

# The Right Care for the Right Cost: Post-Acute Care and the Triple Aim

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September 2014

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## INTRODUCTION

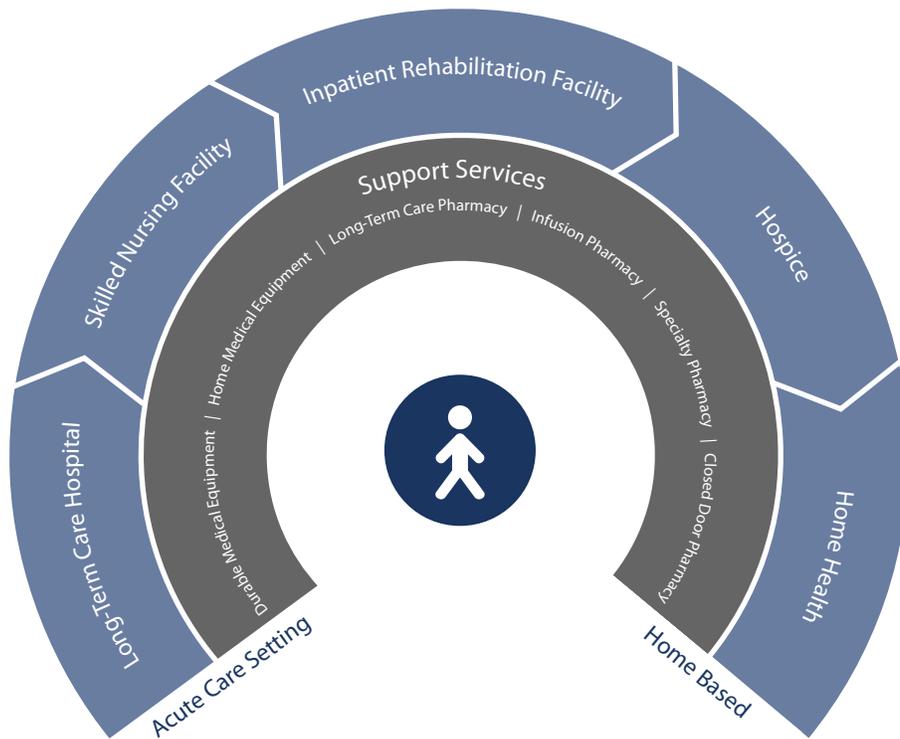
Accountable Care Organizations (ACOs) are financially accountable for the cost and quality outcomes of a population—in many cases, even when services are delivered by a separate health care organization. Because of this, ACOs have a vested interest to coordinate care across the entire care continuum. To influence outcomes beyond their doors, ACOs utilize care coordinators, HIT tools and partnerships with other providers. One area where ACOs have begun to strategically influence outcomes is within the post-acute care (PAC) space. Appropriate post-acute care utilization can help patients recover from acute care procedures, prevent hospital readmissions, and provide effective care for ongoing chronic conditions. Because of their high involvement with Medicare beneficiaries and their important role within the care continuum, PAC providers are an ideal partner for ACOs seeking to achieve the triple aim of improved quality, decreased costs, and better patient satisfaction.

This paper will discuss ACO engagement with PAC providers in administering care, specifically addressing the following: 1) what post-acute care entails and the type of providers operating within post-acute care, 2) why ACOs need to consider collaborative partnerships with post-acute care providers, and 3) how PAC partnerships fit within the ACO paradigm.

## WHAT IS POST-ACUTE CARE?

Simply defined, post-acute care is any care delivered following an acute hospital stay. In practice, however, the term refers to a broad array of services, regardless of whether

**Figure 1 | Post-Acute Care Spectrum**



or not they are immediately preceded by an acute care procedure. Post-acute care includes care delivered at or by: long-term acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and hospice and home health providers (Figure 1). Post-acute care providers in this wide array of care delivery can play an important role in coordinating care across the PAC continuum, and in doing so help achieve the goal of providing the right care at the right place and at the right time.

An important aspect of post-acute care coordination occurs through support services, such as home and durable medical equipment providers, long-term care pharmacy, home infusion pharmacy, and specialty pharmacy. These support services operate under the coordination of post-acute care providers to contribute care that is integral to patient recovery and wellness. Medical equipment specialists assist care delivery by ensuring that equipment is appropriately selected and adjusted to fit the needs of individual patients. Post-acute pharmacists perform medication regimen reconciliation to ensure that patients adhere to prescribed regimens after transitioning between providers. Closed-door pharmacies in particular, which not only dispense drugs but also provide pharmacist consulting services, represent essential functional support for many post-acute care providers in-house.

“Our LTC Pharmacy is an integral part of the Marquis Care Team,” says Phil Fogg Jr., CEO and president of Marquis Companies, an Oregon-based health care company with 26 post-acute rehabilitation, long-term care and Alzheimer’s care facilities. “In collaboration with our clinical team, the pharmacy provides extensive services, including medication management, regulatory compliance and clinical reviews that help drive care coordination, streamline our administrative burdens and aid in lowering our operational costs. The LTC Pharmacy is a critical partner in our ability to achieve quality outcomes and deliver services that make a difference in our ability to help our clients heal or maintain health.”

Though the spectrum of post-acute services is broad, the availability and acuity of PAC services varies from market to market. A U.S. Department of Health and Human Services report found that utilization of different PAC providers and services correlates with the availability of post-acute care services within a geographic area.<sup>1</sup> Utilization of post-acute care is often dependent on PAC service availability. Likewise, PAC service acuity levels are influenced by the service acuity level offered by non-PAC providers.

## POST-ACUTE CARE AND REFORM

Post-acute care is the subject of various reform efforts, as it not only embodies a large portion of the health care continuum but also represents a significant percentage of health care expenditures. In 2012, Medicare spending for post-acute care services exceeded \$62 billion, comprising nearly 11 percent of Medicare outlays and representing the largest per episode expense per beneficiary.<sup>2,3</sup> Such spending is expected to continue to grow as the percentage of the population aged 65 years and older rises.<sup>4</sup>

In addition to sheer volume of PAC spending, post-acute care utilization impacts variation in total health care spending. A report by the Institute of Medicine indicates that 73 percent of variation in total Medicare spending is due to utilization of post-acute care services.<sup>5</sup> According to the report, hospital referral regions (HRRs) that have high spending in post-acute categories also tend to have high spending overall.<sup>6</sup> In order to impact overall health care spending, it is important to address post-acute care costs and utilization.

A number of reform initiatives that attempt to control post-acute care costs and limit variation are currently underway. Current reforms include increasing PAC sector regulations to encourage more appropriate utilization, direct post-acute care payment changes, and rebasing the home health payment system.<sup>7</sup> Further reforms have been proposed, including rebasing PAC provider reimbursement rates and creating quality measures and reporting programs for various PAC settings.<sup>8</sup> Key to these reforms are new payment models that seek to align provider incentives across health settings as they care for a specific patient population.

In order to affect health care utilization and costs, many reform initiatives focus on changing how health care is reimbursed. The CMS Bundled Payment Initiative contains for models, two of which bundle payments for post-acute care. Model 2 creates a single, retrospective bundled payment for the combination of services performed by acute care hospitals and post-acute care providers. Model 3 provides retrospective bundled payments for post-acute

**Table 1 | Role of PAC Providers within CMS MSSP Quality Measures**

MSSP ACO Measure Category	Example Measure	Sample PAC Provider Role
Patient/Caregiver Experience	<ul style="list-style-type: none"> <li>ACO-1: Getting timely care, appointments, and information</li> <li>ACO-2: How well your provider communicates</li> <li>ACO-3: Patient's rating of provider</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate communication and access to primary care provider</li> <li>Coordination between PAC and ACO to ensure that services are ready for patient upon arrival</li> </ul>
Care Coordination/Patient Safety	<ul style="list-style-type: none"> <li>ACO-8: Risk standardized all condition readmission</li> <li>ACO-9: Ambulatory sensitive conditions admissions</li> <li>ACO-12: Medication reconciliation</li> </ul>	<ul style="list-style-type: none"> <li>Focus on reducing avoidable readmissions of PAC patients</li> <li>Leveraging PAC pharmacist providers for medication reconciliation review</li> </ul>
Preventive Health	<ul style="list-style-type: none"> <li>ACO-13: Falls screening</li> <li>ACO-14, 15: Immunizations and vaccinations</li> <li>ACO-18: Clinical depression screenings</li> </ul>	<ul style="list-style-type: none"> <li>Assist with patient screening of measure target condition and goals</li> <li>OASIS and MDS 3.0 Reporting</li> </ul>
At-Risk Population	<ul style="list-style-type: none"> <li>ACO-22, 26: Diabetes composite</li> <li>ACO-28: Hypertension</li> <li>ACO-29, 30: Ischemic vascular disease</li> </ul>	<ul style="list-style-type: none"> <li>Proper screening, treatment and easily-communicable documentation of efforts</li> <li>Execution of therapy regimens</li> <li>Coordination with acute settings to formulate appropriate nutritional plans</li> </ul>

care only. Both models aim to align incentives for post-acute care providers.

Accountable Care Organizations also align provider incentives, as participating entities together bear responsibility for the financial and clinical outcomes of a defined population. Medicare ACOs are required to report on quality measures, which help quantify care outcomes and health care processes. While coordination with post-acute care providers is not a formal ACO requirement, ACO collaboration with PAC providers can impact overall quality and spending, and help drive clinical and financial results.

ACOs participating in the Medicare Shared Savings Program (MSSP) are required to adhere to 33 care quality measures, 18 of which are impacted by post-acute care providers. Table 1 summarizes roles post-acute care providers can take on to help ACOs achieve CMS quality measures. In addition to the measures stated in the table, ACO MSSP providers are required to report on preventative health measures, of which many PAC providers already capture through MDS and OASIS reporting forms.<sup>a</sup> To ease reporting requirements, ACOs could consult with post-acute care providers and leverage these already established PAC provider reporting standards. PAC provider reporting experience could also be beneficial to improving care processes and coordination.

<sup>a</sup> The Minimum Data Set (MDS) and the Outcome and Assessment Information Set (OASIS) are clinical assessment data sets that nursing homes and home health agencies, respectively, are required to gather and report on for patients reimbursed by Medicare and Medicaid.

With post-acute care services recognized as integral to a patient’s total care, CMS is putting increased emphasis on the development of meaningful quality measures surrounding PAC. The CMS FY 2015 Physician Fee Schedule Proposed Rules calls for public comment on ways to improve care coordination in post-acute care settings for future quality measures, particularly as they relate to care for the frail and elderly. In 2015, ACOs will likely see an additional quality metric that specifically measures skilled nursing facility thirty-day all-cause readmissions.<sup>9</sup> Some quality measures are being directed specifically to post-acute care providers, not just ACOs. PAC providers in some inpatient rehabilitation facilities, long-term care hospitals and hospice facilities must report on quality measures or receive payment penalties. As CMS revises its ACO model, post-acute care will likely play a more direct role in fulfilling quality measures.

Included in MSSP ACO quality measures is the population all-conditions readmission rate. Preventable readmissions, in addition to costing the federal government \$26 billion annually for Medicare beneficiaries alone, are also disruptive to patient recovery.<sup>10</sup> With the MSSP quality measures, the Affordable Care Act also implemented the Hospital Readmissions Reduction Program (HRRP) to provide financial incentives for hospitals to reduce preventable readmissions. Since FY 2013, hospitals with excess Medicare readmissions receive a financial penalty of up to 2 percent of their Medicare reimbursement. The penalty will increase

**Table 2 | Acute Hospital All-Cause Readmissions from Post-Acute Settings**

PAC Setting	Discharged from Hospital to PAC Setting	Rehospitalized after using PAC Setting	Died in PAC Setting	Discharged to a Second PAC Setting	Most Common Second PAC Setting Used
SNF	17.3%	22.0%	5.4%	29.3%	Home Health
Home Health	15.0%	18.1%	0.8%	2.3%	--
Inpatient Rehabilitation	3.2%	9.4%	0.4%	56.8%	Home Health
Hospice	2.1%	4.5%	82.2%	2.4%	Home Health
Long-Term Care Hospital	1.0%	10.0%	15.5%	53.4%	SNF
Inpatient Psychiatric	0.5%	8.7%	0.4%	25.4%	SNF
Total	40%	19.0%	6.2%	19.8%	--

**Table 3 | Comparison of Cost of Post-Acute Care for Various Procedures**

Hospital Condition	PAC Average	OP Rehab	Home Health	SNF	IRF	LTCH
Stroke	\$10,680	\$569	\$2,478	\$8,527	\$18,923	\$22,070
Hip & Femur Procedures for Trauma	\$10,392	\$1,217	\$2,595	\$8,761	\$16,018	\$22,738
Cardiac Bypass with Catheterization	\$5,230	\$837	\$1,778	\$5,737	\$14,631	\$24,526
Heart Failure	\$4,144	\$612	\$1,611	\$6,462	\$14,698	\$20,236

to 3 percent by 2015, and will include more diagnoses that commonly require post-acute care, such as hip and knee replacements and COPD.<sup>11</sup>

Here again, PAC providers and facilities are positioned to have a significant impact on a central ACO performance measure. As indicated in Table 2, patients discharged from post-acute settings often comprise a large portion of hospital all-cause readmissions.<sup>12</sup> Hospitals that are not able to optimize the quality of care offered by post-acute care providers may be at greater risk for readmission penalties.

Health care reform initiatives have the potential to impact all providers, including post-acute care providers. These same initiatives are also establishing and defining the integral role PAC providers play in achieving desired outcomes. Collaboration with post-acute care settings can help non-PAC providers not only avert financial penalties, such as those associated with avoidable hospital readmissions, but also improve overall health spending and care quality.

### POST-ACUTE CARE AND ACHIEVING THE TRIPLE AIM

Government and economic pressures have influenced new models of care delivery. The CMS Bundled Payment Initiative and Physician Fee Schedule amendments modify how care is paid for. The Accountable Care Organization model, on the other hand, not only aligns provider incentives but also sets out to redesign care delivery processes to control costs and improve care quality. Because the purpose of post-acute care is to not only care for chronic conditions in the most appropriate setting but to also discharge patients to lower-cost, lower-acuity providers during the recovery process,

the PAC spectrum creates leverage for ACOs to impact expenditures and health outcomes.

Patients who transition to post-acute care facilities following a major inpatient procedure often have better outcomes and avoid being readmitted to the hospital. Between 1994 and 2009, the National Institutes of Health found that for the most common inpatient hospital procedures, post-acute spending comprised 47 percent, 39 percent, and 73 percent of growth in expenditures, for heart attacks, congestive heart failure, and hip fractures, respectively.<sup>2</sup> Such increases in spending correlated with improved patient outcomes.

Providers and policymakers alike realize that improved patient outcomes correlate with PAC utilization. However, better care may not necessitate high post-acute care spending. Table 3 summarizes a MedPAC analysis of post-acute care Medicare patient claims.<sup>13</sup> For each common acute inpatient procedure, post-acute care needs can be addressed in a variety of settings. Hip procedure patients can receive appropriate post-acute care in out-patient rehabilitation clinics, with home health care, or in skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals (LTCH). By directing hip fracture patients to less expensive out-patient rehabilitation facilities rather than the most expensive LTCH, more than \$21,500 can be saved per beneficiary per episode. Thus, ACOs can significantly decrease spending while still using equally effective facilities that satisfy clinical protocols.

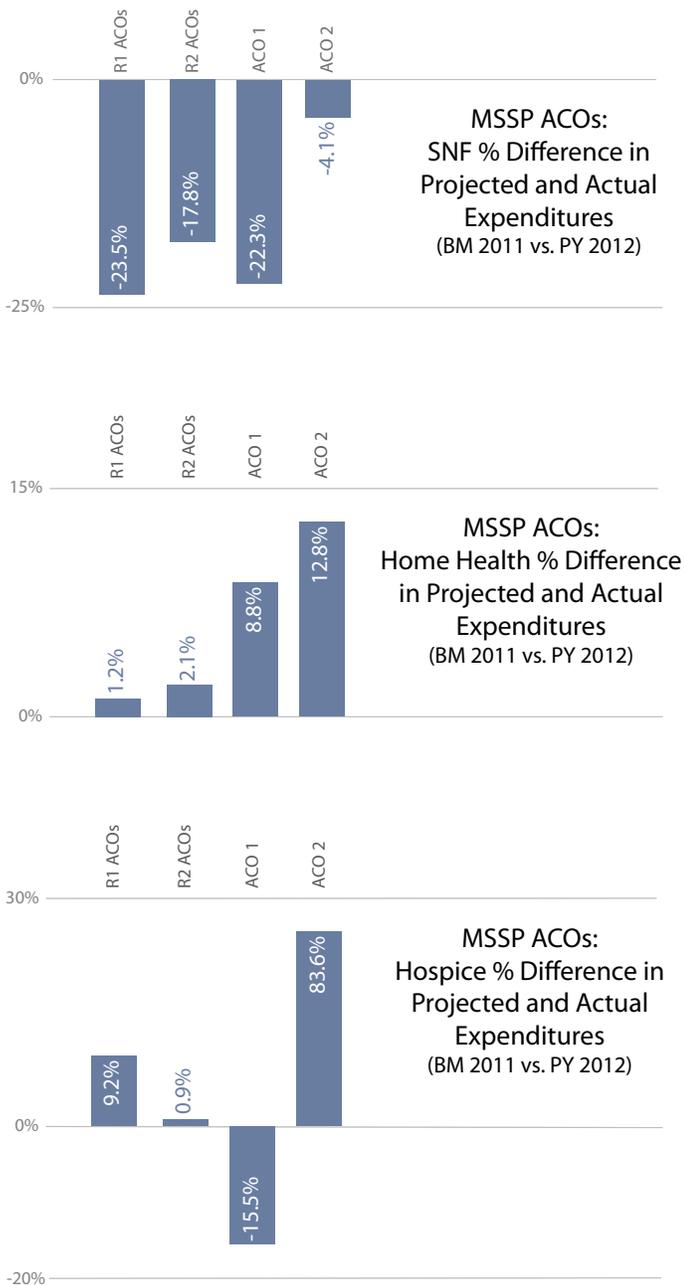
There is evidence that ACOs are already targeting post-acute care as a means to reduce costs. A Leavitt Partners MSSP ACO financial analysis suggests that ACOs are already pursuing strategies to more appropriately utilize post-acute care settings according to a patient's clinical

state. Our analysis (see Figure 2 below) compares projected benchmark expenditures for 2012 (“2011 BM”) against actual performance year (“PY 2012”) expenditures for skilled nursing facilities, home health and hospice expenditures.<sup>14</sup> Results include a comparison of the first cohort of MSSP ACOs (“R1 ACOs”) and the second cohort of MSSP ACOs

(“R2 ACOs”) alongside the results of two individual ACOs (labeled “ACO 1” and “ACO 2”) to show the range of possibilities on both a program and individual ACO level.

The analysis revealed that the most significant decrease in total spending for the majority of round one and two MSSP ACOs during their first performance year occurred in skilled nursing facility expenditures (Figure 2).<sup>15</sup> As expenditures for skilled nursing facilities (SNFs) have decreased, expenditures for other PAC services have increased. Both home health and hospice post-acute care facilities have seen increased expenditures from MSSP ACOs. Lower acuity entities along the PAC spectrum are seeing more utilization, which may represent a market substitution effect as ACOs attempt to shift costs and direct patients to lower cost, lower acuity post-acute care facilities.

**Figure 2 | Average Annual PAC Expenditure Comparison for Select Groups**



**POST-ACUTE CARE WITHIN THE ACO PARADIGM**

Presently, strategies for deploying PAC provider resources within the covered populations of ACOs range from very light arrangements to close integration between these providers. The form and function of these arrangements depend on a number of factors, including the market conditions in which providers operate, the infrastructure already owned by an ACO, and the savings potential that an ACO may be able to realize through an engagement.

The ACO-PAC Engagement Spectrum (Figure 3) provides a framework to describe the various collaborations that ACOs and post-acute care providers are already considering or have engaged in. On the lowest-touch part of the spectrum, “Minimal Commitment,” ACOs control PAC utilization and costs by directing patients to preferred post-acute providers. In more involved strategies, such as “Conditional Collaboration” and “Partnership,” PAC providers within an ACO’s referral network agree to comply with ACO-established standards. Full ACO-PAC integration requires both ACO and PAC providers to share financial risk and have equal access to patient records.

ACOs can more effectively direct PAC service utilization and improve patient care and costs by understanding the types of PAC providers and services that are available in a market. The below case studies provide examples of partnerships that fall within different categories on the Engagement Spectrum and detail unique aspects of each arrangement. These studies, compiled from publically available data and Leavitt Partners ACO interviews, demonstrate that successful collaborations can occur at any level of engagement.

**Table 4 | ACO-PAC Engagement Spectrum**

Minimal Commitment	Conditional Collaboration	Partnership	Financial and Data Integration	Fully Integrated Care Continuum
<ul style="list-style-type: none"> <li>• Little interaction between ACO and PAC</li> <li>• ACOs discharge to certain PAC providers</li> </ul>	<ul style="list-style-type: none"> <li>• PAC providers work to stay within preferred provider network</li> <li>• Shared standards and protocols</li> <li>• Shared utilization data</li> <li>• Clear care transition</li> </ul>	<ul style="list-style-type: none"> <li>• All characteristics of "Conditional Collaboration"</li> <li>• Transition coordinators</li> <li>• Quality measures for PAC providers</li> <li>• Some patient data sharing</li> </ul>	<ul style="list-style-type: none"> <li>• All characteristics of "Partnership"</li> <li>• Shared financial risk</li> <li>• PAC access to EHR</li> <li>• ACO shares certain technologies</li> </ul>	<ul style="list-style-type: none"> <li>• All characteristics of "Financial and Data Integration"</li> <li>• PAC providers are owned by the ACO</li> </ul>

## CASE STUDIES

### Minimal Commitment

Though not formally engaged with post-acute providers, an ACO in the Southeast is attempting to manage post-acute care costs at the ACO physician level.<sup>16</sup> The ACO informs physicians of their referral patterns through a monthly provider utilization report that include details on what types of services were billed, historic utilization trends, and how a physician's utilization trends compare to his or her peers. The reports also include readmission rates and average lengths of stay for surrounding PAC facilities in order to encourage referrals to the most effective post-acute care providers. The ACO executive noted, "The whole idea is to not only get them involved with the cost of their own services, but also the downstream cost that they incur...It's [about] the post-acute side."

### Conditional Collaboration

A Midwest ACO is directly engaging with the post-acute care community by including PAC providers in the ACO's cost reduction strategies<sup>16</sup>. PAC providers become a preferred discharge site by adhering to ACO-established standards and protocols to provide quality care. To ensure smooth patient transitions and care quality, the ACO and PAC providers share utilization data and work together to prevent readmissions, decrease costs, and improve patient outcomes in both settings.

New York's North Shore–Long Island Jewish Health System ACO (North Shore–LIJ) has developed an informal continuing care network of independent post-acute care providers, which includes 19 skilled nursing facilities selected based on quality.<sup>17</sup> The collaboration has resulted in standardized

treatment and assessment protocols for patients with severe conditions in both ACO and PAC settings. North Shore–LIJ has also created a universal transfer form to standardize critical patient information that is transferred with the patient between acute and post-acute providers. North Shore–LIJ's conditional collaboration with SNFs has reduced the ACO's all-cause readmission rate by 5.5 percent and heart failure re-hospitalizations by 4 percent between 2010 and 2012.

### Partnership

To effectively coordinate across the continuum of care, Franciscan Alliance ACO developed the Continuing Care Network, a group of select PAC provider<sup>17</sup>. This network consists of six skilled nursing facilities, a long-term care facility, a home health agency, and an acute inpatient rehab facility, all of which utilize shared quality metrics and discharge reports. To enhance communication, the skilled nursing facilities have access to Franciscan's EHR system to view hospital records and lab reports.

A Minnesota ACO has also formed a partnership with a nearby skilled nursing facility.<sup>16</sup> Key to their partnership is the inclusion of care transition coordinators, who are responsible for transferring care instructions and certain patient data to the PAC provider. Pharmacists have also been recruited to help with medication reconciliation when a patient is discharged to a post-acute care provider.

### Financial and Data Integration

Partnering with providers in the post-acute care space was a part of one Houston ACO's initial care coordination strategies<sup>16</sup>. They are actively building a partnership with a local post-acute hospital that includes PAC quality measures and shared risk. The ACO has also given preferred PAC

providers, even those that are non-affiliated, access to its EHR in order to connect all pieces of the continuum.

Hospice of Michigan engaged Detroit Medical Center ACO in a three-year contract to utilize Hospice of Michigan's @HOME support, an illness-management service.<sup>18</sup> Hospice of Michigan is paid 100% on a risk basis, dependent upon whether savings are realized and quality measures are achieved. According to the hospice providers, @HOME saves 36 percent in medical costs and provides quality care during the last 24 months of life. Data from 2011 showed an average savings of \$2,000 per enrolled patient per month, a 75 percent reduction in days spent in intensive care, and halved hospitalization rates.

@HOME Support is a home-based delivery model that provides advanced illness management through interdisciplinary teams that support patient medical, social and emotional needs. The program focuses on managing pain, providing a comfortable environment, home visits, patient education, and individualized medication and treatment plans. @HOME seeks to reduce emergency room visits by providing an around-the-clock nurse call center and reporting quality and cost data.<sup>19</sup>

### **System Integration**

Holzer Health System's original integration model included PAC providers.<sup>20</sup> Within the system's Post-Acute Care Division, Holzer owns a range of PAC services, including home health, nursing homes, hospice, and assisted living facilities. The system also emphasizes smooth transitions between acute and post-acute settings as well as transitions between different PAC settings.

As an integrated system, a Michigan MSSP ACO integrated post-acute services with the ACO's physician group<sup>16</sup>. The ACO shares risk for cost and quality with its owned skilled nursing facilities, long-term care facilities, inpatient and outpatient rehab services, home care, retail pharmacy home infusion, durable medical equipment components, and laboratory services. Actual integration of PAC within the ACO allows care management teams, which include transition coordinators, to access all patient data and more easily ensure quality care. The post-acute providers are also responsible for MSSP quality measures. As a result of careful coordination across the whole care continuum, the ACO has reduced readmissions by 6.5 percent.

## **BARRIERS TO ACO-PAC ENGAGEMENT**

Challenges present in a regional market can influence the way ACO-PAC arrangements arise. A few issues providers should consider when looking at existing or potential partnerships include market dynamics, ACO configuration and experience, and data interoperability.

### **Market Dynamics**

Significant pressures to reduce readmissions and overall costs can be transferred to post-acute care providers, some of which have resources optimized for a fee-for-service payment environment. A high penetration of risk-based arrangements in a regional market incentivizes PAC providers to anticipate and plan for the transition to value-based payments. ACOs operating in markets that have few ACO-covered lives may find it challenging to share risk for quality and cost with other providers, including PAC, due to the opportunity cost of moving away from fee-for-service payment arrangements without a significant penetration of value-based arrangements.

### **ACO Configuration**

The MSSP and commercial ACO programs give little direction as to an ACO's provider configuration, such as who is involved and to what degree. The ACO structure must account for a number of important issues, including leadership structures, savings distribution determination, and care coordination strategies. Coordinating these organizational challenges with PAC providers could compound the difficulties ACO leadership already face in dealing with these issues, particularly as they relate to disparate data and financial systems. These problems could become more complicated in a market where a single PAC provider is coordinating with a number of ACOs, or vice-versa.

### **Lack of ACO Experience**

ACO providers may not have a working knowledge of the quality and availability of post-acute care services in their geographic region. Planning for and executing a PAC partnership requires labor and time commitments to educate both PAC and ACO providers of the benefits of engaging with each other. Consistent leadership is also necessary to ensure the success of the ACO-PAC partnership in achieving the triple aim.

### **Data Interoperability**

An effective partnership requires a freer exchange of data as the arrangement becomes more involved. Interoperability among EHR platforms and other care management is essential for effective coordination, but can also be costly to facilitate.

### Quality Measures

Additional quality measures provided by commercial and government payers would increase the urgency for ACO and PAC providers to collaborate to effectively address the coordinated impact of each provider in the covered lives of an ACO.

care coordination. By creating more efficient care processes, ACO-PAC integration gives the various areas of the health care continuum the ability to work together to affect total cost of care and improve patient outcomes.

### CONCLUSION

The spiraling costs of health care and increased need to demonstrate quality have sparked considerable reforms to realign incentives for providers through various ACO programs. By understanding the role post-acute care providers can play in a patient's recovery and care, ACOs can begin to form partnerships with PAC providers in order to optimize the full spectrum of care for their covered lives and achieve the triple aim. Partnerships between ACO and PAC providers can utilize the wide array of post-acute services by more efficiently coordinating care and directing patients to lower-cost, lower-acuity PAC providers. To achieve their aims, providers involved in emerging care models must educate themselves on post-acute care and consider the benefits of ACO-PAC engagement. A number of unique ACO-PAC partnership arrangements within the market have already seen positive results through enhanced

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### MHA ACO NETWORK

The MHA ACO Network represents the nation's largest network of post-acute care (PAC) providers including: Skilled Nursing, Assisted Living and Rehabilitation facilities, Long Term Care (LTC) pharmacies, Home Infusion and Specialty pharmacies, and DME and Respiratory providers. Working with Commercial and Medicare ACOs across all markets, the MHA ACO Network leverages its management experience, PAC leadership position and unmatched data capabilities to drive collaborative opportunities that allow ACOs to achieve the triple aim and succeed in their respective healthcare markets.

Additional information on the MHA ACO Network for both post-acute providers and Accountable Care Organizations is available by contacting Michelle Templin, Vice President of Strategic Business Development at 1-855-303-3430 or [aconetwork@mhainc.com](mailto:aconetwork@mhainc.com).

### LEAVITT PARTNERS

Leavitt Partners is a health care intelligence business. We track, analyze, and understand the industry's leading uncertainties and what they are likely to be in the future. The intelligence we share with our clients gives them a better understanding of what the future likely holds which helps our clients make better, more informed strategic decisions that will improve the strength of their position in the market and their bottom line.

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