Crosswalk: CMS Shared Savings Rules & NCQA ACO Accreditation Standards
12/1/2011

The table below details areas where NCQA's ACO Accreditation standards overlap with the CMS Final Rule

CMS Pioneer ACO	CMS Shared Savings Program Final Rule	NCQA ACO Accreditation Standard
Definition of Pioneer ACO Definition and requirements of Pioneer ACO is parallel to Medicare Shared Savings Program, with the exception that the Pioneer ACO is comprised of Pioneer Providers/Suppliers rather than participants.Providers/Suppliers in Rural Health Centers and Federally Qualified Health Centers will become eligible to participate existing Pioneer ACOs starting in Performance Year 2.	**Definition of ACO** A legal entity that is recognized and authorized under applicable state, federal or tribal law as identified by a Taxpayer Identification Number (TIN), and formed by one or more ACO participants that work together to coordinate and manage care for Medicare FFS beneficiaries. The ACO must be accountable for the quality, cost, and overall care of the beneficiaries assigned to the ACO. **Eligible entities include:** • Professionals in group practice arrangements • Partnerships or joint ventures between hospitals and professionals • Hospitals employing ACO professionals • Critical access hospitals billing under Method II • Rural Health Centers* • Federally Qualified Health Centers* • Combinations of the above list *Note these entities were added in the final rule and were excluded in the proposed rule. As part of the application, ACOs must submit to CMS documents that are sufficient to describe the ACO participants and ACO providers/suppliers rights and obligations in and representation by the ACO, including how the opportunity to receive shared savings or other financial arrangements will encourage ACO participants and ACO providers/suppliers to adhere to the quality	**NCQA Definition:** ACOs are provider based organizations that are accountable for both quality and costs of care for a defined population **Eligible entities could include:** • Providers in group practice arrangements • Networks of individual practices • Hospital/provider partnerships or joint ventures • Hospitals and their employed or contracted providers • Publically governed entities that work with providers to arrange care* • Provider-health plan partnerships* *Not specified for the CMS Shared Savings Program • *NCQA does not specifically name Rural Health Centers and FQHCs, however these entities are eligible.* Features required as part of the CMS application are captured in specific NCQA standards around governance and use of incentives.

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	assurance and improvement program and evidence-based clinical guidelines.	
	Eligibility and Governance	
Legal Entity The Pioneer ACO is the legal entity comprised of its Pioneer Providers/Suppliers. Prior to each performance year, the Pioneer ACO submits a list of all TIN/NPIs participating as Pioneer Providers/Suppliers in the upcoming performance year. As part of its application, the applicant organization had to provide documentation that it was recognized as a legal entity by the state in which it is located as well as a description of its formal legal structure, including all suppliers, providers, joint ventures, partnerships, etc. that constitute the applicant organization. The applicant organization also had to calculate PSA share and provide further documentation, as required. .	**Legal Entity** must be formed under applicable State, Federal, or Tribal law, and authorized to conduct business in each State in which it operates for purposes of receiving and distributing shared savings, repaying shared losses, establishing, reporting and ensuring provider compliance with health care quality criteria, and fulfilling other ACO functions in regulations. An ACO formed by two or more otherwise independent ACO participants must establish a separate legal entity. The ACO must have its own TIN. Each ACO participant must be enrolled in the Medicare program. (The ACO itself need not be.)	The organization is a **legal entity** that is recognized and authorized under applicable federal or state law. NCQA considers the organization's legal structure to identify the legal entity accountable for the defined population. • *NCQA does not require the ACO to have its own TIN* • *NCQA does not require each participant to be enrolled in Medicare*
Governance Parallel to Medicare Shared Savings Program. Governing body members must have a fiduciary duty to the Pioneer ACO, must act consistently with that duty, and must abide by	**Governance** The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities.	**PO1 Element A: Program Structure** The organization's program description includes the following: **The governing body of the ACO**

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conflict of interest provisions. The Pioneer ACO's governing board must also include a consumer advocate and a patient, who may be one in the same person. There is no analogous 75% ACO participant control requirement.	The governing body must have a transparent governing process. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty. The governing body of the ACO must be separate and unique to the ACO in cases where the ACO comprises multiple, otherwise independent ACO participants. Otherwise, separate governance is not required so long as it otherwise satisfies the requirements. The governing body must provide for meaningful participation in the composition and control of the ACO's governing body for ACO participants or their designated representatives. It must include a Medicare beneficiary representative or provide for meaningful representation in ACO governance by Medicare beneficiaries. At least 75 percent control of the ACO's governing body must be held by ACO participants or provide for meaningful involvement of ACO participants on the governing body. As part of the application process, ACOs must submit evidence that the governing body is an identifiable body, that the governing body is comprised of representatives of the ACO's participants, that the participants have at least 75 percent control of the ACO's governing body, and that the body includes a Medicare beneficiary	**The specific role, structure and functions of the governing body, including meeting frequency** **Accountability to the governing body (Explanation)** The **governing body is the organization's board of directors, which is responsible for organizational governance. The organization determines the composition and size of its governing body. The governing body provides leadership, establishes accountability and provides the structure to align the functions of an ACO.** The organization must identify its board members; define their roles; and describe the responsibilities of the board (e.g., identify decisions reserved for the board), including meeting frequency. **PO2 Element B: Stakeholder Participation** The organization involves the following stakeholder groups in the oversight of the ACO • Primary care practitioners and specialists who provide care for the organization's patients. • Hospitals that provide care for the organization's patients • Consumers (e.g., individual patients or consumer organizations). Consumer organizations are non-profit, mission-oriented organizations that represent a specific constituency of consumers or patients who do not have a financial or business stake in the health care system.

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	representative.	• Purchasers (e.g., employers, states, health plans), which may include entities that contract directly or indirectly with the organization to provide health care services for a specified population. *NCQA does not require that:* • *The board must include a Medicare beneficiary representative* • *At least 75 percent control of the ACO's governing body must be held by ACO participants.*
Leadership & Management Structure: Parallel operational and clinical management requirements to Medicare Shared Savings Program. As part of its application, the Applicant organization had to list its leadership team and describe how responsibilities would be spread across its governance structure, including project management responsibilities and design to ensure accountability.	**Leadership & Management Structure** ACO leadership and management structure must include: • Management by an executive, officer, manager, or general partner (subject to the board) • A leadership team that has demonstrated the ability to influence or direct clinical practice to improve efficiency processes and outcomes • Clinical management and oversight by a board-certified, licensed senior-level medical director (must be physically present on a regular basis at an ACO location) • ACO participants/providers/suppliers that have a meaningful commitment to the ACO's clinical integration program. Examples: o a meaningful financial investment o a meaningful human investment (for example, time and effort) As part of the application, ACOs must document the ACOs organization and management structure, including an organizational chart, a list of	**PO1 Element A, factor 1** requires the organization to describe their organizational structure. The organization must describe the individuals (as well as the organizations) responsible for managing the clinical and administrative functions of the ACO. **PO1 Element A factor 4 requires** the organization to have a designated physician or clinician leader with substantial involvement in the ACO. The designated physician or clinician leader must participate on or advise the board, or have a substantial management function (e.g., chief executive officer, chief medical officer, chief nursing officer, medical director). The organization must describe how it involves key stakeholder groups in the oversight of ACO functions. Involvement may be through: • Board membership • Participation on a subcommittee of the board • As part of the organization's management staff. (This option does not apply to consumer or purchaser

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	committees and their structures, and job descriptions for senior administrative and clinical leaders.	stakeholders.) *Although NCQA does not require the organization to provide evidence that the selected leadership holds specific qualifications (e.g. board-certified medical director), NCQA requires an annual evaluation of the organization and the governing body's performance.*
Evidence-based medicine Similar to Medicare Shared Savings Program. The Pioneer ACO must maintain, implement, evaluate, and periodically update the processes and protocols in the care improvement plan it described in its RFA submission that relate to the promotion of evidence-based medicine and patient-centered care.	**Evidence-based medicine** • The ACO must define, establish, implement, evaluate, and periodically update processes to promote evidence-based medicine. These processes must cover diagnoses with significant potential for the ACO to achieve quality improvements taking into account the circumstances of individual beneficiaries. • The ACO must develop an infrastructure for its ACO participants and ACO providers and suppliers to internally report on quality and cost metrics that enable the ACO to monitor, provide feedback, and evaluate its ACO participants and provider supplier performance and use these results to improve care over time.	**PO1 Element A factor 5 requires** the organization to define goals addressing clinical quality, patient experience, and cost. **PO2 Element A** requires the organization to adopt evidence-based guidelines and disseminate decision support tools to clinicians. Tools may be embedded in EHRs. **PO2 Elements B, C, D** require the organization to monitor practice patterns for excessive utilization, appropriateness of care or activities that waste resources and provide reports and training to clinicians when care patterns vary from expected or "best care." **PO1 Element A, factor 6** requires the organization to have a documented process to review the organization's performance with the governing body. This process must include a description of the activities it has undertaken to improve care. **PR 1 A, Element B** requires the organization to measure and report clinical quality of care, patient experience and resource stewardship. **PR 2 Element A** evaluates the organization's QI process.
Patient Engagement, Centeredness and Diversity Similar to Medicare Shared Savings	**Patient Engagement, Centeredness and Diversity** The ACO must promote patient engagement – addressing compliance with patient experience of	**PO2 Element A and B** require the organization to adopt evidence-based guidelines, have a process to periodically update guidelines, disseminate

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Program. The Pioneer ACO must maintain, implement, evaluate, and periodically update the processes and protocols in the care improvement plan it described in its RFA submission that relate to patient and caregiver engagement through shared decision-making processes.	care survey and beneficiary representative requirements, and a process for evaluating the health needs of the ACO's population including consideration of diversity in its patient populations and a plan to address the needs of its population. In the plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders. ACOs must communicate clinical knowledge and evidence-based medicine in a way that is understandable to beneficiaries. Beneficiary engagement and shared decision-making should take into account the beneficiaries' unique needs, preferences, values, and priorities. Written standards must be in place for beneficiary access and communication and a process must be in place for beneficiaries to access their medical record. As part of the application, ACOs must submit a description, or documents sufficient to describe, how the ACO will implement the required processes and patient-centeredness criteria, including descriptions of the remedial processes and penalties that will apply if an ACO participant or provider/supplier fails to comply with and implement these processes.	decision support tools to clinicians and to make patient decision aids available to practitioners to assist with shared-decision making. **CM3 Elements A and B** requires the organization to provide and engage patients in population health programs (e.g. wellness, DM). **CM4 Element C** requires the organization to provide resources to support patient self-management (e.g. education materials, connection to community resources) **RR (Rights & Responsibilities**) outlines patient rights and responsibilities in the ACO. **PR2 Element C** requires the organization to conduct an analysis on patient experience results and implement interventions to improve results **AA1 Element H: Access to Culturally Competent Care** The organization: **1. Analyzes the capacity of its practitioners to meet the language needs of its patients** **2. Analyzes the capacity of its practitioners to meet the needs of its patients for culturally appropriate care** **3. Develops a plan to address any gaps identified as a result of analysis, if applicable** **4. Acts to address any gaps based on its plan, if applicable.** Explanation (abridged):

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		To link patients with practitioners who can meet their cultural, racial, ethnic and linguistic needs and preferences, the organization is expected to collect data on its population and analyze their needs. To address any gaps, organizations may provide training on cultural competence to existing providers and/or link patients with services and providers that meet their preferences. **PR2 Element D: Use of Data to Assess Disparities** The organization uses race/ethnicity and language data and the following methods to determine if health care disparities exist. **1. Analyze one or more valid measures of clinical performance, such as HEDIS, by race/ ethnicity** **2 Analyze one or more valid measures of clinical performance, such as HEDIS, by language** **3 Analyze one or more valid measures of eligible individual experience, such as CAHPS, by race/ethnicity or language.** Explanation (abridged): The organization must stratify its data by race/ethnicity and language to assess health care disparities. It may use direct or indirect data, or a combination, to determine disparities. **PR 2 Element E: Addressing Health Care Disparities** **Based on the results of measurement of health care disparities, the organization annually:** **1. Identifies and prioritizes opportunities to reduce health care disparities** **2. Implements at least one intervention to address a disparity**

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		3. Evaluates the effectiveness of the intervention. Explanation (abridged): The organization must perform annual QI interventions to reduce health care disparities.
Community engagement The Pioneer ACO must include a consumer advocate on its governing board. As part of its application, the applicant organization had to provide a description of the history of collaboration among major stakeholders in the community being served and commitment from relevant community stakeholders to achieve seamless care; it also had to provide a narrative of its ability to provide care that is integrated with the community resources that beneficiaries require.	**Community engagement** In its plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders to improve the health of its population. An organization that has a stakeholder organization serving on its governing body will be deemed to have satisfied the requirement to partner with community stakeholders.	*NCQA does not directly require organizations to demonstrate additional partnerships with community stakeholders However, the standards include expectations that organizations partner with community stakeholders in considering access to the ACO as well as participation in ACO oversight functions. Examples may be found below* **AA 1: Access and Availability of Practitioners** requires organizations to arrange for the provision of community and home based services. *Community and home-based services* are services designed to help people remain independent and in their own homes. Services include, but are not limited to, senior centers, transportation, delivered meals or congregate meals sites, visiting nurses or home health aides, adult day care and home services. (These services may also be referred to as “long-term care.”) A service may be provided by a participating provider or by another entity with whom the organization has made arrangements for service (e.g., contract with an urgent care facility). Arrangements could be contractual, through collaborations, ownership arrangements or joint ventures.

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		PO 1: ACO Description requires the organization to involve stakeholder groups in the oversight of ACO functions. Stakeholders include: • Primary care practitioners and specialists who provide care for the organization's patients • Hospitals (if applicable) that provide care for the organization's patients • Consumers (e.g., individual patients or consumer organizations). Consumer organizations are non-profit, mission-oriented organizations that represent a specific constituency of consumers or patients who do not have a financial or business stake in the health care system • Purchasers (e.g., employers, states, health plans), which may include entities that contract directly or indirectly with the organization to provide health care services for a specified population.
The Pioneer ACO must maintain, implement, evaluate, and periodically update the processes and protocols in the care improvement plan it described in its RFA submission that relate to: the coordination of care, including through the use of health care documentation and improvement technologies, including, for example, telehealth and remote patient monitoring; the use of formal assessments for quality of care measurements within the Pioneer	**Care coordination** The ACO must define its methods and processes established to coordinate care throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO). As a part of its application, the ACO must submit a description of its individualized care program along with a sample individual care plan and explain how this program is used to promote improved outcomes for, at a minimum, its high-risk and multiple chronic	**CT standards** require that the organization has a coordinated system to facilitate timely information exchange between multiple providers. Key capabilities include: • Proactively identifying patients at risk of transitioning and ensuring timely exchange of information between clinicians, patients and caregivers • Having agreements with providers to

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ACO; and maintaining and improving upon existing teaching and training initiatives aimed at care improvement.	condition patients. The ACO also must describe additional target populations that would benefit from individualized care plans. Individual care plans must take into account the community resources available to the individual.	exchange information in a timely manner. **PC 1 Element E** requires practices within the organization to collaborate with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit and assess and address barriers when the patient has not met treatment goals. **PC 1 Element D** requires practices to implements evidence-based guidelines through point-of-care reminders for patients with clinically important conditions and high-risk/complex conditions (as defined by the primary care practice) . **CM 3, Population Health Management, Elements A and B,** requires the ACO to identify patients who are eligible for: • Wellness and health promotion programs • Chronic disease management programs and • Complex case management.
Similar to Medicare Shared Savings Program. For Pioneer ACOs assuming downside risk in a given performance year, the Pioneer ACO is also required to have a financial guarantee in place to cover 25% of potential losses.	**Distribution of Savings** ACO must indicate as part of its application how it plans to use potential shared savings to meet the goals of the program, including the criteria it plans to employ for distributing shared savings among ACO participants and providers and suppliers.	The **PO 2 Resource Stewardship** standards ensure that the organization provides resources to patients and providers to aid with clinical decision making and monitors practice patterns to ensure that needed care is delivered. To meet **PO3 Element A** the ACO must base at least a portion of participating providers' compensation on the performance of the ACO as a whole using clinical quality, cost and patient experience indicators if it provides performance-based compensation.

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CMS requires Pioneer ACOs to have a minimum of 15,000 aligned Medicare beneficiaries (except ACOs that have the majority of their member clinicians located in rural areas, which must have at least 5,000 Medicare beneficiaries) but may adjust resources applied to the Model and/or the number of organizations selected based on the actual number of aligned Medicare beneficiaries.	**Sufficient Number of Primary Care Providers and Beneficiaries** ACO would be determined to have a sufficient number of primary care ACO professionals if the number of beneficiaries historically assigned over the three-year benchmarking period using the ACO participant TINs exceeds the 5,000 threshold for each year. Orgs that fall under 5000 would be issued a warning and placed on a Corrective Action Plan. If it falls under 5000 for a consecutive year, they will be terminated from the program. Asks for sample agreement.	Eligible entities must provide care for at least 5,000 patients using the quality systems evaluated in the *ACO Standards and Guidelines* when the application and agreement are submitted.
Parallel to Medicare Shared Savings Program.	**Compliance Plan** The ACO must have a compliance plan that includes the following elements – a designated compliance official, mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance, a method for receiving anonymous reports of suspected problems, compliance training, and a requirement to report violations of law.	*Not Applicable*
Parallel to Medicare Shared Savings Program. By the end of 2012, at least 50% of the Pioneer Provider/Suppliers that are primary care providers must furthermore have met requirements for meaningful use of certified electronic health records.	**HIT** ACOs are encouraged to develop a robust electronic health record infrastructure. As part of the quality performance score, the quality measure regarding EHR adoption will be measured based on sliding scale. Performance on this measure will be weighted twice that of any other measure for scoring purposes and for determining compliance	**CM 1 Elements A and B** require the organization to use an electronic system to collect structured patient information and clinical data. **CM 1 Element C** measures the access that providers have to electronic data. **CM 1 Elements D** requires the organization to exchange clinical information with external entities.

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	with quality performance requirements.	**CM 1 Elements E, F and G** evaluates the organizations' data use, data integration and data completeness.
	Quality Measures	
Parallel to Medicare Shared Savings Program.	CMS establishes quality performance measures to assess the quality of care furnished by the ACO. If the ACO demonstrates to CMS that it has satisfied the quality performance requirements and the ACO meets all other applicable requirements, the ACO is eligible for shared savings. CMS selects the measures designated to determine an ACO's success in promoting the triple aim and designates the measures for use in the quality performance standard. ACOs must submit the data according to CMS's method of submission. Starting in 2014, ACOs must choose a CMS certified vendor to administer the patient experience of care survey. CMS maintains the right to audit and validate quality data through medical record review – if there is a discrepancy of more than 10 percent after the third phase of the audit review, the ACO will not be given credit for meeting the quality target for affected measures. The final rule contains 33 measures for the first year of implementation; CMS will seek to improve the quality of care furnished by the ACOs over time by specifying higher standards, new measures, or both.	**PR1 Element A** requires the organization to annually monitor metrics from a set of 40 core performance measures related to cost and quality and to evaluate patient experience using CAHPS. NCQA collects evidence of monitoring activities during the accreditation survey. Prior to the release of NCQA specifications for core performance measures, the organization may use one or more of the following methods to calculate the rates: • If the organization participates in a regional or national measurement collaborative (e.g., California IHA, Minnesota Community Measurement), it may submit up to 15 of these measures towards meeting the element. • The organization may base measure calculations on **NQF-endorsed measure specifications**. The organization must indicate the endorsed specification on which it modeled its calculation in the Performance Measure Worksheet. • The organization may submit internally developed measures produced as part of ongoing monitoring activities. If internally developed measures are used, the organization must describe the data collection methods it used, including a description of the numerator and denominator, data sources (e.g., claims data, etc.) and data collection and sampling

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		techniques (if used).
Similar to Medicare Shared Savings Program**.**	**Relation to PQRS** Submission of measures by the ACO qualifies eligible professionals to receive the PQRS incentive payment. ACO participants and ACO providers/suppliers who are eligible professionals cannot earn a Physician Quality Reporting System incentive outside of the Medicare Shared Savings Program.	*Not Applicable*
	Beneficiary Information and Notification	
Parallel to Medicare Shared Savings Program. Pioneer must notify all newly aligned beneficiaries about the ACO and must provide them with an opportunity to opt-out of data sharing.	ACOs may not provide gifts or other remuneration to beneficiaries as inducements for receiving items or services, however they may provide in-kind items or services if there is a reasonable connection between the items and services and the medical care of the beneficiary and the items or services are preventive care items or advance a clinical goal for the beneficiary. ACOs may not require beneficiaries to be referred only to ACO participants within the ACO. ACOs must notify beneficiaries at the point of care that their ACO providers/suppliers are participating in the Shared Savings Program, post signs in their facilities to notify beneficiaries that their ACO providers and suppliers are participating, make available standardized written notices regarding participation in an ACO and provide the opportunity to decline data sharing. Such notices must be provided in primary care settings. ACOs have the option of notifying beneficiaries on the preliminary prospective assignment lists; if so they must use the standardized written notice. Beneficiaries have the ability to decline having their data shared with ACOs. ACOs must inform the beneficiary (using a written notice) that it may	**RR 1 Element C: Written Policies for privacy and Confidentiality** **The organization implements written policies and procedures for the handling of protected health information (PHI) that address:** **1. Information included in notification of privacy practices** **2. Access to PHI** **3. The process for patients to request restrictions on use and disclosure of PHI** **4. The process for patients to request amendments to PHI** **5. The process for patients to request an accounting of disclosures of PHI** **6. Internal protection of oral, written and electronic information across the organization.** **PO 3 Element A, Factor 2**, requires organizations to inform patients about performance-based payment arrangements with participating providers. **RR 1 Element A: ACO Responsibilities**

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	request PHI about the beneficiary for purposes of care coordination and quality improvement before requesting claims data and give the beneficiary meaningful opportunity to decline having his or her claims information shared.	**The organization has a process and materials that it provides patients addressing the role of the ACO, which include the following:** **1. Distribution of information about the organization, its services, its practitioners and providers and patient rights and responsibilities** **2. Distribution of information on attribution method used to assign patient and language on how patients may opt out**
Parallel to Medicare Shared Savings Program.	**Public Reporting** Each ACO must publicly report the following information in a standardized format – Name and location Primary contact Organizational information, including identification of ACO participants, participants in joint ventures, members of the governing body, associated committees and committee leadership. Shared savings and losses information including amount of any savings or losses for the ACO, total proportion of shared savings invested in infrastructure, redesigned care processes and other resources towards the three-part aim, and total proportion distributed among ACO participants. **R**esults of patient experience of care and claims-based measures	*NCQA does not specifically require the ACO to publicly report participants in joint ventures, members of the governing body, associated committees and committee leadership, shared savings and losses information including amount of any savings or losses for the ACO, total proportion of shared savings invested in infrastructure. However, NCQA does require the following:* **Regarding Public Reporting of Clinicians participating in the ACO** **AA1 Elements F and G** require the organization to publish a directory listing clinicians and facilities participating in the ACO with demographic information including name, location and contact information. **Regarding reporting of payment arrangements:** **PO3 Element A, factor 2** requires organizations to inform patients about performance-based payment arrangements with practitioners. **Regarding Public Reporting of Quality Measures scores:**

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		PR 1D: Reporting Performance Publicly **At least annually, the organization publically reports valid and reliable results for:** **1. Clinical quality** **2. Patient Experience** **3. Expenditures, Resource use, or Appropriateness.**
Pioneers must submit marketing materials to CMS for approval prior to use.	**Marketing materials** Marketing must meet all of the following – use of template language developed by CMS, not be used in a discriminatory manner, comply with beneficiary inducement regulations, not be materially inaccurate or misleading.	*NCQA Accredited Accountable Care Organizations must comply with NCQA's ACO Marketing and Advertising Guidelines.*