

Health Policy Brief

Medicare changes in post-acute care payment Shaking up the way acute care hospitals approach post-acute care

Produced by the Deloitte Center for Health Solutions
and the Deloitte Center for Regulatory Strategies



Executive summary

“Humans are intended to be upright, weight-bearing, and in motion and the sooner the patient is mobilized, the better the outcomes in terms of fewer complications, less rehospitalization, and likelihood that the individual will be able to live independently and actively.” – Gerben DeJong¹

In 2013, nearly half of all Medicare beneficiaries who stayed in an acute care hospital were discharged into a post-acute care (PAC) setting, with options including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and care in the patient’s residence by home health agencies (HHAs).² The US Centers for Medicare and Medicaid Services (CMS) uses four payment systems for PAC services in Medicare, and each pays different amounts for care.

For years, acute care hospitals have had few financial incentives to coordinate care across PAC settings, often leading to higher costs and readmissions to acute care hospitals.³ But, three policy levers are joining forces to change the way that Medicare pays for PAC services:

- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 set into motion the transformation of PAC payments in Medicare. It required the Medicare Payment Advisory Commission (MedPAC) to develop a prototype prospective payment system (PPS) spanning PAC settings.
- Hospitals increasingly are focused on avoiding penalties under CMS’ Hospital Readmissions Reduction Program (HRRP).
- The Bundled Payments for Care Improvement Initiative and Comprehensive Care for Joint Replacement Program are increasing the use of bundled payments to health care providers.

Why should acute care hospitals care about changes in PAC payment? Together, the above initiatives have the potential to shake up the way acute care hospitals approach PAC. For example, MedPAC’s recommendations to Congress, published in June 2016, say that a unified Medicare payment system for PAC, combined with the shift to value-based payments, quality improvement, and reduced readmissions, would emphasize patient acuity and preference over the care setting.⁴ As a result, PAC providers will likely see higher payments for medical stays, especially for patients on ventilators and for the most medically complex patients, while payments would likely decrease for physical rehabilitation services and for providers with high costs unrelated to their patient mix.

In the near term, acute care hospitals should consider reviewing their approach to PAC referrals and using three strategies:

- Establish stronger policies and processes around patient referrals to PAC to emphasize the most appropriate setting, with goals to reduce readmissions and enhance outcomes.
- Strengthen alignment with high-quality PAC providers through acquisitions or strategic collaborations.
- Work to minimize the impact of the new payment system on any PAC businesses the hospital owns.

While the unified payment system for PAC services in Medicare may be years down the road, the changes occurring now emphasize the urgency that organizations should consider acting with. Acute care hospitals that start planning now are likely to be well-positioned for the new PAC payment landscape.

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Introduction

Individuals who have stayed in an acute care hospital often need follow-up rehabilitative and other services that would be prohibitively expensive to provide through an extended hospital stay. Post-acute care settings, including SNFs, IRFs, LTCHs, and HHAs care for patients in a very fragile state – when they are no longer in critical condition but need constant care and monitoring to continue improving. Many patients (42 percent in the Medicare population) receive care in PAC settings; most at SNFs or by home health agencies (20 percent and 17 percent, respectively). Much less common is care in IRFs and LTCHs (four percent and one percent, respectively). (See Figure 1.)

Current Medicare PAC payment policy

PAC spending in Medicare is significant and growing. In 2013, CMS paid for 9.6 million PAC encounters across the four major settings in Medicare. Medicare spending on PAC services also has more than doubled since 2001, growing from \$27 billion in 2001 to \$59 billion in 2013.⁵

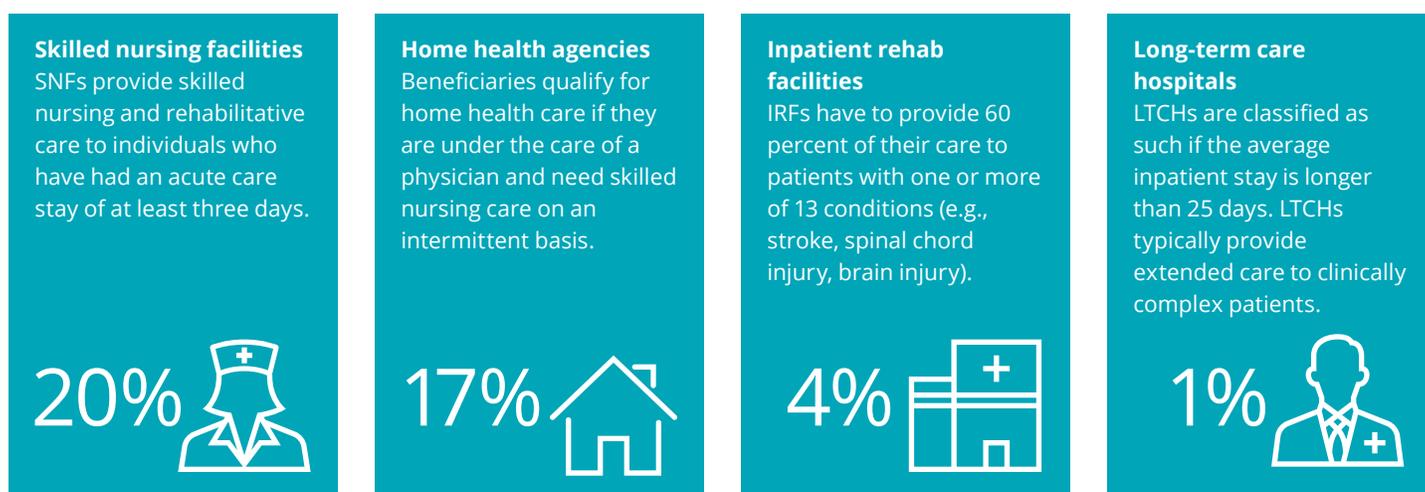
CMS pays for services in each PAC setting using different payment systems, units of service, and case-mix

adjusters. This policy has several problems, according to MedPAC. Among them: payment rates may be too high for certain settings; the various payment systems are inconsistent with each other; and CMS and hospitals have little information to judge the appropriateness of care. For years, MedPAC has said that “Medicare’s payments for PAC are too generous and that its payment systems have shortcomings.”⁶ MedPAC’s concerns have been in three primary areas:

- **Four payment systems mean that the same service performed in different settings is paid for at different rates, regardless of the outcome.**

Medicare pays for services in each PAC setting differently, using four separate PPSs, rates per unit of service, and case-mix adjustments. (See Appendix I.) Patients with the same condition can be discharged to different settings, leading to vastly different costs. For example, for the average stroke patient, Medicare might spend \$13,344 on home health care services, \$33,266 in a SNF, or \$40,881 in an IRF.⁷

Figure 1. Medicare beneficiaries in need of post-acute care are discharged to four main settings



Sources: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/Downloads/pac_reform_plan_2006.pdf; <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html>

- **Acute care hospitals tend to refer patients to PAC providers based on pre-established relationships, market factors, and availability.**

The average hospital refers patients to more than 50 different PAC providers. However, most of the PAC providers in hospitals' networks account for less than one percent of a hospital's referrals, indicating that most hospitals are referring patients to a small subset of PAC providers.⁸ Availability of PAC providers also varies depending on geographic factors.^{9,10} Research suggests that Medicare spending would decrease 73 percent if the geographic spending variation was eliminated.¹¹

- **Few measures exist to understand whether patients go to the most appropriate PAC setting.**

Today, acute care providers have few good measures upon which to base their choice of PAC setting. Regulators and providers rely on proxy measures (e.g., readmissions) to assess settings' appropriateness. The lack of good measures has made it challenging to compare outcomes for this population.¹²

A glimpse into the future

The IMPACT Act of 2014 requires MedPAC to develop a PPS for the four PAC settings. The new payment system would pay for services based on patient acuity versus setting and likely would not be implemented until after 2023, at the earliest.¹³ In the meantime, initiatives such as site-neutral payments, readmissions penalties, and bundled payments may create pressure to accelerate change. A unified payment system would likely increase payments for medical stays, especially patients on ventilators and for the most medically complex patients. However, payments for physical rehabilitation services and for providers with high costs unrelated to their patient mix would likely decrease.

A unified payment system for Medicare PAC

The IMPACT Act requires MedPAC to use the uniform assessment data collected through the Post-Acute Care Payment Reform Demonstration (PAC-PRD) to establish a payment system that would span all four PAC settings. (See sidebar.) MedPAC released its initial report to Congress in June 2016; it details how a future unified payment system could work. Specifically, MedPAC analysts concluded that a unified payment system would achieve two goals:

- Payments would be based on patient acuity rather than the PAC setting.
- PAC providers would have fewer incentives to selectively admit some patients over others because payment would track patient resource needs better.¹⁴

MedPAC’s model for payments across the four settings of care includes:

- A common unit of service (i.e., a stay or HHA episode) with a risk-adjustment system to account for patient characteristics.
- A payment adjustment to reflect lower costs in HHA settings.
- Separate payments for routine and therapy services and for non-therapy ancillary services such as drugs (SNFs, IRFs, and LTCHs are paid for routine and therapy services and non-therapy ancillary services, while HHAs are paid only for routine and therapy services). (See Figure 2.)
- Outlier policies for unusually high-cost stays and unusually short stays.

MedPAC-suggested companion policies may further encourage care coordination and promote high-quality care. The Commission encourages CMS to consider a readmission policy to prevent unnecessary readmissions to hospitals and a resource use measure to counter incentives to provide unnecessary services to boost revenues. MedPAC says transitioning PAC providers to a unified payment system is a first step, but it emphasizes that future payments should be based on episodes of care, thus reducing the need for companion policies.

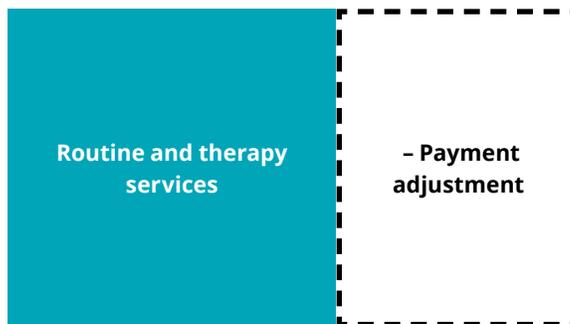
MedPAC recommends that the US Department of Health and Human Services (HHS) Secretary waive certain setting-specific requirements, such as the 60 percent rule for IRFs and the LTCH 25-day average length of stay. It says that CMS could then develop longer-term regulatory requirements that span all PAC providers, with additional requirements for providers who treat the most complex patients.¹⁵

Figure 2. PAC payments would differ for institutional settings and home health services

Patients admitted to SNF, IRF, LTCH



Patients admitted to HHA



Post-Acute Care Payment Reform Demonstration (PAC-PRD)

CMS laid the groundwork for measuring outcomes across PAC settings in the PAC-PRD, which collected information on the PAC system to develop a standardized assessment instrument for use in all four PAC settings.

The Deficit Reduction Act of 2005 authorized the PAC-PRD program to collect uniform data on patients being discharged into PAC settings, assess PAC services in a standardized way, and measure outcomes associated with PAC services.

Nearly 200 PAC providers participated in the demonstration. They provided medical, functional, and cognitive information on patients and data on the resources they used to treat patients in these settings. The information obtained from the PAC-PRD has helped both policymakers and providers better understand how PAC providers function and how their roles differ if other options exist in the immediate area. CMS, in turn, will use these findings to inform its work on the unified payment system for Medicare PAC services.¹⁶

Other initiatives may begin to move the needle

CMS initiatives to penalize hospitals with high readmission rates may encourage acute care hospitals to refer patients to the most appropriate setting for their condition. Additionally, bundled payments initiatives (described below) will likely require acute care providers to shift their thinking as they assume the role of payer and become responsible for PAC services that are part of an episode.

In addition to reviewing MedPAC’s unified payment recommendation, the HHS Secretary must begin to collect unified data on PAC services starting in 2018. After two years, the HHS Secretary must recommend to Congress a unified payment system for PAC. Given this timeline, it is likely that a unified payment system will not be implemented until after 2023, at the earliest.¹⁷

In the meantime, CMS has two initiatives to reduce costs and prohibit both PAC and acute care providers from billing for more services than are needed. The

convergence of these two programs may encourage providers to promptly examine their PAC relationships to control costs and reduce avoidable readmissions:

- **Bundled payments:** The Bundled Payments for Care Improvement (BPCI) Initiative, which launched in early 2013, encourages acute and post-acute care coordination by testing four episode-based models. All four of the models begin with an acute care hospital stay, and three include PAC services. Initial results from the BPCI indicate that participants in one model (Model 2) discharged fewer patients to institutional PAC providers (SNF, IRF, LTCH), decreasing from 66 percent to 47 percent.¹⁸ While the BPCI Initiative is voluntary, as of April 1, 2016, CMS also requires organizations in 67 geographies to accept bundled payments for joint replacement procedures through the Comprehensive Care for Joint Replacement (CCJR) model.¹⁹ In both cases, the bundled payment model establishes a financial relationship between acute care hospitals and PAC providers that places the hospitals in a “payer” role and makes them financially responsible for PAC services that are delivered as part of an episode of care. This further emphasizes the need for improved care coordination across settings and more efficient use of resources.
- **Readmissions penalties:** The HRRP imposes penalties on acute care hospitals for high rates of readmissions – defined as 30 days for a selected set of conditions.²⁰ Phased in over three years, the program began in 2012. Penalties have increased from a one percent payment reduction for all Medicare admissions in fiscal year (FY) 2013 to three percent in FY2015. In late 2014, CMS extended the 30-day readmission penalty to SNFs and HHAs, responding to MedPAC and other stakeholder recommendations that acute and PAC providers both need to be responsible for readmissions.²¹ Generally, readmissions penalties aim to emphasize that what happens after the patient leaves the hospital is equally as important as what happened during their stay. Also, holding PAC organizations to readmissions penalties could strengthen the relationship between acute care and PAC providers and create shared responsibility to select the right setting for patients.

Even as it has been considering a unified PAC payment system, MedPAC, in its 2015 Report to the Congress on Medicare Payment Policy, recommended establishing site-neutral payments for SNF and IRF services. For many conditions that are treated in both settings (e.g., major joint replacement, hip and femur procedure), patient risk profiles are similar but Medicare payments to IRFs are much higher. Using the PAC-PRD quality measures, MedPAC found no significant outcome differences between settings and recommended that IRFs and SNFs be paid the same for these services. It also recommended phasing-in the change over three years and ensuring that IRFs remain in compliance with service mix and intensity requirements by giving them regulatory relief around those conditions.²²

What are the implications for acute care providers?

For more than a decade, SNF and HHA providers have seen margins of 10 percent or higher, even as other providers' margins have been lower, reflecting the effects of payment and delivery reform initiatives.²³ CMS' efforts to reduce readmissions and move toward bundled payments may make it crucial for acute care hospitals to enhance patient referral strategies and strengthen alignment with high-quality PAC providers. In addition, changes to the Medicare payment policy may lower PAC margins, impacting any hospitals that own PAC organizations.

In the near term, acute care hospitals should consider focusing on three strategies:

- **Establish stronger policies and processes around patient referrals to PAC to emphasize the most appropriate setting:** New strategies may require novel metrics, as few measures to evaluate PAC services currently exist, and those that do are basic, at best. New policies also may require acute care providers to develop a deeper understanding of the experiences patients are having in different settings: Do patients who receive PAC services for a stroke fare better in a SNF or LTCH setting? Does it depend on whether the patient has multiple co-morbidities? What about patients who need step-down services (i.e., starting in one PAC setting and transferring to a less-intensive setting)? Acute care providers may need answers to these questions to help decide which settings are most appropriate for referring different patient populations and how to move patients between PAC settings.

- **Strengthen alignment with high-quality PAC providers through acquisitions or strategic collaborations:** As care continues to extend beyond hospital boundaries, acute care providers should consider aligning with high-quality, high-value PAC providers. This may come through unique collaborations or partnerships, or through acquisitions. Medicare Advantage (MA) health plans' strategies for network contracting may serve as examples for acute care providers. (See sidebar.)
- **Understand how the new payment system will work to minimize the impact on any PAC businesses the organization owns:** According to MedPAC, "a unified PPS [for PAC services] in which payments are properly aligned with costs will shift payments from some types of cases, providers, and settings to others."²⁴ For example, a unified payment system would likely increase PAC payments for medical stays, especially for patients on ventilators and the most medically complex patients. However, payments for physical rehabilitation services and for providers with high costs unrelated to their patient mix would likely decrease.²⁵ As a result, acute care hospitals that have acquired PAC providers may see lower margins in some areas.

MA plans use network contracting to include high-quality providers and manage PAC services

Acute care providers may look to lessons from MA health plans to effectively navigate the changing PAC landscape. Whereas in traditional Medicare the onus is on acute care providers to transition patients and guide them through the PAC setting, in MA, health plans typically have established rules to guide decision-making around PAC services. However, applying these strategies in traditional Medicare would require policy changes.

MA health plans establish provider networks and require beneficiaries to visit high-value PAC providers or pay more out of pocket. While providers in traditional Medicare may not limit beneficiary freedom of choice, acute care providers may leverage similar strategies for identifying high-value providers and educating beneficiaries, their families, and/or caregivers about their options.²⁶

PAC provider consolidation may create additional challenges

Federal initiatives to limit PAC spending likely will continue to impact hospitals, even as increasing numbers of PAC providers consolidate. For example, while the home health industry has seen exponential growth in the last decade, analysts expect that growth to slow over the next five years as major players continue to merge and the market becomes more concentrated.²⁷ Consolidation among PAC providers may result in fewer options for referrals and lead to higher costs. The latter could be particularly important as providers initiate bundled payment agreements with payers.

On the other hand, consolidation among PAC providers may lead to better patient outcomes and lower costs if any resulting efficiencies spur improvements in care transitions, streamlined services, supplier purchasing power, and lower administrative costs.

Expect winners, losers, and disrupters

PAC is quickly becoming a primary focus in the next wave of health care innovation. New technologies such as wearables, remote patient monitoring, and telehealth are transforming the way patients are cared for in all settings. These advancements will likely require acute care hospitals to remain nimble while integrating new policies and processes for care transitions.

Many acute care hospitals are expected to employ traditional strategies such as acquiring organizations along the PAC spectrum. More advanced hospitals, however, may pursue alternative strategies such as making large technology and analytics investments and hiring workers with actuarial, analytics, predictive modeling, health economics, and population health experience. Finally, new entrants may leverage innovative technologies and acquire PAC providers

to disrupt traditional players. For example, some companies that built their business models on providing medical surgical products and services have begun to move into this space through PAC acquisitions.

Aging populations and greater effectiveness in managing chronic illness leaves little doubt that the need for PAC services will continue to increase. The IMPACT Act may, eventually, better align payment for these services, but other initiatives and market trends may have more near-term impact. Therefore, acute care providers may need to monitor the PAC landscape as it evolves. First-mover organizations that choose to act now may find themselves ahead of competitors – and may even have the opportunity to share lessons learned with regulators and policymakers as they look to change the way PAC services are administered and paid for.

As with all health care services, the focus should be on patients – getting them to the right setting at the right time and delivering the highest-quality services at the lowest cost. Medicare’s move toward a unified payment system is the first step along the path to value-based care for PAC services.

Appendix I: CMS pays for services in each setting using different payment systems, units of service, and case-mix adjusters; a unified payment system for PAC services would change this

Component	Skilled nursing facility	Home health agency	Inpatient rehab facility	Long-term care hospital	Unified payment system
Payment system (year implemented)	Skilled Nursing Facility PPS (1998)	Home Health PPS (2000)	Inpatient Rehabilitation Facility PPS (1998)	Long-term care hospital PPS (2002)	Uniform PPS
Rate per unit of service	1 day	60 days	Per discharge	Per discharge	Common rate and unit of service
Case-mix adjustment	Minimum Data Set (MDS)	Outcome and Assessment Information Set (OASIS)	Inpatient rehab facility patient assessment instrument (IRF-PAI)	Diagnosis-related group (DRG)	Common case-mix
Other adjusters	Costs outside of the providers' control (vary by setting)				Adjustment to align HHA payments to costs
Outlier payment	Payment adjusted upward if the patient is extraordinarily costly in some settings				High-cost and short-stay outlier policies

Source: MedPAC, "Components of prospective payment systems: PAC settings," September 2015, <http://medpac.gov/documents/pac-pps-sept-2015.pdf?sfvrsn=0>; <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Long-Term-Care-Hospital-PPS-Fact-Sheet-ICN006956.pdf>; <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/snfprospaymtfctst.pdf>; <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-PPS-Fact-Sheet-ICN006816.pdf>; <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/InpatRehabPaymtfctst09-508.pdf>; <http://medpac.gov/documents/default/april-2016-meeting-transcript.pdf>

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Endnotes

1. Gerben DeJong, "Are We Asking the Right Question About Postacute Settings of Care?" *Archives of Physical Medicine and Rehabilitation* Volume 95, Issue 2 (2014): 218-221.
2. Medicare Payment Advisory Committee, "Public Meeting" (September 2015), transcript by B&B reporting. Available at <http://medpac.gov/documents/september-2015-meeting-transcript.pdf?sfvrsn=0>.
3. Medicare Payment Advisory Committee, "Medicare's post-acute care: Trends and ways to rationalize payments" *March 2015 Report to the Congress: Medicare Payment Policy* (March 2015). Available at [http://www.medpac.gov/documents/reports/chapter-7-medicare's-post-acute-care-trends-and-ways-to-rationalize-payments-\(march-2015-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-7-medicare's-post-acute-care-trends-and-ways-to-rationalize-payments-(march-2015-report).pdf?sfvrsn=0).
4. Medicare Payment Advisory Committee, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2016). Available at <http://medpac.gov/documents/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf>
5. Ibid.
6. Ibid.
7. Medicare Payment Advisory Committee, "Approaches to bundling payment for post-acute care" *Report to the Congress: Medicare and the Health Care Delivery System* (June 2013). Available at http://medpac.gov/documents/reports/jun13_ch03.pdf?sfvrsn=0.
8. Christopher Lau, et al., "Post-acute referral patterns for hospitals and implications for bundled payment initiatives," *Healthcare* Volume 2, Issue 3 (2014): 190-195. doi: 10.1016/j.hjssi.2014.05.004.
9. Barbara Gage, et al, "Examining Post Acute Care Relationships in an Integrated Hospital System" (February 2009). RTI: 0208824.002.001.
10. American Hospital Association, "Maximizing the Value of Post-acute Care" *TrendWatch* (November 2010). Available at <http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf>.
11. Greg D. Sacks, et al., "Variation in Hospital Use of Postacute Care After Surgery and the Association With Care Quality," *Medical Care* Volume 54, Number 2 (February 2016). doi: 10.1097/MLR.0000000000000463.
12. Ibid.
13. Ibid.
14. Ibid.
15. Medicare Payment Advisory Committee, "Mandated report: Developing a unified payment system for post-acute care" by Carol Baker (March 2016). Available at <http://medpac.gov/documents/march-2016-meeting-presentation-mandated-report-developing-a-unified-payment-system-for-post-acute-care.pdf>
16. Centers for Medicare and Medicaid Services, "Post-Acute Payment Reform Demonstration: Final Report" by Barbara Gage, et al. (March 2012). RTI: 0209853.005.001. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/PAC-PRD_FinalRpt_Vol1of4.pdf.
17. *Improving Medicare Post-Acute Care Transformation Act, 2014*, Pub. L. No. 113-185, 113th Congress, (October 6, 2014).
18. Lewin Group, "CMS Bundles Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report" (February 2015). Available at <https://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf>.
19. Centers for Medicare and Medicaid Services, "Comprehensive Care for Joint Replacement" (May 2016). Available at <https://innovation.cms.gov/initiatives/cjr>
20. Centers for Medicare and Medicaid Services, "Readmissions Reduction Program (HRRP)" (April 2016). Available at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>
21. *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection*, 42 CFR § 483 (2015). Available at <https://federalregister.gov/a/2015-18950>.
22. Ibid.
23. Ibid.
24. Medicare Payment Advisory Committee, "Public Meeting" (September 2015), transcript by B&B reporting. Available at <http://medpac.gov/documents/september-2015-meeting-transcript.pdf?sfvrsn=0>.
25. Medicare Payment Advisory Committee, "Mandated report: Developing a unified payment system for post-acute care" by Carol Baker and Dana Kelly (September 2015). Available at <http://medpac.gov/documents/september-2015-meeting-presentation-mandated-report-developing-a-unified-payment-system-for-post-acute-care-.pdf?sfvrsn=0>
26. Ibid.
27. IBISWorld "Home Care Providers in the US; Market Research Report" (November 2015). NAICS: 62161.

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