Considerations for Long-Term Care Providers Participating in Value-Based Care Models

White Paper Published by AHCA/NCAL and NAACOs

Executive Summary

Some of the most significant cost savings and care improvements realized by community-based accountable care organizations (ACO) and other episodic payment and delivery system reform models have been generated by intentional and targeted post-acute care partnerships. Despite this, long-term and post-acute care (LTPAC) providers have been challenged in their ability to meaningfully participate in the Center for Medicare and Medicaid Services' (CMS') value-based care models. Fewer than 2,000 Skilled Nursing Facilities (SNFs) participate in ACOs, representing less than 10 percent of SNFs nationwide. Further, SNF participation is concentrated in a small number of ACOs, particularly in the ACO Realizing Equity, Access, and Community Health (REACH) model. Fewer than 10 percent of ACOs account for nearly three-quarters of SNF participation.[1]

To find better ways to create meaningful participation options in ACOs for LTPAC providers, the American Health Care Association | National Center for Assisted Living (AHCA|NCAL) and National Association of ACOs (NAACOS) convened a roundtable of stakeholders, including long-term care representatives, ACO leaders, patient advocacy organizations, providers, and healthcare payers. Through a robust discussion, roundtable participants coalesced around a series of recommendations for CMS to improve existing value-based arrangements and develop future model concepts that would enable LTPAC providers to engage within broader accountable care arrangements more effectively.

Key recommendations resulting from the Roundtable discussions include:

Roundtable Participants

AMERICAN HEALTH CARE ASSOCIATION | NATIONAL CENTER FOR ASSISTED LIVING
NATIONAL ASSOCIATION OF ACOS
ADVION
AMERICA'S HEALTH INSURANCE PLANS
AMERICAN HOSPITAL ASSOCIATION
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION
ATI ADVISORY
BLOOM HEALTHCARE
CARDON & ASSOCIATES
CARECONNECTMD
FAMILIES USA
HEALTH CARE TRANSFORMATION TASK FORCE
KNG HEALTH CONSULTING
LEADING AGE
LONG-TERM CARE ACO
NATIONAL ASSOCIATION FOR HOME & HOSPICE CARE
NATIONAL HEALTH CARE ASSOCIATES
PREMIER
SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE
SPECIAL NEEDS PLAN (SNP) ALLIANCE
VILLAGE MD

Alignment/participation options for beneficiaries residing in long-term care facilities

- When examining visit history to determine plurality of care for purposes of attribution, CMS should remove the long-term care Nursing Facility (NF)[2] population from the Medicare Shared

[1] Institute for Accountable Care and NAACOS analysis of CMS data.

[2] SNF (short-stay) vs. NF (long-stay): SNF populations are individuals receiving care in a short stay rehabilitation facility that are recovering from hospital stay, largely funded by Traditional Medicare, Medicare Advantage and commercial health plans. NF populations are institutionalized patients that are receiving care from providers that come into the facility, largely funded by Medicaid and some private insurance.

Savings Program (MSSP) and other shared savings models to prevent inappropriate overlap and misalignment to community-based providers that no longer provide primary care to these beneficiaries. Long-term care patients could be misaligned to community-based ACOs based on a prior relationship with a community-based clinician they no-longer see. CMS already excludes short-term care SNF patients from MSSP attribution by identifying if a SNF stay overlapped with a qualifying primary care visit.

- CMS should allow attribution at the facility level, through the facility CMS Certification Number (CCN), recognizing the important role nursing facility staff play in coordinating care for institutional beneficiaries. CMS already does something similar with Federally Qualified Health Centers, and CMS recognizes the important role of NFs in Medicare Advantage Specials Needs Plans for Institutional beneficiaries. Clinician-level attribution methodologies are not appropriate for the long-term care NF participation. CMS could also improve the attribution methodology and capture patients in the NF by using the institutional level of care flag.
- CMS should add to the common working file (CWF) which ACO a patient is attributed to. This currently does not exist, and would seamlessly pinpoint the specific ACO to which a patient is attributed, streamlining the coordination of care and resources available to patients.
- Given the average length of stay of 2.5 years for institutional nursing home beneficiaries, prospective assignment methodologies often lead to inappropriate alignment of institutional beneficiaries to their historic community-based providers that no longer treat them. CMS should use retrospective alignment, or more frequent prospective alignment approaches, for this population, such as what is done in the Kidney Care Choices (KCC) Model.

Financial Methodology

- CMS should ensure appropriate adjustments are made so that the reference population includes a similar rate of institutionalized patients.
- CMS should use the concurrent risk adjustment model that is being tested in ACO REACH for the SNF/NF population. Any changes to the risk adjustment model, including a blended approach with the revised Version 28 model that is being implemented for Standard ACOs and New Entrant ACOs in 2024, must be evaluated to ensure historical references are accurate. This is particularly important for newly institutionalized beneficiaries.

Quality Measurement

- The SNF/NF population necessitates a distinct set of quality metrics rooted in clinically pertinent and meaningful criteria. CMS should prioritize metrics that encourage hospitals and healthcare providers to establish superior care transitions and discharge planning. This can be achieved through a few essential elements: the timely completion of discharge summaries by healthcare providers upon transfer from an acute care hospital to the SNF/NF, in addition to a comprehensive order set for admission to SNF, both of which would elevate the quality of care and reduce avoidable emergency department (ED) visits and readmissions. Advanced care planning is also an important piece to improved quality.
- CMS should improve data sharing on appropriate and meaningful quality measures with value-based care entities to support partnership between these entities and CMS.

Data

- The Medicare system used to check benefits should list the ACO a patient is aligned to for prospective attribution participants; similar to identifying the Medicare Advantage plan a patient has elected.
- CMS should regularly share performance data during the performance period and provide a feedback loop for any data updates or corrections.
- When providing claims data to ACOs, CMS should flag which beneficiaries have been prospectively attributed to other ACOs or other Shared Savings programs.
- CMS should leverage data sharing networks to share real-time information with both acute care and SNF/NF providers. This includes automated admission, discharge, and transfer feeds.
- CMS should regularly share utilization and cost data for attributed members throughout the performance period to help ACO participants, physician practices, and SNF/NFs understand point in time progress regarding financial performance. This should be provided through the CWF. This may require technical assistance, particularly for SNF/NFs who are less likely to have robust data infrastructure.
- Funding is one of the biggest challenges to advancing data infrastructure for SNF/NFs. CMS should provide more funding and technical assistance to support and advance data maturity among SNFs and NFs.
- CMS should strive to achieve full integration between NF/SNF records and hospital, physician and specialist records, through interoperability between these provider types.

Future Model Concepts – Through a discussion on future model concepts, roundtable participants agreed upon key principles that CMS should adopt for developing a voluntary episode-based payment model designed for SNF providers that could be nested within an ACO, including*:*

- Address persistent and unresolved healthcare delivery system problems;
- Deliver improved patient outcomes while reducing unnecessary healthcare costs;
- Ensure scalability;
- Entail meaningful risk and reward for participants within the ACO;
- Align with the Center for Medicare and Medicaid Innovation's (CMMI's) strategic vision;
- Create a sense of predictability and stability;
- Create a voluntary model with adequate non-financial incentives to spur participation; and
- Prioritize data sharing.

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Background

Some of the most significant cost savings and care improvements realized by community-based ACOs and other episodic payment and delivery system reform models have been generated by intentional and targeted post-acute care partnerships. Despite this, LTPAC providers have been challenged in their ability to meaningfully participate in CMS' value-based care models. Fewer than 2,000 SNFs participate in ACOs, representing less than 10 percent of SNFs nationwide. Further, SNF participation is concentrated in a small number of ACOs, particularly in the ACO REACH model. Fewer than 10 percent of ACOs account for nearly three-quarters of SNF participation.[3]

The LTPAC workforce and patient population is heterogenous and complex. LTPAC providers offer a range of services delivered by NFs, SNFs, home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Between NFs and SNFs, the focus of this white paper, there are differences in patient populations, care team members, care interventions, and expected length of stays. For example, SNFs are designed for short-term rehabilitative support, with an average length of stay of about 30 days and a goal of returning the patient to the community or resuming normal activities and function, while NFs offer longer-term care including supporting activities of daily living, often with the goal of preserving the patient's quality of life and health as much as possible. LTPAC providers should not be viewed as monolith, and a one-size-fits-all approach for engagement will not work.

Engaging LTPAC in Value-Based Care

LTPAC has played a critical role in the success of value-based care models, with some of the most significant cost savings and care improvements in ACO and episodic payment models generated by intentional and targeted post-acute care partnerships. In a synthesis of findings from 21 CMS Innovation Center models, 14 models (or 66 percent) had reductions in spending driven by post-acute care utilization.

Despite this, LTPAC providers and facilities have been challenged in their ability to meaningfully participate in value-based care models to date. Current program policies in ACO models do not align well with LTPAC providers, including those that determine which patients ACOs are accountable for, setting financial benchmarks, and the quality measures that must be reported. As a result, LTPAC providers very rarely participate as Participant Providers in models and have been limited to SNF Affiliates, Preferred Providers, Other Entities, and/or enter separate contractual arrangements with ACOs; all of which pose limitations.

As Preferred Providers, SNF affiliates or Other Entities, LTPAC providers are not considered in beneficiary alignment, not used for quality measure scoring, and are not eligible for Qualifying Participant (QP) status and the associated incentive payment. The alternative option of entering into contractual agreements, which most model participants have elected to pursue, has been a point of contention for some LTPAC providers who feel they are generating savings without seeing benefits, such as shared savings payments or alternative payment model (APM) incentive payments. In these arrangements, LTPAC providers are expected to provide better and more efficient management of patients but may not share in savings or other means of recouping the investments required to provide improved care delivery. In certain cases, providers may also experience added pressure from a reduction in fee-for-service (FFS) payments for specific ACOs, such as those currently in the ACO REACH model.

From the ACOs' perspective, there are limited ways in which shared savings payments and incentives can be spent, and while ACOs can and should share savings with LTPAC providers, the opportunities are limited for a few reasons. Shared savings are reinvested in other ways, including building patient-focused care

[3] Institute for Accountable Care and NAACOS analysis of CMS data.

management programs such as adding patient call lines and chronic care management programs; building infrastructure such as through more robust health information technology; and structuring provider compensation. Additionally, the "ratchet effect" on ACO benchmarks are lowering the shared savings ACOs generate. The ratchet occurs when ACOs' benchmarks, which are based on their providers' historic spending, are continually lowered over time as ACO providers lower the spending on their patient populations. As benchmarks lower, it both becomes harder to achieve, and generate high levels of, shared savings.

As one of the highest-cost and most complex patient populations, LTPAC patients and their providers present a significant opportunity for improved outcomes and reduced costs for Medicare beneficiaries. Medicare spent nearly $57 billion on post-acute care, around 15 percent of total spending. Forty percent of inpatient hospital discharges are followed by LTPAC services, totaling nearly two million SNF stays per year alone. As such, meaningful integration of these patients into broader APM efforts will be essential for CMS to meet its laudable goal of having all traditional Medicare beneficiaries in accountable care relationships by 2030.

Roundtable Overview

On August 24, 2023, AHCA|NCAL, the nation's largest LTPAC association, and NAACOS, representing over eight million beneficiary lives through population health-focused payment and delivery models, convened a roundtable of key stakeholders to develop targeted, mutually beneficial solutions to better integrate LTPAC with broader value-based care efforts. Roundtable participants included LTPAC providers and facilities, payers, ACOs, health systems, and patient advocacy groups. See Appendix A for a full list of participants.

ACHA|NCAL and NAACOS

The **American Health Care Association | National Center for Assisted Living (AHCA|NCAL)** is the nation's largest association of long term and post-acute care providers representing more than 14,000 member facilities who provide care to approximately 1.7 million residents and patients every year, is committed to delivering solutions for quality care. In keeping with its mission, AHCA/NCAL established the Population Health Management (PHM) Council, in 2019, to convene and support long term care providers who are engaged in value-based care and population health management (PHM) initiatives. The Council's mission is to strengthen long term care provider-led PHM models through advocacy, education, and quality improvement data, thereby enhancing the quality of care and quality of life for beneficiaries in senior living settings. The Council consists of AHCA/NCAL member providers who lead and meaningfully engage in PHM models including provider-led Special Needs Plans (SNPs).

The **National Association of ACOs (NAACOS)** represents more than eight million beneficiary lives through Medicare's population health-focused payment and delivery models. NAACOS is a member-led and member-owned nonprofit of more than 400 ACOs in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce healthcare cost.

The roundtable discussion focused on options for effective leadership and partnership with LTPAC providers – referred to as SNF and NF[4] providers – in two priority areas. First, AHCA|NCAL and NAACOS

[4] SNF (short-stay) vs. NF (long-stay): SNF populations are individuals receiving care in a short stay rehabilitation facility that are recovering from hospital stay, largely funded by Traditional Medicare, Medicare Advantage and commercial health plans. NF populations are institutionalized patients that are receiving care from providers that come into the facility, largely funded by Medicaid and some private insurance.

led roundtable participants in a discussion of how existing risk-based arrangements, such as the ACO REACH model and MSSP, could be improved to increase SNF/NF provider participation.[5] The second part of the discussion focused on future model concepts that would enable SNF providers to take on risk and meaningfully engage within broader accountable care arrangements. Roundtable participants agreed upon a series of recommendations for each of these two objectives, outlined in detail below.

Improving Existing Value-Based Arrangements for NF/SNF Providers

Roundtable participants coalesced around several recommendations for CMS to improve existing value-based arrangements and more meaningfully integrate NF/SNF providers. These recommendations ranged from short- to long-term, and varied from smaller tweaks to major programmatic changes.

Given the challenges and recommendations we note below, in the long-term, CMS must recognize the unique needs of the SNF and NF populations and should create a separate track in MSSP or ACO model for this population.

Alignment/Participation Options for Beneficiaries Residing in Long-Term Care Facilities:

ACO alignment determines which patients ACO providers are accountable for. These methodologies have been designed for primary care providers and do not capture the important role of long-term stay NF operators in the coordination of care for institutional beneficiaries. For example, CMS determines where the beneficiary receives the plurality of their primary care services when aligning a patient to an ACO, which would not consider the NF where the beneficiary receives their care. Roundtable participants noted that beneficiaries admitted to a NF within the past two years are at risk of being prospectively misaligned to an ACO REACH or MSSP in which their prior community-based care provider participates. This methodology does not keep pace with changes in these primary care relationships that typically occur once the beneficiary permanently moves from the community to a NF.

There are two alignment methodologies, retrospective and prospective. Under retrospective alignment, beneficiaries are assigned based on services provided throughout that performance year. Under prospective alignment, beneficiaries are assigned based on services provided during the prior one to two year(s). Given the relative short length of stay for institutional nursing home beneficiaries, prospective assignment methodologies often lead to inappropriate alignment of institutional beneficiaries to their historic community-based providers that no longer treat them. Alternatively, LTPAC services would be captured with a retrospective assignment period, however challenges remain given the preferential status both prospective alignment and primary care services receive in current alignment methodologies. Prospective alignment has priority over retrospective alignment, meaning that if a patient who resides in a NF has already been prospectively assigned, they cannot be retrospectively assigned to the NF during the performance year. Similarly, primary care physicians also receive priority in assignment methodologies as the first phase of assignment is based on a plurality of primary care services. If a beneficiary is not assigned by during this phase, they can then be assigned based on services performed by certain specialists; however, about 90 percent of beneficiaries are assigned to a primary care physician during this first phase.

Recently, there has been an emerging focus on voluntary alignment through the ACO REACH model. This enables ACOs to proactively communicate with beneficiaries regarding alignment, allowing the beneficiary to designate their “primary clinician” electronically, and thus align to a Participant Provider. This is difficult in the SNF/NF setting for a number of reasons. As already noted, SNF/NF providers are challenged to become Participant Providers because current claims-based alignment methodologies do

[5] The term ‘provider participant’ refers to health care providers who engage with an ACO, including ACO participants, physicians, and SNF/NF providers.

not align patients to them. Further, given that the majority of SNF/NF residents experience both physical and cognitive impairments, voluntary alignment would be significantly challenging, if not impossible.

Roundtable participants also noted that attribution policies are made more complicated by the fact that, in some instances, care in SNF/NF facilities also are provided by contracted physician groups that may participate in other models. This complicates attribution policies using a combination of the taxpayer identification number (TIN) and National Provider Identifier (NPI), as is done in many CMS Innovation Center models.

Recommendations:

CMS can make immediate or near-term changes to assignment methodology in existing models that will better capture the NF population.

Roundtable participants recommend the following actions:

- When examining visit history to determine plurality of care for purposes of attribution, CMS should remove the long-term care NF population from the MSSP and other shared savings models to prevent inappropriate overlap and misalignment to community-based providers that no longer provide primary care to these beneficiaries. These long-term care patients could be misaligned to community-based ACOs based on a prior relationship with a community-based clinician they no-longer see. CMS already excludes short-term care SNF patients from MSSP attribution by identifying if a SNF stay overlapped with a qualifying primary care visit.
- CMS should allow attribution at the facility level through the facility CCN, recognizing the important role nursing facility staff play in coordinating care for institutional beneficiaries. CMS already does something similar with Federally Qualified Health Centers and CMS recognizes the important role of NFs in Medicare Advantage Specials Needs Plans for Institutional beneficiaries. Individual provider-level attribution methodologies are often not appropriate for NF participation. CMS could also improve the attribution methodology and capture patients in the NF by using the institutional level of care flag.
- CMS should add to the common working file (CWF) which ACO a patient is attributed to. This currently does not exist, and would seamlessly pinpoint the specific ACO to which a patient is attributed, streamlining the coordination of care and resources available to patients.
- Given the average length of stay for institutional nursing home beneficiaries, prospective assignment methodologies often lead to inappropriate alignment of institutional beneficiaries to their historic community-based providers that no longer treat them. CMS should use retrospective alignment, or more frequent prospective alignment approaches for this population, such as what is done in the Kidney Care Choices (KCC) Model.

Financial Methodology:

Successful participation in a value-based care model hinges on accurate benchmarking, risk adjustment, and quality measurement. Financial benchmarks, which are the spending targets for models, are often based on historical spending. Under current policy, these may not always be appropriate for the long-term NF population, as the cost of their historic care in the community is unlikely to reflect the true cost of their care in a facility. Risk adjustment models are also likely to under predict NF patient costs for similar reasons.

Recommendations:

Financial methodologies are typically designed with the community-based population in mind and, in many cases, are not appropriate for NF patients and providers. Roundtable participants recommend CMS

consider the following adjustments to enable NF providers and facilities to succeed in value-based care models.

Roundtable participants recommend the following actions:

- CMS should ensure appropriate adjustments are being made so that the reference population includes a similar rate of institutionalized patients.
- CMS should use the concurrent risk adjustment model that is being tested in ACO REACH for the SNF/NF population. Any changes to the risk adjustment model, including a blended approach with the revised Version 28 model that is being implemented for Standard ACOs and New Entrant ACOs in 2024, must be evaluated to ensure historical references are accurate. This is particularly important for newly institutionalized beneficiaries.

Quality Measurement:

Quality measurement is foundational for holding providers accountable for patient outcomes. The Agency for Healthcare Research and Quality identifies six domains of healthcare quality: safe, effective, timely, efficient, equitable, and patient-centered. Quality metrics should reflect each of these domains; encapsulate care that needs improvement; and include measurable, relevant metrics for providers, payers, and patients.

Quality measurement currently poses challenges for NF providers for a number of reasons. Measures are difficult to establish and measure for this population, reference populations can be challenging to identify, and existing measures are not always appropriate. When compared to ACOs serving community-based Medicare beneficiaries, ACOs serving this population will often appear as outliers on measures designed for the community-dwelling majority of Medicare beneficiaries.

Recommendations:

As financial incentives in models are increasingly being tied to quality measures, such as the quality withhold payment in ACO REACH or the sliding savings scale based on quality results in MSSP, clinically appropriate and straightforward quality components are essential for successful participation in a value-based care model.

Roundtable participants recommend the following actions:

- The SNF/NF population necessitates a distinct set of quality metrics rooted in clinically pertinent and meaningful criteria. CMS should prioritize metrics that encourage hospitals and healthcare providers to establish superior care transitions and discharge planning. This can be achieved through a few essential elements: the timely completion of discharge summaries by healthcare providers upon transfer from an acute care hospital to the SNF/NF, in addition to a comprehensive order set for admission to SNF, both of which would elevate the quality of care and reduce avoidable ED visits and readmissions. Advanced care planning is also an important piece to improved quality.
- CMS should improve data sharing on appropriate and meaningful quality measures with value-based care entities to support partnership between these entities and CMS.

Data:

To take on financial risk, and improve quality and outcomes for their patients, providers need reliable data surrounding all aspects of care delivery. This is important both for measuring their performance on value-

based metrics and to make informed care decisions for aligned beneficiaries. A central component to this is the infrastructure to manage timely data sharing and collaborate with partners.

Data presents a challenge to SNF/NF providers on multiple fronts. SNF/NF providers are often operating in a silo from community-based providers. Roundtable participants remarked that it is often impossible for a SNF/NF provider or facility to determine whether an admitted patient is attributed to a particular ACO or not and that they would feel more comfortable discharging a patient knowing another provider was accountable to ensure continued care coordination and management. Thus, this lack of knowledge is contributing to longer patient stays than if the SNF was aware that a patient had additional wrap around care management to prevent readmissions. Further, LTPAC providers were excluded from the Health Information Technology for Economic and Clinical Health (HITECH) Act, which created reimbursement incentives for healthcare organizations using electronic health records (EHRs). As a result, many SNF/NFs lag behind the rest of the healthcare industry in data maturity and lack the infrastructure necessary for effective partnerships.

Roundtable participants emphasized the importance of CMS arming providers, hospitals, SNF/NFs, and ACOs with timely data. Current gaps do not stem from a lack of data – CMS has access to significant data from hospitals and SNF/NFs – but a lack of meaningful data sharing for providers to make informed decisions.

ACOs require more regional data from CMS to develop partnerships in their geographic area, while SNFs/NFs require the resources and technical assistance needed to meaningfully engage in value-based care. CMS has begun to recognize this through the proposed Universal Foundation, which will prioritize development of interoperable, digital quality measures, and allow for cross-comparisons across programs. In developing this measure set, CMS must consider perspectives and capabilities across the care continuum, including both community-based and LTPAC providers, and strive to create a level playing field that meets the unique needs of each provider.

Roundtable participants recommend the following actions[6]:

- The Medicare system used to check benefits should list the ACO a patient is aligned to for prospective attribution Participants; similar to identifying the Medicare Advantage plan a patient has elected.
- CMS should regularly share performance data during the performance period and provide a feedback loop for any data updates or corrections.
- When providing claims data to ACOs, CMS should flag which beneficiaries have been prospectively attributed to other ACOs or other Shared Savings programs.
- CMS should leverage data sharing networks to share real-time information with both acute care and SNF/NF providers. This includes automated admission, discharge, and transfer feeds.
- CMS should regularly share utilization and cost data for attributed members throughout the performance period to help ACO participants, physician practices, and SNF/NFs understand point in time progress regarding financial performance. This should be provided through the CWF. This may require technical assistance, particularly for SNF/NFs who are less likely to have robust data infrastructure.
- Funding is one of the biggest challenges to advancing data infrastructure for SNF/NFs. CMS should provide more funding and technical assistance to support and advance data maturity and analytics capabilities among SNFs and NFs.

[6] Several of these recommendations stem from NAACOS' Voluntary Best Practices to Advance Data Sharing, developed with the American Medical Association (AMA) and America's Health Insurance Plans (AHIP).

- CMS should strive to achieve full integration between NF/SNF records and hospital, physician and specialist records, through interoperability between these provider types.

Future Model Concepts

One approach to support accountable care and to create an avenue for short-term care SNF providers to participate in value-based care initiatives is through episode-based payment models. However, it is difficult to develop a one-size-fits-all model episode that fits all clinical episodes in all care settings. An ACO's interest in a specific bundle will also vary based on their experience, patient needs, participant providers, and geographic considerations. We believe that CMS may need to develop more targeted approaches, either based on provider type or clinical conditions, when developing episode-based payment models. Below, we highlight considerations for such a voluntary episode-based payment model designed for SNF providers that could be nested within an ACO.

Roundtable participants appreciate CMS' interest in creating a new episode-based payment model, outlined in a recent request for information (RFI). As noted in NAACOS' RFI response, episode-payment models provide an opportunity to support nesting bundles within ACOs. While CMS has focused on nested bundles as a way to increase specialty integration in value-based care models, AHCA|NCAL has encouraged CMS to broaden its view and from the onset consider the important role that SNF providers play in the specialty care provided to Medicare beneficiaries and in managing the myriad of chronic and medical conditions that require the connection between primary care, specialty care and the senior services continuum.

As an initial step, roundtable participants recommend that CMS adopt the follow principles for a SNF-based nested bundle[7]:

- ***Address persistent and unresolved healthcare delivery system problems*:** Identify specific healthcare delivery issues that post-acute or long-term care providers would be well-positioned to address and that could be resolved refining the payment system to better align incentives. Ideas include enhancing care coordination across care settings, improving discharge planning, and caring for high-cost, high-need patients.
- ***Deliver improved patient outcomes while reducing unnecessary healthcare costs*:** While it is critical for the APM to result in more efficient care and smarter spending for Medicare, the model should be equally focused on enhancing quality of care, improving access, and better serving underserved populations of Medicare beneficiaries and delivering improved clinical outcomes.
- ***Ensure scalability*:** The model design should be broadly applicable to multiple specialty provider types and accessible to a variety of participants, including long-term care, rural and small, independent providers, those that are inexperienced testing value-based payment models, and across diverse geographies. This should include an extended phase-in period specifically for smaller providers, with shared learning or partnership opportunities with larger entities.
- ***Entail meaningful risk and reward for participants*:** The model should include the possibility for meaningful risk and reward sharing between provider participants and CMS. However, the model should also consider unique challenges facing smaller, rural, less experienced with value-based care and/or underserved communities' providers and include a ramp-up/phase-in period that provides a

[7] AHCA|NCAL led an internal workgroup that developed guiding principles and concepts for a SNF-led nested bundle. See Appendix B for more information.

glide path to varying levels of risk. The model should also consider outlier cases, refined risk adjustments and clearly define exclusion criteria to ensure providers are not unfairly penalized.

- ***Align with CMMI's strategic vision*:** The model should align with CMS' strategic priorities and those in the post-acute sector, such as improving care coordination. To the degree possible, model development should take broader CMS objectives into account, including promoting interoperability, increasing providers assumption of risk, and reducing administrative burden by focusing on the most meaningful and aligned quality measures across CMS models and initiatives.
- ***Create a sense of predictability and stability*:** The model design should include key elements and assurances that evoke prospective participants' confidence in the stability of critical model design details, including financial predictability. Specifically, a dynamic target pricing mechanism that can adjust and fluctuate based on real-time data or periodic assessments; fair risk adjustment accounting for an increasingly dynamic healthcare marketplace; guidance on how key model design or methodological changes will be evaluated and managed throughout the program; and the flexibility for participants in lieu of anticipated major changes.
- ***Create a voluntary model with adequate non-financial incentives to spur participation*:** The model should include benefit enhancements, similar to the ACO REACH model, that are tailored to this population. The model should also ease requirements and reduce provider burden wherever possible. CMS should conduct a deeper dive into the specific challenges and needs of LTPAC providers to tailor incentives accordingly.
- ***Prioritize data sharing*:** For the model to be successful, CMS must arm providers, facilities, and ACOs with access to timely data. CMS must also ensure SNFs have the resources and technical assistance to adopt the technology needed to effectively communicate and coordinate care with ACOs. This includes engaging with key stakeholders to define clear, actionable steps towards promoting interoperability, especially for LTPAC providers.

Building on the above principles, roundtable participants discussed the need for reciprocal arrangements that benefits both the ACO and the SNF. To that end, we discussed various approaches for administration of the bundled payment model. One approach is to have the ACO itself administer the bundle. Under this approach, the ACO would enter into a contract with the SNF, bypassing CMS altogether. Under a second approach, CMS would administer the bundle, bringing the ACO and SNF together and providing oversight and guardrails around the arrangement. While the group did not come to consensus on either one of these approaches, roundtable participants discussed unique considerations that should be top of mind for ACOs and/or CMS as potential administrators of such a model.

Roundtable participants highlighted the following considerations for a SNF-led nested bundle model:

- ***Patient Volume:*** To build and support a model of care with an ACO, a SNF must have either a certain volume of patients from an ACO or bring together patients from several ACOs. When developing a model, CMS should work with SNF facilities and providers to develop appropriate criteria for patient volume. Adequate patient volume is critical for a SNF to deploy interventions across a patient panel, spread risk, and achieve sufficient return on investment. One option to generate this volume would be facility-based alignment, which would ensure all FFS patients in a SNF align to the ACO.
- ***Episode Initiation:*** An episode should be initiated by admission to a SNF regardless of the entry point (hospital or community). The episode could either be defined as a diagnosis or by certain patient criteria. In this instance, similar to the ACO REACH model, the target price should be set based on an average Medicare beneficiary cost for the given condition in a SNF

- ***Considerations for Financial Alignment***: While both the ACO and SNF should be rewarded (or liable) for shared savings (or losses), the financial arrangement should reflect the specific partnership and engagement between the ACO and SNF. In certain instances, it may be appropriate for the SNF to accrue most savings or losses. One approach to this could be fully removing the bundled episode from the ACO benchmark upon reconciliation and having it attributable solely to the SNF. However, because the ACO's longitudinal care will always impact the outcome of the episode, the ACO should always share in savings or losses.

While the roundtable participants did not have adequate time to discuss how SNFs/NFs might be financially incentivized within an ACO, we believe this, too, warrants future discussion and might include a population based per member per month payment. We encourage the CMS Innovation Center to consider how SNF providers play an integral role in managing costs and care for the Medicare population that live in their communities. There may be cost-saving strategies that could be deployed, such as treating in place with an add-on payment for more intensive care or directly admitting to their SNF in lieu of hospitalizations, or utilizing hospice and/or palliative care for end-of-life care.

Conclusion

Stakeholders across the healthcare system agree that there are opportunities for CMS to more meaningfully engage SNF/NF providers in broader delivery system transformation efforts through adjustments to existing accountable care arrangements and developing future models with the unique needs of SNF/NFs in mind. Greater accountable care adoption and integration will provide SNF/NF residents with more coordinated, efficient, patient-centered care. Further, engagement with NF/SNFs will be essential for CMS to meet its goal of having all Medicare FFS beneficiaries in accountable care relationships by 2030.

CMS and stakeholders from the value-based care and LTPAC communities must work together to address this important, but complex, patient population. This includes further developing and building consensus around the principles and recommendations highlighted in this document, which are intended to serve as a strong starting place for this critical work.

Appendix

Roundtable Participants

1. Aisha Pittman, NAACOS
2. David Pittman, NAACOS
3. Jennifer Gasperini, NAACOS
4. Nisha Hammel, AHCA
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AHCA Internal Work Group - "Nested Bundles" Guiding Principles and Concepts

Key Concepts for Model Development

1. Episode Initiation: The initiation of the Episode of Care (EOC) should be well-defined. Model design should support different tracks with different points of episode initiation including a. upon hospital discharge that account for the occurrence of acute events (i.e., hospitalization) and b. proactive management of patients in the community with the presence of defined chronic condition(s) to prevent a hospitalization.
    a. Participants could set a group of providers across settings of care, including owned and non-owned organizations and include multiple settings of care for initiation such as skilled nursing facility and home health agency points of episode initiation. This would incentivize a diverse range of patients to be managed as well as shifting to lower levels of care, direct admits from the community into the most appropriate initiation point and avoiding unnecessary ED and hospital utilization all under the same episode of care construct.
    b. Patient attribution should consider both access point (e.g., NPI) as well as clinical identifiers (e.g., DRG) dependent upon final model design elements.
2. Episode Duration: There should be varied durations, including longer durations up to 90 days which have been proven successful in the evaluation reports for both BPCI and BPCI-Advanced.
3. Clinical Conditions: Model design should include both medical and surgical conditions with the ability of the EOC participant to select categories of conditions they are prepared to accept accountability (e.g., CESLGs in BPCI-A). The conditions selected should include the most prevalent chronic conditions among the Medicare population and include the highest utilizers and highest cost patient conditions. Additionally, this selection approach will encourage broader participation due to varied clinical capabilities of providers and rural vs. suburban provider capability.
4. Waivers: CMS should continue to include care delivery flexibility by allowing for certain waivers during the episode of care including the three-day stay waiver and telehealth waiver.
5. Financial Alignment: The ACO and EOC participants should both be rewarded through lower costs of care with most savings accruing to the EOC participant if within the EOC. For example, the ACO could be rewarded prospectively with all or a share of the episode discount (two to three percent) plus some small portion (e.g., five percent) of the overall savings upon reconciliation. The payment mechanisms should include both prospective payment mechanisms in addition to reconciliation savings retrospectively.
    a. Note: Episode of care historical costs should be removed from the global payment model participant benchmark and fully removed out of actual total cost of care expenditures upon reconciliation. Savings or losses upon reconciliation would be fully removed from the ACO benchmark and attributable solely to the EOC participant.
    b. Prospective payments would address areas such as promoting access and enhanced services for underserved communities, encourage rural, smaller independent providers, and infrastructure investment for those less experienced with value-based care payment models.
6. Target Price Methodology: Based on BPCI-A experience, unpredictable and extraordinary volatility in the target price methodology has created instability in provider participation and caused many participants to exit the program. Considering this experience, a highly predictable and stable target price methodology will be paramount to attracting participants to any future episode of care model and should consider the following factors:
    a. Historical benchmarks should remain constant throughout the program. Resetting the three-year baseline period each performance year creates a rachet effect on target prices and creates a constant variable in the target price methodology whereas the most valid control group to the program is the one prior to program implementation/start date.

b. The gap between retrospective trend factors and prospective trend factors should be significantly narrowed such that a retrospective trend applied at reconciliation to a prospective trend cannot exceed +/- two percent. Prospective trends should be applied annually and retrospective trends should only be calculated annually, applying to all performance period reconciliations during the performance year.

7. Eligible Participants: Post-Acute providers should be allowed to be the EOC participant.
    a. The EOC participant could take accountability for only episodes initiated for their owned Episode Initiators (EI) or participate as a Convener with other non-owned EIs as part of their participation. Conveners should continue to be defined as only licensed Medicare providers outside of the ACO entity.
    b. Tracks within the model should be part of the model design with lower discounts and downside risk options for those participants with less VBC experience to have a glide path to higher financial risk levels (e.g., recent changes to the MSSP model giving providers a longer period in upside only tracks).
    c. Tracks within the model should be part of the model design with lower discounts for patient populations that are historically underserved, clinically higher risk and/or clinical condition categories that have proven more difficult to generate savings (e.g., medical vs. surgical conditions).
8. Risk Adjustment: The risk adjustment methodology should factor into clinical condition complexity at the condition level (e.g., primary + secondary DRG/ICD-10 codes, HCC), presence of co-morbid chronic conditions, and SDOH/health equity (e.g., ADI and eventually Z codes).
9. Quality Metrics: Quality metrics selected should be streamlined and align with existing QRP and VBP programs, payment models design and other CMS initiatives to reduce administrative burden and create alignment among quality improvement efforts and reporting. The reduction in administrative burden is especially critical for smaller, rural, and providers newer to risk-based payment models.
10. Participation Enrollment/Criteria: CMS should allow participants to enter into the program on an annual basis aligned with existing annual ACO timelines and notification periods. Participation should create sufficient enhanced incentives to encourage participation by both the ACO and EOC participant such that the program remains voluntary, not mandatory. Participants should also be allowed to exit the program on an annual basis.