ACO Contracting Guide for SNFs

Part 1: Background on Guide and ACO Primer

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ACO/SNF MODEL AGREEMENT
ACO PARTICIPANTS

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PART I: BACKGROUND ON THE GUIDE AND ACO PRIMER

Uses of this Guide and the Model Agreement:

This background on the guide and ACO primer (Part I) accompanies a Model Agreement (Part III) that is intended to provide information for skilled nursing facilities (SNFs) about the issues to consider in contracting with a Medicare-qualified accountable care organization (ACO) as an ACO “participant” as this term is defined in the federal regulations that implement the federal law that created ACOs for the Medicare program. The federal law creating ACOs is the health care reform act known as the Affordable Care Act (ACA). Medicare-qualified ACOs are entitled to share savings derived from efficiently serving Medicare beneficiaries while enhancing the quality of care provided. Therefore, the program is called the Medicare Shared Savings Program (MSSP) and creates ACOs as the vehicle through which the savings—and losses in certain instances—are shared. Two additional programs are the Pioneer ACO, which was organized by the Center for Medicare and Medicaid Innovation (CMMI) to test out certain concepts about designing and operating ACOs, and the Next Generation ACO Model, CMMI’s newest model. The Pioneer ACO and Next Generation ACO Models are also described in this paper.

This guide also includes information about how a SNF might contract with an ACO as an “other entity” rather than as an “ACO Participant.” “Other entities” are required to agree to ACO rules but are not “ACO Participants” and as a result, their TINs are not submitted to the Centers for Medicare and Medicaid Services (CMS) by the ACO and they are not included for purposes of patient attribution, benchmarking, and quality reporting. Other entities may receive a share of the savings generated by the ACO. They do not have to be exclusive to one shared savings program. In other words, a SNF could have a contract as an “other entity” with both a traditional MSSP and a Pioneer ACO. And if the SNF is not a “provider” of the Pioneer ACO, it would not

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be subject to the reimbursement withholding that Pioneer ACO providers may become subject to in the third year of the Pioneer ACOs’ operations.

Medicare-Qualified versus Private Sector ACOs

The private sector is also developing ACOs through contracts with private payers that offer incentives if providers coordinate care and achieve quality metrics. These ACOs are subject to federal and state laws (e.g., insurance, antitrust, and licensing laws) but are not regulated directly by CMS under the MSSP. Therefore, they can vary considerably and are beyond the scope of this guide. However, some of the issues that arise in negotiating with Medicare-qualified ACOs would also arise in negotiations to participate in private sector ACOs. Further, as Pioneer ACOs are required to enter into outcome-based arrangements with private payers as well, it is likely that ACO-type arrangements with third-party payers will continue to proliferate.

ACO Participants versus Providers/Suppliers

The federal ACO regulations identify certain types of Medicare-enrolled providers that may form ACOs and other types of Medicare-enrolled providers that may participate in ACOs but not form ACOs. Both types of Medicare-enrolled providers are referred to as “ACO Participants.” ACO Participants must account for 75% of the ACO’s governing body and must have “meaningful participation” in the composition and control of the governing board. ACO Participants may share in Medicare savings but may also be required by the ACO to participate in Medicare losses for those ACOs who share in downside risk. SNFs are not eligible under the regulations to form an ACO on their own, but they may be ACO Participants. ACO Participants are typically involved at the time of formation and are referenced in the CMS application, but they may also be added after the ACO is formed.

Key ACO Terms

Please note: All definitions are found in 42 C.F.R. § 425.20 except where noted.

“ACO Participant” means an individual or group of ACO Provider(s)/Supplier(s), that is identified by a Medicare-enrolled taxpayer identification number (TIN), that alone or together with one or more ACO Participants comprises an ACO and is on the list of ACO Participants submitted to CMS.

“ACO Provider/Supplier” is Medicare-enrolled individual or entity that bills under a Medicare billing number that is assigned to an ACO Participant’s TIN. In other words, the ACO Provider/Supplier bills for items and services under a billing number assigned to an ACO Participant and is included on the list of ACO Provider/Suppliers submitted to CMS.

“ACO Professional” is a physician, physician assistant, nurse practitioner, or certified nurse specialist that is an ACO Provider/Supplier.

A SNF could either bill as an ACO Provider/Supplier under another ACO Participant’s TIN or could bill under its own TIN as an ACO Participant. SNFs may in turn have professionals who are enrolled in the Medicare program and bill under the SNF TIN;
these providers would have to agree to participate in the ACO as ACO Providers/Suppliers that bill under the ACO Participant SNF. If they do not agree to do that, the SNF could not join as a Participant. Please see Attachment A for a copy of CMS Guidance on Provider/Suppliers versus Participants.

“Eligible Providers” is a term applied to ACO Providers and professionals who comprise a Pioneer ACO and are analogous to ACO Participants. (See “Pioneer Accountable Care Organization Model, Request for Applications,” May 17, 2011, p. 19; http://innovation.cms.gov/files/x/Pioneer-ACO-Model-Request-for-Applications-document.pdf.)

“Next Generation Participant” means an individual or group of ACO Provider(s)/Supplier(s), that is identified by a Medicare-enrolled TIN, that has an agreement with a Next Generation ACO to participate in the Next Generation ACO model, report quality data through the ACO, and to comply with care improvement objectives and quality performance standards of the ACO. (See “Next Generation ACO Model, Request for Applications,” p. 33; https://innovation.cms.gov/Files/x/nextgenacorfa.pdf.)

“Preferred Provider” means an ACO-selected individual or group of providers who enters into an arrangement with a Next Generation ACO to provide high-quality care and care coordination for beneficiaries. Preferred Providers may provide beneficiary enhancements to Next Generation beneficiaries under the Next Generation ACO Model. (See “Next Generation ACO Model, Request for Applications,” p. 34; https://innovation.cms.gov/Files/x/nextgenacorfa.pdf.)

Other Relationships with ACOs

A SNF may decide not to formally affiliate with an ACO. A SNF could establish a relationship with a hospital or group of physicians that happen to be part of an ACO. The relationship could be based on shared programming and protocols that enhance the quality of patient transitions and care between the two providers, without the SNF committing to the data submission and other requirements of ACO participation. SNFs also may continue to treat and admit Medicare beneficiaries assigned to ACOs as they have done without their participation whether or not they participate in the ACO. This kind of relationship is beyond the scope of this document but in some instances may be a desirable alternative to contracting as an ACO Participant. New ACO requirements encourage real-time data and medical records sharing through technological integration between ACOs and providers.

Some of these alternative arrangements could position the SNF to become part of either a Medicare ACO if developed later or part of a private payer risk-bearing arrangement.

Example: a SNF could enter into an agreement with a hospital to follow clinical protocols to ease admission and reduce readmissions. The arrangement could include a closer working relationship between the SNF’s medical director or advance practice
clinical staff and attending physicians in transitioning patients and providing care in the SNF so that quality metrics that are particularly dependent on post-acute care are met. *In fact, CMS recently agreed to pay physicians for professional services that they render in coordinating the care of patients who have recently been discharged from a hospital or SNF by accepting new CPT codes that physicians can utilize to bill for these services.* Once the patient is a resident of the SNF, the use of clinical protocols developed jointly by the hospital and SNF can reduce readmissions. Of course, health care is heavily regulated and novel arrangements would have to be developed within the framework of health care integrity statutes.

About ACOs

This section of the guide describes features of ACOs that are important to understand in order to effectively negotiate with them. Many of these ACO elements also suggest lines of due diligence research in preparation for entering into negotiations with an ACO.

*Definition of ACOs—Who is the Party to the Agreement?*

The federal government has implemented regulations or guidance for three types of ACOs: MSSP, Pioneer, and Next Generation.

- Many of the requirements that apply to the MSSP ACOs apply to the Pioneer and Next Generation ACOs unless the Center for Medicare and Medicaid Innovation (CMMI) states otherwise in the Pioneer ACO Request for Applications (Pioneer RFA) or in the Next Generation ACO Request for Applications (NextGen RFA). There are important differences between the three programs particularly as it relates to reimbursement for providers. These differences are summarized below.

- All three ACOs must be housed in a legal entity capable of receiving and distributing shared savings from Medicare or repaying losses to CMS/CMMI.

The “Pioneer ACO,” was developed by CMMI after the proposed MSSP ACO rules were published. The Pioneer ACOs were designed to test new features of interest to CMMI that might later influence regulation of the MSSP ACOs. Key differences between the two are that the Pioneer ACO must include larger numbers of Medicare beneficiaries (15,000 versus 5,000) and, if successful, move to a population-based method of payment after the first two years of operation instead of the shared savings/loss model of the MSSP ACO. Moreover, Pioneer ACOs must adopt outcome-based care as a business model and secure third-party payer contracts that reflect outcome-based (risk) arrangements. ([www.innovations.cms.gov](http://www.innovations.cms.gov))

The “Next Generation ACO” is the newest model developed by CMMI. The Next Generation ACO Model was designed as an initiative for entities experienced in population health management. The model builds on the MSSP and Pioneer ACO
models and requires ACOs to assume greater financial risk with the added incentive of greater financial rewards. Next Generation ACOs must have at least 10,000 attributed beneficiaries with a lower 7,500 minimum for rural Next Generation ACOs. On January 21, 2016, twenty-one (21) Next Generation ACO Participants were announced and a second enrollment period has been announced for 2017 participation.

In April 2015, CMS announced that 404 ACOs were participating in the MSSP program and 19 were participating in the Pioneer ACO. Another 21 Next Generation ACOs were announced in January 2016. The MSSP ACOs now serve over 7.92 million Medicare beneficiaries.

Governance and Leadership of ACOs

The CMS MSSP regulations require that ACOs meet certain governance and leadership requirements to fulfill the three primary goals set out in the health care reform act for ACOs: better care for individuals; better health for populations; and lower growth in expenditures through continuous improvement. Some important points about governance and leadership:

- ACO Participants (as opposed to non-participants) must control 75% of the governing body, but this may be done in a number of ways.
- ACO Participants or their designated representatives must have meaningful participation in the composition and control of the ACO’s governing body.

To establish meaningful participation in control of the Board, the ACO Participants may elect a delegate who serves on the Board or each Participant may have a seat directly on the Board. A delegate approach means that all or a certain group of Participants (e.g., all post-acute providers) may vote for persons that will represent them as group. In the alternative, an ACO Participant may have the right to appoint a Board member directly. The method would be reflected in the ACO’s governing documents.

- The ACO’s governing body must also include a Medicare beneficiary and may include investors in the ACO who do not provide services such as managed care companies. (See Section 14 of the Template Agreement.)
- The Pioneer and Next Generation ACOs’ governing bodies must include both patient representatives and consumer advocates.
- The leadership requirements include the demonstration of a “meaningful commitment” from each ACO Participant and Provider/Supplier to the mission of the ACO. This commitment may be in the form of a “financial or human investment in the ongoing operations of the ACO such that the potential loss or recoupment of the investment is likely to motivate the ACO Participant and Provider/Supplier to achieve the ACO’s

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3 Governance requirements can be found in 42 C.F.R. § 106.

4 Pioneer RFA, p. 20; NextGen RFA p. 6.
mission…” The regulations also state that the commitment can be demonstrated by the ACO Participant’s or Provider/Supplier’s agreement to comply with ACO processes set out in the regulations (described below) and meeting the performance standards for each process. These requirements have to appear in some form in the contract with the ACO. (See Section 5 of the Template Agreement.)

Among the four mandatory processes in the MSSP regulations is one that requires the ACO to coordinate care across and among primary care physicians (PCPs), specialists, and acute and post-acute providers and suppliers.

- The other three specific processes included in the regulation are: (i) promotion of evidence-based medicine; (ii) promotion of patient engagement; and (iii) development of an infrastructure for its participants and providers to report on quality metrics.

- The processes for the promotion of evidence-based medicine include those that cover diagnoses “with significant potential for the ACO to achieve quality improvements.” An example of a diagnosis with significant potential for improvement is congestive heart failure. Patient engagement processes must address patient survey requirements and beneficiary representative requirements. The ACO is also charged with identifying the health needs of its populations and formulating a plan to address those needs.

Many of these quality requirements will seem familiar to SNF leadership as they are obligated now to regularly assess the health of their patients and extensively consult and inform them and their families about their health status and SNF services.

**Beneficiary Attribution**

- Medicare beneficiaries are not “assigned” to ACOs for the purpose of receiving their health care, so they are not and can not be required or financially incentivized to use a specific provider under the program.

- Medicare beneficiaries are completely free to choose their health care provider regardless of whether they are assigned or attributed to an ACO. ACOs are precluded from requiring referrals of beneficiaries to ACO Participants.

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5 42 C.F.R. § 425.108(d)(1)

6 42 C.F.R. § 425.112(b)(1-4)

7 42 C.F.R. § 425.112(b)
• Beneficiary Attribution:

○ Beneficiary attribution for the MSSP was changed in 2016. CMS first attributes beneficiaries to an ACO on a preliminary basis and adjusts the count quarterly. The attribution is based on the CMS determination of where the particular beneficiary receives a plurality of his or her primary care services from ACO Participants or Provider/Suppliers of an ACO. CMS first determines if the beneficiary received primary care services from a physician who is a PCP ACO Provider/Supplier (first in the most recent 12 months). If the beneficiary has received primary care services from a physician who is not a PCP (either inside or outside an ACO), CMS will determine what ACO Professional has provided the greatest volume of primary care services based on allowed charges as compared to ACO Professionals in another ACO or a physician, nurse practitioner, physician assistant or clinical nurse specialist not affiliated with an ACO. Effective as of January 2016, ACOs participating in Track III of the MSSP will have prospective beneficiary assignment done using the same principles as for the other two tracks.

○ While Pioneer ACO attribution uses similar principles for attributing beneficiaries (that is, what primary care professionals provided the most services), attribution is different from attribution of beneficiaries to an MSSP ACO because attribution for a Pioneer ACO may be retrospective or prospective.

○ For the Next Generation ACO Model, assignment is done prospectively. Additionally, beneficiaries have the opportunity to voluntarily choose to participate in the Next Generation ACO. Assignment is based on prior claims data for QEM services. The Next Generation ACO Model also includes a Beneficiary Coordinated Care Reward for will make direct payments to each Next Generation Beneficiary who receives at least a certain percentage of his or her Medicare services from the ACO’s Next Generation Participants and Preferred Providers.

Primary care services are defined by reference to specific HCPCS codes rather than by specific providers or settings, therefore primary care services may be provided in SNFs and these would count as long as they were delivered by an ACO Participant or

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8 42 C.F.R. § 425.402
9 Pioneer RFA, pp. 5-7.
10 Next Gen RFA, pp. 18-20.
11 See Next Generation ACO Model, Request for Applications, § (VI)(D).
Provider/Supplier. (These HCPCS codes include 99304-99340, skilled nursing facility evaluation and management codes.) Any TIN under which primary care services are billed (including a SNF if it bills primary care services), may only be an ACO Participant in one ACO because beneficiary assignment is based on that TIN. In no primary care services are billed under the TIN of a SNF, the SNF does not need to be exclusive to an MSSP ACO, even if it is an ACO Participant. The Final Rule clarified the primary care services definition to exclude certain services provided by designated specialists, regardless of the HCPCS code billed.

Payment to ACO/Achievement of Quality Measures

- ACO Participants and Provider/Suppliers are paid on a fee-for-service basis for services provided to Medicare beneficiaries attributed to the ACO. Under the MSSP ACO Model, CMS first establishes a cost benchmark. If an MSSP ACO has costs (i.e., Medicare charges) for a year that are less than the benchmark by more than a margin, called the Minimum Savings Rate (MSR), the ACO will be entitled to a share of savings depending on whether, and to what extent, the MSSP ACO has met the quality triggers and quality criteria. If all quality criteria are met, an MSSP ACO may receive up to 50% of the savings in the one-sided model (Track I); up to 60% under the two-sided model (Track II); or up to 75% in the three-sided model (Track III). If the ACO does not maintain its qualifications (e.g., serving at least 5,000) or does not meet any quality metrics, or does not generate cost savings that exceed the MSR it will not be eligible to receive shared savings. It may also be exposed to losses depending on which “Track” it has chosen. (See Attachment B for more information on ACO savings and losses calculations.)

- As of 2016, there are 34 quality measures utilized under the MSSP organized into four domains: two of these domains involve better care for individuals and two involve better health for populations. (See Attachment C for list of quality measures.)

Many of these measures are affected by post-acute care decisions. Quality measures for individuals include, for example, unnecessary readmissions for all conditions as well as the avoidance of unnecessary admissions for certain conditions, namely, congestive heart failure and chronic pulmonary disease. Another indicator that is particularly important for post-acute care includes medication reconciliation within 60 days of discharge. These are metrics that are most likely to be affected by the services provided by post-acute providers, including SNFs.

- Other individual measures will be captured by administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Quality measures for population health include: flu and pneumonia vaccines, various screenings, including for depression, breast cancer, colorectal, diabetes, high blood pressure, and smoking.

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Because of these measures, SNFs may be asked to participate in special protocols or use certain software programs such as INTERACT that address unnecessary admissions or readmissions. SNFs that participate in ACOs are required to submit certain data and will be asked to report more data that will vary from the data they are capturing now. See Section 8 of the Model Agreement.

**Compensation for Providers**

As indicated, ACO Participants and ACO Providers/Suppliers in the MSSP continue to bill Medicare as they have in the past. Savings or losses are calculated later by CMS and distributed or charged to the ACO. The ACO may in turn distribute the savings, if any, to the ACO Participants or contracted other entities as set forth in the Agreement with the ACO or it may reinvest the savings in the ACO itself.

The method for distributing shared savings, if applicable, should be covered in the ACO contract. ACO’s in Track II or Track III of the MSSP are also responsible to share in losses. Such losses might be imposed on ACO Participants as a method for ensuring that they have an incentive to meet certain goals. If the ACO proposes to impose losses (or other financial penalties) on ACO Participants, the method for doing so should be clearly specified in the ACO Agreement. (See Section 16 of the Template Agreement.)

Although providers also submit bills for Medicare beneficiaries to their intermediary for Pioneer ACOs, the reimbursement for Pioneer ACOs is very different over time from the reimbursement for MSSP ACOs. Pioneer ACOs are subject to receiving a portion of both savings and losses in the first two years but at a different rate than MSSP ACOs. However, in the third year, if they have been eligible to receive savings in the first two years, they would be paid through a population-based methodology. Pioneer ACOs are paid through a Core Arrangement although there are different options that could apply that vary the Core Arrangement. 12 Essentially, under one option under the Core Arrangement, CMS pays the Pioneer ACO a Per Beneficiary Per Month (PBPM) payment as partial reimbursement for their care. The other part of the reimbursement would be paid directly to Providers but at a reduced level: The ACO Providers would also bill Medicare for services provided to beneficiaries but would be paid 50% of the amount they would otherwise be entitled to be paid by Medicare. CMS would also pay the ACO up to 70% of the savings generated by the ACO in serving the Medicare beneficiaries. The ACO then pays the Pioneer ACO Providers some portion of the PBPM payment and savings received from CMS as it sees fit to accomplish its goals. Under the two other alternative arrangements that CMS adopted, the Pioneer ACO would receive a population-based payment for all of Part B services or for both Part A and Part B services. 13 Therefore, it is likely that the Pioneer ACO Providers would have a good portion of their potential reimbursement at risk under this model both for Medicare and under private pay contracts.

12 Pioneer ACOs are invited by CMMI to suggest other variations of compensation (Pioneer RFA, p. 8) so the actual details of a Pioneer ACOs payment arrangement may be different from the description here.

Under the Next Generation ACO Model, the benchmark is set prospectively. The Next Generation ACO Model offers four different payment mechanisms. The first two are just like the MSSP addressed above in which each Next Generation Participant and Preferred Provider will be paid by CMS on a FFS basis and savings or loss will be distributed directly to the ACO at the end of the performance year. In the third, the ACO will receive a population-based payment and Next Generation Participants and Preferred Providers will agree to accept a reduced fee for service payment for aligned beneficiaries from CMS. This is very similar to the Pioneer model. In the fourth, the ACO will accept all-inclusive population-based payments, and will be responsible for paying all Next Generation Participants and Preferred Providers at a negotiated rate.

The payment mechanism and the amount at risk, and the precise nature of the risk factors, should be clearly spelled out in the ACO contract.

Providers might perform different duties for the ACO then they have in the past that would contribute to the ACO’s attainment of its goals. These duties may be well above and beyond what SNFs are obligated to do to provide quality care in accordance with the regulations that govern the SNF. If these responsibilities are to advance the ACO’s mission, the parties may wish to explore compensation by the ACO to the SNF for these additional duties. The compensation may be payment for specific duties (e.g., use of the SNF medical director to provide oversight of additional data collection responsibilities) or it may be a combination of payment and other resources. An example of the latter might be the assignment of ACO staff to perform certain duties that are required by the ACO but not independently an obligation of the SNF, such as coordination of care between the two facilities according to protocols that are different from those ordinarily required of the SNF.

If a SNF is an ACO Participant or Provider/Supplier, it should consult with counsel to determine whether it is subject to regulation by the department of insurance in the state in which it operates as a risk-bearing entity.

SNFs must also have a good handle on their own cost data particularly if they are going to engage in any risk-based reimbursement. They have to be able to project how much they can put at risk in serving these beneficiaries and the likelihood that they will meet the key quality and cost metrics. See Section 16 of the Model Agreement that suggests different risk-bearing reimbursement methods for Pioneer ACOs.

Data Use and Disclosure for ACOs

The ACOs are obligated to collect certain information from their ACO Participants and ACO Provider/Suppliers and/or Preferred Providers as applicable in order to document whether they meet certain requirements imposed by the rules. (See also Sections 42 C.F.R. §§ 425.302 and 425.500 concerning required Data Submission by ACO Participants.)
SNFs that serve as ACO Participants will be required to provide extensive information about the Medicare beneficiaries in their care—they should understand exactly what the ACO will require them to report about beneficiaries and when. MSSP ACOs and ACO Participants will be required to submit data on the quality measures selected by CMS.

Beyond this generalization, each ACO may deal with the transfer of patient identifiable information differently. The ACO regulations emphasize the need to develop information infrastructure to achieve some of the more innovative aspects of patient care through an ACO, including coordination of care and evaluation of the effectiveness of care. The health information infrastructure created by an ACO will no doubt result in increased requirements for data sharing from a SNF to the ACO and back to the SNF from the ACO.

ACO Participants, ACO Providers/Suppliers and others performing functions related to ACO activities must agree to maintain and provide access to designated federal officials to the books, contracts, records, documents, and other evidence concerning the ACO performance for a period of not less than 10 years from the last day of the contract period or from the end of any audit (if later).

**About Waivers**

Several waivers of other federal laws were developed by federal agencies as required by the ACA pertaining to fraud and abuse, antitrust, and tax exemption. Of most importance to SNFs are the waivers that pertain to fraud and abuse laws: federal anti-kickback and Stark laws and the law imposing civil monetary penalties for reducing or limiting care to beneficiaries or providing inducements to beneficiaries.\(^\text{14}\) These waivers include very technical requirements that must be observed in order to enjoy the protection they provide to ACO Participants and ACO Providers/Suppliers. The waivers apply to the shared savings distributions made by an ACO to ACO Participants and ACO Providers/Suppliers and also protect ACO Participants and ACO Providers/Suppliers that offer certain preventive services to beneficiaries. The waivers also protect activities undertaken to reduce costs that might otherwise be viewed as limiting care to beneficiaries. An ACO must take affirmative steps to benefit from a waiver. It is very important for the SNFs contracting with ACOs as Participants to be aware of whether the ACO has taken the required steps to qualify for the protection under the waivers. If so, the Participants and Provider/Suppliers should be able to rely on this protection in certain dealings with the ACO.

**Next Generation ACO Programmatic Waivers and Beneficiary Enhancements**

To enhance access and increase participation in the Next Generation ACO, the Next Generation Model includes optional benefit enhancements that an ACO may choose to implement after acceptance into the program. The optional benefit enhancements include the 3-Day SNF Rule Waiver, the Telehealth Expansion, and Post-Discharge Home Visit. This guide describes the 3-Day SNF Rule Waiver in detail because of its relevance SNFs.\(^\text{15}\)

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\(^{15}\) NextGen RFA, pp. 20-22.
The 3-Day SNF Rule Waiver\(^{16}\): This benefit enhancement is a waiver of the three-day inpatient stay requirement prior to admission to (1) a qualifying SNF or (2) a qualifying acute-care hospital or CAH with swing-bed approval for SNF services.\(^{17}\) The purpose of the waiver is to allow beneficiaries to be admitted to qualifying SNFs either directly or with an inpatient stay of fewer than three days. In order to implement the waiver, an ACO must submit an implementation plan that:

- describes the ACO’s planned strategic use of the benefit enhancement;
- includes self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences; and
- documents authorization by the governing body to participate in the benefit enhancement.

When implementing the 3-Day SNF Rule Waiver, ACOs will also have to:

- identify which SNFs and swing-bed hospitals with which they will partner to exercise the waiver, and
- describe how the identified participants and preferred providers have adequate staff capacity and infrastructure to carry out the proposed coordination activities.

To be able to participate, a SNF must have a rating of three or more stars under the CMS 5-Star Quality Rating System as reported on the Medicare Nursing Home Compare website.

**Recent and Constant Updates**

ACO regulations are updated regularly to decrease administrative burdens while improving program quality. In August 2015, CMS finalized rules amending the MSSP program. Some of the amendments to the MSSP program were effective as of January 1, 2016, whereas others will be effective in 2017. In pertinent part, the Final Rule made the following changes to the MSSP program that will impact post-acute care providers:

- A new requirement in the eligibility requirements that requires an ACO to describe how it will encourage and promote technology use for care coordination such as real-time medical records and data access with post-acute care providers, and a provision to require an ACO applicant to describe how it intends to partner with long-term and post-acute care providers to improve care coordination. § 425.112(b)(4)(ii).

\(^{16}\) Note this waiver is also available to MSSP ACOs participating in Track III.

\(^{17}\) NextGen RFA, pp. 20-22.
New data reporting requirements that include utilization rates of Medicare services including detailed post-acute services data. The data could include the location and type of care. § 425.702 & 425.708

New requirements for agreements between an ACO and an ACO Participant or Provider/Supplier that will be effective in 2017. § 425.116:

- (1) the ACO may directly contract with each ACO Participant or Provider/Supplier rather than through an existing Independent Practice Association (IPA) or Physician-Hospital Organization (PHO);
- (2) the agreement must obligate all contracting providers to comply with MSSP regulatory requirements including the requirements of the ACO’s provider agreement with CMS and must include remedial measures for the provider and ACO for any non-compliance with MSSP regulatory requirements;
- (3) the agreement must be for a term of at least one performance year with articulated consequences for early termination from the ACO;
- (4) the agreement must include a close-out process after termination or expiration of the agreement that requires furnishing all data necessary to complete the ACO’s annual assessment.

Current Pitfalls in Contracting with ACOs

Unfortunately, the new regulations and waivers formulated by the federal agencies to enable development of ACOs did not address all of the issues that are faced by SNFs in participating in ACOs or even if entering into a preferred provider arrangement. This section outlines these issues.

- One issue for a hospital participant in an ACO is the requirement that it respect patient freedom of choice in the selection of post-acute care providers. Therefore, hospitals are required to provide information about available SNFs in the geographic area. The law does not permit the hospital to steer a patient or require that a patient be admitted to a specific SNF upon discharge from the hospital. Beneficiary choice must be honored.

- ACOs will have metrics that they are trying to achieve to control costs. Most ACOs will have to be very aggressive in cost reduction to realize savings. They and the professionals that staff them may have “cutting edge” or “stretch” goals that would be difficult or impossible for a SNF to meet because of the regulations imposed on SNFs which are different from short-term acute care hospitals. For example, residents can only be
discharged or transferred from a SNF for certain reasons and only after the SNF has completed a process to ensure that residents and their families are informed of the reason. These requirements may collide with the ACO goals aimed at cost reduction.

- A SNF should also be aware that a successful Pioneer ACO will move to population-based reimbursement in the third year of operation. This reimbursement method places potential additional risks on the health care providers who serve the Medicare Pioneer ACOs as Providers and also contract with the private payers with which the Pioneer ACO has outcome-based contracts.

- A SNF should be very alert to how achievement of goals and metrics will be rewarded and how failure to reach those goals and metrics are penalized—either financially or through termination of the contract. The contract should be clear about how the rewards and penalties are determined and whether the SNF Participant can review the data that these are based upon.