ACO Qualifying Criteria to Be Released This Fall

BY MARY ELLEN SCHNEIDER

The National Committee for Quality Assurance has convened a task force to study the concept of accountable care organizations, and this fall it plans to release its recommendations for what qualifying criteria these organizations should meet.

The task force includes representatives from organizations that consider themselves to be ACOs or that are developing plans to launch one. The diverse group has been working on setting out specific criteria – from governance structures to the ability to manage financial risk – that will help ACOs to succeed in the coming years.

"The idea [of ACOs] is mom and apple pie, and it's terrific to talk about in its generalities," said Tricia Barrett, vice president of product development at the National Committee for Quality Assurance (NCQA). "But as soon as you start talking about specifics, you realize that nobody's talking about the same thing."

Over the past few months, task force members have delved into the details and found some common ground, she said, recognizing that there will be a variety of ways to run an ACO. For example, there is consensus within the task force that primary care and the principles of the patient-centered medical home need to be at the foundation of the ACO. The extent to which specialists and hospitals are part of the same legal entity, rather than contracted with primary care physicians, will depend on the dynamics in individual marketplaces, she said.

The task force is also making headway on the specific qualifying criteria that ACOs should meet to demonstrate that they are set up for success. For example, task force members generally agree that there should be rules around the composition of provider networks within ACOs. This would ensure that patients have a certain level of access to both primary care and specialist physicians.

Performance measurement will also be a critical way to evaluate ACOs, Ms. Barrett said.

The NCQA task force members are also focused on ensuring that there are consumer protections built into the ACO structure. Consumers need to be considered in the design and policies of an ACO so that they have a full understanding of what their obligations and rights are, Ms. Barrett said. ■

POLICY & PRACTICE

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Access Doesn't Guarantee Care

Making sure that patients visit a primary care physician regularly does not guarantee they will receive recommended care or have better outcomes, according to a report from the Dartmouth Atlas Project. For example, the report found no relationship between a population's amount of visits per year to a primary care provider and the likelihood that women would have mammograms done. The report also found no relationship between this measure of delivered primary care and the rate of hemoglobin A_{1c} testing among Medicare beneficiaries with diabetes. "Our findings suggest that the nation's primary care deficit won't be solved by simply increasing access to primary care, either by boosting the number of primary care physicians in an area or by ensuring that most patients have better insurance coverage," Dr. David Goodman, lead author of the study, said in a statement.

E-Prescribing Varies by State

Massachusetts physicians conveyed more than 11 million prescriptions electronically in 2009, nearly one-third of their total, to lead all states, according to the operator of the nation's largest e-prescribing network. Michigan, Rhode Island, Delaware, and North Carolina rounded out the top five e-prescribing states, the company Surescripts announced. The technology is growing rapidly everywhere, Surescripts said: In 2009, 47 states more than doubled their use of electronic prescription routing while 39 more than doubled their use of computer-generated prescription benefit information. More than 300 million prescriptions nationwide were sent electronically in 2009, compared with just 500,000 prescriptions in 2004, Surescripts said.

Study: Nutrition Education Lacking

Only 27% of 105 surveyed U.S. medical schools reported providing the minimum of 25 hours of nutrition instruction recommended by the National Academy of Sciences, according study results in Academic Medicine. That represents a drop from 2004, when 38% of medical schools provided the recommended minimum number of hours in nutrition education, said researchers of the Nutrition in Medicine Project at the University of North Carolina at Chapel Hill. Almost all the medical schools surveyed offered some form of nutrition education, although only one-quarter required a dedicated nutrition course. On average, students received less than 20 hours of nutrition instruction during their medical school careers, although one school provided up to 70 hours.

Claims Processors Deemed So-So

About 70% of physicians reported they were satisfied with the contractors who process their Medicare claims, in the annual Centers for Medicare and Medicaid Services survey on contractor performance. Meanwhile, 14% of physicians said they were neither satisfied nor dissatisfied, and more than 15% said they were dissatisfied with contractor performance. Hospitals were slightly happier, with three-quarters saying they were satisfied with contractor performance. Improvements in several areas would increase satisfaction, according to the CMS. For example, providers said they don't like having to make multiple inquiries of claims processors to resolve problems. They also want better information through an automated telephone system, promptly returned calls, and consistently correct information.

Report Cards Weak on Quality

Information provided in public physician report cards, such as education, board certification, and malpractice history, related only weakly or not at all to those physicians' performance on clinical quality measures, according to a study in the Archives of Internal Medicine. The researchers calculated overall performance scores on 124 quality measures for more than 10,000 Massachusetts physicians making 1.1 million health insurance claims. They then compared those data with the recorded characteristics of the physicians. On a mean overall quality score of 62%, board certification boosted a physician by 3.3%, female sex accounted for 1.6% over male sex, and graduation from a domestic medical school gave a 1% better score. There was no significant association between physician performance and malpractice claims.

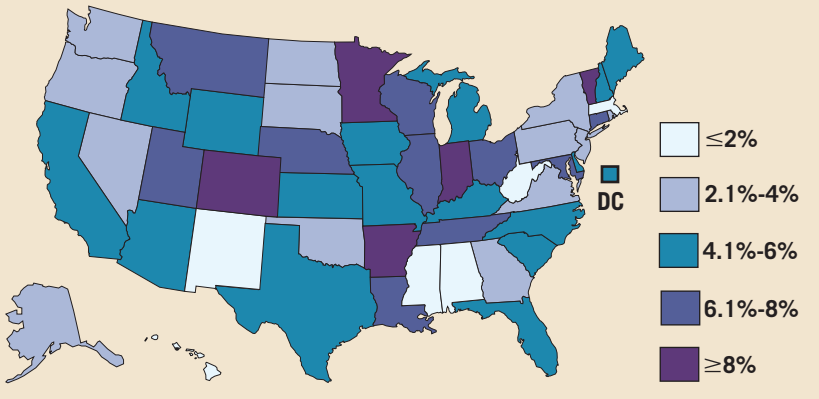
Suit Targets California Blue Shield

The California Medical Association has filed a class action lawsuit against Blue Shield of California, claiming the health insurer's Blue Ribbon Recognition Program harms physicians and their patients by failing to accurately assess patient care. The program places blue ribbons next to the profiles of physicians who score above average in preventive screening and other categories. The ratings are based on quality information and do not consider cost information, according to Blue Shield of California. But the medical association pointed out that the rating system does not use chart reviews or evaluate patient outcomes. It doesn't use enough claims data to make valid ratings and doesn't give physicians a fair chance to correct errors, the CMA charged. "I found that my ratings report was inaccurate after spending significant time reviewing the report against my patient records," Dr. Richard Stern, a San Pablo cardiologist and one of two doctors named as plaintiffs in the suit, said in a statement. The lawsuit seeks an injunction against the rating system and unspecified monetary relief.

–Jane Anderson

DATA WATCH

Enrollment in HSA/HDHPs as a Percentage of Total Private Insurance Enrollment



Notes: 93 companies reported coverage in HSA/HDHP products for those younger than age 65. HSA/HDHP = health saving account/high-deductible health plan.
Source: America's Health Insurance Plans

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