# OIG Study Highlights How High-Performing ACOs Controlled Costs and Improved Quality by Working Collaboratively with SNFs and HHAs

H. Carol Saul and Charmaine A. Mech

On July 19, 2019, the Office of Inspector General (OIG) noted seven successful strategies used by twenty high-performing Accountable Care Organizations (ACOs) to reduce spending and improve quality of care.[1] This study was a follow-up to an August 2017 OIG study, which estimated ACOs achieved a nearly one billion dollar net reduction in Medicare spending from 2013 to 2015.

As part of the transition to value-based care, the OIG recommended that as the Centers for Medicare & Medicaid Services (CMS) considers changes to the Shared Savings Program and other alternate payment models, CMS consider the following actions to better to support efforts to reduce unnecessary spending and improve patients' quality of care:

- Review the impact of programmatic changes on ACOs' ability to promote value-based care.
- Expand efforts to share information about strategies that reduce spending and improve quality among ACOs and more widely with the public.
- Adopt outcome-based measures and better align measures across programs.
- Assess and share information about ACOs' use of skilled nursing facilities (SNF) three-day rule waiver and apply these results when making changes to the Shared Saving Program or other programs.
- Identify and share information about strategies that integrate physical and behavioral health services and address social determinants of health.
- Identify and share information about strategies that encourage patients to share behavioral health data.
- Prioritize ACO referrals of potential fraud, waste, and abuse.

This article focuses on how ACOs controlled costs and improved quality by working collaboratively with SNFs and home health agencies (HHAs). It highlights the five strategies used by successful ACOs in working with SNFs and HHAs:

## Designating Certain SNFs and HHAs as Preferred Providers:

Many of the high-performing ACOs in the study identified certain SNFs and, less frequently HHAs, as preferred providers. While ACO hospitals must honor a patient's choice of post-acute provider, and are required by the Balanced Budget Act of 1997 to give their patients a list of all available SNFs and HHAs in the geographic area who request to be listed, nothing prohibits the recommendation of a preferred provider. The applicable law prohibits hospitals from specifying or limiting the choice of provider, but not from recommending one. In exchange ACOs may require preferred providers to meet additional requirements, including data sharing arrangements, such as notice of beneficiaries' admissions, discharges, and expected length of stay; participation in ACO meetings; and pledges to accept all ACOs' patients that select that provider.

## Embedding Staff in SNFs and HHAs to Monitor ACO Beneficiaries:

A number of ACOs also embedded their staff in preferred SNFs to more closely monitor beneficiaries. Successful examples included an ACO care manager who attended meetings about

1 The OIG defined "high-performing ACOs" as ACOs that had both a reduction in spending relative to their benchmark and an overall quality score of 90 or above during their second, third, or fourth performance year.

its beneficiaries, monitored the implementation of care, and advocated for treatment changes when necessary; an ACO which provided recommendations about when to discharge to SNFs that typically kept beneficiaries for the maximum Medicare payment period; and an ACO whose advanced clinical and geriatric nurses participated in clinical rounds to monitor beneficiaries' progress.

The participating ACOs noted less direct staff involvement with HHAs. However, certain ACOs fostered communication by including HHA representatives in ACO interdisciplinary meetings and designating ACO staff to help coordinate HHA visits and ensure durable medical equipment was ordered and delivered when needed.

### Conducting Warm Handoffs to Improve Care Transitions:

Involving ACO staff in transfers also helped improve care coordination by building relationships between care coordinators, providers, beneficiaries, and their families. Involving ACOs in transitions provides an opportunity to reconcile medication and clarify information, preventing errors. In addition, multiple ACOs ensured beneficiaries had an easier transition by ensuring they had transportation to appointments and medical equipment was delivered. ACOs also provided specific examples of effective "warm handoffs" including having ACO care managers establish relationships with beneficiaries prior to discharge from hospital, being responsible for handing off the beneficiaries to a post-acute facility, and monitoring the beneficiaries' care for thirty days after discharge.

### Enlisting Primary Care Physicians to More Closely Scrutinize Care Needs:

In addition, a number of successful ACOs used primary care physicians to more closely scrutinize their beneficiaries' need for skilled nursing and home healthcare. Many ACOs had primary care physicians review orders and care plans to eliminate unnecessary services. For example, ACOs asked physicians to consider whether home healthcare is an appropriate alternative to a SNF, because SNFs are generally more expensive than home health, or whether home health physical therapy services were necessary. Another ACO's physicians contributed to its beneficiaries' care plans and discharge goals.

### Using the SNF Three-Day Rule Waiver for Flexibility in Accessing Needed Care:

Six of the twenty high-performing ACOs analyzed in the OIG study were also eligible to use the SNF three-day rule waiver.[2] These ACOs reported that the waiver was helpful for beneficiaries that could not be safely discharged home but otherwise would not quality for a SNF stay. One such ACO also found the three-day rule waiver helped reduce emergency department spending, and found the waiver useful for beneficiaries who had a history of inappropriate emergency department visits.

Please click here to read the full report.

2 Generally, Medicare only covers SNF stays if a beneficiary has a prior inpatient hospital stay of three consecutive days within 30 days of the beneficiary's admission to the SNF. The SNF three-day rule waiver permits certain eligible beneficiaries to go directly to an approved SNF from their home, physician's office, or hospital when their stay is less than the generally required three days.

## Authors and Contributors

**H. Carol Saul**
Partner, Atlanta Office
404.873.8694
carol.saul@agg.com

**Charmaine A. Mech**
Associate, Atlanta Office
404.873.7018
charmaine.mech@agg.com

not *if*, but *how*.®

## About Arnall Golden Gregory LLP

Arnall Golden Gregory (AGG), an Am Law 200 law firm with 167 attorneys in **Atlanta** and **Washington, DC**, takes a "business sensibility" approach when advising clients. AGG provides industry knowledge, attention to detail, transparency and value to help businesses and individuals achieve their definition of success. AGG's transaction, litigation, regulatory and privacy counselors serve clients in healthcare, real estate, litigation matters, business transactions, fintech, global commerce, government investigations and logistics and transportation. AGG subscribes to the belief "not if, but how."
Visit us at www.agg.com.

**Atlanta Office**
171 17th Street, NW
Suite 2100
Atlanta, GA 30363

**Washington, DC Office**
1775 Pennsylvania Avenue, NW
Suite 1000
Washington, DC 20006

To subscribe to future alerts, insights and newsletters: **http://www.agg.com/subscribe/**