CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Learning Systems
for Accountable Care Organizations

Care Transformation Toolkit

Introduction

Numerous Medicare accountable care organizations (ACOs) have achieved shared savings since 2012 by using a variety of strategies to improve population health and the quality of care while reducing costs. Each ACO is unique and has a different approach to providing value-based care; strategies developed by one ACO may not always be suited for another. In recognition of this, the Centers for Medicare & Medicaid Services (CMS) developed a series of toolkits exploring different aspects of ACO operations while highlighting potential common goals and approaches. Through these toolkits, CMS aims to educate the general public about strategies used by some ACOs to deliver value-based care while also providing actionable ideas to current and prospective ACOs to help them improve or begin operations, particularly as they consider a shift to a two-sided risk model.

This toolkit presents an array of Medicare ACOs' strategies for transforming the delivery of care, improving the quality of care, lowering health care costs, and enhancing the beneficiary care experience. Many of these strategies involve implementation of Medicare policies that provide financial incentives for ACOs and ACO participants (for example, integrating and aligning billable services into ACO strategies) or that reduce administrative and/or clinical burden (for example, by taking advantage of available waivers related to traditional fee-for-service payments). Although ACOs' initiatives to transform the delivery of care are diverse, they generally use similar processes to implement them. For example, before launching their initiatives, ACOs establish certain foundational

Overview of the CMS ACO Learning System and Toolkit

Since 2012, CMS has supported ACOs in their efforts to improve the delivery of care for their attributed patient populations through model-specific learning systems. These learning systems provide ACOs with a forum in which they can collaborate with and learn from one another. Across the model-specific learning systems, CMS hosts approximately 70 virtual events and 18 in-person events each year on topics tailored to the needs and interests of current ACOs.

This toolkit describes ACOs' strategies for developing and implementing programs that transform the delivery of care. For example, ACOs may implement telehealth programs to expand beneficiaries' access to care or home visit programs to provide high-risk beneficiaries with options for receiving care in their home. ACOs that participate in certain value-based care initiatives may also implement the Skilled Nursing Facility (SNF) 3-Day Rule Waiver to shorten or avoid hospitalizations before a SNF stay and to provide beneficiaries with timely post-acute care.

This is the fourth toolkit in a broader series of resources that explore different aspects of how ACOs operate to provide value-based care. The toolkits bring together insights gathered during CMS-sponsored learning system events and through focus groups with the ACOs. Through these toolkits, CMS aims to educate the general public about strategies used by ACOs to provide value-based care while also providing actionable ideas to current and prospective ACOs to help them improve or begin operations.

elements of the program that are essential to operations, including reviewing policy requirements to define program objectives and identifying and engaging stakeholders. Once the programs are implemented, ACOs develop processes that help support consistency in day-to-day program operations throughout the organization, such as identifying and engaging beneficiaries who would benefit from the initiatives and measuring implementation progress and impact.

This toolkit begins by reviewing ACOs' common approaches to, and best practices for, implementing sustainable care transformation initiatives that deliver high quality, efficient care. The toolkit then explores the development and implementation of specific programs related to:

- Using telehealth to expand access to care and increase efficiency
- Supporting high-risk beneficiaries through home visits
- Providing beneficiaries timely access to skilled nursing care

To produce this toolkit, the CMS ACO learning system conducted focus groups with representatives from eight ACOs that participate in the Medicare Shared Savings Program and in the Next Generation ACO Model. The learning system offered ACOs an opportunity to participate in the focus groups if they had shared effective care transformation strategies during past learning system events; it also extended an open invitation to ACOs with care transformation programs via newsletters for each Medicare ACO initiative.[1] During each focus group, the participants described their strategies for transforming the delivery of care. This toolkit is also based on the insights of 33 ACOs who participated in CMS-sponsored events such as peer-to-peer learning webinars, individual technical assistance calls, and case studies. For a list of the ACOs that contributed to this toolkit, please see page 21.

While many of the ACOs that contributed to this toolkit focused on programs that yielded positive results, some ACOs candidly discussed programs that were less successful than expected or for which results were not yet available. This toolkit includes lessons learned from ACOs' attempted interventions along with snapshots that offer current and prospective ACOs a more complete picture of available options and possible implementation challenges.

[1] When considering which ACOs to include in the focus groups, we did not limit invitations strictly to ACOs that had consistently achieved shared savings. Doing so could have inadvertently excluded ACOs that were starting out in new, higher-risk programs or that were investing in infrastructure, creating situations in which they accepted short-term losses to position themselves for longer-term financial and quality successes.

Implementing Care Transformation Initiatives

Care transformation initiatives are diverse in the services offered, the populations served, and the resources needed for implementation. However, ACOs generally implement the initiatives in similar ways (Figure 1). The implementation process begins with ACOs reviewing relevant policy requirements in order to define their initiatives' objectives. They then identify and engage internal and external stakeholders to support planning and workflow redesign. Next, ACOs consider which beneficiaries are most appropriate for participation in their programs and how best to engage those beneficiaries. The last step is to pilot test program workflows and processes. Throughout implementation, ACOs measure and monitor their initiatives' progress and assess preliminary effect on outcomes, which informs decision making on whether to refine the initiative and/or expand it beyond the pilot test.

REVIEW POLICY REQUIREMENTS TO DEFINE INITIATIVE OBJECTIVES

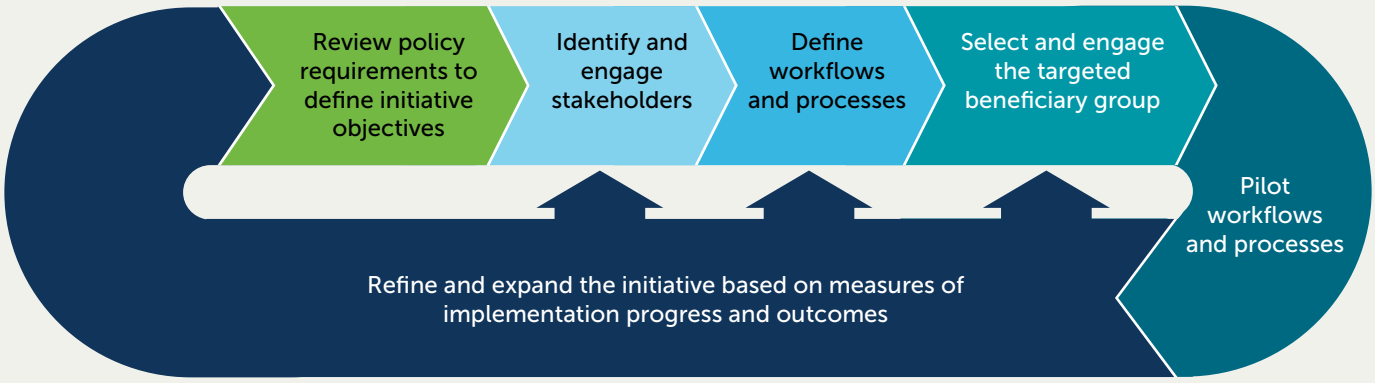
ACOs begin the implementation process by carefully reviewing CMS regulations and guidance that relate to their targeted initiative and ensure that it meets relevant Medicare policy requirements. In some instances, Medicare fee-for-service reimbursement is dependent on meeting certain billing criteria. For example, reimbursement may only be possible for services provided to beneficiaries who have certain characteristics, such as specific diagnoses or utilization patterns. In other instances, reimbursement may depend on the completion of clinical documentation or on the credentials of those who deliver the services.

After reviewing relevant Medicare policies and requirements, ACOs then define the objectives of their initiatives so that these objectives align with the ACO's overall strategic goals and priorities. This step includes considering the extent to which the initiative will have a meaningful impact on specific quality measures, a specific type of utilization, or beneficiary outcomes. ACOs may also consider how an initiative supports providers, particularly primary care and specialty clinicians in the ambulatory setting, to better meet the needs of a subset of high-need and high-cost beneficiaries (such as those with multiple chronic conditions or recent changes in health status).

Having defined the initiative's objective(s), ACOs consider which investments will be required in recruiting and developing staff; in procuring, adapting, and maintaining facilities and equipment; and in updating the health information technology (IT) infrastructure. For example, some initiatives make it necessary for ACOs or participating provider groups to recruit and hire additional staff, reallocate existing staff, or offer them training or credentialing opportunities. Many initiatives require ACO administrative leaders' time to conduct important tasks, such as engaging stakeholders, closely monitoring and providing support for implementation, and overseeing the process for collecting and submitting measures and claims data.

To support the implementation process, many ACOs develop documents that clearly define the objectives of the initiative, the plan to acquire needed resources, and the

Figure 1. Steps in Implementing Care Transformation Initiatives



pertinent regulatory requirements. These documents may be considered an internal tool that ACO administrative staff regularly update with new decisions and insights. Some ACOs create specific versions of these documents for broader groups of stakeholders involved in implementing the program, such as frontline providers, which complement other training tools for the initiative.

> My compliance manager and I always build our toolkits and our processes around the [CMS requirements]. If you know what you're going to be audited on, then you build your program around that.
>
> —ACO administrator

IDENTIFYING AND ENGAGING STAKEHOLDERS

ACOs note that implementing care transformation initiatives involves complex processes that affect multiple types of stakeholders, including the ACOs' executive leaders, operational leaders at the care site, care team members who have direct contact with beneficiaries, and community-based partners who play supporting roles in the workflow. Each stakeholder group plays an important and distinct role in successfully implementing the initiative. By identifying and seeking the perspectives of a diverse set of stakeholders early in the implementation process, ACOs increase stakeholder awareness of the initiative and can use stakeholders' insight to inform design decisions. Strategies for engaging these stakeholders range from presenting at previously scheduled meetings, identifying a peer champion for the initiative, and distributing educational materials on the initiative's objectives and proposed processes. Many ACOs view engagement as an ongoing activity, and they continue to reach out to certain stakeholders throughout implementation to solicit feedback in order to refine processes and to educate new staff about the initiative.

Engaging ACO executive leaders. An ACO's executive leaders commonly include the Board of Directors or representatives of a parent organization. These leaders oversee strategic decision making, through which the ACO achieves the overall goals of the quadruple aim (meaning better outcomes, lower cost, improved care experience, and improved care team experience). Depending on how an ACO is structured and on the scale of the care transformation initiative, administrators may engage these executive leaders early in the implementation planning process to secure their approval of the required resources and to integrate their experience and insight into the design of the program.

Some ACO administrators have found that executive leaders appreciate reviewing a business case argument for an initiative. The business case may focus on a projected return on investment, which considers the expected financial impact on operational costs and revenues not only for the ACO, but also for key partners, such as large provider groups or hospitals. In addition, the business case may consider the impact on quality-related measures, such as changes in emergency department (ED) use; in vaccination rates; or in beneficiaries' experience with their health care, such as shorter wait times to see specialists.

Engaging operational leaders and care teams from health care settings. ACOs reach out to operational leaders at the care sites in which the initiative would be implemented, such as hospitals or practices. These leaders confirm the site's ability to participate in the program, based on criteria such as provider and staff availability and on how the initiative aligns with other existing care delivery processes. The leaders can introduce ACO administrators to key staff who would be involved in the program, such as specific care teams or IT staff.

Although ACOs often begin outreach to the health care setting by engaging operational leaders, they also focus on collaborating with the care team members who implement workflows and who connect directly with beneficiaries. ACOs seek input from a diverse array of staff—including primary care and specialty providers, pharmacists, dieticians, and care managers—because of their essential roles in treating and supporting beneficiaries. ACOs have emphasized the importance of engaging care team members throughout implementation: both to establish workflows initially and, subsequently, to refine processes.

Recognizing the busy schedules of staff in the health care setting, ACOs try to meet with them to introduce the initiative during regularly scheduled meetings rather than creating new meetings. When meeting with these staff, ACOs typically describe the implementation process, highlight early data that may be available on the program's impact at other health care sites, and give examples of how the initiative can meaningfully impact beneficiaries. ACOs

may also provide care team members with informative and user-friendly documents that communicate essential information about the initiative, such as the primary objective, the target population, and the action steps required to achieve the desired objectives. Some ACOs encourage the care team to direct their questions and concerns about the initiative to an onsite champion or to someone from within the site who is invested in the initiative and can serve as a resource for other care team members.

> "If you talk to physicians about numbers or cost [of the initiative], sometimes they glaze over. Seeing the impact that we've had and sharing actual stories that they can relate back to their own patients has been really beneficial."
>
> —ACO administrator

Engaging external partners. External partners include any organizations that support the initiative and are not preferred providers in the ACO, such as skilled nursing facilities (SNFs) or community-based organizations that address health-related social needs. These external partners provide resources and staff that are not readily available in the ACO's infrastructure or in its care delivery sites but are vital to the initiative's success. To engage external partners, ACOs start by describing how the program supports the partner's values and goals. ACOs also encourage partners to contribute to planning meetings to help shape the program. To strengthen and formalize the relationships with external partners, some ACOs have also found it helpful to meet representatives from partner organizations in person and to document details of the relationship in informal agreements or in a formal contract.

DEFINING WORKFLOWS

Workflows are the processes that staff use to deliver care to beneficiaries.[2] When documenting an initiative's workflows, ACOs define the roles and responsibilities of all providers and staff involved in the program and put their action steps in order, highlighting which steps are decision points and/or interdependent. These workflows can be documented in tools and in diagrams that convey to stakeholders the whole process and their specific contributions. Examples of these concrete, visual supports include checklists and process maps. In addition to their function as a communication tool, workflows also provide a foundation to monitor implementation progress and identify necessary refinements.

Operational leaders and care team members provide helpful input for defining workflows in the early stages of implementation planning. ACOs continue to seek input from care team members throughout implementation because their on-the-ground perspectives shed light on the successes and challenges to date and provide insight into how to improve processes. ACOs also provide ongoing training to care team members to ensure that they continue to comply with the workflows, to educate new staff on the workflows, and to further embed the workflows into their routines and culture.

IDENTIFYING AND ENGAGING BENEFICIARIES

ACOs commonly focus care transformation initiatives on a specific population of beneficiaries. They do this to make the most of their finite resources by supporting beneficiaries who are likely to experience the greatest benefit. The target population may be defined based on beneficiaries' demographic characteristics, diagnoses, and/or health risk. Additionally, if integrating billable Medicare services into their initiatives, ACOs must ensure that the program focuses on beneficiaries who meet Medicare reimbursement criteria.

ACOs use a range of methods to identify beneficiaries who are good candidates for care transformation initiatives, including care team referrals, self-referrals, and predictive analytics based on readily available claims and electronic health record (EHR) data. ACOs typically encourage care team members to use their clinical judgment to identify beneficiaries, so they provide regular training opportunities to remind care team members of which beneficiaries are likely to be appropriate for an initiative.

In addition to identifying potential beneficiaries, ACOs also consider strategies for engaging them and their caregivers in the program. For example, ACO staff or the care team may describe the services offered through the initiative and its expected impact on the beneficiary's experience and health; in this conversation, ACOs may also prepare beneficiaries and their caregivers to participate actively in the initiative. This approach occurs most often in person and in a clinical setting (such as the hospital, ED, or practice site) and less frequently by phone. To support the conversations, the ACO may send beneficiaries educational materials, such

[2] For more information, see the Agency for Healthcare Research and Quality (AHRQ) "What is workflow?" Available at: https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/workflow. Accessed August 21, 2020.

as brochures or videos. Staff who have these conversations with beneficiaries often receive training on motivational interviewing and/or on shared decision-making techniques so that they can help beneficiaries to decide whether the program matches their needs.

PILOT TESTING NEW WORKFLOWS AND PROCESSES

Most ACOs that implement a new initiative pilot test a small-scale version of their program to assess whether their strategies work and to fine-tune their processes and tools before investing in expansion. ACOs create pilot tests by focusing on a subset of care delivery sites (such as practices that use a certain EHR or those located in a small geographic region), targeting a subset of beneficiaries (for example, those with a particular diagnosis or receiving a specific treatment), or both. Through this very specific lens, ACO administrators can closely monitor how staff adopt the preliminary workflows, determine whether training modules and guidance tools provide staff with enough support, and quickly investigate the successes and pitfalls associated with implementation. For example, smaller efforts enable ACOs to rapidly conduct Plan-Do-Study-Act cycles to validate small process changes.[3]

The results of a pilot test help ACOs to decide when and how to scale up their initiatives, for example, to new geographic regions or for a broader beneficiary population.

Figure 2. Elements from an ACO Readiness Checklist for Initiative Expansion

- **Resources for determining beneficiary eligibility** *(e.g., define agreement with hospital to send discharge information to the care team; generate targeted beneficiary lists by using predictive analytics)*
- **Process for engaging beneficiaries** *(e.g., develop materials to support care team members when introducing beneficiaries to the initiative and in obtaining their consent to participate)*
- **Training for staff participating in program workflows**
- **Data collection capabilities** *(e.g., build health IT infrastructure to meet new clinical documentation requirements)*
- **Plan for calculating impact on outcomes** *(e.g., use claims data to measure changes in care delivery)*

If the expansion requires the participation of a new care delivery site, ACOs will assess the availability and readiness of key operational elements at candidate sites. Figure 2 is an example from a readiness checklist used by an ACO to guide the expansion decision.

MEASURING AND MONITORING IMPLEMENTATION PROGRESS

Collecting and analyzing data on their care transformation initiatives allows ACOs to measure and monitor implementation progress and the impact of the program on key outcomes. Both process and outcome measures can be based on a combination of quantitative and qualitative data sources, such as claims and EHR data, and on feedback from beneficiaries, care team members, and external partners.

ACOs rely on process measures to update ACO executive leaders and partners on how an initiative is going, and to inform their decisions about expanding a pilot test to new sites. In the initial stages of launching a program, process measures help ACOs identify opportunities to refine the steps in a workflow, reassign roles to different staff, develop additional support tools, and/or hire care team members. For example, if an ACO notices that the rate at which beneficiaries are consenting to participate in the program is low, it can develop a strategy for improving the consent rate by talking to care team members about the challenges that they have observed and experienced in engaging beneficiaries. In addition, as ACOs expand their initiatives to additional settings, process measures provide a standard method to track implementation progress so that the ACOs can modify the resources and workflows at each site to better meet site-specific needs.

Outcome measures help an ACO to determine whether the initiative meets its objectives and its overall strategic goals; these measures also help ACO executives decide whether to sustain or expand the initiative. ACOs carefully design their analyses to account for factors that might make ordinary fluctuations in outcomes appear to be attributable to the initiative. ACOs also consider whether the sample in pilot tests is large enough to adequately measure changes in outcomes. In addition, they consider the fact it may be months or years before they can determine an initiative's impact on beneficiaries' care patterns. Taking these challenges and limitations into account helps ACOs to make a more informed assessment of the extent of their initiative's impact and whether further investments are warranted.

[3] For more information, see the AHRQ "Fillable Plan Do Study Act (PDSA) Tool for Health Care Quality Improvement (QI)." Available at: https://www.ahrq.gov/evidencenow/tools/pdsa-form.html. Accessed August 21, 2020.

Using Telehealth to Expand Access and Increase Efficiency

Medicare ACOs have launched telehealth initiatives to improve the care delivered to their beneficiaries by using new technology to expand access and increase efficiency. For instance, telehealth allows ACOs to draw on a larger pool of clinicians and to potentially shorten wait times when connecting their beneficiaries to specialists and other providers outside their geographic region. Telehealth also allows ACOs to deliver selected services in beneficiaries' homes, which can greatly improve access for beneficiaries who live in rural areas or otherwise face challenges in traveling to in-person appointments. In addition, some ACOs use telehealth to improve the efficiency with which they deliver care by reducing the travel time of clinicians who normally conduct home visits or work in multiple practice sites.

HIGHLIGHTS OF TELEHEALTH REIMBURSEMENT FOR ACOS

Over the past several years, CMS has expanded the telehealth services for which ACO participants can be reimbursed. Beginning in 2016, CMS provided NGACOs with waivers that allow beneficiaries to receive covered telehealth services in their homes (as opposed to in clinical settings) and in urban areas (as opposed to rural areas).[4] Starting in January 2020, the Bipartisan Budget Act of 2018 applied this flexibility to all ACOs operating in two-sided risk models.[5] Additionally, CMS began allowing all providers eligible to bill for telehealth, including those who are not participating in ACO models, to be reimbursed for telehealth services delivered to beneficiaries in their homes or in urban areas during the COVID-19 public health emergency.[6]

Synchronous video visits are the most frequently used form of telehealth services for which CMS reimburses providers under the ACO models. In a synchronous visit, a beneficiary has a live video visit with a provider located at another site (called the "distant site provider"). If the beneficiary is located at a clinical site at the time of the service, then the provider on the beneficiary's side of the visit is called the "originating site provider." The platform used for video visits must by HIPAA compliant and must meet other requirements for the service to be considered reimbursable.[7]

DEVELOPING THE FOUNDATIONAL ELEMENTS FOR IMPLEMENTATION

The design and features of ACOs' telehealth initiatives vary in accordance with ACOs' care transformation objectives and in response to their beneficiaries' needs and demonstrated care gaps. For example, ACOs that serve beneficiaries in rural areas or those who face other challenges in traveling to in-person appointments (such as physical limitations or limited access to transportation) may decide to deliver services in their beneficiaries' homes. This decision may lead ACOs to use technology that is designed to make it easier for older beneficiaries to use on their own devices. In contrast, ACOs that are addressing limited capacity at their care sites may opt to deliver telehealth in the clinical setting. This approach has two advantages: (1) the beneficiary does not have to understand the technology that makes telehealth possible, and (2) the beneficiary does not have to have an internet connection at home.

Before launching a telehealth initiative, ACOs decide which specialties—including primary care as well as medical and surgical subspecialties—will deliver services through telehealth and what technology will be used to conduct the visits. Additionally, ACOs lay the groundwork for their telehealth program by reaching out to key stakeholders in the specialties that will deliver services to educate them about telehealth and obtain their buy-in.

Selecting a provider specialty for the telehealth initiative

Many ACOs use telehealth to increase access to care when they cannot meet the demand for in-person visits for a

[4] Centers for Medicare and Medicaid Services (CMS). "Medicare Telemedicine Health Care Provider Fact Sheet." https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. Accessed July 30, 2020.

[5] Bipartisan Budget Act of 2018, Pub. L. 115-123, section 50324.

[6] CMS. "Medicare Telehealth Frequently Asked Questions." https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf. Accessed August 12, 2020.

[7] In response to the COVID-19 public health emergency, the U.S. Department of Health and Human Services announced in March 2020 that it would use its enforcement discretion to not impose penalties on providers who deliver telehealth services through popular video conferencing programs that may not be HIPAA compliant, such as Zoom, Skype, or FaceTime. See "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency," U.S. Department of Health and Human Services, https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

given specialty—either primary care or a medical or surgical subspecialty. For example, some ACOs that exceeded their local capacity to deliver behavioral health services—often requiring beneficiaries to wait up to six months for an appointment—contracted with behavioral health providers who were interested in seeing patients remotely. Another ACO relied on telehealth to expand the capacity of a small pool of primary care providers (PCPs) who travel to beneficiaries' homes to deliver services (for more information, see ACO Snapshot 1).

Some ACOs use telehealth to deliver services to beneficiaries who have trouble attending in-person appointments and value receiving care in their homes. ACOs in rural areas in which beneficiaries must drive long distances to reach the nearest city often use telehealth services for population health, urgent care, behavioral health, and dermatology. One rural ACO described its telehealth initiative that provides post-surgical care to beneficiaries, allowing them to check in with their surgeons after they return home.

When selecting a provider specialty for telehealth, ACOs carefully consider whether providers in that specialty are likely to engage in a new telehealth initiative or whether they have a strong preference for in-person visits. For example, behavioral health is compatible with telehealth technology in part because behavioral health visits do not require in-person assessments of physical findings. In contrast, telehealth may be less effective for delivering care for other specialties; for example, ACOs note that oncologists and orthopedists have mentioned the limitations of using telehealth to care for their patients.

Selecting technology for the initiative

ACOs select both software and hardware for their telehealth visits. In doing so, they consider the needs and comfort levels of beneficiaries and providers, as well as factors such as functionality and cost. They also consider the fact that technology will affect both the workflow for day-to-day program operations and the need for support staff.

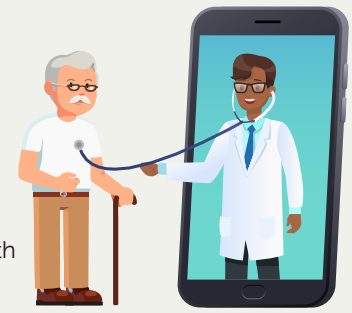
In selecting software, ACOs aim for products that are easy for beneficiaries to use, and that can be integrated into the clinical setting's existing systems for distant site providers. On the beneficiary end of the visit, some ACOs rely on software that beneficiaries can download to their own devices, which limits the burden of preparing beneficiaries to use the technology. ACOs might encourage beneficiaries to access their visits through their patient portal, or to download the software from an application store to a smartphone or a similar device. For distant site providers, ACOs consider whether the software can be integrated with the EHR and whether it is compatible with any peripheral devices on the beneficiary side of the visit.

With respect to hardware, ACOs supply technology to the distant sites and to the clinical originating sites, including dedicated devices such as high-quality cameras, microphones, and headsets to distant site providers who may not otherwise have the technology to conduct the visits. They may also invest in peripheral devices to help the distant site provider examine the beneficiary remotely as opposed to simply talking to the beneficiary via video. In addition,

ACO Snapshot 1: Using Virtual Visits to Increase Access to Care for Beneficiaries

Objective: Expand the capacity of a physician home visit program.

Tactic: Convert follow-up appointments to exam-enabled virtual visits.



Strategy: After finding that travel time and scheduling constraints limited the number of beneficiaries served, a Next Generation ACO sought to expand the capacity of a program in which physicians deliver services to beneficiaries in their homes by revising program operationsto include telehealth. Following the program redesign, physicians continue to travel to beneficiaries' homes for an initial visit and then conduct subsequent visits virtually by using a web-based platform with portable examination devices operated by tele-presenters. Tele-presenters are typically home health aides or community health workers who travel to beneficiaries' homes to facilitate the visits and conduct on-site exams while the physician joins the session virtually via a desktop or laptop. Tele-presenters bring all necessary equipment to the beneficiary's home, including tablets, mobile hotspots to connect to the internet in case of poor connectivity, and instruments for conducting remote exams such as stethoscopes, blood pressure cuffs, pulse oximeters, and digital scales. The equipment transmits the vitals and video feed to the physician in real time.

Before conducting the virtual visits, physicians and tele-presenters are trained on the technology used to deliver the virtual visits and on the soft skills necessary to conduct these visits effectively. For example, the ACO stresses that the physicians' "web-side manner" is as critical as their bedside manner in terms of ensuring that patients feel comfortable during the visit and confident in the care they receive. The tele-presenters' training also includes hands-on opportunities to practice setting up the technology, troubleshooting issues, and facilitating the visits.

ACOs that serve beneficiaries in the home may send them hotspot devices to ensure sufficient internet connectivity.

Engaging providers as key stakeholders

ACOs encourage providers to become involved in telehealth initiatives by giving them an opportunity to participate in the care transformation process. For instance, ACOs look to practice groups and individual providers for input to inform the development, and ultimately the implementation, of new workflows for delivering telehealth services. Additionally, many ACOs look to providers to explain the value of telehealth to beneficiaries and to describe the program.

Many ACOs engage providers by inviting them to presentations that describe how telehealth improves the beneficiaries' care experience. The audience for the presentations includes practice representatives, specialty practice leaders, and sometimes the providers themselves. The presentations cover the advantages of delivering services through telehealth, the objectives of the program, and reimbursement available under fee-for-service Medicare. One ACO found that these presentations were an effective strategy for identifying clinics and providers who were enthusiastic about the new initiative and interested in volunteering for the pilot test. Some ACOs also use these presentations to identify clinical, operational, or administrative staff willing to serve as champions. If these champions are engaged early in the outreach process, they can help provider groups adapt proposed telehealth workflows to their existing operations. This ensures that someone on the ground who is invested in the initiative's success can address questions and provide the ACO with feedback on adjusting the implementation strategy, if needed.

Rather than using presentations to focus on groups of providers, a few ACOs use data to target specific providers who would be promising candidates for the use of telehealth. One ACO leveraged established metrics to identify PCPs who treat beneficiaries fewer times over the course of the year than would be expected given their diagnosed conditions. When launching its telehealth initiative, the ACO contacted these providers to inquire about their interest and found that many were eager to use the new technology, as they served patients in rural areas who had to travel long distances to their appointments.

CONSIDERING AN OPERATIONAL STRATEGY

ACOs design telehealth operations that reflect the goals of the initiative and the unique features of the selected program design and provider groups. Although the specific elements of individual telehealth workflows vary, ACOs note that they laid the groundwork for successful virtual visits in similar ways. This process ensures that both sides of the visit—the beneficiary and the distant site provider—are prepared for and comfortable with the telehealth experience. Using process and outcome measures, ACOs can assess the scale and scope of the implementation of their telehealth initiatives and identify opportunities for refinement and expansion.

Identifying and engaging beneficiaries

ACOs' workflows often begin with identifying beneficiaries who would be comfortable receiving services through telehealth and engaging those beneficiaries to both explain the benefits of telehealth and schedule a virtual visit. ACOs note that identifying a sufficiently large volume of beneficiaries who are interested in telehealth is a critical element to financial feasibility for program launch and ongoing sustainability. To support busy providers with identifying promising candidates for telehealth visits, one ACO asks providers who already participate in its telehealth initiative to review clinic visits scheduled for the next month and flag any appointments that could be converted to telehealth visits. The ACO recommends that providers, particularly specialists, focus on follow-up visits and appointments that do not require a physical exam.

Having identified candidates for telehealth, providers then engage the beneficiaries in order to understand their preferences for care delivery, assess their comfort with technology, and answer their questions about the change in the service delivery method. Providers can use the occasion of an in-person appointment to talk to beneficiaries about telehealth, building on their existing rapport. One ACO supports providers in these conversations by emphasizing the following three key talking points: (1) telehealth visits maintain confidentiality, (2) telehealth makes it more convenient for the beneficiary to receive safe and effective care, and (3) telehealth gives beneficiaries more timely access to their providers than in-person visits. ACOs also provide beneficiaries with written materials, videos, or other online resources to walk beneficiaries through the benefits and logistics of telehealth visits. If a beneficiary responds positively to these efforts, staff at the provider's office work with the beneficiary to schedule a telehealth visit.

Preparing to use technology to conduct video visits

Beneficiaries often need support to use technology for telehealth services, but the type of support depends on the

selected technology. If a beneficiary receives telehealth at home and via his or her own device, the ACO may reach out to the beneficiary before the appointment to make sure that he or she is prepared for the visit. For example, one ACO has a telehealth patient coordinator who calls beneficiaries to help them download the necessary software and to conduct a test call. Another ACO has medical assistants or other staff call patients immediately before the visit to prepare them for the visit and to conduct any initial workup requested by the provider.

At the start of the telehealth appointment, the provider logs into the telehealth platform to meet with the beneficiary. The process may be more complicated for telehealth initiatives that rely on dedicated devices such as remote stethoscopes, blood pressure cuffs, pulse oximeters, and digital scales. If these devices are involved, home health aides or community health workers travel to the beneficiary's home to set them up, take vitals, and launch the visit. In addition, the ACO's workflow would include steps to track the location of devices and to ensure they are charged and ready to use.

Supporting providers to conduct telehealth visits

Given the challenges involved in making effective use of new technology, many ACOs find that providers appreciate dedicated training to support the shift from delivering services in person to delivering them virtually. This training covers not only the technology but also the soft skills necessary for a successful telehealth visit. With respect to the technology, ACOs deliver trainings and conduct practice sessions to make sure that both the distant site providers and the staff on the beneficiary side of the visit can use the technology well enough for the distant site provider to deliver services and conduct exams remotely. With respect to soft skills, ACOs understand that providers may be able to show empathy, listen to beneficiaries, and explain clinical concepts in person, but they may struggle to do so via video. The training in soft skills therefore focuses on helping providers to develop a rapport with their beneficiaries through a video screen. This may involve coaching on small details that providers might not otherwise consider, such as whether pictures or other visible objects behind them on the video screen may be distracting for beneficiaries.

To deliver this training on both technology and soft skills, some ACOs have dedicated trainers who travel to clinical sites and work with providers individually, in small groups, or during staff meetings. Some ACOs have used chairside trainings and mock visits to give providers a chance to both experience delivering care through telehealth and to receive feedback before working with beneficiaries. ACOs may also create their own on-demand online learning modules or tip sheets with screenshots and step-by-step instructions. ACOs that have large telehealth initiatives may develop customized training materials for a range of specialties.

Assessing telehealth implementation and impact

ACOs have identified several metrics to track the reach of their telehealth programs, the financial benefits to the organization, and the convenience for beneficiaries. Examples of metrics used by ACOs include:

- Number of virtual visits
- Number of specialties and/or provider groups that deliver telehealth services
- Number of distant and originating site providers involved in telehealth services
- Revenue associated with telehealth
- Number of travel miles saved by beneficiaries and providers
- Beneficiary satisfaction with their visit(s)

ACOs also leverage data from beneficiary charts to assess their telehealth efforts. For example, one ACO performs chart reviews for providers in the early phases of a telehealth initiative in order to ensure that the documentation for telehealth visits is comparable to in-person visits.

Strategies for Transforming Care Through Telehealth

- Design key features of the telehealth initiative—including the services offered, the originating site, and the technology for conducting the visit—according to the needs of targeted beneficiary populations and identified gaps in care.
- Engage relevant practice groups and individual providers to obtain buy-in for the initiative before launching.
- Measure initiative progress by capturing metrics that track the spread of telehealth, the financial benefits to the ACO, and the convenience for beneficiaries.

Supporting High-Risk Beneficiaries with Home Visits

ACOs use home visits to improve health outcomes and the care experience for beneficiaries who are high risk or whose mobility is impaired. These visits make care more convenient for beneficiaries by minimizing travel and other logistical barriers. Home visits also increase the breadth and depth of information available to the care team. By seeing beneficiaries in their home environment, the home visit team gains a much richer perspective of each individual's circumstances, insights that the team can feed back to the broader group of providers who care for the beneficiary to ensure that the appropriate mix of supports and services is delivered. In turn, home visit programs may provide corollary benefits for ACOs in terms of their performance on financial and quality measures.

> "We implemented the home visit program because we anticipated improvements in transitions from the acute and post-acute care setting for those patients going home. We wanted to reduce ED utilization and rehospitalizations which would in turn lower cost and improve the patient experience."
>
> —ACO administrator

DESIGNING HOME VISITS

ACOs design home visit programs with a diverse set of objectives in mind, but all these programs seek to provide more convenient and comprehensive care for high-risk, high-need beneficiaries. Some ACOs see home visits as a substitute for office- or facility-based care, particularly for beneficiaries with mobility impairments. In these cases, home visits may serve beneficiaries who are homebound in a way that parallels traditional home health but with more flexibility. In other cases, home visits supplement in-person clinical care with insight that can only be gleaned in the home. Some ACOs look to home visits to support a beneficiary's transition to the home and to clinical care in outpatient settings following a recent discharge from a facility stay. For example, ACOs may design a program to focus on follow-up care after a particular surgical procedure (such as joint replacement) or to support beneficiaries in managing a particularly challenging chronic condition (such as acute heart failure). Other programs offer visits on an as-needed basis for beneficiaries identified as high risk, such as individuals with multiple comorbidities, a high volume of urgent care or ED visits, or challenging psychosocial circumstances.

Some ACOs have had the opportunity to leverage Medicare policies built into their models, which may provide a reimbursement mechanism. Under the Next Generation ACO model, the Post-Discharge Home Visit (PDHV) and Care Management Home Visit (CMHV) waivers offer novel reimbursement mechanisms that allow for "incident to" billing under general (rather than direct) supervision of a Next Generation Participant or Preferred Provider.[8] Alternatively, some ACOs opt not to seek reimbursement for each home visit, looking instead for support from foundations through grants in order to defray the costs associated with launching or operating a program. Other ACOs provide home visits as a strategy for improving patient care, without seeking reimbursement or other external funding.

DEVELOPING THE FOUNDATIONAL ELEMENTS FOR IMPLEMENTATION

ACOs that operate home visit initiatives stress the need to carefully consider foundational decisions about program structure and staffing before launching the program. They emphasize the need for collaborative design that draws on expertise across clinical and administrative domains. Before launching a program, ACOs must identify and engage stakeholders, select a starting point, and craft a staffing plan. ACOs also note the value of designing an implementation strategy that allows for iterative testing to refine and, later, to grow the initiative.

For one ACO's approach to implementing a home visit program, see the case study on UnityPoint ACO: https://innovation.cms.gov/files/x/aco-casestudy-unitypoint.pdf.

[8] For more information on the PDHV and CMHV waivers for Next Generation ACOs, see https://innovation.cms.gov/files/x/nextgenaco-pd-caremgmt-homevisit-waivers.pdf. Accessed August 5, 2020.

Identifying and engaging stakeholders

ACOs identify and engage a diverse set of stakeholders in data-supported discussions during initial design stages of the initiative to ensure that the workflow is realistic, that it includes appropriate support tools, and that it is adequately funded and staffed. ACOs identify the following stakeholders as examples of representatives who are critical to program design:

- Executive-level ACO leadership, to champion the initiative and to provide centralized funds and resources
- Inpatient leadership at relevant acute care facilities, to champion the initiative and to support dedicated staff time to inform workflow design and beneficiary identification efforts
- Inpatient staff at relevant acute care facilities, including case management and discharge planning staff, to support workflow design and beneficiary identification efforts
- PCPs, to support workflow design with respect to communication and collaboration among providers
- Post-acute care providers, to support beneficiary identification efforts and workflow design with respect to communication and collaboration among providers
- Visiting nurse associations or home health agencies, to support partnership design for staff resources (if relevant)
- Billing and compliance staff, to support reimbursement strategy and policy design

When engaging stakeholders, many ACOs point to a business case argument for the home visit initiative. Such business cases consider potential improvements to the beneficiary's care experience and their health outcomes, as well as the anticipated direct and indirect costs associated with implementation and operations. The business case may project the number of beneficiaries who would elect to participate in the initiative. It may also consider increases in revenue associated with reimbursement for the home visits, if applicable, and anticipated reductions in inpatient, urgent care, or ED utilization as a result of the initiative. One ACO created a methodology to customize its business case calculations for each practice that it approached about participating in the initiative.

Although business case arguments based on clinical and financial data are powerful communication tools, ACOs note that success stories from actual beneficiary experiences and outcomes are equally meaningful. ACOs generally pair business cases with these real-life stories when meeting with potential stakeholders to generate interest in participating in home visit initiatives.

Selecting the starting place

ACOs start small in order to pressure-test home visit initiatives, focusing on the feasibility of initiative workflows and tools, and on the estimated impact of the program on the health and care experience of targeted beneficiary groups. This insight enables the ACO to both refine the initiative and determine when and how to expand operations. This stepwise approach to piloting the program lowers the financial risk to the ACO and provides proof of concept, which increases engagement among current and future stakeholders.

When selecting a starting place, ACOs generally begin with specific beneficiary populations, as defined by clinical characteristics or patterns of utilization. Some ACOs prioritize beneficiaries for ad hoc home visits based on chronic conditions, including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and/or diabetes. A smaller number of ACOs have designed programs consisting of a pre-defined series of visits to serve groups of beneficiaries based on their specific clinical needs, such as those recovering from joint replacement or other surgeries, or those with individual chronic conditions. One ACO designed a series of home visits specifically for beneficiaries with CHF (for more information, see ACO Snapshot 2 on the next page). Other ACOs focus on the complexity of beneficiaries' health care needs by considering ED or inpatient utilization patterns, gaps in care, and psychosocial needs. This approach, however, may identify a larger number of beneficiaries who would benefit from home visits than the ACO can accommodate, particularly given resource limitations during the pilot phase. To target more specific groups of beneficiaries, some ACOs leverage claims-based algorithms to determine beneficiaries' risk of readmission.

To promote buy-in and grow momentum, ACOs pilot their home visit programs with selected practices or individual providers. These early participants supply feedback on the feasibility of program operations while serving as referral sources for the program. Ultimately, these providers may also serve as champions for home visits during broader initiative roll-out.

> We implemented the home visit program because we anticipated improvements in transitions from the acute and post-acute care setting for those patients going home. We wanted to reduce ED utilization and rehospitalizations which would in turn lower cost and improve the patient experience.
>
> —ACO administrator

Designing the staffing model

ACOs generally create dedicated home visit teams not only to allow for the development of the specialized skill sets necessary to conduct home visits but also to ensure protected time to visit homes throughout the community. ACOs' approaches to identifying staff for those teams vary considerably. Some ACOs use existing staff employed by provider practices to conduct visits for beneficiaries treated by those providers. Other ACOs hire or reassign staff to form a specialized ACO-wide home visit team or a team at the regional level. ACOs have also considered partnering with home health agencies or regional ambulance services to staff their home visit programs. These ACOs note that such partnerships involve reimbursement negotiations that require considerable attention; they also require clearly defined processes that distinguish the ACO's home visits from pre-existing agency services.

ACOs often look to registered nurses to conduct home visits, though others select nurse practitioners or physician assistants. ACOs may also deploy social workers for visits to conduct assessments and address care needs related to social determinants of health (SDOH). A few ACOs rely on community paramedics with support from supervisory clinicians and in accordance with state regulations. ACOs generally do not use physicians to conduct home visits, due to the high cost of this staffing model.

CONSIDERING AN OPERATIONAL STRATEGY

ACOs design home visit operations to address the needs and goals of the program within the context of existing ACO services and infrastructure. By defining the home visit workflow, ACOs proactively identify potential concerns and associated solutions while supporting consistent implementation of home visits across teams, practices, and beneficiary groups. Although the specific elements of operational strategies vary, ACOs highlight consistent areas of focus. Key focus areas include the importance of

ACO Snapshot 2: Delivering Home Visits to Support High-Risk Beneficiaries with CHF

Objective: Reduce avoidable readmissions and ED use by improving beneficiaries' self-management skills.

Tactic: Deliver a series of home visits that provides education on CHF and addresses SDOH.

Strategy: A Next Generation ACO provides a CHF "bootcamp" that offers comprehensive, integrated support to beneficiaries and their caregivers in their homes. The bootcamp consolidates the ACO's existing condition-specific educational materials into a structured, four-week series of home visits. Building on previous experience, the program leaders worked closely with the ACO's home health department to develop home visit policies and procedures. Noting the high rates of SDOH-related needs in this beneficiary population, the ACO staffed the initiative with social workers and community health workers who had experience engaging beneficiaries in self-management skills.

Each beneficiary's series of home visits begins with an SDOH assessment in his or her home, which informs the structure and content of the home visit series. During the remaining visits, home visit staff review items in the beneficiary's pantry and his or her dietary needs, working with the beneficiary to develop grocery lists. Throughout the visit series, the bootcamp team assesses beneficiaries to determine their need for additional support and connects them to community resources accordingly. Beneficiaries have provided positive feedback on the program, noting their appreciation for the personal touch of the visits. Given the success of this pilot program, the ACO intends to launch a similar program for beneficiaries with COPD.

identifying and engaging beneficiaries in the home visit initiative, specifying the care and services provided in each visit, and standardizing an approach to communicating and coordinating with the beneficiary's broader care team. By collecting data on process and outcome measures, ACOs can further refine and improve operations and assess the initiative's impact.

Identifying and engaging beneficiaries

ACOs use a combination of provider expertise and electronic tools to identify and prioritize beneficiaries who would benefit from a home visit. Some ACOs depend on referrals from providers in the community or care team huddles in the inpatient setting to generate candidates for home visit programs. Other ACOs use automated processes to identify home visit candidates who recently had an ED visit or an inpatient stay by, for example, automating the aggregation of data from EHRs or admission, discharge, and transfer (ADT) feeds. A few ACOs expand their pool of potential beneficiaries by incorporating data from state-level health information exchanges into their identification processes. At least one ACO uses transition care coordinators and risk stratification algorithms to further prioritize high-need beneficiaries.

Having identified target beneficiaries, the ACO home visit staff engage them by describing the care delivery opportunity. For instance, staff may discuss the benefits of receiving care and services in the home, including access to specialized staff and the in-depth nature of the visits. Home visit staff use plain language talking points and written materials, including flyers, to convey the value of home visits to beneficiaries. To make beneficiaries more comfortable with having clinicians in their homes, these communications explicitly note the ongoing collaboration between the home visit team and beneficiaries' PCPs. Some ACOs allow trust in their initiatives to develop over time by scheduling multiple touch points between the home visit staff and beneficiaries before the visits.

Conducting the home visit

While in the home, home visit staff assess the beneficiary to better understand his or her clinical, environmental, and social needs. Home visits almost always include functional assessments, which collect information on an individual's health conditions and functional needs; environmental assessments, in turn, collect information on individuals' home environments to assess and mitigate safety risks.

Most ACOs' home visits incorporate social services assessments and caregiver/family support assessments, which address the extent of a beneficiary's social and caregiving supports in order to identify any ongoing needs. Some ACOs also include financial assessments in home visits. Home visit staff use the collective insights derived from these assessments to identify appropriate services and the types of care to be delivered in both the present and in future visits.

Almost all ACOs conduct medication reconciliation at every home visit, recognizing that high-risk beneficiaries often are prescribed multiple medications that may be contraindicated, and their treatment may have changed between visits. The majority of ACOs deliver beneficiary education during home visits, including a review of discharge instructions when applicable. ACOs may also incorporate caregiver education into their home visits when indicated.

In some cases, ACOs select a different staff member to conduct a given home visit based on the beneficiary's needs. For example, ACOs report that some beneficiaries receive skin and wound care during home visits, which may necessitate specialized expertise. Several ACOs make social workers available to beneficiaries to address health-related social needs, perhaps referring beneficiaries to community-based organizations for additional support. Some ACOs deploy respiratory, physical, or occupational therapists, as needed.

Communicating across teams

To ensure that insights from home visits are integrated into a beneficiary's care plan and ongoing services, ACOs stress the need for cross-team communication regarding home visit findings. This approach protects against the fragmentation or duplication of care. Many ACOs look to their EHRs to relay notes from the home visit team to primary care practices. One ACO's program incorporates collaborative care planning sessions, in which the home visit team and the beneficiary's PCP use insights from the home visits to jointly update the beneficiary's care plan. More broadly, ACOs support ongoing cross-team communication with recurring program-wide meetings, which can include home visit staff, care advisors, and relevant clinical leaders from acute care hospitals, post-acute care facilities, and community practices across the ACO. Such meetings provide a forum for celebrating positive beneficiary outcomes and program successes as well as an opportunity

to bring potential improvement opportunities or general program trends to the surface.

Measuring program effectiveness

ACOs track several metrics to assess the extent to which home visits are being used and to demonstrate the value of their initiatives. ACOs break these metrics into process and outcome categories.

Examples of process metrics:

- Number of beneficiaries identified as candidates for home visits
- Number of beneficiaries offered a home visit, and number of home visits accepted
- Assessments conducted during home visits
- Services provided during home visits

Examples of outcome metrics:

- Preventable ED use in beneficiaries who received a home visit
- 30-day readmission for beneficiaries who received a home visit
- Beneficiary satisfaction with their visit(s)

Several ACOs pull monitoring data from their EHR platforms to analyze patterns of care for beneficiaries who receive home visits. Other ACOs have measured beneficiary experience via patient satisfaction surveys.

Strategies for Supporting High-Risk Beneficiaries with Home Visits

- Engage a diverse set of ACO stakeholders in data-supported discussions during initial program design stages to ensure that the workflow is realistic, that the program includes appropriate support tools, and that it is adequately funded and staffed.
- Start small to pressure-test operational feasibility and the program's impact on targeted beneficiary groups before expanding operations.
- Leverage a combination of provider expertise and electronic tools to identify and prioritize beneficiaries who would benefit from a home visit.

Providing Beneficiaries with Timely Access to Skilled Nursing Care

In some value-based care initiatives, Medicare offers a waiver from the requirement that beneficiaries have a three-day inpatient stay before receiving coverage for SNF care. The waiver does not change or modify any other existing Medicare SNF coverage policies. This waiver is known as the SNF 3-Day Rule Waiver.[9] Once program rules for use of the waiver are met, Medicare Shared Savings Program and Next Generation ACOs look to this waiver to shorten inpatient stays or to avoid unnecessary hospitalizations before a SNF stay, which in turn may reduce the cost associated with inpatient care and improve the beneficiary care experience.

HIGHLIGHTS OF THE SNF 3-DAY RULE WAIVER

Through the SNF 3-Day Rule Waiver, CMS reimburses the cost of SNF care for ACO beneficiaries who are admitted to an eligible SNF after a one- or two-day inpatient stay, from a hospital outpatient department (such as an observation unit or ED), or from the community (such as a physician's office, urgent care facility, or the beneficiary's home). In order to be eligible for the waiver, CMS requires beneficiaries to meet certain criteria, some of which differ by model or program type. For ACOs in the Next Generation ACO Model, the beneficiary must be aligned to the ACO at the time of SNF admission or within the 90-day grace period.[10] For ACOs in the Medicare Shared Savings Program, the beneficiary must appear on an eligible Assignment List Report.[11] For all ACOs, the beneficiary must not reside in a long-term care facility (such as a nursing home or SNF) for custodial care at the time of the decision to admit them to a SNF. The beneficiary must also meet all other CMS criteria for SNF admission, including:

- Being medically stable
- Having confirmed diagnoses (e.g., does not have conditions that require further testing for a proper diagnosis)
- Not requiring inpatient hospital evaluation or treatment
- Having an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services

CMS also requires Next Generation ACOs to establish networks of preferred SNFs for waiver-related admissions and Medicare Shared Savings Program ACOs to provide a list of SNF affiliates with which the ACO will partner on waiver implementation. These SNFs must maintain a rating of three or more stars for 7 of the previous 12 months under the CMS Five-Star Nursing Home Quality Rating System.[12] ACOs are responsible for verifying SNFs' eligibility each year.

DEVELOPING THE FOUNDATIONAL ELEMENTS FOR IMPLEMENTATION

CMS requires that ACOs establish certain foundational elements of their waiver programs in order to comply with Medicare program rules for use of the waiver. Before implementing the SNF 3-Day Rule Waiver, ACOs carefully consider and develop these and other components of the program that they deem essential to launching and sustaining waiver operations. To do so, ACOs may initiate a small pilot to develop and refine processes, tools, and guidance documents before scaling and spreading waiver operations. As part of the pilot, ACOs may focus on identifying and coordinating with partnering SNFs, defining pilot parameters, and engaging providers as key stakeholders.

Identifying and coordinating with partnering SNFs

When identifying SNFs for their waiver networks, ACOs look for facilities with a record of delivering high quality care as well as an interest in partnering to implement the care transformation initiative. ACOs explain to SNFs that the partnership is a collaborative one that includes defining best practices for care transitions and developing tools to facilitate effective communication between hospitals, providers, and SNFs.

[9] Section 1861(i) of the Social Security Act (the Act) requires a three-day inpatient hospital stay prior to skilled nursing facility (SNF) admission. Section 1899(f) of the Act permits the Secretary to waive requirements as may be necessary to carry out the Medicare Shared Savings Program. Section 1115A of the Act also permits the Secretary to waive requirements for models tested by the CMS Innovation Center.

[10] For more information about the SNF 3-Day Rule Waiver for Next Generation ACOs, see https://innovation.cms.gov/files/x/pioneeraco-snfwaiver.pdf. Accessed August 5, 2020

[11] For more information about beneficiary eligibility for the SNF 3-Day Rule Waiver for Medicare Shared Savings Program ACOs that have selected preliminary prospective assignment with retrospective reconciliation or prospective assignment, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SNF-Waiver-Guidance.pdf.

[12] CMS. "Five-Star Quality Rating System." Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html. Accessed June 11, 2020.

More specifically, ACOs identify SNFs based on analyses of both internal and external data sources. The data sources include publicly available data (such as the CMS Five-Star Quality Rating System on Nursing Home Compare) and claims data, which ACOs use to evaluate performance metrics related to clinical quality (such as average length of SNF stay, hospital and ED use after SNF discharge, and overall post-acute care spending on beneficiaries who received care from the SNF). When developing their networks, ACOs also consider other factors related to SNFs, such as their proximity to ACO hospitals, their capacity to accept a potentially substantial volume of ACO-attributed beneficiaries, their staffing levels and the ability to address the specific care needs of beneficiaries, and their use of IT, such as interoperability with the ACO's EHR platforms. ACOs review these data annually to refine their networks.

SNFs have an incentive to partner with ACOs on waiver implementation and operations because it may give them an opportunity to treat more ACO-attributed beneficiaries that are appropriate for the waiver relative to facilities that are not in the waiver network. Many ACOs ask partnering SNFs to collaborate with them on specific continuous quality improvement efforts—such as participation in regular quality improvement meetings—to streamline processes, improve the beneficiary experience, and coordinate with beneficiaries' care team members in other settings. Many ACOs also expect SNFs to admit patients after hours to facilitate beneficiaries' access to appropriate post-acute care and to conduct additional clinical assessments soon after beneficiaries are admitted.

Piloting waiver operations

Most ACOs use a phased approach to waiver implementation and begin with a pilot test at a specific point of care (i.e., inpatient, ED, observation, or physician office), in a single geographic region, or with a specific patient population. Some ACOs base decisions about where to introduce the pilot program on their assessments of beneficiaries' health care needs (such as those who have had joint replacement surgery) or on a review of utilization patterns (such as hospitals and EDs with a high volume of SNF admissions). These pilot tests can help ACOs to direct the limited resources available during the pilot phase to beneficiaries who would benefit the most from the waiver while ensuring that the sample of beneficiaries is large enough to support analyses of waiver processes. Other ACOs decide where to introduce their pilot according to which locations have not only the staff to manage waiver admissions but also leaders who are willing to support waiver processes. Most ACOs therefore pilot the waiver in a hospital or an ED, given the volume of patients who would benefit from a SNF stay and the relative availability of staff who can manage waiver operations in these settings. A small pilot helps ACOs to test the feasibility of waiver operations, troubleshoot issues in order to refine waiver processes, and refine the business case to generate stakeholder support before expanding operations to scale.

After a successful pilot, ACOs leverage insight from their early experiences with the waiver to expand operations to additional regions, populations, and originating points of care in order to increase SNF waiver admissions. For example, one ACO piloted the waiver in a single geographic region, focusing primarily on admissions from the ED and after short inpatient stays. The ACO then built on the momentum of its pilot by expanding waiver operations to additional regions. The ACO later expanded further by including admissions from a community setting (see ACO Snapshot 3 on the next page for more information). Another ACO focused its pilot on beneficiaries who had short inpatient stays for joint replacement surgery before it expanded to other populations and originating points of care, such as the ED and physicians' offices.

Engaging providers

ACOs engage providers in waiver planning and implementation in recognition of their important role both in identifying beneficiaries appropriate for waiver-related admissions to SNFs and in facilitating the care transition. ACOs reach out to providers in multiple care settings—including inpatient, ED, and the community—to describe the waiver policy, communicate the value of the waiver for beneficiaries, and collaborate on defining processes for the initiative. Specifically, ACOs solicit providers' feedback on

For two ACOs' approaches to implementing the SNF 3-Day Rule Waiver, see the case studies on:

- Partners HealthCare ACO: https://innovation.cms.gov/files/x/aco-casestudy-partners.pdf.
- Southwestern Health Resources Accountable Care Network: https://innovation.cms.gov/files/x/aco-casestudy-swhealth.pdf.

ACO Snapshot 3: Using the SNF 3-Day Rule Waiver to Increase Timely Beneficiary Access to Skilled Nursing Care

Objective: Leverage effective processes and build on existing momentum when expanding operations of the SNF 3-Day Rule Waiver.

Tactic: Implement processes to identify beneficiaries appropriate for SNF admission from the community, specifically primary and specialty care sites.

Strategy: A Next Generation ACO began waiver operations by focusing on identifying beneficiaries for SNF admission from the ED and after short inpatient stays. Based on positive feedback from beneficiaries and early analyses indicating positive health and cost outcomes, the ACO began to expand the waiver to beneficiaries from primary or specialty care sites who needed skilled nursing care.

The ACO's care management team developed a process to encourage primary care and select specialty providers to identify beneficiaries who would benefit from the waiver. To ensure that the new process aligned with existing, validated waiver workflows, the care management team developed protocols and workflows relevant to the outpatient setting that leveraged established waiver processes. The team created training materials and tools to make it easier for primary and specialty care teams to identify beneficiaries who qualified for skilled nursing care during office visits. For teams that identified potential candidates for SNF admission, providers had a streamlined mechanism for contacting the ACO's care management team to verify beneficiary eligibility and initiate a transfer to a SNF.

To promote the community-based providers' understanding of the waiver, the ACO's provider engagement team developed a one-page handout that proactively addressed common questions about, for example, waiver eligibility criteria and appropriate use of the waiver; the handout also included information on an ACO point of contact. The provider engagement team also presented during monthly meetings with providers and spoke one on one with those who had additional questions about the waiver. During both the group meetings and the individual conversations, the team emphasized the anticipated positive impact of the waiver on cost, utilization, and the beneficiary care experience.

preliminary workflows, including steps for streamlining the confirmation of beneficiary eligibility for the waiver, as well as how to speak with beneficiaries and their caregivers about the waiver. ACOs also engage frontline staff, including discharge coordinators and care managers, who play an integral role in supporting beneficiaries through the care transition process.

ACOs note the challenge of capturing the attention of busy providers and engaging them as stakeholders in developing the waiver processes, particularly providers in the ED or in community settings. These providers might not be accustomed to the process for facilitating direct admission to SNFs or might not have considered a SNF as an option to meet a beneficiary's need for skilled nursing care. ACOs therefore host webinars, present at staff meetings, and develop written materials (such as brochures and newsletter articles) to describe the indications that a beneficiary might be appropriate for direct admission to a SNF under the waiver and to help providers secure a bed. For example, one ACO engaged ED providers by distributing pocket-sized laminated cards that both outline basic medical conditions treated in SNFs and provide contact information so that providers can ask the ACO questions about the waiver. Some ACOs feature the SNF perspective in their educational materials, such as videos that show SNF staff describing the care transition process and the services available to beneficiaries during a SNF stay.

ACOs emphasized the importance of frequent communication in continuing to educate providers about, and engaging them in, the waiver process. Ongoing education helps not only to ensure that providers and their staff follow established transition processes but also to promote more appropriate referrals, particularly for newly hired providers who are not familiar with the SNF referral process. Continual education also encourages communication between providers and ACOs, which produces feedback that ACOs use to support refinements to waiver processes and facilitates expansion efforts.

> You have to have ongoing communication and re-education with your referral sources, your hospitals, inpatient and ED [staff], your PCPs. It's just education and re-education.
>
> —ACO administrator

CONSIDERING AN OPERATIONAL STRATEGY

ACOs begin by defining a workflow to ensure that day-to-day waiver operations run smoothly. Workflow steps include identifying and engaging beneficiaries from various care settings, facilitating care transitions in order to admit beneficiaries to high quality SNFs, and identifying opportunities for continuous process improvement by measuring waiver implementation and impact.

Identifying beneficiaries

ACOs establish processes that help a diverse array of providers and staff to identify and admit beneficiaries appropriate for skilled nursing care. The timely transfer to a SNF depends, among other things, on quickly determining a beneficiary's eligibility for SNF care. This can be challenging since beneficiaries' current ACO attribution status must be confirmed and the suitability for SNF-level care without a three-day inpatient stay must be assessed. To meet this challenge, ACOs develop workflows and tools for various clinicians, nurse care managers, and other care team members in multiple care settings (i.e., inpatient, ED, and community) to ensure consistency in the identification process. For example, some ACOs use a checklist (either as a handout or embedded in the EHR) to provide guidance on each step of the identification process. Most ACOs document and share workflows with staff involved in waiver operations. These checklists and workflows outline the processes for identifying beneficiaries in different settings who would benefit from the waiver, verifying their alignment with the ACO, and sharing their health information with SNFs and other providers.

In addition, many ACOs have a centralized team that is available by telephone or email to verify eligibility and support providers from multiple care settings when they transfer patients to SNFs. At one ACO, discharge planners monitor a dedicated email address for waiver eligibility questions from referring providers and reply to confirm eligibility. Discharge planners include a reference tool that describes the Medicare SNF admission requirements and a list of the available SNFs in the region and their quality rating as part of their response.

Engaging beneficiaries

ACOs communicate with beneficiaries and their families about the waiver process to help beneficiaries make informed decisions about their care. Many ACOs produce handouts, brochures, or webpages with information about the waiver, including answers to common questions and, in some cases, a list of partnering SNFs. Providers and other frontline staff also use these resources when speaking with beneficiaries and their caregivers to help them select the SNF that best meets their needs and preferences.

With respect to helping beneficiaries make informed decisions when selecting a SNF, ACOs note all facilities in the local region and flag those that participate in the waiver network. The ACOs often also share quality data, such as ratings from Nursing Home Compare or composite measures that reflect claims analyses of length-of-stay data and hospital utilization rates. ACOs may also share analyses of changes in beneficiaries' physical functioning during the stay (for example, the ability to eat and manage personal hygiene) for each SNF or the results of feedback surveys that highlight the facilities most recommended by other beneficiaries. ACOs note that beneficiaries and caregivers value the data on quality but often also consider which facilities are closest to loved ones or to the hospital.

Facilitating care transitions and coordinating care in the SNF

To facilitate and streamline care transitions, many ACOs coordinate with SNFs in their waiver network to define expectations for the admission process based on their combined experience and their understanding of best practices. The partnership between ACOs, referring providers, and SNFs ensures that beneficiaries receive high quality care even without the typical three-day inpatient stay. The coordination between ACOs and SNFs includes practices such as a 'warm' hand-off between the referring provider and the SNF clinician, in which they meet to discuss the beneficiary's health condition and needs[13]; coordinating a care plan before, during, and after the SNF stay; and sharing discharge instructions with the patient's PCP after a SNF discharge.

[13] For more information, see the AHRQ "Warm Handoff: Intervention." Available at: https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html. Accessed September 29, 2020.

ACOs provide SNF staff with hands-on support for beneficiaries admitted under the waiver, beginning with transition to the facility and through discharge, both of which might occur after regular business hours or over a weekend. Discharge planners and ACO staff coordinate with each other to ensure that the beneficiary meets the waiver requirements and to verify bed availability at the SNF in a timely manner, which facilitates rapid turnover of ED and hospital beds for other patients. ACOs with centralized eligibility verification teams employ staff with extensive knowledge of waiver requirements and who have access to CMS ACO alignment verification systems to verify that the beneficiary meets waiver use requirements and guidelines. These staff also help to standardize waiver admission processes throughout the ACO to ensure that beneficiaries receive care in the most appropriate setting. ACO staff also help to manage beneficiaries' care while they are in the SNF and to arrange follow-up visits with their PCPs upon SNF discharge. One ACO described how its staff conducts "tele-rounding" with SNFs that have a high volume of waiver admissions: tele-rounding includes conference calls with the beneficiary's primary care team and SNF staff to discuss the beneficiary's emerging care plan. Another ACO embedded nurse practitioners in select SNFs to participate in the development of care plans for recently admitted patients, engage in preliminary discussions about discharge planning, and facilitate follow-up care with a PCP.

Measuring waiver implementation and impact

ACOs use multiple process and outcome metrics to monitor the use of the SNF 3-Day Rule Waiver, paying particular attention to the quality of care through the transition to and from the SNF. ACOs' outcome metrics often focus on utilization of health care services after admission to or discharge from the SNF. This approach facilitates analyses of the criteria used to identify beneficiaries for the waiver and the effectiveness of SNF care. Examples of commonly used process, care transition, and outcome metrics are listed below.

Process metrics

- Number of beneficiaries identified as appropriate for the waiver in each care setting
- Number of SNF admissions by type of care setting
- Number of SNF admissions by diagnosis group
- SNF length of stay by admission type

Care transition metrics

- Number of beneficiaries who received a warm hand-off during a SNF admission
- Number of beneficiaries who received a physical exam within 24 hours of a SNF admission
- Number of beneficiaries with a preliminary care plan in place within two days of a SNF admission
- Number of beneficiaries' PCPs who received discharge notes after a SNF stay

Outcome metrics

- ED visits within 7 and 30 days after SNF discharge
- Hospital admissions within 7 and 30 days after SNF discharge
- 30-day SNF readmissions after SNF discharge
- Beneficiary satisfaction with SNF stay

To facilitate continuous improvement efforts and to identify opportunities for process improvement, ACOs schedule regular meetings with SNF leadership and staff to review data and to collaborate on improving workflows and communication. During these meetings, ACOs provide feedback to SNFs about opportunities to refine processes and to share best practices across the waiver network. ACO leaders also use these data to identify strategic improvement opportunities and to support decisions about maintaining and expanding their waiver networks.

Strategies for Providing Beneficiaries With Timely Access to Skilled Nursing Care

- Initiate a small waiver pilot at a specific originating point of care (such as ED or inpatient), in a single geographic region, or with a specific beneficiary population (such as those who have had joint replacement surgery) to develop and refine waiver processes before scaling operations.
- Establish partnerships with SNFs to implement the waiver and support its operations by, for example, defining best practices for care transitions on nights and weekends and measuring implementation progress to identify opportunities for improvement.
- Coordinate with SNFs in the waiver network to facilitate care transitions from SNF admission and through discharge, including a warm hand-off, developing a care plan, and sharing discharge instructions with beneficiaries' PCPs.

This toolkit was prepared on behalf of CMS's Innovation Center by Nazihah Siddiqui, Sonya Streeter, Maggie Glos, Ethan Jacobs, Rumin Sarwar, and Candice Talkington of Mathematica under the Learning Systems for ACOs contract (HHSM-500-2014-00034I/ HHSM-500-T0006). Special thanks to Aleksandra Wec, Eugene Rich, Daryl Martin, and Brigitte Tran from Mathematica and to Karin Bleeg, Erin Carrillo, Hannah Markuson, Melissa Murphy, and Terri Postma from CMS. CMS released this toolkit in January 2021.

We are tremendously grateful to the many staff from ACOs who contributed their care transformation strategies through participation in CMS-sponsored learning events and offered feedback on the toolkit in focus groups, interviews, and via email. These ACOs included Accountable Care Coalition of Tennessee, Accountable Care Options, AdvantagePoint Health Alliance – Blue Ridge, Aledade, Allina Health, Atrius Health , Banner Health Network, Baptist Health Care Partners, Beacon Health, Bellin Health, Best Care Collaborative, CareMount Health Solutions, Carilion Clinic Medicare Shared Savings Company, CHESS NextGen, Covenant Accountable Care Organization, CoxHealth Accountable Care, Deaconess Care Integration, Fresenius Kidney Care, Health Leaders Medicare Accountable Care Organization, Healthy Communities Accountable Care Organization, Henry Ford Physician Accountable Care Organization, Indiana University Health, Integra Community Care Network, MemorialCare Regional Accountable Care Organization, MetroHealth Care Partners Accountable Care Organization, Mount Auburn Cambridge Independent Practice Association, Northwest Momentum Health Partners, OneCare Vermont, Park Nicollet Health Services, Partners HealthCare Accountable Care Organization, Pioneer Valley Accountable Care, ProHealth Solutions, Prospect Accountable Care Organization Northeast, Revere Health, Silver State Accountable Care Organization, St. Luke's Clinic Coordinated Care, Southwestern Health Resources Accountable Care Network, Triad HealthCare Network, Trinity Health Accountable Care Organization, UNC Senior Alliance, and UnityPoint Health.