



Changes in Health Care Financing & Organization (HCFO)

findings brief

key findings

- Between 2000 and 2006, rehospitalizations within 30 days following discharge to a skilled nursing facility increased by 29 percent.
- Initial site of residence prior to a hospitalization affects the likelihood of a rehospitalization.
- There is a significant variation across states in the rate of rehospitalizations following discharge to a skilled nursing facility.

Rehospitalization from Skilled Nursing Facilities: Implications for Policy

One in five Medicare patients discharged from a hospital returns within a month, and the number is even higher for those referred for post-acute care after a hospitalization. Evidence shows that most readmissions after an initial hospitalization are unplanned and avoidable, yet reversing the current pattern is challenging. Incentives are not aligned to ensure a smooth transition across care settings. In fact, providers have a disincentive to coordinate care insofar as rehospitalizations constitute additional revenue.

Reducing rehospitalizations has become a high priority for policymakers seeking to contain health care costs. New research suggests that financial incentives alone are unlikely to address the multiple factors that contribute to rehospitalizations from skilled nursing facilities.

The discharge path for patients who experience a hospitalization is highly variable. After a hospital stay, patients may be discharged to their home in the community, to a nursing home, a rehabilitation facility,

or to a skilled nursing facility. It is the latter group, those discharged to skilled nursing facility, that is the focus of HCFO-funded work by Vince Mor, Ph.D., Brown University, and colleagues.¹ The research team examined the experience of patients discharged to a skilled nursing facility, including the frequency and cost of rehospitalizations.

Analysis

Mor and colleagues examined skilled nursing facility episodes during the period 2000-2006. They examined all Medicare hospitalizations that were followed by a Medicare skilled nursing facility stay and calculated the proportion of these patients who were rehospitalized within 30 days. The researchers calculated the total Medicare reimbursement associated with rehospitalizations and separately calculated costs for those who had previously resided in a nursing home versus in the community. They also compared state-level variation in the rate of rehospitalizations for 2006. Finally, to estimate resource use, the researchers examined



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physician claims for beneficiaries' last two years of life.

Key Findings

Between 2000 and 2006, the rate of rehospitalization within 30 days following discharge to a skilled nursing facility increased by 29 percent. In 2006, the cost to Medicare associated with the skilled nursing facility rehospitalizations was \$4.3 billion, with an average rehospitalization Medicare payment totaling \$10,352.

Mor and colleagues found that the initial site of residence prior to hospitalization made a big difference in the likelihood of rehospitalization. Specifically, individuals who previously resided in a nursing home experienced a higher likelihood of rehospitalization, as compared to their counterparts entering skilled nursing facility via hospitalizations from the community.

The researchers found significant variation across the states in the overall rates of rehospitalization following discharge to a skilled nursing facility. The rates varied by state from 15.1 percent in Utah to 28.2 percent in Louisiana, with nine states falling below 17 percent and nine states exceeding 25 percent.

The analysis also suggested that areas of the country with high numbers of physician visits during the last two years of Medicare beneficiaries' lives also had among the highest rates of rehospitalization within 30 days following discharge to a skilled nursing facility.

In sum, the findings underscore the multitude of factors creating and sustaining the revolving door phenomenon, including significant perverse incentives that increase the likelihood of a rehospitalization for patients discharged to a skilled nursing facility.

Implications for Policy & Practice

"As policymakers retool the current delivery system to address the rehospitalization problem," says Mor, "they will need to consider a combination of broad strategies and targeted interventions." Mor and colleagues point out that there are a number of policy

levers that have the potential to reverse the trend of preventable rehospitalizations. The key, they say, is to provide skilled nursing facilities with the resources and incentives necessary to avoid rehospitalizations.

Potential solutions include changing the current payment system, adjusting Medicaid policies, and modifying physician practice patterns. Nonetheless, the researchers caution that any recommendation for policy change is likely to present implementation challenges.

Payment Policies

Bundled payments for episodes of care are one strategy currently receiving much attention. Under this system, a bundled payment is made for all services associated with a defined episode of care for a defined period. Such a payment model fosters efficient care delivery; reduces the likelihood of unnecessary services; and eliminates the perverse incentives of a fee-for-service system. In the context of rehospitalizations, a bundled payment folded into a diagnosis-related group payment has the potential to foster improved hospital care and successful transitions out of the hospital.² However, determining which provider should receive the incentive payment and be accountable for the rehospitalizations is likely to be contentious.

Another strategy currently being explored is using pay-for-performance financial incentives in nursing homes. In 2009, the Centers for Medicare and Medicaid Services launched the Nursing Home Value-Based Purchasing (NHVBP) Demonstration in three states. As part of the demonstration, nursing home quality is assessed across a variety of domains, including inappropriate hospitalizations. CMS expects savings to accrue from avoidable hospitalizations and stays in skilled nursing facilities. Nursing homes that rank in the top 20 percent in terms of performance may be eligible for a share of those savings.³ It is still too early in this demonstration to determine how states and providers will solve the many challenges they face in aligning the measured incentives, including reduced hospitalizations.

Medicaid Policies

As noted above, individuals who resided in a nursing home prior to the initial hospitalization have a greater likelihood of rehospitalization following discharge to a skilled nursing facility. Typically, Medicaid is the primary payer of nursing home stays, while Medicare pays for hospitalizations, post-acute care, and rehospitalizations. Although considerable evidence suggests that skilled nursing facilities that invest in nurse practitioners and medical staff produce better care outcomes, it is not in the financial interest of Medicaid to adopt policies that encourage investments that lower Medicare hospital and skilled nursing facility spending.

Although policies that create global payments could realign incentives across all payers, there may not be sufficient political will to do so. Moreover, the issue is complicated by varying state nursing home bed-hold policies, which are designed to discourage nursing homes from discharging low paying, costly, or complicated patients and encourage residence continuity.

Provider Practice Pattern Policies

Evidence suggests that non-financial factors affect the level and variation of rehospitalizations. These factors include physician supply and their practice patterns. The "culture" of intensive use of medical services can be clearly seen in a similar pattern of "transitioning" through the "revolving door" as measured by the hospitalization and rehospitalization rates. As such, policy solutions need to address direct care delivery, but are likely to run counter to current practice norms.

In addition, system-based interventions to address rehospitalizations could be considered, including spending benchmarks, such as budgetary caps benchmarked to low-cost areas; shared decision-making, i.e. decision support systems providing patients with balanced information about treatment options; and the promotion of centers of excellence, hospitals, provider networks or organizations representing regional coalitions which establish "best practice" models.⁴ Nonetheless, like bundling, such system interventions require an

understanding of which provider or providers should be held accountable for the rates of transition.

Conclusion

With an aging population, increasing numbers of individuals are likely to be discharged to skilled nursing facilities and other post-acute settings following hospitalizations. Reducing avoidable rehospitalizations presents not only an urgent dilemma but also a real opportunity to reduce health care costs and improve the quality

of care and quality of life for individuals transitioning across care settings.

About the Author

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Endnotes

1 For additional details of the analysis and complete findings, see Mor, V., et al., “The Revolving Door of Rehospitalization from Skilled Nursing Facilities,” *Health Affairs*, Vol. 29, No. 1, January 2010.

2 Pham, H., et al., “Episode-Based Payments: Charting a Course for Health Care Payment Reform,” National Institute for Health Care Reform, No. 1, January 2010. <http://www.nihcr.org/EpisodeBasedPayments.html>.

3 <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1198946&intNumPerPage=10>

4 Wennberg, J. et al., “Geography and the Debate Over Medicare Reform,” *Health Affairs*, 2002; 21:w96-114.