NURSE PRACTITIONERS AND ACCOUNTABLE CARE ORGANIZATIONS

FELLOWS OF THE

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The concept and development of accountable care organizations (ACO), while not new, has taken on increased energy with the inception of the Primary Care Shared Saving ACO Pilot contained in the body of the Patient Protection Affordable Care Act (PPACA) of 2010. Initially, ACOs were private entities developed by hospitals and specialty physicians to share resources and save money. Savings incurred were divided among the participating practices and hospitals. With the advent of the PPACA, a pilot Medicare ACO program, called Shared Savings, was created that includes primary care practices in a Medicare ACO. In the Shared Savings pilot, savings are shared between member primary care practices and the Medicare program as long as minimum requirements are met. These include a minimum number of patients (5,000) where 1) the majority of their previous year's visits were with primary care physicians offering primary care services, and 2) a series of quality indicators were met during that time.

Additional ACO designs such as the Pioneer program are currently being piloted by CMS and many private health plans. With the current emphasis on quality outcomes and cost savings in today's health care arena, it has become imperative that nurse practitioners be involved in the development and ongoing management of efforts to transform health care with that objective in mind. One of the central pieces of this effort has become the accountable care organization (ACO). Nurse practitioners need to become involved in the development and management efforts of ACOs to guarantee the inclusion and participation of nurse practitioners and their patients in these healthcare entities.

Shared Savings Pilot

As the Shared Savings pilot was initially developed, nurse practitioners were included as ACO professionals with all the rights and responsibilities of physicians. When the legislation passed however, nurse practitioners were authorized to be participating ACO professionals, but their patients could not be recognized as beneficiaries. That is, patients were recognized as patients in the ACO if the majority of their visits were with a primary care physician and not any other type of provider. While this was later modified in regulation to include patients that had been seen at least once in the measuring year by a primary care physician and the rest by authorized non-physician primary care providers, a serious barrier had been erected regarding the participation of nurse practitioners and their patients in this important ACO system. While pathways existed for nurse practitioners and their patients in very large practices that could meet the minimum requirements and still include nurse practitioners and their patients as "other" providers, this adjustment did nothing for nurse practitioner practices without physician participants, or nurse practitioners in smaller physician practices where all patients would need to be seen by a primary care physician in the course of a year in order to be counted. In addition, it totally prevented nurse practitioners from forming their own ACOs. More importantly it set a precedent that created barriers for nurse practitioners in all ACO program development and implementation that now must be overcome.

While currently, this exclusion extends only to the Shared Savings Program, its impact extends to other ACOs that, based on the Shared Savings rules, follow precedents that do not include nurse practitioners, nurse practitioners practices or nurse practitioner ACOs. For this reason, it is necessary that action be taken to assure participation, planning and decision making, recognition in the billing and payment processes and ultimately full partnership without discrimination in all ACO endeavors, including Shared Savings.

Actions Needed

Currently CMS has recognized the necessity to include all primary care providers in these systems, particularly the Shared Savings programs. In that light, CMS has issued a proposed rule that places nurse practitioner patients in the shared saving first tier for recognition as beneficiaries in that program. However, there is still work to be done in behalf of nurse practitioners and their patients if accountable care organizations are to become the focal point for value based payment and movement away from traditional fee for service practices.

The main elements for action extend to education regarding nurse practitioners, nurse practitioner practice, and patient outcomes in nurse practitioner practices and negotiation for inclusion and participation in several arenas at several levels:

CMS: Staff turnover has required constant vigilance by the Federal AANP team to keep ACO agendas at the forefront. As a result of those efforts, currently proposed rules address the nurse practitioner beneficiary issue in a constructive light; the president's 2016 budget addresses the need to be provider inclusive and identifies a cost saving associated with it; and legislation has been introduced to address the issue. Nurse practitioner communication with their legislators can reinforce this movement.

States: As accountable care organizations are being recognized by state governments, legislators and regulators need to be informed about the contribution nurse practitioners can make for the citizens in their jurisdictions through full partnership in the development of statute and regulation centered on accountable care and related issues such as the authorization of medical homes and other alternative payment systems to be included in accountable care frameworks. Educating these officials and their offices about the contributions nurse practitioners make to the health care system, and how they and their practices can be incorporated into accountable care efforts at the development, management and clinical levels is necessary to provide for the inclusion of nurse practitioners and their patients in these developing systems. Likewise, negotiating with legislators and regulators for positioning nurse practitioners and developing modes of access for patients when authorizing ACOs within the state becomes an essential factor for nurse practitioners and their patients.

Accountable Care Organizations: Accountable care organizations are not new, nor are they all government based. Their number continues to grow as steps continue to be taken to revise the health care systems to be value based rather than volume based. Meeting with their leadership to

educate and become involved in their systems will be a necessary step. Addressing how nurse practitioners and their patients can contribute to the quality, cost effectiveness and access to care will help persuade ACOs to include nurse practitioners as members (both individuals and practices) and participants in the management and clinical arms of their organization will be important.

Health Plans: Health plans are involved in creating their own ACOs as well as contracting with independent and government driven programs. Again, in order to involve nurse practitioners and their patients, meetings must be arranged with leadership in the health plan to educate and encourage them to include nurse practitioners, both as clinicians and nurse practitioner practices, in their endeavors.

Nurse practitioners: Unfortunately many nurse practitioners do not understand the accountable care concept or how they and their patients can and should be involved. Some already may be participating without their knowledge because of the management processes of their employers. Others may not realize that they should be involved, or how they can take steps to be a part of accountable care systems in their communities. Nurse practitioners need to be informed in their educational programs, in continuing education offerings as well as through regular communication from their professional organization.

Involvement with Other Stakeholders: Stakeholder identification is an important element in dealing with multi-faceted entities such as accountable care organizations. Recognizing and interfacing with potential allies and opponents can prevent problems, obstructions and misunderstandings that can create barriers to the participation of nurse practitioners and their patients. Furthermore, working with allies can strengthen forward movement toward inclusion of nurse practitioners and their patients in all ACO entities, government and otherwise.

Next Steps

1. Develop talking points for use with stakeholders.

2. Identify best practices that demonstrate quality of care, cost effectiveness and access

3. Conduct further research that evaluates quality, cost effectiveness and access

4. Interact with stakeholders to educate and negotiate

Conclusion

Nurse practitioners are important contributors to the primary care of patients of all ages, genders, races and socioeconomic status in the United States. It is important that they be directly involved as full partners in the development and implementation of constructive health care agendas and transitions as they develop throughout the country.

All activities (educational, strategic planning, clinical and organizational management) require the sharing of knowledge about nurse practitioners and their patients including examples of their success, the quality of their care and the outcomes that have been produced by and with their patients. Transparency is essential in all communication and undertakings, including the development of business plans and the clinical implementations of any ACO. Nurse practitioners will need to strive for their own as well as their patients' inclusion in the ACO world as it contributes to the transition of health care from fee for service to the projected value based provision of care.