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Managing Population Health as Part of a Post-Acute Care Network

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As post-acute and long-term care providers are very aware, the reimbursement landscape is evolving to focus on rewarding value over the volume of healthcare services provided. Along with this migration to value-based care has come an imperative for health systems and acute care providers to more effectively work with post-acute care providers and integrate them into their delivery model. Long-term and post-acute care providers are presented with the opportunity and challenge of evaluating the best ways to engage with other providers along the care continuum, to not only participate but also garner benefits from their participation in these payment systems. Multiple strategies exist to build or expand a post-acute care network, from partnerships, to contractual relationships for specialty services, to full ownership of the care provider. The decisions made as to which options to pursue largely depend on the prevailing payment model or models the parties are trying to accommodate, the population health management goals for a particular community, and the availability of certain types of post-acute care in the area. A review of the financial, operational, and legal considerations relevant to participation in value-based payment models together with a market assessment will assist post-acute care providers with determining what options may best support their ability to thrive in new payment models.

I. Reimbursement Trends and Value-Based Care Initiatives

A. Overview

"Value-based" health care includes health care delivery and payment models that involve financial and other incentives (and risks) to ensure patients receive appropriate, high-quality care to increase the overall "value" of that care. Value-based payments are not solely based on the volume of healthcare services delivered, which is the case under the traditional fee-for-service model. The "value" in value-based healthcare is derived from measuring clinical process and health outcomes (quality) against the cost of delivering care.

Value-based payment models range widely but all prioritize value over volume. These models are generally referred to as alternative payment models (APMs). Payment models can be organized into categories based on the payment backbone and the amount of financial risk passed from payers to providers:

- Fee-for-Service (no risk)
- Pay-for-Coordination
- Pay-for-Performance
- Upside Shared Savings
- Downside Shared Savings (shared risk)
- Bundled Payment (episode-based)
- Partial/Full Capitation
- Global Budget (most risk)

Hospitals and health systems have been primary adopters of these health care delivery models to accommodate recent payment reforms. They understand that payment will now depend on certain collaborative activities among care providers across the continuum, such as working together differently to enhance quality and reduce cost, care coordination, managing the total cost of care for populations and defined episodes, and developing/using evidence based protocols to reduce variation. In particular, hospital and health system parties will require strong post-acute care partners for engagement in episodic bundling and shared-savings model approaches and strategies, discussed further below.

Top of mind concerns for providers transitioning to value-based care models and evaluating potential partner or network relationships now include:

- How do I get reliable and timely data on cost, quality, clinical decision support?
- How much should I invest in health management infrastructure (e.g., IT, clinical teams)?
- How will we align compensation and payments under new models?
- How fast can we transition to value-based care?
- Who is our key patient population?
- How can we better engage with consumers?
- How will we manage multiple payers?
- **Who will be the right partner(s)?**

B. Shifting Physician Payment

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted in April 2015 with bipartisan support.[1] MACRA fundamentally transformed the way Medicare pays physicians for professional services. While Medicare traditionally paid physicians on a fee-for-service basis, MACRA marks a shift to paying physicians for successful treatment processes and outcomes and rewarding value over volume.

MACRA repealed the Sustainable Growth Rate and required CMS to implement the Quality Payment Program, which provides two pathways for physician payment:

- The Merit-Based Incentive Payment System program (MIPS). Payments to physicians who elect the MIPS option are adjusted (positively or negatively) based on how the physicians score on a number of performance metrics relative to their peers. MIPS streamlines multiple legacy CMS quality and incentive programs, such as PQRS and the Meaningful Use incentive program.

- Advanced APMs. Physicians who elect to participate in an Advanced APM instead of MIPS can be exempt from MIPS's reporting requirements and may be eligible to receive a 5% annual payment bonus, if a sufficient portion of their revenue comes through Advanced APMs. Starting in 2026, they are also eligible for higher annual Medicare Physician Fee Schedule adjustments.

Healthcare providers in APMs seek to align themselves with the goal of taking better care of a certain population of patients to improve quality and lower cost. If an organization adopts one of CMS' APMs, all participants agree to be paid according to the payment model's rules.

Providers may choose to align themselves in order to participate in an APM through formation of a Clinically Integrated Network (CIN) or Accountable Care Organization (ACO). While CIN and ACO are often used interchangeably when broadly referencing value-based payment models, they may differ in scope related to the purpose of the network. A CIN often serves as the physician network on which an ACO is built. Both CINs and ACOs are a means to participate in alternative payment systems (both commercial and CMS) and specifically APMs (CMS).

Ultimately, MACRA signaled an overall need for providers to transition to value-based care. Uptake of risk-bearing Advanced APMs has increased year over year and is anticipated to continue to increase.[2] The Centers for Medicare and Medicaid Services (CMS) programs like the Medicare Shared Savings Program (MSSP) and its episodic payment models (Bundled Payments for Care Improvement (BPCI) program and Comprehensive Care for Joint Replacement (CJR)) have driven much of this APM adoption. While government programs supported by CMS have been a driver in the shift to value-based care, many commercial plans and employer-sponsored plans are now implementing similar payment models.

[1] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10, 129 Stat. 87, 2015. Retrieved from: https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf.
[2] The Health Care Payment Learning & Action Network (LAN), APM Measurement Progress of Alternative Payment Models, 2019 Methodology and Results Report. Retrieved from http://hcp-lan.org/workproducts/apm-methodology-2019.pdf.

C. Significant Changes for Post-Acute Care Providers

Other recent CMS decisions have also had impacts on reimbursement for post-acute care providers, including skilled nursing facilities (SNFs) and home health agencies (HHAs). Further changes to reimbursement of services by post-acute care providers are proposed. These changing reimbursement rules, combined with the APM and other value-based payment arrangements, contribute to expanded opportunities for long-term and post-acute care providers.

As part of overall efforts to move Medicare payment away from fee-for-service and toward a structure that holds providers accountable for patient outcomes and costs, CMS has made significant changes to the HHA and SNF payment systems. The SNF Patient-Driven Payment Model (PDPM) began October 1 (the start of fiscal year 2020), and the Home Health Patient-Driven Groupings Model (PDGM) began January 1, 2020.[3] Both of these payment systems align payment with patient characteristics, conditions, and needs, and eliminate the connection between reimbursement and the volume of therapy services provided—time spent and number of visits. These payment methodology changes will force disruption to how services are delivered at these post-acute care sites. For example, some providers may increase their use of telehealth and telemonitoring to make their services more cost-effective.

In addition to participation in APMs with other health care providers, post-acute care providers have a few other opportunities to participate in value-based programs and models. CMS launched a home health Value-Based Purchasing Model (VBPM) in January 2016.[4] Under the demonstration, which is currently active in nine states representing each major U.S. region, participating providers compete on value, with their payments adjusted accordingly based on certain quality metrics. As they await an expected national expansion of the demo, several home health providers have entered into their own value-based arrangements with insurers.

CMS also has one primary value-based payment program targeted directly at post-acute care providers: the SNF Value-Based Purchasing Program (SNF VBP).[5] Under the program, SNFs are evaluated on a single measure – 30-Day All-Cause Readmission Measure – and will be eligible for incentive payments based on their relative performance.

D. Medicare Advantage

Medicare Advantage plan enrollment also continues to increase. These plans are offered by private companies approved by Medicare and involve care of the Medicare beneficiary population on a full capitation basis. As of the end of 2019 more than 22 million Medicare beneficiaries, or thirty-four percent (34%) of the total Medicare population, are enrolled in Medicare Advantage plans. The share of Medicare beneficiaries enrolled varies from state to state, from one to forty percent (1 - 40%). The engagement of providers with these plans provides opportunities for post-acute care providers to serve as preferred care partners, especially for providers with robust data and a willingness to share that information transparently. These plans also provide opportunities for providers of non-skilled in-home

[3] 83 Fed. Reg. 39162 (Aug. 8, 2018); 83 Fed. Reg. 56406 (Nov. 13, 2018).
[4] The Centers for Medicare and Medicaid Services, Home Health Value-Based Purchasing Model. Retrieved from https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model.
[5] The Centers for Medicare and Medicaid Services, The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.

care and those that would aid in shifting utilization from the skilled nursing facility site to lower-cost home health and telemedicine providers.

E. Removing Barriers to Value-Based Care

More broadly, there have been multiple recent Department of Health and Human Services (HHS) and CMS Requests for Information, and two recent separate notices of proposed rule-making (NPRMs), by CMS and the HHS Office of Inspector General (OIG), seeking to remove regulatory barriers to in various laws and promote value-based innovation and care. Multiple industry players have submitted and will submit comments in response to these requests. The two NPRMs relate to implementation of the Federal Physician Self-Referral or "Stark Law" and the Federal Anti-Kickback Statute (AKS).[6][7] Through these NPRMs, the agencies convey the intent to move the health care payment and incentive systems away from fee-for-service to those focused on quality, cost control and financial risk.

If finalized in their current form, the proposed rule changes would likely provide an improved regulatory framework for existing and innovative value-based initiatives in the health care industry. While the exact timeline for these developments is yet to be determined, the continued focus by CMS on value and push to further coordinate care are apparent. In addition to the proposed new value-based Stark Law and AKS safe harbors and exceptions, this process may result in further fraud and abuse waivers for value-based arrangements, similar to those used in the MSSP, and changes to FMV requirements and the Advisory Opinion process. There may also be additional encouragement of sharing of technology and infrastructure by providers.

II. Legal Structures and Options

The evaluation and decision to participate in any value-based payment model should include analysis of the potential structure together with an understanding of any incentives provided by payers to participants and any pressures or relative risks that accrue to preferred post-acute care providers, including legal and compliance risks.

A. Evolving Roles of the Post-Acute Care Provider

The building and expanding of a post-acute care network can take many forms, whether through partnership, contractual relationship or ownership by another provider. In the past, a post-acute care provider may have had as its strategy to serve as the preferred provider or efficient downstream provider for a few select acute care hospitals, providing high quality services but at an arm's length. Now, the post-acute care provider may desire to position itself as the preferred collaborator and favored partner for risk-taking hospitals, through more aligned relationships, whether through network or ACO participation or other contractual relationships. Consider also whether, at some point in the future, a post-acute care provider might be ready and able to take on the risk of managing a patient population on behalf of a health system, hospital or network partner. There is not a one-size-fits-all approach, but every organization can take steps to evaluate its evolving roles in this environment and determine if it can fit within one of the potential care models available to it. Two

[6] The Centers for Medicare and Medicaid Services (2019, Oct. 17). *Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule.* **CMS-1720-P.**
[7] Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) (2019, Oct. 17). *Notice of Proposed Rulemaking, Revisions to the Safe Harbors Under the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements.* OIG-0936-AA10-P.

government value-based care programs, the MSSP, and Bundled Payments for Care Improvement-Advanced, present unique opportunities for post-acute care providers and will be discussed here.

B. Medicare Shared Savings Program ACOs

This shift to value-based care has been further cemented through CMS' recent "Pathways to Success" final rule, making permanent changes to the MSSP.[8] As background, the MSSP was originally authorized by the Affordable Care Act in 2010, which also authorized Medicare "Accountable Care Organizations" and the CMS Innovation Center (CMMI).[9] 2012 was the first performance year for MSSP ACOs.

CMS' primary justification for its changes to the MSSP at the end of 2018 were because of the observation that some Track 1 models (no downside risk) increased costs to Medicare, while Tracks 2 and 3 (both upside potential and downside risk) have resulted in net savings to Medicare while improving quality. CMS is also making distinctions between low revenue ACOs (typically physician practices and rural hospitals) and high revenue ACOs (typically involving hospitals with more than 100 beds). The primary change to the program is a shortened amount of time that ACOs can participate in upside-only tracks of the program. CMS also established incentives for ACOs to take on downside risk earlier in the program. These incentives relax certain coverage requirements for skilled nursing facility (SNF) care and telehealth services. ACOs with downside risk may use a SNF three-day rule waiver to place beneficiaries into a SNF (each, a "SNF Affiliate") without having a prior hospital stay of three days or longer. SNFs may desire to pursue relationships with these ACOs as SNF Affiliates. These same ACOs may use the telehealth waiver to provide telehealth services to prospectively assigned beneficiaries in non-rural areas rather than only rural areas. These beneficiaries may also receive telehealth services at their home rather than solely in a location designated for telehealth services.[10]

In 2018, 548 MSSP ACOs cared for 10.1 million beneficiaries. According to CMS data for that year, 66 percent of ACOs saved Medicare money, compared to CMS-set spending targets or benchmarks, and 37 percent saved enough money to earn shared savings bonuses. Both of these numbers are increases from previous years.[11] According to CMS Administrator Seema Verma, ACOs that received shared savings payments had decreases in inpatient, emergency room, and post-acute care spending and utilization.[12] As of July 2019, there were 559 ACOs, serving more than 12.3 million Medicare beneficiaries, with hundreds more commercial and Medicaid ACOs serving millions of additional patients.[13]

C. BPCI-Advanced

Bundled Payments for Care Improvement-Advanced (BPCI-A) is a voluntary episode payment model. This is building off the prior BPCI program and CMS made some improvements to it and to the Comprehensive Care for Joint Replacement (CJR) model which was a mandatory program. It

[8] 83 Fed. Reg. 67816 (Dec. 31, 2018).
[9] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).
[10] 83 Fed. Reg. 67816 (Dec. 31, 2018).
[11] CMS 2018 Shared Savings Program (SSP) Accountable Care Organizations (ACO) Public-Use File. Retrieved from https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2018-Shared-Savings-Program-SSP-Accountable-Care-O/v47u-yq84.
[12] Commins, John (2019, Oct. 1). *Medicare Shared Savings ACOs Generated $1.7B in Savings in 2018*. Retrieved from https://www.healthleadersmedia.com/finance/medicare-shared-savings-acos-generated-17b-savings-2018.
[13] National Association of ACOs Homepage. Retrieved from http://www.naacos.com.

tests bundled payments for 32 Clinical Episodes and aims to align incentives among providers for reducing expense and improving quality of care for Medicare beneficiaries.

To participate in BPCI-A, post-acute care providers partner with participating hospitals or physician groups to help those entities manage risk. Under this model, a convener participant brings together multiple downstream entities, facilitates coordination among these entities, and bears and apportions financial risk under the model (a kind of subcapitation). Conveners have typically been a health system, insurance company, or consultant specializing in managing bundled payments or post-acute care rather than a post-acute care provider.[14]

All providers get Medicare fee-for-service rates under the model; however, participants will likely seek to achieve savings by changing post-acute care patterns, and by controlling claims made to Medicare (i.e., shortening SNF days, but balancing this against the risk of hospital readmission). The BPCI-A entity then receives a check from CMS for the savings.

The first cohort of Participants started participation in the Model on October 1, 2018, and the Model Performance Period will run through December 31, 2023. A second cohort started Model Year 3 on January 1, 2020. While enrollment of new participants in the program is now closed, there are still opportunities available for post-acute care providers to become BPCI-A Net Payment Reconciliation Amount (NPRA) Sharing Partners. These NPRA Sharing Partners are a post-acute care provider that: (1) is participating in BPCI Advanced Activities; (2) is identified as an NPRA Sharing Partner on the Financial Arrangement Screening List; and (3) has entered into a written NPRA Sharing Agreement that satisfies all of the applicable requirements of the BPCI Advanced Model Participation Agreement. The NPRA Sharing Partner will receive a portion of the NPRA commensurate with its investment in care coordination under the program.

Further, if a provider is willing to take steps to engage with a health system or hospital participant in a program like BPCI-A at present, it can serve as a good foundation to build infrastructure for engagement in future bundled payment programs. There continues to be interest in voluntary bundled payment programs, as well as growth in commercial value based payment programs that mirror government bundle programs, that we anticipate will extend beyond the expiration of the BPCI-A program.

D. Legal Considerations Affecting Alignment Structures and CINs

There are multiple laws and regulations that apply as providers consider their alignment options such as CIN and ACO formation or participation in bundled payment programs.

1. Fraud and Abuse Laws

The federal Stark Law prohibits physician referrals for designated health services to entities with which the physician has a financial relationship, unless an exception applies.[15] The federal Anti-Kickback Statute prohibits offering, soliciting, providing, or receiving remuneration in exchange for referral of Federal health care program business.[16] The Civil Monetary Penalties Law prohibits offering

[14] Medicare Payment Advisory Commission (June 2019). *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 9 Payment issues in post-acute care.* Retrieved from http://www.medpac.gov/docs/default-source/reports/jun19_ch9_medpac_reporttocongress_sec.pdf?sfvrsn=0.
[15] 42 U.S.C. § 1395nn.
[16] 42 U.S.C. § 1320a-7b(b).

or providing remuneration to Federal health care program beneficiaries that is likely to influence beneficiary's choice of provider, and also prohibits a hospital from knowingly making (or physician from knowingly receiving) a payment to a physician to reduce or limit medically necessary services for Federal health care program beneficiaries.[17] Each of these laws is implicated by physician financial and referral relationships, by the hospital incentives and payments made under alternative payment systems to reduce care, and by any payments to beneficiaries (potential beneficiary inducement).

2. Antitrust, Tax and Privacy Considerations

Antitrust laws are implicated by the impact on competition by too many providers coming together in a CIN, requiring exclusivity in the market or joint action by competitors, without integration.[18] Further, laws relating to tax exempt organizations are implicated by the use of charitable assets for private inurement or private benefit to network participants.[19] The Health Insurance Portability & Accountability Act, HIPAA, is also implicated through the use and sharing of patients' protected health information and restricted records.[20]

3. State Law Issues

State fraud and abuse laws and fee splitting prohibitions, corporate practice of medicine, licensure and liability concerns, laws governing the business of insurance and bearing of risk, and other applicable state and local laws also can apply to these alternative payment systems.

4. Compliance Strategies

Many of the "traditional" Medicare compliance concerns (e.g., False Claims Act, attestation, fraud and abuse, etc.) can be addressed through ensuring that bonuses or performance incentives tied to quality metrics stay within fair market value. Multiple Stark Law exceptions may apply for example, like the Professional Services or Fair Market Value compensation exceptions, or the Risk Share exception.[21] In addition, if the model used is an APM, broad waivers are available for MSSP participants,[22] and narrow program specific waivers are available for CMMI programs, like BPCI-A.[23] On the other hand, it is yet unknown how enforcement will occur under commercial alternative payment systems.

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[17] 42 U.S.C. § 1320a-7a.

[18] For more information about compliance of MSSP ACOs with antitrust laws, see Federal Trade Commission (FTC) and Department of Justice (2011, Oct. 28), *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program.* Retrieved from https://www.govinfo.gov/content/pkg/FR-2011-10-28/pdf/2011-27944.pdf. Multiple FTC Advisory Opinions, Enforcement Actions and other agency resources are available to support analysis of CIN and ACO compliance with antitrust laws.

[19] For more information about charitable organization participation in MSSP ACOs, see Internal Revenue Service (2011, Oct. 20), *Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations*, FS-2011-11. Retrieved from https://www.irs.gov/pub/irs-news/fs-2011-11.pdf.

[20] For more information about ACOs' use of technology for information sharing, see OIG (May 2019), *Use of Health Information Technology to Support Care Coordination Through ACOs*, OEI-01-16-00180.

[21] 42 C.F.R. §§ 411.357(d), (l), and (n).

[22] 80 Fed. Reg. 66726 (Oct. 29, 2015).

[23] The Centers for Medicare and Medicaid Services (2018, May 25). *Notice of Waivers of Certain Fraud and Abuse Laws in Connection with the Bundled Payments for Care Improvement Advanced Model.* Retrieved from https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/BPCI-Advanced-Model-Waivers.pdf.

5. Enforcement

With the high volume of data that will be produced to the government for payment, there will be increased scrutiny of that data for accuracy. Providers can expect contractors to monitor and test quality data. Participating provider agreements should be structured consistent with regulations and any CMS awardee contract, and providers should seek to utilize any available waivers by strictly complying with available guidance. Further, all metrics should be clear and benchmarked against actual performance, and providers should beware of any overlapping payments. False certification claims can be based upon attestations to accuracy of data. Providers should focus on the accuracy of diagnosis coding and documentation which is used to risk adjust capitated payments.

III. Evaluation of Post-Acute Care Network Opportunities

Traditionally post-acute care providers have served an entire community and a whole spectrum of short-term/high acuity to long-term/low acuity patients, with a mix of Medicare, private, and Medicaid payers. In the evolving payment environment, providers are considering how to focus resources specifically on certain target patient populations with a known payer mix. For one, accommodating patient choice has become key. Baby boomers, for example, prefer a "spa-like" experience for rehabilitation. Also, if desiring to attract certain health system and hospital partners, specializing in high acuity care for specific conditions (e.g., mental illness, comorbidities, or wound care) may be necessary. Finally, if targeting Medicare beneficiaries, post-acute care providers have to plan towards maintaining a high volume of short-term admissions.

Providers also need to assess whether they have available to them other non-post-acute care providers to assist with other beneficial services to patients. For example, if there are other available community partners to assist them with addressing food insecurity, housing, and health and wellness education, strong relationships with those partners can assist the post-acute care provider with positioning itself as an attractive partner for the hospital or health system.

Ultimately, a post-acute care provider evaluating the mix of preferred payment models for its organization needs to understand the priorities of potential health system, hospital and network partners, as well as its own population health management strategy and the current post-acute care landscape. To determine whether and what mix of post-acute care network opportunities are desired (i.e., through partnerships, contractual relationships, or a more significant affiliation), post-acute care providers should ask themselves the following questions:

- What capabilities does my organization have to manage complex patients or patients with unique needs (advanced wound care, vent weaning, etc.)?
- Where is my organization located relative to the system or acute care provider's primary patient populations' residences?
- What is the quality of my organization's services, as measured by rates of readmissions, complications and return to the community?
- How can my organization help serve a potential partner's currently owned and affiliated post-acute care assets to meet the needs of the community's patients and their families?

- What is my organization's financial strength and what is the impact of proposed Medicare payment reductions?

IV. Conclusion

There are many strategies for post-acute care providers to engage in value-based payment models and engage in building or expanding post-acute care networks. Network formation and other strategic partnerships among providers and vendors – that contribute shared resources (e.g., infrastructure, care delivery redesign, data management) – can help a post-acute care provider prepare for changes in reimbursement.

One option for post-acute care providers is to cooperate with risk-bearing entities as early as the application process for any government APMs – and build on those relationships to continue collaborating once the applicant has been awarded participation. This strategy can also apply to providers negotiating value-based contracts with commercial payers.

As discussed previously, post-acute and long-term care providers can determine areas of cost savings and care coordination to market to potential health system and hospital partners. These providers also can offer cost savings initiatives to include in care redesign, and include those in any Implementation Protocols for awarded CMS contracts, or in a bid to become a SNF Affiliate or NPRA Sharing Partner under government APMs.

Post-acute care providers also can focus on elements that demonstrate successful provider contracting and compliance, like infrastructure, data collection, and data analysis. To improve case management and care coordination, providers can increase resources devoted to cost reduction and quality improvement, revise and update their quality improvement and data analytics processes, and facilitate participation in care redesign and care process standardization. As discussed, providers also can demonstrate willingness to engage with health systems, hospitals and ACOs in ways that have been shown to create success for them in controlling costs and improving quality.

Finally, providers can actively learn more about the other post-acute care providers and SNFs in the area community, and assess those post-acute care partners using several quality metrics, such as nurse staffing ratios and star ratings, to distinguish themselves in the market. Providers also may consider utilizing long-term care provider networks to band together to share data and best practices.

All of these endeavors will benefit post-acute care providers seeking to engage in both government and commercial value-based care payment models. Evaluating and adopting a strategy to engage in building or expanding post-acute care networks can help providers ease their way into value-based payment models, while simultaneously helping them develop and implement care redesign strategies that will help them thrive in the ever-expanding value-based payment environment.

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