CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Case STUDY

Learning Systems
for Accountable Care Organizations

Partners HealthCare ACO and the Three-Day Rule Waiver: Implementation Approach and Lessons Learned

This case study describes how Partners HealthCare's Accountable Care Organization (ACO), a large integrated delivery system participating in the Next Generation ACO (NGACO) Model, implemented the skilled nursing facility (SNF) three-day rule waiver. The Partners HealthCare ACO strategy emphasizes strong communication channels across multiple operating levels: central ACO staff that oversee and support decision-making around appropriate use of the waiver, the partnering local physician organization waiver teams that identify and initiate the waiver process for clinically-appropriate patients, and SNFs that work with the physician organizations to serve patients. Partners HealthCare ACO identified three areas where they learned important lessons: 1) identifying patients who are appropriate for the waiver; 2) dedicating staff to focus on waiver operations; and 3) engaging providers to further the waiver implementation effort. This experience is valuable to ACOs implementing the waiver or seeking to refine the waiver operations strategy.

BACKGROUND ON THE THREE-DAY RULE WAIVER

The Centers for Medicare & Medicaid Services (CMS) Innovation Center provides NGACOs with a waiver from the Medicare rule that restricts SNF coverage to beneficiaries who have had at least three consecutive inpatient days within a month of the SNF admission (known as the three-day rule).[1] Under the waiver, participating ACOs can admit patients aligned to the ACO that meet certain clinical criteria directly to waiver-approved SNFs after an emergency department (ED) stay, from the observation setting, from the community, or after an inpatient stay of one to two days.[2]

With this waiver, NGACOs have access to a new tool to provide timely and effective skilled nursing facility care to a select population and each NGACO is left to determine how to implement the waiver for its particular population and organizational structure.

INCREMENTAL APPROACH TO WAIVER IMPLEMENTATION

Partners HealthCare ACO, consisting of a consortium of nine physician organizations, is located in the urban and suburban areas of Massachusetts. The Partners HealthCare system also includes two academic medical centers and community and specialty hospitals and its

own home health agency. Partners HealthCare ACO operates under a decentralized model that cares for almost 100,000 aligned beneficiaries. Initially part of the Pioneer ACO Model, Partners HealthCare ACO transitioned to the Next Generation ACO Model in January 2017. Though Partners HealthCare ACO maintains a decentralized operational model, a team from the Partners HealthCare Center for Population Health leads implementation of the three-day rule waiver under the guiding principle of "centrally guided, jointly decided, locally led."

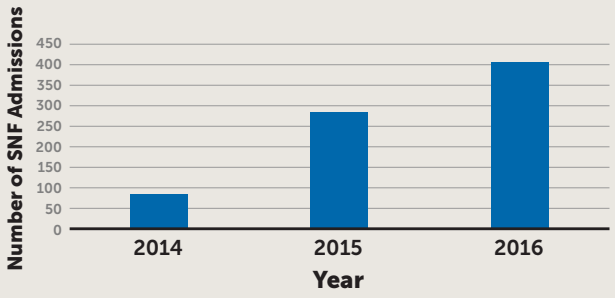
Partners HealthCare ACO and it's partnering physician organizations adopted an incremental approach to implementing the waiver from the start, building on insights gleaned from participating in the CMS Case Management for High Cost Beneficiaries demonstration program.[3] In 2010, Partners HealthCare ACO's largest physician organization, Massachusetts General Physician Organization, launched a SNF waiver pilot within the demonstration program to allow SNF admissions for beneficiaries who did not meet the three-day hospital stay requirement. Partners soon expanded this pilot to two additional hospitals in the Partners network (Brigham & Women's Physician Organization and North Shore Health System). Over the next year and a half, Partners evaluated almost 500 beneficiaries for the pilot program.

> ***"The program didn't just pop up, out of nowhere. The Pioneer ACO [waiver] was built upon the platform of a very integrated high-risk care management program."***
>
> —Dr. Charles Pu, Medical Director of Care Transitions and Continuum, Partners HealthCare Center for Population Health

By 2014, recognizing the similarities between the demonstration experience and the Pioneer ACO Model three-day rule waiver, Partners HealthCare ACO expanded the program across its system and to 78 waiver-eligible SNFs. This expansion allowed Partners HealthCare ACO to target a larger patient population of ACO-aligned beneficiaries that were more likely to benefit from goal-directed, short-term SNF care than the high-risk patients in the demonstration program. Over the next 2.5 years, the partnering physician organizations of Partners HealthCare ACO continued to grow waiver operations, with more than 700 waiver admissions in total. Figure 1 shows steady annual growth of the ACO's waiver use from April 2014 to December 2016.

Figure 1

Partners HealthCare ACO's Use of Three-Day Rule Waiver, 2014–2016



Source: Partners HealthCare Accountable Care Organization

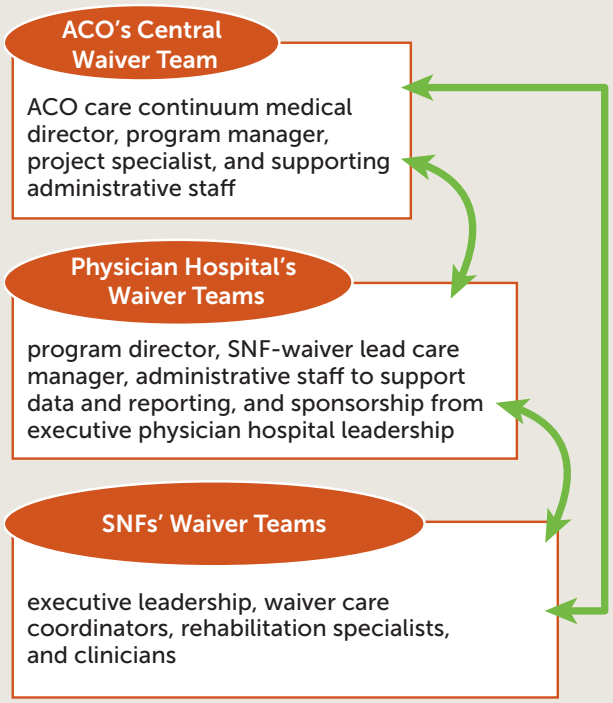
OPERATING THE THREE-DAY RULE WAIVER

Partners HealthCare ACO's approach to the three-day rule waiver emphasizes strong communication channels across multiple operating levels: central ACO staff that oversee and support decision-making around the waiver, the local physician organizations that identify patients for the waiver, and the SNFs that serve waiver patients. The leadership within the physician organizations and their partnering SNFs establish a coordinated care team to engage in the three-day rule waiver efforts (Figure 2). This layered approach to operations aims to encourage collaboration, data sharing, and continuous quality improvement.

The Partners HealthCare ACO central waiver team is responsible for the program design and oversight throughout the ACO, including collecting data and reporting to CMS. Partners HealthCare ACO's central waiver team encourages the local teams to maintain ownership of waiver program implementation and process improvement. The central team further supports the physician organizations by clarifying CMS policy, developing guidance documents, and drafting protocols and suggested workflows. Appendix 1 contains a sample workflow developed by the Partners HealthCare ACO's central waiver team for a physician organization.

Figure 2

Communication pathways among physician organizations implementing the Partners HealthCare ACO three-day rule waiver



The waiver leadership teams within the physician organizations are encouraged to build a program that reflects the particular structure and culture of their organization. They are responsible for implementing the waiver, including developing workflows in the acute and primary care settings in which patients might be identified for the waiver, conducting trainings, and developing checklists. The waiver leadership team provides physician organizations with criteria for selection of SNFs eligible to participate in the waiver, including: 1) three or more stars in the CMS Nursing Home Compare quality rating system; 2) high quality metrics based on the Massachusetts Department of Public Health's nursing home survey performance tool, and 3) strong collaborative relationships with the physician organization.

For programmatic oversight, the waiver leadership teams participate in a monthly call hosted by central ACO staff to discuss programmatic updates from CMS, review recent waiver quality data, and share insights to help inform ACO-wide operational refinements and improvements.

For clinical oversight, the waiver leadership teams engage with partnering SNFs that are eligible to receive waiver patients to identify opportunities for care improvement. These SNFs have established waiver teams that are responsible for communicating with the physician hospital organizations on a weekly basis, via telephonic clinical rounds, to discuss patients' progress during care transition to the SNF, through their stay at the SNF, and when discharged from the SNF. When appropriate, in-person support at SNFs is provided by the physician organizations. In addition, the clinical teams have monthly calls to discuss broader programmatic quality improvement opportunities to optimize care delivery for waiver patients.

In addition to facilitating collaborations between physician organizations and SNFs related to waiver operations, Partners HealthCare ACO established a SNF Network Learning Collaborative to directly engage regional SNFs that meet certain quality measures and commit to shared goals of providing high quality care. Staff from these SNFs meet in person biannually to discuss programmatic updates, waiver-related performance data, clinical case reviews, SNF stay management, and general program successes and challenges. In between in-person meetings, an electronic mailing list is used for communications with the SNFs and Partners ACOs' central waiver team.

LESSONS LEARNED

Reflecting on its experience operating the Pioneer ACO Model three-day rule waiver, Partners HealthCare ACO identified three areas where they learned important lessons: 1) identifying patients who are appropriate for the waiver; 2) dedicating staff to focus on waiver operations; and 3) strategies to engage providers to implement the waiver.

Real-time identification of patients appropriate for the waiver admission to a SNF

Partners HealthCare ACO noted that a major challenge to implementing the waiver is developing efficient workflows to allow for real-time identification of patients that are eligible and appropriate for waiver admission to a SNF. Patients must be aligned to the ACO and meet the clinical eligibility criteria for the waiver, which adheres to CMS's standard SNF admission criteria.

Identification of waiver patients can occur in multiple settings, including a patient's home, primary care office, ED, or hospital. Partners HealthCare ACO staff noted that without dedicated staff available, identifying patients in the ED is particularly difficult because the workflow requires rapid decision-making about patients' care. ED providers sometimes conclude that the full clinical picture is not yet available and a patient should transition to observation status before determining clinical eligibility for the waiver.

Noting that beneficiary alignment to the ACO changes through the year, Partners HealthCare ACO developed several resources for providers to access ACO alignment data provided by CMS. The primary resource to investigate patients' ACO alignment is an icon built into their electronic medical records (EMRs). For example, ED providers click on the icon to view a patient's payer, alignment to the ACO, the name of the primary care physician, and the local entity responsible for the patient's care. Although the development of the icon required a substantial investment, Partners HealthCare ACO considers the EMR icon to be crucial to real-time identification of patients appropriate for the waiver. If the icon is unavailable, a stand-alone, web-based tool, called the Population Health Management Look-Up Tool, displays the same information as the EMR icon.

Dedicating staff to the waiver promotes effective operations

The participating physician organizations of Partners HealthCare ACO developed a strategy of longitudinal care management across both the inpatient and outpatient setting. When implementing the waiver, the physician organizations identified the need for waiver-specific care managers to provide care teams with real-time decision support. As a best practice, Partners HealthCare ACO provided each physician organization with funding to hire waiver-specific care managers.

> ***"We saw a direct correlation between a dedicated resource at the site and the ability to generate appropriate waiver referrals.… Over the years, [we] have had to move all the physician organizations to adopt that kind of best practice model."***
>
> —Dr. Charles Pu, Medical Director of Care Transitions and Continuum, Partners HealthCare Center for Population Health

The contribution of the waiver care manager is particularly important to the success of implementing the waiver in the ED. For example, a patient may arrive in the ED at midnight and be identified as a potential candidate for the waiver. The ED cares for the patient until the morning when the waiver care manager confirms eligibility, clinical appropriateness, and facilitates the SNF transfer. "The EDs [are] high utilizers of the waiver and we have had to make those physicians feel very comfortable that we can help them make a plan that's going to be the best for the patient," noted Marianne Turner, Director of Care Continuum, Partners HealthCare Center for Population Health.

Engaging local physician organizations through tailored messaging and regular meetings

To expand the waiver across the network of physician organizations during the Pioneer ACO Model, Partners HealthCare ACO sought to capture the attention of clinical leaders in each organization by referencing data on the high use of acute care services in the ACOs' geographic region, compared with the national trends. These data highlighted the need for change, but the solution to reducing patients' total medical expenses was unclear. Reflecting back, Dr. Pu said, "I think there was a recognized urgency that this usual care pathway from the old fee-for-service system wasn't going to work anymore."

Partners HealthCare ACO viewed the three-day rule waiver as a strategy to deliver more appropriate post-acute care and developed a messaging strategy to encourage the partnering physician organizations to embrace the waiver. The messaging focused on how the waiver creates an opportunity to identify patients appropriate for direct SNF admission and avoid unnecessary inpatient stays, thereby improving care and lowering cost. This messaging resonated with academic medical centers facing limited bed capacity and with physician organizations affiliated with smaller medical practices that experienced full-risk payments. Some physician organizations with community-based hospitals did not readily adopt the waiver, largely due to concerns that the waiver limited or even eliminated hospital stays. For these physician organizations, Partners HealthCare ACO's central waiver team tailored the messaging to emphasize the benefits for patients who are appropriate for waiver admission, namely the improved patient care experience and reduced ACO costs.

To better foster relationships, the Partners HealthCare ACO central waiver team conducts biannual in-person meetings with each physician organization. In addition to improving communication across waiver teams, the goal of the meeting is to remove utilization barriers and identify opportunities to improve care and avoid hospitalizations. Through these conversations, the Partners HealthCare ACO central waiver team and physician organizations collectively refine strategies to implement the waiver.

NEXT STEPS

Partners HealthCare ACO and it's participating physician organizations collectively views the three-day rule waiver as an initial, significant step toward promoting culture change that focuses on avoiding unnecessary hospitalizations. "The waiver program is the one system-wide [hospitalization] avoidance pathway currently in place across Partners HealthCare ACO that has demonstrated broad reaching success … and this is just the first of many programs that we're trying to build to advance this work," said Dr. Charles Pu. These programs will not only improve the quality of care for patients, but will also promote value-based care in the appropriate settings.

ABOUT THE ACO LEARNING SYSTEMS PROJECT

This case study was prepared on behalf of CMS's Innovation Center by Sonya Streeter of Mathematica Policy Research under the Learning Systems for ACOs contract (HHSM-500-2014-00034I/ HHSM-500-T0006). CMS released this case study in July 2017. We are tremendously grateful to the many staff from Partners HealthCare ACO for participating in this case study.

For more information, contact the ACO Learning System at ACOLearningActivities@mathematica-mpr.com.

ENDNOTES

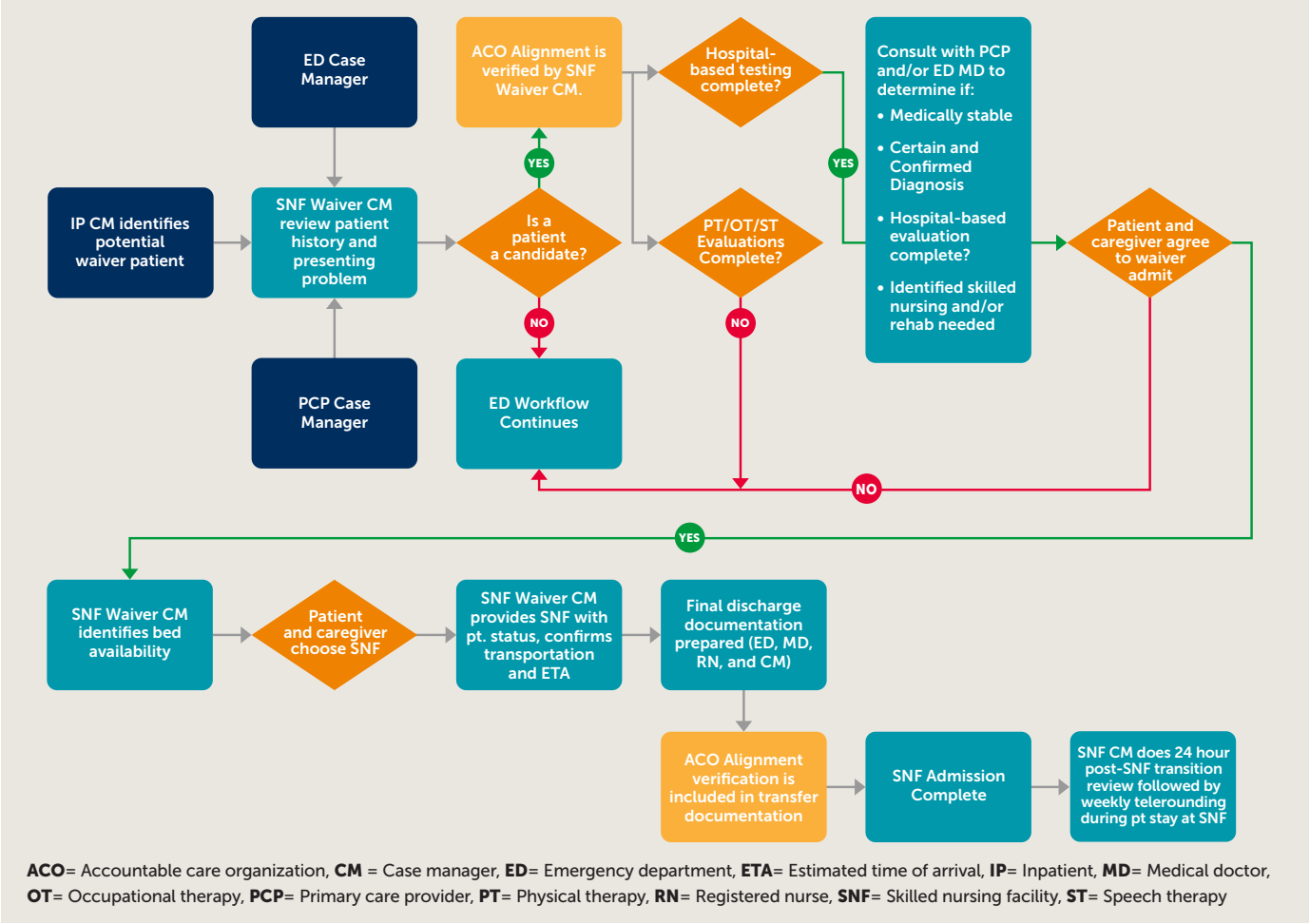
[1] The Pioneer ACO Model three-day rule waiver was available from April 2014 to December 2016, when the Model concluded. Currently, ACOs in the Next Generation ACO Model and Track 3 of the Medicare Shared Savings Program have access to a similar three-day rule waiver.

[2] CMS's standard SNF admission criteria requires that patients (1) be medically stable, (2) have a confirmed diagnosis that does not require additional testing, (3) not require further inpatient hospital evaluation or treatment, and (4) have an identified skilled nursing or rehabilitation need that cannot be provided in the outpatient or home settings

[3] The demonstration program was approved to provide disease management services to Medicare beneficiaries served by six organizations. The demonstration tested provider-based intensive care management services as a way to improve quality of care and reduce costs for fee-for-service beneficiaries who have one or more chronic diseases and generally incur high Medicare costs.

Appendix 1

SNF Three-day Waiver Approval Workflow



ACO= Accountable care organization, **CM** = Case manager, **ED**= Emergency department, **ETA**= Estimated time of arrival, **IP**= Inpatient, **MD**= Medical doctor, **OT**= Occupational therapy, **PCP**= Primary care provider, **PT**= Physical therapy, **RN**= Registered nurse, **SNF**= Skilled nursing facility, **ST**= Speech therapy