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## Alliance Position Paper: A SNF Rehospitalization Initiative

### Background

Avoidable rehospitalizations represent one of the highest-profile issues in both acute and post-acute care. One out of every five Medicare beneficiaries discharged from the hospital is readmitted within 30 days -- 90% are unplanned -- and cost Medicare over \$17 billion annually.<sup>1</sup>

Research indicates the majority of these unplanned readmissions are preventable. MedPAC estimates the cost to Medicare of potentially preventable readmissions at \$12 billion per year.

Forty percent of Medicare beneficiaries are discharged to post-acute care settings such as skilled nursing or inpatient rehabilitation facilities. This is important because gaps in care coordination *between* acute and post-acute settings (e.g., inadequate exchange of information about care and treatment in acute settings or lack of medication reconciliation) are widely cited as risk factors for rehospitalization. Improvement in care coordination across settings is becoming even more essential to providing quality care, because the ongoing decline in hospital length of stay that began in 1990s continues to result in the discharge of sicker patients to SNFs. The readmissions reduction program in the Affordable Care Act, however, focuses *solely on hospitals* -- and ignores the crucial role of hospital and post-acute coordination in reducing this problem.

The Alliance for Quality Nursing Home Care believes a fully effective rehospitalization program must cross care settings and align incentives across providers. Until such a program is developed, however, the Alliance supports establishing an interim initiative to reduce Medicare rehospitalizations from SNFs based on the Administration's proposal.

**Administration proposal:** Beginning in 2015, individual skilled nursing facilities with above-average rehospitalization rates would have their reimbursement rates cut by up to 3 percent. The Administration proposal is very similar in approach to the hospital readmission reduction program in the Affordable Care Act.

**Alliance position: The Alliance will support the Administration proposal, with the following modification:** CMS would be required to consult with independent academics and other stakeholders regarding the manner in which the definition of rehospitalization and/or readmission would: (1) account for the geographic variations in readmission patterns; and (2)

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<sup>1</sup> MedPAC. MedPAC Report to Congress, *Promoting Greater Efficiency in Medicare*. June 2007.

risk adjust for patient mix and in doing so account for the substantial differences in patient characteristics and readmission patterns between Medicare post acute patients in SNFs and long-stay nursing home patients. These factors are well documented in the professional literature and demonstrate that a definition designed primarily for hospitals is not appropriately applied to SNFs.

Given that the SNF rehospitalization initiative would not begin until 2015, there is ample time to develop such a SNF-specific metric without jeopardizing the savings to be generated within the relevant budget window.