



## The Importance of **Post-Acute Care** Within ACOs

Accountable Care Organizations (ACOs) have been around for nearly a decade, but ongoing changes to the model can be hard to keep up with. As a result, there is often a misconception that only short-term acute care hospitals are included in ACOs. In reality, long-term acute care hospitals play a vital role as well.

**In this white paper, learn the latest changes and trends in ACOs as well as strategies needed in post-acute care to succeed in the changing value-based landscape.**

### **What Is an ACO?**

ACOs are legal entities voluntarily assembled by providers for the purpose of improving patient outcomes and reducing costs. They do this by providing a seamless continuum of care focused on preventive health and quality outcomes. ACOs also provide support for participating physicians with interoperability, Electronic Healthcare Records (EHR), the Merit-based Incentive Payment System (MIPS) bonus eligibility and reporting technology.

In addition to this eligibility for MIPS value-based payment adjustments, ACO providers are rewarded financially by receiving a share of the cost savings achieved. CMS has provided waiver protection for ACOs to enable savings to be shared, and for post-acute provider network utilization management with the objective of improving care. These waivers allow providers to coordinate care improvement, while remaining compliant with Stark Law.

## Evolving ACOs and Benefits to Providers

The ACO model has evolved since its debut in 2009, and it looks as though ACOs are here to stay. Patients covered by Medicare ACOs rose from 10.5 million in 2018 to 10.9 million in 2019, according to CMS.<sup>1</sup>

Growth is good, but what about the changes that mandate migrating more of the risk to ACO members? Previously, ACOs were only rewarded for quality and cost savings, and were not held responsible for missing such targets. But a January 2020 redesign of the federal Shared Savings Program requires ACOs to take on more risk in the form of repaying CMS when they miss their cost-savings targets. In exchange for sharing in the risk, ACOs will be rewarded with “higher levels of shared savings and greater regulatory flexibility,” according to *Health Affairs*.

ACOs are permitted to shift to the new program over a number of years, but nearly half of new ACOs starting on July 1, 2019, had opted for the downside risk program. And early data suggests the model isn't as risky as it sounds. ACOs that have taken accountability for missing cost-savings targets perform better than ACOs still in shared savings-only programs.<sup>2</sup>

With the coming ACO changes, providers should consider their network partners carefully.

## Three Keys to a Successful ACO

Successful ACOs benefit providers, patients and taxpayers. There are three keys to making an ACO successful:

**1 Prevention.** With metrics based on quality and patient outcomes, working with patients to help them stay well is the crux of everything ACOs do. This, of course, is reliant on maintaining good connections with patients as well as being proactive and consistent with PCP and specialist visits. These efforts and good post-acute partners help ensure that when an acute episode of care occurs, the ACO patient is steered back into preventive pathways by the post-acute setting.



**2 At-Risk Patient Identification.** High-risk patients are the most costly to treat. About 20% of all healthcare expenditures come from the top 1% of the nation's neediest patients, according to the National Academy of Medicine.<sup>3</sup> So in order to control costs, ACOs need to be able to identify their highest-risk patients. They then must assist them with preventive care and offer chronic disease management to keep them from requiring more costly acute care.



**3 Care Transitions.** Every time patients transition from one care setting to another there is the potential that they'll disengage from the healthcare system or there is a gap in care, putting them at risk for further health problems and rehospitalizations. ACOs must shepherd patients through such transitions to keep patients actively participating in the preventive care loop and maintaining wellness.



It is important for all members of an ACO to be aware of – and to execute – these success factors for optimal patient and provider benefit, including participants in the acute and post-acute setting.

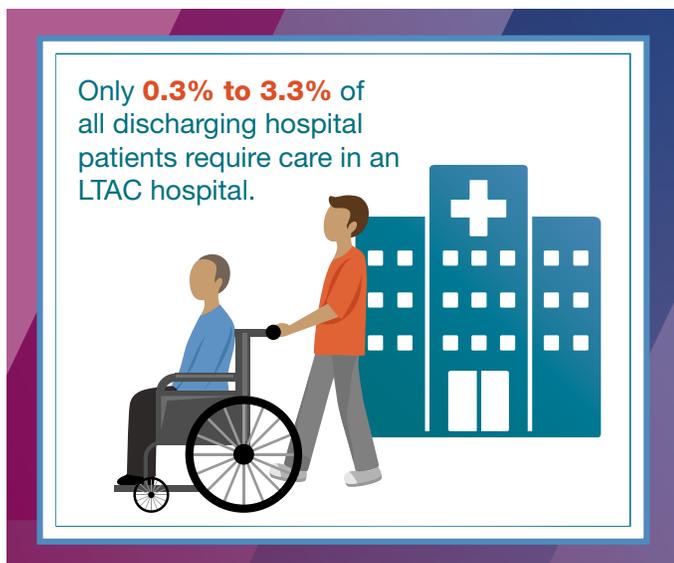


## The Role of Post-Acute Care in an ACO

Building a clinically robust continuum of care includes long-term acute care (LTAC) hospitals. Only a small percentage of patients – between 0.3% and 3.3% – require transitional care in an LTAC hospital,<sup>4</sup> but they are some of the sickest patients, meaning they are the highest risk for readmission, suffer from multiple chronic conditions and have the greatest need to connect with PCPs and specialists on an ongoing basis. Further, placing this population in the most clinically appropriate care settings offers the greatest opportunity to affect outcomes and cost of care.

Releasing chronically, critically ill patients from acute care settings directly to a skilled nursing facility (where care is nurse-led rather than physician-led) can pose substantial risk to patient health and is therefore misaligned with the goal of an ACO. And yet, keeping patients in acute care settings long-term is costly. LTAC hospitals provide intensive care while actively preparing patients to transition home, improving outcomes and reducing costly readmissions.

CMS data consistently show that LTAC hospitals provide cost-efficient clinical care to patients identified as the “sickest” – meaning they spend three or more midnights in an ICU and require ventilator management. The data concludes that the patients receive care that is “as good or better” and “costs the same or less” than patients who bypass an LTAC and receive care in a short-term hospital or skilled nursing facility. And, according to 2012 data, which is the most recent available, matched patients treated in LTAC hospitals were readmitted 44% less often than similar patients who were treated in other post-acute settings.<sup>5</sup>



## Choosing a LTAC Hospital Partner for an ACO

Acute care providers and ACOs need partners that can continue to provide physician-directed care with the extended recovery time required by chronically, critically ill patients. Kindred Hospitals specialize in the post-intensive care treatment of patients with complex medical cases requiring continued intensive care and specialized rehabilitation in an acute hospital setting. With daily physician oversight, ICU- and CCU-level staffing and specially trained caregivers, we work to improve outcomes, reduce costly readmissions and help patients transition home or to a lower level of care.

We are committed to pursuing innovations in care delivery and payment models to provide new tools and solutions to our patients and their families as well as our provider partners. Many of these resources and initiatives are designed to ensure efficient care management for each patient, for whom we have the honor to provide care and play perfectly into the three key factors of an ACO mentioned above.

One such service is our **AfterCare** program. The AfterCare program ensures a smooth transition for patients who discharge directly home from Kindred. Our Registered Nurses contact patients by phone in the first 24-48 hours post-discharge and then one week, two weeks and 30 days post-discharge to assess their progress and identify any post-discharge needs, such as explaining their medication and getting an appointment scheduled with their PCP within 7-14 days. The AfterCare program has proven successful in decreasing rehospitalization rates and removing gaps/barriers in care at the patient's home, offering immense benefit to upstream partners in the aim of prevention.

Additionally, with a focus on at-risk patient identification, our hospitals all across the country have achieved or are seeking disease-specific certification from The Joint Commission for sepsis and respiratory failure. While we have proven success in treating these patients, the changing landscape of older patients with more chronic conditions encourages the continued clinical growth and expertise this population will demand.



## Case Study: Kindred's Long-Time ACO Experience

Kindred is the LTAC hospital partner of choice for many health systems and ACOs across the country. We are well-versed in the drivers of value-based care and are proven participants in generating ACO savings. We believe that being collaborative and transparent with our partner ACOs and payers is behind that success.

In 2014, Kindred became the majority owner of Silver State Accountable Care Organization. This strategic partnership created the largest ACO in the market and in the top 20% nationally, with more than 400 physician partners serving approximately 42,000 patients.<sup>6</sup>

Kindred has been not only Silver State ACO's LTAC hospital of choice, but we've also handled all network and care management for the ACO for the past five years, helping Silver State ACO consistently generate savings to share with CMS:

- \$6.3 million in 2015
- \$15 million in 2016
- \$15 million in 2017

To learn more about how Kindred can help your ACO achieve similar shared savings, visit us at [kindredhospitals.com](http://kindredhospitals.com).

---

## References

1. *Shared Savings Program Fast Facts – As of July 1, 2019*
2. *More ACOs Taking Accountability Under MSSP Through 'Pathways To Success'*
3. *Effective Care for High-Need Patients*
4. *2017 MEDPAR Final File*
5. *Post-Acute Care Payment Reform Demonstration: Final Report*
6. *Silver State ACO 2018 CMS Data Files*