



Accountable Care Organizations

What the Nurse Executive Needs to Know

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A B S T R A C T

In April 2011, the Federal Government published draft regulations regarding the implementation of Section 3022 of the Affordable Care Act, which contains provisions relating to Medicare payments to providers of services and suppliers participating in accountable care organizations. It is important for the nurse executive to understand these proposed regulations and how they may impact the provision of nursing care should the organization for which the nurse executive works decide to become or join an accountable care organization.

On March 23, 2010, the Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) was passed on March 30, 2010, and amended certain provisions of Pub. L. 111-148. These 2 laws are collectively known as the Affordable Care Act. The Affordable Care Act has a number

of goals: to improve the quality of Medicare services, to support innovation and the establishment of new payment models in Medicare, to better align Medicare payments with provider costs, to strengthen Medicare program integrity, and to improve Medicare's financial status. The Act's attempts to improve quality include provisions expanding value-based purchasing, broadening qual-

ity reporting, improving the level of performance feedback available to suppliers, creating incentives to enhance quality, improving beneficiary outcomes, and increasing the value of care.

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Goals of the Affordable Care Act as Carried Out in the Regulations

In April 2011, the Federal Government published draft regulations regarding the implementation of Section 3022 of the Affordable Care Act, at 42 CFR Part 425. The preliminary materials to the regulations provide a great deal of helpful information for the nurse executive in understanding the scope and impact of these regulations on nursing practice in organizations that become or join accountable care organizations (ACOs). The materials discuss value-based purchasing, a concept that links payment directly to the quality of care provided. By linking payment to quality of care, this strategy aims to transform the current payment system by rewarding providers for delivering high-quality, efficient clinical care. In addition to improving quality, value-based purchasing is expected to reduce growth in healthcare expenditures, by better coordinating care and reducing unnecessary services. The materials also list several specific ideals and goals toward achieving improved quality of care:

1. Value-based payment systems and public reporting should rely on a mix of standards, processes, outcomes, and patient experience measures, including measures of care transitions and changes in patient functional status. These measures should be adjusted for risk or other appropriate patient, population, or provider characteristics.
2. Measures should be aligned across Medicare and Medicaid's public reporting and payment systems. A focused core set of measures appropriate to each specific provider category that reflects the level of care and the most important areas of service and measures for that provider will be developed.
3. The collection of information should minimize the burden on providers, and measures should be aligned with the adoption of meaningful use standards for health information technology, so that the collection of performance information is part of care delivery.

Much of the Act pertains to lowering costs and therefore government expenditure on healthcare products and services. Principles of the Act and the regulations implementing it that relate to lowering expenditures include the following:

1. Providers should be accountable for the cost of care, should be rewarded for reducing unnecessary expenditures, and should be responsible for excess expenditures.
2. Providers should continually improve the quality of care they deliver and must honor their commitment to do no harm to beneficiaries.
3. Providers should apply cost-reducing and quality-improving redesigned care processes to their entire patient population.

ACOs and the Shared Savings Program

Section 3022 of the Affordable Care Act requires the Secretary of the Department of Health and Human Services (the Secretary) to establish the Medicare Shared Savings Program (SSP), which is intended to encourage the development of ACOs in Medicare. The Medicare SSP is intended to be a program "that promotes accountability for a patient population and coordinates items and services under parts A and B and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery" (Pub. L. 111-148, Section 3022). The SSP is said to be a new approach to the delivery of healthcare aimed at

1. better care for individuals—representing the 6 dimensions of quality described by the Institute of Medicine (IOM): safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity;
2. better health for populations by means of educating beneficiaries about the causes of ill health, such as poor nutrition, physical inactivity, substance abuse, and economic disparities, as well as the importance of preventive services such as annual physicals and flu shots; and
3. lower growth in healthcare expenditures by eliminating waste and inefficiencies without denying needed care.

The Centers for Medicare & Medicaid Services (CMS) refers to this approach as the 3-part aim. The ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for "shared savings" from the SSP.

Sections 1899(b)(1)(A) through (E) of the Act indicate that the following groups of providers of services and suppliers are eligible to participate:

- ACO professionals in group practice arrangements,
- networks of individual practices of ACO professionals,
- partnerships or joint venture arrangements between hospitals and ACO professionals,
- hospitals employing ACO professionals, and
- such other groups of providers of services and suppliers as the Secretary determines appropriate.

Section 1899(h)(1) of the Act defines the term "ACO professional" as a physician, or a practitioner described in section 1842(b)(18)(C)(i) of the Act (a physician assistant, nurse practitioner, or clinical nurse specialist).

Sections 1899(b)(2)(A) through (H) of the Act list the requirements that eligible groups of providers of services and suppliers must meet to participate in the program as ACOs:

- The ACO must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service (FFS) beneficiaries assigned to it.
- The ACO must enter into an agreement with the Secretary to participate in the program for at least 3 years.

- The ACO must have a formal legal structure that will allow it to receive and distribute payments for shared savings to participating providers of services and suppliers.
- The ACO must include primary care ACO professionals that are sufficient for the number of Medicare FFS beneficiaries assigned to the ACO. At a minimum, the ACO must have at least 5,000 FFS beneficiaries assigned to it to be eligible to participate.
- The ACO must provide information regarding ACO professionals participating in it to support the assignment of Medicare FFS beneficiaries to an ACO, the implementation of quality and other reporting requirements, and the determination of payments for shared savings.
- The ACO must have in place a leadership and management structure including clinical and administrative systems.
- The ACO must define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.
- The ACO must demonstrate that it meets patient-centeredness criteria specified by the Secretary.
- The regulations define an ACO as a legal entity that is recognized and authorized under applicable state law, as identified by a TIN (taxpayer identification number), and composed of an eligible group of ACO participants who work together to manage and coordinate care for Medicare FFS beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO's decision-making process.

Regulations Implementing the Affordable Care Act

The proposed regulations and the preliminary materials are more than 400 pages long. The most important part of these regulations in terms of impact on nursing care are the sections related to Processes to Promote Evidence-Based Medicine, Patient Engagement, Reporting, and Coordination of Care. These parts of the regulations are aimed at implementing Section 1899(b)(2) of the Act. This section establishes a number of requirements that ACOs must satisfy to be eligible to participate in the SSP. Several of these standards deal with how patient care is provided by the ACO, with a focus on processes and methods to (1) promote higher quality of care, (2) better coordinate care, and (3) meet the needs and concerns of patients and their families, including effectively engaging patients and their families in medical decision making. These are all functions that fall squarely within the scope of nursing practice and thus represent an opportunity for nurse executives to take the lead in designing and implementing systems to achieve these goals in support of their organization, should it decide to become or join an ACO. Specifically, section 1899(b)(2)(G) of the Act requires an ACO to “define processes to promote evidence-based medicine and patient engagement, report on quality and

cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.”

To be eligible to participate in the SSP, an ACO must provide documentation in its application describing how it will (1) promote evidence-based medicine, (2) promote beneficiary engagement, (3) report internally on quality and cost metrics, and (4) coordinate care. Accountable care organizations must choose the tools for meeting these requirements that are most appropriate for their practitioners and patient populations. The nurse executive is a key stakeholder in helping an organization make these important choices. Nurse executives have significant experience in promoting evidence-based care, patient and family engagement, promotion of quality, and coordination of care. It is imperative that any organization seeking to become an ACO engage its nurse leaders to obtain their expert input on these important requirements.

Promoting Evidence-Based Medicine

Section 1899(b)(2)(G) of the Act requires an ACO to “define processes to promote evidence-based medicine. . . .” Evidence-based medicine can be defined as the application of the best available evidence gained from the scientific method to clinical decision making. It assesses the evidence of the risks and benefits of treatments (including lack of treatment) and diagnostic tests and applies this evidence to the processes of medical decision making and treatment. It should involve the establishment and implementation of evidence-based guidelines, based on the best available evidence concerning the effectiveness of medical treatments, at the organizational or institutional level. An evidence-based approach should also involve regular assessment and updating guidelines to promote continuous improvement in the quality of care in light of new evidence on the effectiveness of medical treatments currently in use. As part of its application, the ACO needs to describe the evidence-based guidelines it intends to establish, implement, and update. Nurse researchers have been publishing on evidence-based practice for years; the nurse executive can bring a strong skill set to the development and implementation of these guidelines for nursing practice in the organization.

Promoting Patient Engagement

Section 1899(b)(2)(G) of the Act also requires an ACO to “define processes to promote. . . patient engagement.” The term *patient engagement* is defined by the Act as the active participation of patients and their families in the process of making medical decisions. Patient engagement requires that the organization provide the opportunity for patients and families to assess prospective treatments in the context of their own values and beliefs. Methods for promoting patient engagement may include the use of decision support tools and shared decision-making methods with which the patient can assess various treatment options in the

context of his/her values and beliefs. Patient engagement also includes methods for fostering “health literacy” in patients and their families. Health literacy is defined by the regulations as the possession of basic knowledge about maintaining good health, avoiding preventable medical conditions, and managing existing conditions, as well as knowledge about how the care system works. As part of the application, the ACO must describe the patient engagement processes it intends to establish, implement, and update. Given the role of nurses in educating patients about a variety of health information, including those encompassed by health literacy, the nurse executive is in a position to lead the development of these processes for the organization.

Reporting on Quality and Cost Measures

Section 1899(b)(2)(G) of the Act requires an ACO to “define processes to . . . report on quality and cost measures.” Accountable care organizations are expected to be able to monitor both costs and quality internally and make appropriate modifications based on their collection of this information. As part of the application, the ACO must describe its process to report internally on quality and cost measures and how it intends to use that process to respond to the needs of its Medicare population and to make modifications in its care delivery.

Coordinating Care

Section 1899(b)(2)(G) of the Act requires an ACO to “define processes to . . . coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.” Coordination of care involves strategies to promote, improve, and assess integration and consistency of care across primary care physicians, specialists, and acute and postacute providers and suppliers, including methods to manage care throughout an episode of care and during transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist. Compliance with this requirement may involve the following:

- using predictive modeling to anticipate likely care needs;
- utilization of case managers in primary care offices;
- having a specific transition of care program that includes clear guidance and instructions for patients, families, and caregivers;
- remote monitoring;
- telehealth; and
- the establishment and use of health information technology, including electronic health records and an electronic health information exchange to enable the provision of a beneficiary’s summary of care record during transitions of care both within and outside the ACO.

The provisions of any free services (telehealth, case managers, etc) between parties in a position to generate

Federal healthcare program referrals could trigger evaluation under the relevant fraud and abuse laws; therefore, it is important that corporate counsel be involved in the planning, application, and implementation stages of starting an ACO. The strategies used by an ACO to optimize care coordination cannot keep a beneficiary from seeking care from providers or suppliers that are not participating in the ACO. The ACO cannot develop policies that place any restrictions that are not legally required on the exchange of medical records with providers who are not part of the ACO.

Promoting Patient-Centered Care

Section 1899(b)(2)(H) of the Act requires an ACO to “demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.” The regulations note that a patient-centered orientation can be defined as care that incorporates the values of transparency, individualization, recognition, respect, dignity, and choice in all matters related to one’s person, circumstances, and relationships in healthcare. Patient-centered care should extend to the family and caregivers of the patient. The regulations repeatedly cite the IOM’s 2001 report and note that patient-centeredness is one of the IOM’s aims for improvement in healthcare. The preliminary materials to the regulations note that in the IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, providing patient-centered care is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” (To view the IOM’s report, visit <http://iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-forthe-21st-Century.aspx>.) The materials also reference a list of principles for patient-centered care: (1) care is comprehensive, coordinated, personalized, and planned; (2) patients’ experience of care is routinely assessed and improved; (3) patients and their caregivers are full partners in their care; (4) transitions between settings of care are smooth, safe, effective, and efficient; (5) patients can get care when and where they need it; (6) care is integrated with the community resources patients need to maintain health and well-being; and (7) continuous quality improvement and elimination of disparities are top priorities (statement of Debra L. Ness, president, Nat’l Partnership for Women & Families, Senate Finance Committee, Roundtable on Delivery System Reform, April 21, 2009; http://www.nationalpartnership.org/site/DocServer/090421_SenateFinanceRoundtableStatement_Ness.pdf?docID=4881).

The proposed regulations list the following patient-centered principles that should guide the care provided by an ACO participating in the SSP:

- Care should be individualized based on the person’s unique needs, preferences, values, and priorities.

- Beneficiaries should have access to their own medical records and to clinical knowledge so that they may make informed choices about their care.
- Beneficiaries (and their caregivers and/or family members where applicable) should be encouraged to be partners in care and to make choices regarding the care they receive, based on both the evidence-based medicine provided by their ACO and the beneficiary's individual values.
- Beneficiary and caregiver/family experience of care should be routinely assessed, and the ACO should act on opportunities for improvement that are identified.
- Care should be integrated with community resources.
- Transitions in care among providers in the ACO, as well as providers outside the ACO, should be supported consistent with the patient-centeredness goals of coordinating care and having information follow patients.

The proposed regulations indicate that an ACO will be considered patient-centered if it has all of the following:

- A beneficiary experience of care survey in place and the ACO's application should describe how the ACO will use the survey results to improve care over time. As part of the requirement to implement this survey, ACOs will be required to collect and report on measures of beneficiaries' experience of care and will submit a plan on how they will promote, assess, and improve in weak areas identified by the survey. Under the proposed regulations, ACOs will be required to use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The ACO will also be required to adopt an appropriate functional status survey module that may be incorporated into the CAHPS survey. The CAHPS survey is a nationally recognized survey, developed by the Agency for Healthcare Research and Quality, which is widely used across the healthcare spectrum. It is designed to compare results across sponsors and over time, which identifies the issues that are important to consumers and that influence their decisions. The Centers for Medicare & Medicaid Services will be able to use this survey data to more easily compare outcomes and beneficiary satisfaction across ACOs, as well as in certain modules in common between ACOs and Medicare FFS and Medicare Advantage plans. It would also help to ensure that survey measures are adequate to meet the program's purposes and that measures used in the instrument are valid and reliable.
- Patient involvement in ACO governance. The ACO would be required to have a Medicare beneficiary on the governing board.
- A process for evaluating the health needs of the ACO's assigned population, including consideration of diversity in their patient populations, and a plan to address the needs of their population. The ACO will be required to describe this process as part of the application, how it will consider diversity in its patient population, and how it will address the needs of its population.
- Systems in place to identify high-risk individuals and processes to develop individualized care plans for targeted patient populations, including integration of community

resources to address individual needs. The plan must be tailored to (1) the beneficiary's health and psychosocial needs, (2) account for beneficiary preferences and values, and (3) identify community and other resources to support the beneficiary in following the plan. This plan is voluntary for the beneficiary, is privacy protected, and would not be shared with Medicare or the ACO governing body; it would be used by the patient and ACO providers/suppliers for care coordination. If applicable, and the beneficiary consents, the care plan should be shared with the caregiver, family, and others involved in the beneficiary's care. An ACO would be required to have a process in place for developing, updating, and, as appropriate, sharing the beneficiary care plan with others involved in the beneficiary's care and providing it in a format that is actionable by the beneficiary. To satisfy this requirement fully, the development of individualized care plans should be a result of shared decision making that fully engages beneficiaries and their families, taking into account their values and preferences in developing a unique plan of care for each individual. The individualized care plans should include identification of community and other resources to support the beneficiary in following the plan. A wide variety of organizations may be considered a community resource, including employers, commercial health plans, local businesses, state/local government agencies, and local quality improvement organizations or collaboratives (such as health information exchanges). An ACO will be required to submit a description of its individualized care program, along with a sample care plan, and to explain how this program is used to promote improved outcomes for their high-risk and multiple chronic condition patients. In addition, the ACO should describe additional target populations that would benefit from individualized care plans. Accountable care organizations will also be required to describe how they will partner with community stakeholders as part of their application. Accountable care organizations that have a stakeholder organization serving on their governing body will be deemed to have satisfied this requirement.

- A mechanism in place for the coordination of care. The ACO would be required to describe its mechanism for coordinating care for Medicare beneficiaries. In addition, the ACO should have a process in place (or clear path to develop such a process) to electronically exchange summary of care information when patients transition to another provider or setting of care, both within and outside the ACO, consistent with meaningful use requirements under the EHR Incentive Program. The ACO would be required to describe their process or their plan to develop a process to electronically exchange summary of care information during care transitions.
- A process in place for communicating clinical knowledge/evidence-based medicine to beneficiaries in a way that they can understand. The ACO would be required to describe its process for communicating clinical knowledge/evidence-based medicine and describe how the ACO providers/suppliers will engage the beneficiary in shared decision making.

- Written standards in place for beneficiary access and communication and a process in place for beneficiaries to access their medical record.
- Internal processes in place for measuring clinical or service performance by physicians across the practices and using these results to improve care and service over time. The documents submitted to meet leadership and management criteria related to quality assurance and clinical integration program would satisfy this item.

Proposed Measures to Assess the Quality of Care Furnished by an ACO

Section 1899(b)(3)(A) of the Act requires the Secretary to determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of clinical processes and outcomes; patient, and, if practical, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions). Section 1899(b)(3)(B) of the Act requires ACOs to submit data in a form and manner specified by the Secretary on measures that the Secretary determines necessary for the ACO to report to evaluate the quality of care furnished by the ACO. An ACO will be considered to have met the quality performance standard if they have reported quality measures and met the applicable performance criteria in accordance with the requirements for each of the 3 performance years. The quality performance standard will be defined at the reporting level for the first year of the SSP and will be defined based on measure scores in subsequent program years. Quality measures for the remaining 2 years of the 3-year agreement will be proposed in future rule making.

In terms of selection and use of measures, the following goals have been identified:

- Use of outcome and patient experience measures, adjusted for risk or other appropriate patient population or provider characteristics
- Measures should be aligned across Medicare and Medicaid's public reporting and payment systems. A focused core set of measures will be developed appropriate to each specific provider category that reflects the level of care and the most important areas of service and measures for that provider.
- The collection of information should minimize the burden on providers to the extent possible.
- Measures should be nationally endorsed by a multi-stakeholder organization and should be aligned with best practices among other payers and the needs of the end users.
- Providers should be scored on their overall achievement relative to national or other appropriate benchmarks. In addition, scoring methodologies should consider improvement as an independent goal.
- Scoring methodologies should be more weighted toward outcome, patient experience, and functional status measures.

- Scoring methodologies should be reliable, straightforward, and stable over time and should enable consumers, providers, and payers to make meaningful distinctions among providers' performance.

Based on these goals, CMS proposes 65 measures for use in the calculation of the ACO Quality Performance Standard. Under Section 425.12 of the proposed regulations, ACOs will be required to report quality measures and meet applicable performance criteria for all 3 years within the 3-year agreement period to be considered as having met the quality performance standard. For the first year of the program, the quality performance standard will be at the level of full and accurate measures reporting; for subsequent years, the quality performance standard will be based on a measures scale with a minimum attainment level. Accountable care organizations that do not meet the quality performance thresholds for all proposed measures would not be eligible for shared savings, regardless of how much per capita costs were reduced. If an ACO fails to meet the minimum attainment level for 1 or more domains, it will be given a warning and will be reevaluated the following year. If the ACO continues to underperform on the quality performance standards in the following year, the agreement will be terminated. If an ACO fails to report 1 or more measures, it would receive a written request to submit the required data by a specified date and to provide a reasonable written explanation for its delay in reporting the required information. If the ACO fails to report by the requested deadline and does not provide a reasonable explanation for delayed reporting, it would be immediately terminated for failing to report quality measures.

Section 425.12 of the proposed regulations also addresses CMS' monitoring of ACO performance. This monitoring may include the following:

- analysis of specific financial and quality measurement data reported by the ACO as well as aggregated annual and quarterly reports;
- site visits;
- analysis of beneficiary and provider complaints; and
- audits, including analysis of claims, chart review, beneficiary survey reviews, and coding audits.

Conclusion

The proposed regulations dealing with ACOs contain many important requirements that an entity seeking to join or become an ACO must meet. Many of these requirements touch on areas that are well within the expertise of the nurse executive. It is likely that the final version of the regulations will retain much of the content within the sphere of influence of the nurse executive. As such, it is important for the nurse executive to be familiar with these requirements and to be prepared to weigh in on the development and implementation of the required processes in the event that the organization they lead seeks to engage in the ACO process.