increased risk for sexually transmitted infections (STIs), and women at high risk of STIs. Syphilis screening will be covered for pregnant women and men and women at high risk for STIs. Hepatitis B screening will be available for pregnant women at the first prenatal visit and again at delivery for women with new or continuing risk factors. Medicare, which includes end-stage kidney-disease patients and disabled people, also will pay for up to two, 20- to 30-minute, face-to-face counseling sessions for all sexually active adolescents and adults at high risk for STIs.

Women Lack Fertility Knowledge

Many women don't understand how big a factor age is in becoming pregnant, according to a survey of more than 1,000 women aged 25-35 who are currently using birth control or not trying to conceive. The Fertility IQ 2011 survey found that only 31% of respondents agreed that increasing age is the single strongest risk factor for infertility. The survey, which measures knowledge of fertility, showed that women had the least knowledge about how long it takes to become pregnant and the likelihood that they will conceive at various ages. "While these data show that women have a general understanding about fertility issues, there is a clear need to educate further on the impact of age on fertility," Barbara Collura, executive director of the national infertility association RESOLVE, said in a statement. The survey also found that nearly half of women rely on their ob.gyn.s for information on infertility, followed by online sources and family and friends. The survey was supported by EMD Serono, Inc.

Contraceptives Have Wide Appeal

A new analysis from the Guttmacher Institute shows that oral contraceptives appeal to teenagers for benefits beyond contraception, including menstrual pain, menstrual regulation, and acne. Among girls aged 15-19, 82% said they used oral contraceptives for such reasons, compared with 67% of this group who reported taking birth control pills for pregnancy prevention. One-third the 15- to 19-year-olds reported taking the pills solely for noncontraceptive reasons. The analysis involved data from the 2006-2008 National Survey of Family Growth, which is administered by the National Center for Health Statistics.

AMA: Little Insurance Competition

Four out of five metropolitan areas in the United States lack a competitive health insurance market, according to an analysis from the American Medical Association. In addition, in about half of all metropolitan markets, one health insurer controls 50% or more of the market. In half the states, competition is limited to two health insurers who together control about 70% of the market. According to the study, Alabama, Alaska, Delaware, Michigan, Hawaii, the District of Columbia, Nebraska, North Carolina, Indiana, and Maine have the least competitive health insurance markets in the country.

–Mary Ellen Schneider