Case STUDY

Southwestern Health Resources Accountable Care Network Three-Day Rule Waiver: Approach to Communication and Implementation

This case study describes the implementation strategy used by Southwestern Health Resources Accountable Care Network (SWHR ACN) for the skilled nursing facility (SNF) three-day rule waiver, a benefit enhancement for organizations in the Next Generation Accountable Care Organization (ACO) Model. SWHR ACN's approach focuses on establishing a high quality SNF network, engaging early with multiple stakeholders, developing waiver-implementation workflows, and embedding care managers in SNFs. With this strategy, the ACN has continued to increase waiver-related SNF admissions since initiating the program. SWHR's experience is informative for ACOs that seek to implement or optimize processes for using the SNF three-day rule waiver.

BACKGROUND ON THE THREE-DAY RULE WAIVER

The Centers for Medicare & Medicaid Services (CMS) provides both Next Generation and Medicare Shared Savings Program ACOs 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 SNF three-day rule waiver, ACOs can admit aligned patients that meet specific clinical criteria 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. The waiver gives ACOs a new tool for delivering timely and effective SNF care to a select population, though each ACO can implement the waiver in a way that matches its particular population and organizational structure.

BACKGROUND ON THE ACN

The University of Texas Southwestern Medical Center (UTSW) and Texas Health Resources partnered in 2015 to form Southwestern Health Resources, an integrated health care network, which commenced operations in 2016. As of May 2019, the network comprised 29 hospitals and more than 4,000 physicians serving more than 70,000 aligned beneficiaries throughout North Texas. SWHR participated in the Medicare Shared Savings Program from 2014 through 2016 and transitioned to the Next Generation ACO Model in 2017.

SWHR began focusing on SNF utilization after a 2015 internal claims analysis revealed that the ACN's cost of post-acute care was higher than national trends. The ACO explored strategies for improving post-acute utilization and selected the SNF three-day rule waiver as an approach to influencing the delivery of post-acute care for its beneficiaries. Cathy Bryan, Director of Utilization, worked with the existing Post-Acute Care (PAC) Team to lead the initial waiver implementation. The PAC Team included three clinical and non-clinical staff dedicated to managing the post-acute care transitions of SWHR's beneficiaries. In the fourth quarter 2018, Kimberly Taylor, Manager of Post-Acute Utilization, took the lead to scale SNF three-day rule waiver program into a broader post-acute care strategy under the guidance of Jeff Lewis, Senior Director of Operational Integration and Performance Improvement.

LAUNCHING THE WAIVER

SWHR began to plan for the waiver in early 2017, soon after joining the Next Generation ACO Model, and had its first waiver-related SNF admissions in August. The first step in strategic planning and in developing the waiver operations was to select high quality SNFs to establish a network through which hospital and ED providers could refer appropriate beneficiaries to skilled nursing care under the waiver. SWHR then engaged vital staff at the hospitals, EDs and SNFs who would be the most likely to identify and care for beneficiaries eligible for the waiver. Finally, the ACN defined the workflows for verifying beneficiary eligibility for the waiver, transitioning the beneficiary to the SNF, and collecting data for reporting required by CMS.

Selecting high quality SNFs

Early in its waiver implementation experience, SWHR recognized the importance of selecting high quality SNF partners to support the development of the waiver program. The ACO first looked to SNFs that maintain an overall star rating of three or higher (as noted in the CMS waiver requirements[2]) and then considered which SNFs might be interested in partnering on waiver implementation. In 2017, SWHR found that its beneficiaries were admitted to 381 SNFs over six months, far more facilities than the ACN would include in waiver operations. The abundance of SNFs throughout the area is primarily a result of the fact that Texas does not require SNFs to obtain a certificate of need when building new facilities.

SWHR developed an evaluation process to identify high-quality SNF partners by using a performance score based on the following factors: risk-adjusted length of stay, readmissions rate, and risk-adjusted overall post-acute care spending. For the performance score, SWHR also considered results from the CMS Five-Star Quality Rating System, a component of waiver implementation requirements. SWHR initially identified 40 SNFs with the highest performance score to participate in the three-day rule waiver, and 33 of them agreed to participate.

SWHR then focused on developing relationships with the 33 preferred SNFs by holding a series of meetings with administrators, directors of nursing, and admissions teams. During these meetings, Ms. Bryan described the SNF three-day rule waiver, outlined the role that SNF and hospital staff would play in supporting waiver operations, and defined data that SNFs would collect and submit to SWHR. She also explained highlights of the workflow, noting that hospital staff identifies beneficiaries who would benefit from the waiver and works with SWHR's PAC Team to confirm beneficiary eligibility before initiating a SNF admission. In its referral to a SNF, the hospital staff includes written verification of a beneficiary's eligibility for the waiver. During a beneficiary's stay, SNFs are responsible for documentation and data collection related to the care plan, timely physician admitting exam, and discharge planning.

Engaging hospital staff in waiver operations

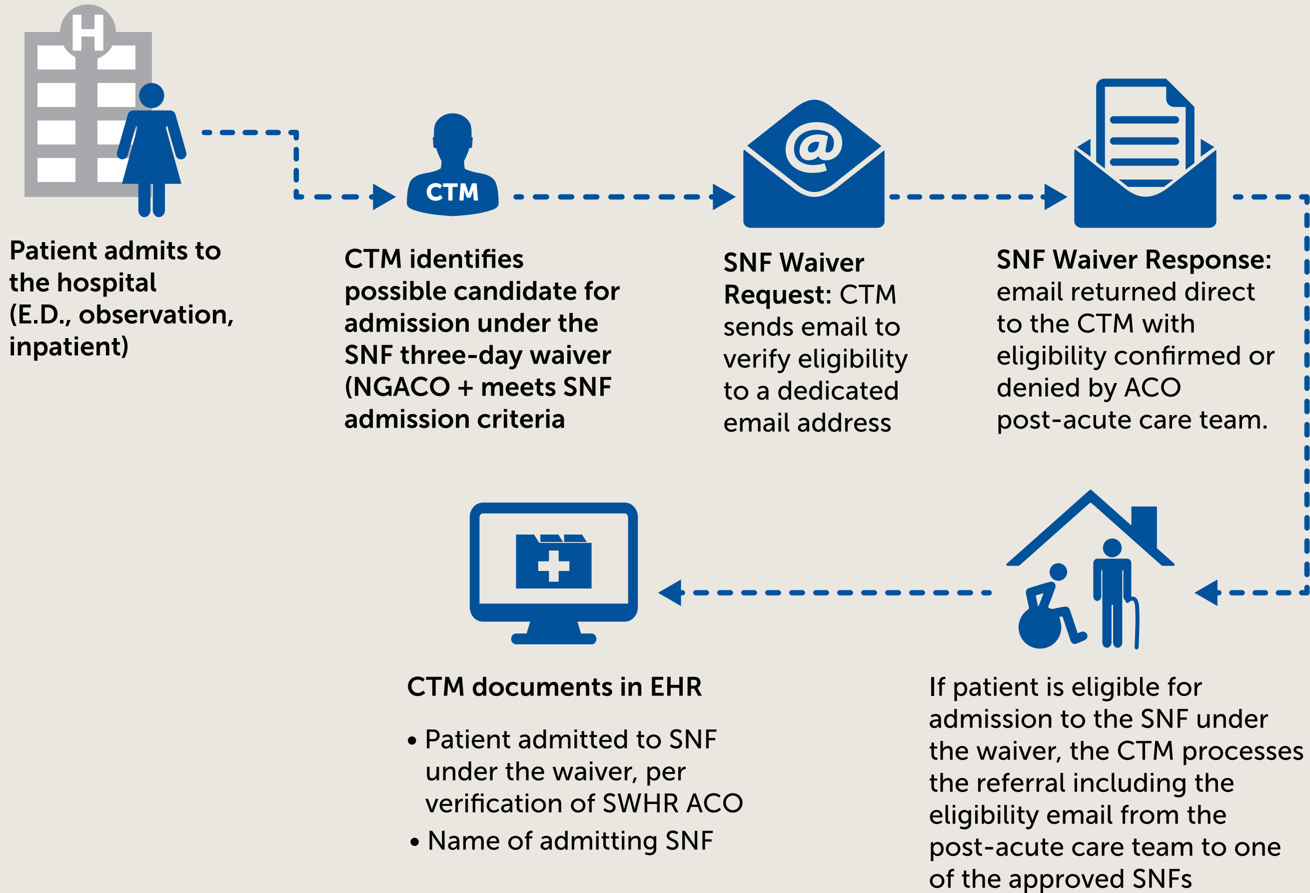
Establishing relationships with hospital staff who would engage in waiver processes was essential to sustaining the ongoing operations of the waiver. Starting with the largest hospitals in the SWHR network, Ms. Bryan met with inpatient and ED clinicians, as well as the care transition managers (CTM) who support discharge planning. As the SWHR representative, she explained the waiver guidelines and requirements, the process for verifying eligibility and expectations of the hospital staff with regard to identifying beneficiaries eligible for SNF-level care. These initial meetings served as an opportunity to present and refine a workflow for the waiver from the ED and inpatient settings. The meetings also allowed the SWHR representative to address questions from clinicians in the ED setting who tend to be unfamiliar with the level of care delivered by SNFs and with the characteristics of beneficiaries who would benefit from skilled nursing care.

Verifying beneficiary eligibility for the waiver

SWHR recognized the importance of documenting and broadly communicating a detailed workflow that shows how to identify beneficiaries who are appropriate and eligible for SNF admission under the waiver. The workflow that SWHR shared with hospital and SNF staff during the initial engagement meetings defines the end-to-end process, beginning when beneficiaries are in an ED, an inpatient setting, or an observation status and continuing through the full transition to the SNF.

As shown in Figure 1, the process begins when a clinician or a CTM identifies a beneficiary who might benefit from an admission to the SNF under the waiver. The CTM emails the ACN's PAC Team, which determines the beneficiary's eligibility for a waiver admission. The PAC Team provides written verification to the hospital staff with the beneficiary's eligibility status, as well as a complete list of SNFs participating in the waiver. The PAC Team is available to verify eligibility from 7:00 a.m. to 7:00 p.m., seven days a week, and generally confirms the

Figure 1
The end-to-end process for transitioning a beneficiary from a hospital to a SNF under the waiver



Source: Southwestern Health Resources Accountable Care Network

beneficiary's eligibility status within two hours. The CTM then processes the SNF referral by identifying a participating SNF with availability to accommodate the beneficiary, forwarding the eligibility verification email to the selected SNF, and notifying the beneficiary of the SNF admission under the waiver. The CTM is also responsible for ensuring the beneficiary has choice in selecting a SNF that is on the list to admit patients under the waiver and documenting the waiver admission in the beneficiary's EHR.

EXPANDING AND REFINING WAIVER OPERATIONS

In 2019, Ms. Taylor led the expansion of SWHR's existing care management program by embedding nursing staff within the SNFs to streamline the transition experience. SWHR continued its expansion of the waiver by engaging hospital staff and additional SNF facilities to increase the number of waiver admissions from the ED and inpatient settings; SWHR also began outreach to primary and urgent care clinicians in order to develop a waiver admission workflow from the community to a SNF.

Enhancing care management

SWHR hired nurse care managers to work within the SNFs participating in the waiver as a strategy for improving care transitions by enhancing communication between hospital, primary care, and SNF staff. It piloted this strategy in nine facilities in 2017. The embedded care managers focus on all SWHR ACN-aligned beneficiaries admitted to the SNF, serving as their advocate and supporting the discharge-planning processes to and from the SNF under the waiver. The care managers also assist with documenting the waiver-required data such as admission and discharge information, care-planning details, and timely exam after SNF admission.

> *"Care management is now an integral part of our program and success."*
>
> —Cathy Bryan, Southwest Health Resource ACN Director of Utilization Management

SWHR recognized the value in having embedded care management as a way to improve hospital and SNF communications and to facilitate care transitions from a hospital to a lower cost setting under the waiver. SWHR hired additional care managers, and by the first quarter of 2018, it had embedded care managers, including nurses and social workers, in more than 10 preferred SNFs.

Identifying community-based beneficiaries for the waiver

Approximately one year after launching the waiver, SWHR expanded its implementation efforts to primary care physicians (PCPs) who had identified beneficiaries who live at home and would benefit from skilled nursing care without first receiving care in an inpatient setting. SWHR began to engage with PCPs more proactively in 2018 by introducing them to the SNF three-day rule waiver. Initial conversations with the PCPs revealed that many were unfamiliar with the process of admitting beneficiaries directly to SNFs rather than to an inpatient setting with an eventual transition to SNFs. In response, SWHR provided the PCPs with an on-demand webinar recording that featured SNF clinicians describing the characteristics of beneficiaries who might benefit from skilled nursing care and the process of admission to a SNF.

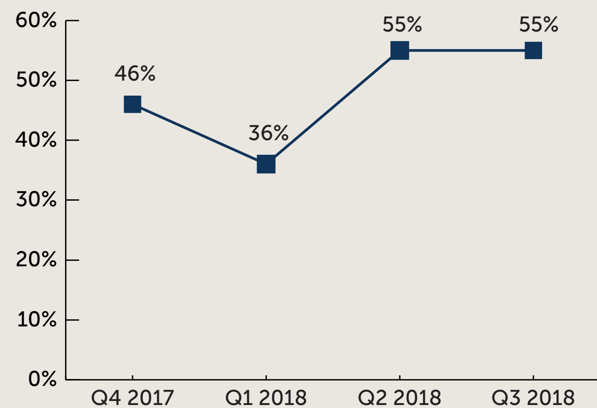
The webinar provided guidance to the process, but SWHR discovered that some PCPs and beneficiaries needed additional help with admitting beneficiaries to a SNF under the waiver from a community setting. For instance, PCPs with less experience admitting patients to non-acute settings might need more support from the SNF staff with the admission process. Additionally, beneficiaries transitioning to SNFs from their home often require additional clinical oversight after admission than do beneficiaries who already received testing and monitoring in an ED or an inpatient setting. To boost community-based waiver admissions, SWHR identified high-performing SNFs to collaborate with primary care and other community-based clinicians. SWHR selected these high-performing SNFs based on factors such as a low turnover rate, staff who have advanced skills such as respiratory therapy, and a demonstrated pattern of timely communication to hospital and community-based clinicians with respect to patient care.

RESULTS OF WAIVER USE

SWHR continually analyzes its waiver use and impact by using claims and data collected by the PAC Team, by the hospital-based care management teams, and by the embedded care managers. This comprehensive, real-time data collection includes information about care-delivery decisions, such as the CTM's confirmation of a beneficiary's waiver eligibility status, whether the request resulted in an actual SNF admission, which SNF admitted the beneficiary, the origin of the waiver admission (i.e., hospital, ED, or community), the SNF's care plan, and discharge details from the SNF.

Over time, SWHR observed an increase in the percentage of requests to confirm waiver eligibility that resulted in a SNF admission. In the fourth quarter of 2017, the PAC Team received 35 requests to verify waiver eligibility, and 16 of those requests (46 percent) resulted in a SNF admission. By the third quarter of 2018, the number increased to 64 requests, with 35 (55 percent) resulting in a SNF admission (Figure 2).

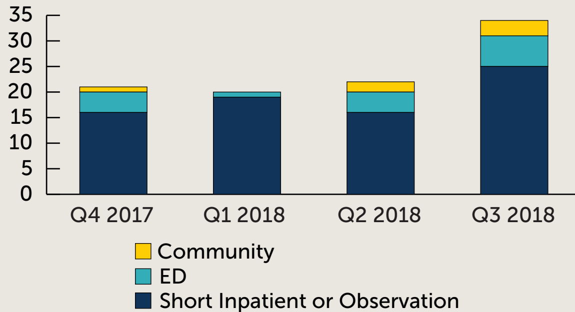
Figure 2
Percent of eligibility requests that resulted in a SNF admission under the waiver



Source: Southwestern Health Resources Accountable Care Network

SWHR's number of waiver-related admissions to a SNF has grown steadily since first implementing the waiver in 2017. The total number of admissions increased from 21 in the fourth quarter of 2017 to 34 the third quarter of 2018, a 60 percent growth rate. Admissions originating from either a short inpatient stay (two inpatient days or fewer) or an observation status, which account for most admission types (Figure 3), increased by 56 percent (Figure 3) in the same measurement period. SWHR noted that use of the waiver continued to grow in the first quarter of 2019, which led them to conclude that initiatives such as the SNF waiver require time for socialization and adoption among hospital discharge planning teams and providers.

Figure 3
Southwestern Health Resources Accountable Care Network SNF waiver admissions, by type



Source: Southwestern Health Resources Accountable Care Network

LESSONS LEARNED

SWHR adopted a phased approach to waiver implementation, which began with a small-scale initiative to refine strategies and identify promising practices before expanding operations. To launch the waiver, SWHR focused on establishing a centralized waiver eligibility process for beneficiaries identified in a hospital setting before turning its attention to partnerships with SNF and hospital staff to build a workflow for the admission process. With a defined and robust admissions process in place, SWHR considered strategies for expanding waiver operations, including creating best practices for using the waiver and extending it to the community setting. As the number of waiver admissions increased, SWHR turned its attention to opportunities to support the SNF staff, including expanding the care management program. This effort involved hiring embedded care managers tasked with streamlining the care transition process within the SNFs. Mr. Lewis noted that the lessons learned have continued throughout the implementation experience and led to changes in processes and strategies, ultimately allowing more beneficiaries to receive better care.

SWHR emphasized the value of early and continued engagement of waiver partners throughout the implementation process. When launching the waiver, the ACN established collaborative relationships with frontline staff in the hospital and SNF settings in order to determine the process for identifying beneficiaries who would benefit from the waiver and to develop an effective workflow for the SNF admissions. By maintaining contact with these staff after the waiver become operational, SWHR was in a position not only to learn how turnover influenced workflows but also to identify a need for ongoing education about the waiver opportunity. SWHR maintains regular communication with hospital and SNF staff, providing updates about new waiver operations to ensure that new employees are aware of the three-day rule waiver, and identifies strategies for making waiver-related processes routine.

> *"Incorporating Lean principles and systems thinking has been essential to our design and deployment of this valuable program."*
>
> —Jeff Lewis, Southwest Health Resources Senior Director of Operational Integration and Performance Improvement

NEXT STEPS

SWHR found the SNF three-day rule waiver is an effective tool for streamlining the delivery of post-acute care and that it has the potential to reduce health care costs and improve the quality of care. In the future, SWHR will set its sights on increasing the number of SNF-waiver admissions from both hospital and community-based settings by keeping open lines of communication with waiver partners; it also intends to continue supporting SNFs that are caring for beneficiaries admitted under the waiver as it did, for example, by providing embedded care managers. To support this effort, SWHR plans to implement a population health platform to facilitate data aggregation and reporting and consider measures such as the average length of stay, the SNF readmission rate, and the cost of care. SWHR has recently added network engagement representatives including a lean Six Sigma specialist to the team, who are responsible for increasing accountability among its SNF partners with a balanced scorecard to review patterns of care more accurately across SNFs.

ENDNOTES

[1] Section 1861(i) of the Social Security Act (the Act) requires a 3-day inpatient hospital stay prior to skilled nursing facility (SNF) admission, which is often referred to as the SNF 3-day rule. 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.

[2] 42 CFR 425.612

About the ACO Learning Systems project
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