CCD Statement on ACO Criteria

The Consortium for Citizens with Disabilities (CCD) Health Task Force, a coalition of over 70 national disability-related organizations, appreciates this opportunity to comment on NCQA's draft criteria for Accountable Care Organizations (ACOs). CCD recognizes that in the current economic climate, there is significant pressure on health care providers and payors to implement cost-savings measures while improving health care quality and outcomes. While some of this can be accomplished through better coordination and efficiencies in care, CCD is very concerned that the ACO model, without appropriate safeguards and standards, may lead to achievements in cost savings through under-service of patient care. The overarching goal of a reformed system must be to provide better care to more people. CCD believes that the need to control costs should not inadvertently threaten access to quality care.

Core Criteria

First, NCQA should require ACOs to inextricably link costs savings to patient outcome measures. That is, providers and payers should only be able to share savings when they can demonstrate maintenance or improvement in outcome standards that measure the quality of care provided. Such measures would ensure the system provides incentives to both improve the quality of care and patient outcomes while working toward better efficiencies.

Second, ACOs must provide access to a range of providers within their networks as well as medical technologies that are consistent with contemporary medical practice. When providers have financial incentives to save money when treating patients, there will be strong pressures to limit access to the most appropriate specialists and latest medical technologies. NCQA should link network adequacy criteria to an assessment of the size of the local population, as well as an assessment of the needs of a wide variety of patients. The criteria should:

- Ensure an adequate number and variety of practitioners and specialists within the networks;
- Ensure that providers accept all patients assigned to them by any payer using an ACO;
- Include guidance as to the categories of specialists an ACO is required to include in its network in order to provide the full spectrum of plan or program benefits and to meet the wide range of needs of its patients, including people with disabilities and chronic conditions;

- Establish an explicit right of choice of provider (both inside and outside a network) so that patients who believe the ACO is more interested in cost savings than in good outcomes can access the care they need in a timely manner; and

- Ensure that patients have been fully informed and consent to participating in an ACO.

Finally, NCQA should implement protections to prevent providers from "cherry-picking" healthy patients to boost outcome measures while appearing to save money from the aggregate baseline of forecasted costs for a given population. These protections are particularly important for patients with disabilities and chronic conditions, as their needs often translate into more extensive treatment, more specialized treatment, and potentially more nuanced outcomes. For instance, a good outcome for a patient with Multiple Sclerosis may be a slowing of the progression of neurological impairment, rather than complete restoration of function after an MS relapse. Likewise, the performance measurement system should not punish providers that specialize in the treatment of individuals with disabilities and chronic conditions and, thereby, have a disproportionate number of patients where cure is no longer an option and improved functionality is the more appropriate measure of a successful outcome.

Performance Measures

Patient outcome measures must reflect the experience of *all* patients over their lifetimes. Each person may be relatively healthy and a low-user of healthcare services at one point in their life and, at another point, be consumed with treatment of an acute injury or a chronic condition that requires intense services and access to an array of providers. In order to reflect a range of experience and accurately capture the quality of care a patient receives, we strongly recommend the development of patient centered outcome measures focused on the functional capabilities and outcomes of patient care.

Simply measuring a person's primary care or acute care health status is not enough. ACOs should be required to measure the *functional status of their patients*, including their ability to perform independent activities of daily living, whether medical rehabilitation services are necessary and effective, quality of life, degree of independent living, and degree of community participation. These and other measures are inextricably linked to the receipt of appropriate health care services and should be considered relevant outcomes along with more acute and primary care measures. The measurement of functional status disproportionately affects people with disabilities and chronic conditions and is a critical set of indicators of successful outcomes for this population.

It is critical for all patients to be able to reflect their healthcare experience in terms of functioning. While current outcome measures in our healthcare system tend to reflect the benefits of short-term acute care, those measurements cannot reflect the experience of patients seeking care for conditions that last for an extended period or for a lifetime. The focus of these treatments is not to provide a cure or ultimate fix for the condition—indeed such a "cure" is rarely an option—but rather to improve a patient's quality of life by improving, maintaining or preventing deterioration of a patient's capacity to function.

It is, therefore, key that ACOs use a multi-dimensional health measure as the basis for health systems performance measurement. For example, the International Classification of Functioning, Disability and Health (ICF), which belongs to the World Health Organizations' family of international classifications, classifies functioning and disability associated with health conditions. It is complementary to the International Statistical Classification of Diseases and Related Health Problems (ICD-10), which gives users an etiological framework for the classification, by diagnosis, of diseases, disorders and other health conditions. "In short, ICD-10 is mainly used to classify death, but ICF classifies health."[1]

The use of these and other relevant measures will help ensure that ACOs are not just about saving money and redistributing those savings to providers at the expense of patient care. For ACOs to be a true advance in U.S. healthcare delivery, good outcomes and high quality care must be the hallmarks of success, even if it means that providers do not share in the savings they achieve.

[1] WHO Family of International Classifications. 2002