



# Reimagining post-acute care

Moving from fragmented to connected at-home support

## Executive insight: the time to act is now

Post-acute care (PAC) is at a pivotal moment. No longer a peripheral component of healthcare strategy, PAC is central to delivering value-based care, optimizing recovery outcomes, and managing escalating costs. For health plans, the changing landscape is an opportunity to lead the transformation toward a more connected, member-first post-acute model.

## Market signals: 2025 trends redefining the post-acute landscape

The traditional PAC model — anchored in institutional care and fragmented provider networks — is giving way to one that prioritizes home-first recovery, care coordination, and data-informed decision-making.

Health plans must now navigate a complex array of demands: an aging population, higher acuity members, and an urgent need to integrate post-acute strategies into broader care continuum goals. Meanwhile, members increasingly expect personalized and coordinated care experiences that extend beyond the hospital walls.

The post-acute space is being reshaped by a convergence of forces:

- **Value-based reimbursement** is prioritizing outcomes and accountability.
- **Home-based recovery models** are gaining traction, supported by flexibility from Centers for Medicare & Medicaid Services (CMS).
- **Digital care coordination platforms** are essential for seamless transitions.
- **Aging populations** and higher acuity demand smarter, data-driven triage.
- **Social drivers of health (SDoH)** are gaining regulatory and operational focus.



## Health plans must confront these strategic challenges

- **Cost and utilization inefficiency:** Inconsistent length-of-stay protocols and an overreliance on high-cost, facility-based care continue to drive avoidable expenditures. Aligning care settings with patient needs remains elusive without data transparency and clinical oversight.
- **Persistent readmission risks:** Readmissions from PAC settings often signal deeper issues in care quality and transition coordination. These events not only double episode costs but also erode member trust.
- **Fragmented transitions of care:** Each handoff — from hospital to skilled nursing facility (SNF), or from home health to primary care — presents a point of vulnerability. Without integrated workflows and clear accountability, critical gaps emerge.
- **Lack of real-time visibility:** PAC provider performance and patient progress data are often delayed, incomplete, or siloed, hampering proactive management and timely interventions.
- **Disparate provider quality:** The variability in outcomes across SNFs and home health agencies undermines member outcomes and creates significant risk for payers.

## A vision for post-acute excellence

What leading health plans are doing differently



**Embracing home-first  
recovery models**



**Operationalizing  
data insights**



**Building high-  
performance networks**



**Modernizing utilization management  
into proactive care alignment**



**Focusing on a holistic member  
and caregiver experience**



## Spotlight: Carelon's Post-Acute Complete — elevating recovery, seamlessly

As health plans face the dual challenge of rising post-acute spend and fragmented recovery, **Carelon's Post-Acute Complete** is a transformative solution that redefines the member experience across the entire post-acute continuum.

### Care coordination that moves with the member

High-risk members are supported beyond traditional touchpoints. Our dedicated Care Navigators coordinate services, close care gaps, and ensure safe transitions, connecting the dots between clinical care, behavioral health, and social drivers of health.

Our Care Navigators use data insights to prevent complications, reduce readmissions, and ensure seamless recovery from hospital to home. They also address social barriers such as food, housing, transportation, and caregiver support, so every member's needs are met along the way.

### From fragmented episodes of care to coordinated recovery

Legacy models are often forced to handle home health, facility-based care, and transitions as separate programs, creating blind spots, inefficiencies, and increased readmission risk. **Post-Acute Complete** unifies these components into a single, data-driven solution that:

- Improves decisions on appropriate care levels across facility- and home-based settings by removing siloes and taking a holistic view of options.
- Manages care from hospital discharge through 30–60 days post-recovery.
- Optimizes appropriate level of care decisions with real-time risk stratification and data-insight-driven decisions.
- Seamlessly integrates utilization management, discharge planning, and care navigation.



### The future of post-acute care starts here

PAC is no longer an operational afterthought. It is a strategic lever for transformation, a catalyst for improved outcomes, and a bridge to whole-person health. Let's redefine recovery — together.

Contact us or visit [carelon.com](https://www.carelon.com) to learn more about our post-acute solutions.