

High-Performing Skilled Nursing Facilities Could Prevent 100,000 Medicare Hospital Readmissions per Year and Save \$56 Billion over 10 Years

Skilled nursing facilities (SNFs)—which play the vital role of helping patients recover after surgical procedures and medical conditions requiring hospital care—provided post-acute services to over 2 million Medicare beneficiaries at a cost of over \$40 billion in 2019.^{1,a}

Inconsistent SNF Performance

Medicare beneficiaries, hospitals, and the Medicare program are challenged by inconsistent SNF performance that contributes to poor outcomes and higher costs. Among Medicare fee-for-service (FFS) beneficiaries:

- 54 percent either return to the hospital or die within 30 days of a SNF discharge.²
- 33 percent experience adverse outcomes or temporary harms during a SNF stay, and 59 percent of these events are preventable.³

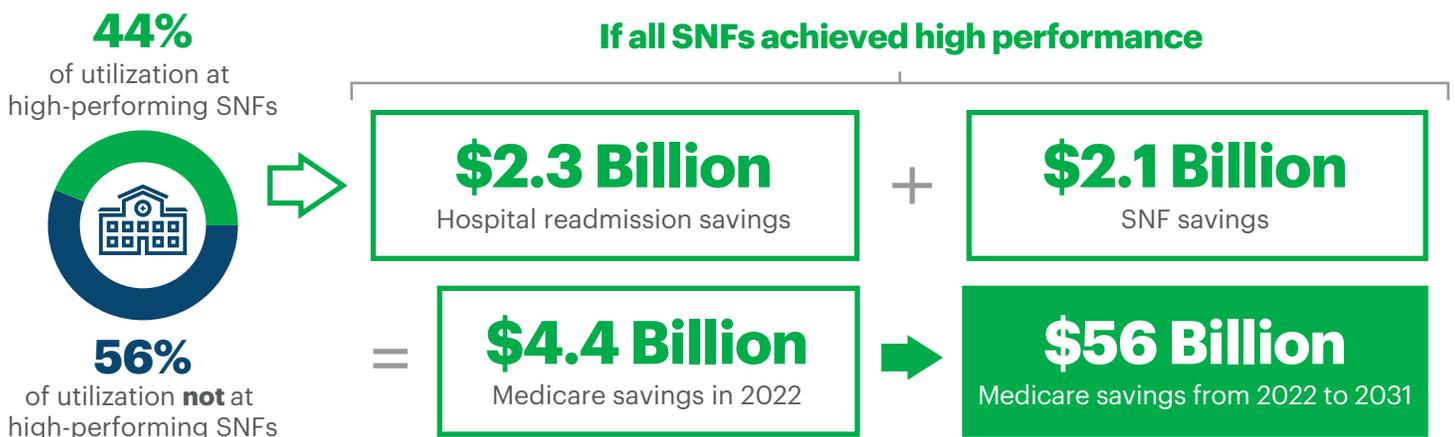
The Opportunity

Variation in hospital readmission rates and length of SNF stays represents an opportunity to improve the quality and lower the cost of care for Medicare beneficiaries. In 2019, UnitedHealthcare Medicare Advantage members who received care at a high-performing SNF experienced:^b

- A 24 percent lower hospital readmission rate; and
- 12 percent lower costs, due to shorter SNF stays and fewer hospital readmissions.

If all SNFs achieved high performance, Medicare beneficiaries could experience 100,000 fewer hospital readmissions per year, and Medicare could save \$4.4 billion during the first year and \$56 billion over 10 years.

Potential Medicare Savings from All SNFs Achieving High Performance



a While 90 percent of the nation's 15,000 SNFs also deliver long-term care, which is most commonly paid for by Medicaid, this analysis focuses exclusively on Medicare-covered post-acute care.⁴

b "High-performing" SNFs accounted for 44 percent of SNF admissions by UnitedHealthcare Medicare Advantage members in 2019. A complete description of UnitedHealthcare's criteria for high performance can be found in the methodology.

Approaches to Improving Post-Acute Care

There are several approaches Medicare Advantage plans, hospitals, and SNFs can take before, during, and after SNF stays to help improve the quality and lower the cost of post-acute care. Federal and state policies can support these approaches.

Before

Provide accessible information

about SNF performance and programs (e.g., advanced wound care) to hospitals, clinicians, and patients during the hospital discharge planning process to inform referral decisions.

Conduct risk stratification

of patients and offer the most intensive post-acute care interventions to patients with the greatest needs.

Improve clinical information-sharing between hospitals and SNFs.

During

Manage care for patients, including identifying and addressing clinical and social barriers to optimal recovery.

Target additional nurse support to ensure patients' clinical needs are met.

Develop a customized care plan before discharge to support patients' ongoing care.

Provide an initial home visit to check safety, assess health status, and/or review the care plan.

After

Offer patients additional clinical support at home by leveraging telehealth, remote patient monitoring, and home visits.

Identify Social Determinants of Health barriers and opportunities to provide non-medical services, such as meal deliveries and transportation.

Offer care coordination and education services to patients to ensure they know what to expect before, during, and after the SNF stay and transition seamlessly to and from each care setting.

Establish payment models that create aligned incentives among plans, hospitals, and SNFs to improve the quality and cost-efficiency of care.

Methodology and sources for citations are available at: <http://www.uhg.com/high-performing-SNFs-research>.