ACOs Turn Up the Heat Among Skilled Nursing Facilities

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ACCOUNTABLE CARE ORGANIZATIONS ARE increasingly entering the post-acute market. It is estimated that about 10% of Medicare recipients currently receive their health care through an ACO, and this number is expected to rise. Post-acute care makes up just over 15% of the average cost per Medicare recipient every year, with skilled nursing being the leading form of service. ACOs are charged with reducing cost while maintaining quality, so it is natural that they are starting to scrutinize ways to improve skilled nursing facility care utilization and performance.

The Concerns

The current prospective payment system (PPS) pays a per diem rate that heavily favors therapy services, which many feel provides little incentive to reduce lengths of stay. Individuals must spend 3 nights as a fully admitted hospital patient to qualify for SNF benefits (the so-called “3-day rule”) under Medicare Part A. Additionally, they have a right to select any SNF that can meet their needs. ACOs would ideally like to refer their patients to SNFs that can treat all manners of medical needs in a timely, cost-effective fashion. The ideal way for an ACO to do this would be to allow them to bypass the 3-day rule, and to allow them to guide patients to select SNFs that provide the best care. The Centers for Medicare & Medicaid Services has been listening to these issues, and on Dec. 1, 2014, CMS proposed a rule to answer these concerns. These proposals are not final and are subject to a comment period, but it is anticipated they will only be refined and left largely unchanged.

3-Day Rule Revisions

The 3-day rule has been a contentious issue for nearly all providers for years. CMS has contended it is necessary to prevent overuse of expensive SNF services. Since ACOs are responsible for all costs, this argument is less applicable. In fact, Medicare Advantage plans, which have similar responsibility for total considerations, have been exempted from the 3-day rule for years. Some Pioneer ACOs, which have more flexibility since they came out of the CMS Innovation Center, started tailored waivers for the 3-day rule in April 2014, but this did not apply to the CMS-run Medicare Shared Savings Program (MSSP) ACOs. The proposed rule now explains under what circumstances MSSP ACOs can waive the 3-day rule.

CMS does not believe a waiver should result in SNF overutilization at the expense of an appropriate acute hospital stay. The patient must be medically stable, have certain defined diagnoses, not require extensive testing and evaluation, and need SNF services and rehabilitation. The greatest utility and savings would result when the entire hospital stay (and expense) is avoided and the patient is directly admitted to the SNF, such as from a physician’s office or emergency department. The SNF would have to demonstrate it has adequate staff, capacity, and infrastructure to care for such patients. SNFs would be expected to have a minimum Three-Star rating and be required to be either an ACO participant or a provider/supplier in order to align incentives.

The ACO would be required to meet various transparency requirements, including indication of their intent to use such waivers on their application and renewals, and submission of a written plan detailing how the waiver would meet the needs of the assigned beneficiaries. The governing body would have to make a bona fide determination of the waiver need, and post the use of such waivers as part of public reporting. The ACO must remain in compliance with the MSSP program. CMS would reserve the right to audit and monitor for possible abuse of the waiver (e.g., premature discharge to the SNF) and terminate the waiver if abuse was determined. Marketing services also would be monitored for potential misleading information or coercion.

Perhaps most importantly, CMS has proposed to limit this waiver to only those MSSP ACOs that are Track 3 programs. Track 3 programs have “two-sided risk,” and incur financial penalties if spending goals are not met. Most MSSP ACOs have been operating on “one-sided risk” — they can share in savings to the program, but do not incur any penalty if they do not save or cost the program more. Many MSSP ACOs are still not ready to transition to two-sided risk, where CMS believes maximal incentives occur. Using a 3-day rule waiver as an incentive to two-sided risk serves CMS’s goals well.

ACO Selection of SNFs

Currently, hospitals are required to provide patients a list of SNFs in their geographic area. They must also disclose any hospital relationship to the SNF, and must not direct patients to a specific provider. Physicians, and at times case managers, give patients information about homes they perceive are better, but this informal direction is not officially recognized, and often does not work to the advantage of the ACO. ACOs would like to utilize high-quality SNFs that can shorten lengths of stay and, more importantly, reduce rehospitalizations in order to meet goals of lowering costs and providing quality. Those SNFs with an established track record of providing such care could benefit tremendously, and those with poorer performance could soon have empty skilled units.

CMS has proposed a narrow waiver for Track 3 MSSP ACOs only. Hospitals that are ACO participants or ACO providers/suppliers still would be required to provide a complete list of all SNFs and respect patient choice, but they would be allowed to make recommendations of preferred SNFs they have a relationship with that provide better continuity of care. Discharge planners would be required to document the data and the rationale they used as the basis for recommending any specific provider of post-hospital services.

SNFs and ACOs would have to meet the criteria listed above for the 3-day rule waiver, such as Three-Star rating and transparency requirement. Generally, CMS is supportive of hospitals recommending certain post-hospital providers based on quality and a beneficiary’s specific needs, as long as the beneficiaries understand their other options and retain their freedom of choice.

Risks and Waivers

There are many issues and concerns with the proposed changes. If ACOs can suddenly admit patients to the SNF from the emergency department or observation status, will there be enough SNF beds — much less high-quality SNF beds — to meet the demand? This could be a welcome opportunity for the better performing SNF, but a difficult time for the ACO trying to find the right home at the right time for each patient. CMS has questioned if the SNF should have to be an ACO provider, which might provide some relief to the access to care problem. Ultimately, if the ACO bears two-sided risk, does it make a difference if the SNF is an ACO provider?

A significant concern is what parameters hospitals should use to formulate their lists of post-acute providers and what information would be shared with beneficiaries. Should hospitals share only information on quality that is publicly reported, such as on Nursing Home Compare, or is it appropriate for hospitals to share information that they have generated internally? There would be real concerns if hospitals steered beneficiaries to providers based on quality information that has not been properly vetted. There should also be concerns if hospitals recommend only their partnering providers when there may be other providers of equal or better quality. CMS is planning to report 30-day rehospitalization rates as part of Nursing Home Compare, and this is obviously a metric that will be of interest to ACOs.

Another concern is whether these waivers are at odds with CMS’s decision in this proposed rule to continue to make the SNF a primary care site. If waivers place patients who were previously cared for in the hospital into the SNF instead, and the SNF is viewed as a care continuity site from the hospital, is the SNF really a primary care site, or is it, instead, a hospital substitute? AMDA has contended that the SNF site should not be a primary care site for the purposes of physician value modifier comparison groups, as the per day cost basis is much higher than in the office setting, leading to unfair penalties to the physician caring for SNF patients under value-based medicine. If the ACO is responsible for all costs at all sites of service and these waivers go into effect, CMS’s rationale for inclusion of SNFs as a primary care site for other value-based programs makes little sense.

Given the proposed waivers, would the current ACO quality measures, such as the new Skilled Nursing Facility 30-Day All-Cause Readmission Measure and other measures used by ACOs, be sufficient to help protect against inappropriate care or withheld care? The ACO proposed rule may bring new solutions to old problems, but it also brings with it new issues. AMDA and other stakeholders are reading it very carefully and deliberating comments that they will develop. AMDA is interested in hearing from you if you currently participate or plan to participate in an ACO. If you would like to share your experiences, please contact AMDA at publicpolicy@amda.com. Ultimately, we are being given an opportunity to improve the health care system. May we and others, including CMS, have the wisdom to build it right.