Patients discharged to home care vs. nursing facilities have higher rates of hospital readmissions

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Spending on post-acute care continues to rise in the United States. Today, nearly 90 percent of Medicare patients discharged to post-acute care receive that care in either a skilled nursing facility or home health care. However, little is known about the differences in outcomes and costs between these two settings. Now, a new study shows that Medicare patients discharged from the hospital and into home health care have higher rates of hospital readmissions compared to those discharged to a skilled nursing facility. The results, published today by Penn Medicine researchers in *JAMA Internal Medicine*, also shows that providers received significantly lower Medicare payments for these patients.

"With the increasing costs of post-acute care and changing payment models that hold providers more accountable for costs across clinical settings, it's important to assess and understand the impacts of these choices," said first author Rachel Werner, MD, Ph.D., a professor of Medicine and director of Health Policy and Outcomes Research in the department of Medicine at Penn's Perelman School of Medicine. "We found clear tradeoffs: While home health care may cost less, it doesn't have the same intensity of care as a skilled nursing facility, which may be sending many of them back into the hospital."

The findings have important implications for today's health care system, which continues to work towards refining payment incentives that optimize provider response and reduced spending. In 2015, Medicare spent more than $60 billion on post-acute care, a figure that has continued to rapidly increase.

Under the Affordable Care Act, Medicare implemented payment reforms designed to reduce the rates of readmission, pushing hospitals to favor skilled nursing facilities, which have been shown to reduce those rates. However, at the same time, alternative payment models, such as accountable care organizations (ACO) and bundled payments, that may push patients toward lower-cost options like home care, have come into play. ACOs can be a network of providers who collaborate to deliver more cost-effective treatments across the spectrum of care for Medicare and other patients in an effort to lower overall health care costs. Studies have shown that these two approaches are associated with lower rates of institutional post-acute care, such as skilled nursing facilities.

Researchers examined the differences in rates of 30-day readmissions, 30-day mortality, functional outcomes, and Medicare payments for over 17 million discharges of eligible Medicare beneficiaries to home health care versus skilled nursing facilities between 2010 and 2016. They found that patients receiving home health care were 5.6 percentage points more likely to end up back in the hospital within 30 days of discharge than patients receiving post-acute care from a skilled nursing facility.

Differences in Medicare payments were also significant. The average payment for patients discharged to home health was $5,384 less than for patients discharged to skilled nursing facilities, the researchers reported. Also, total Medicare payments after 60 days for patients discharged to home care was $4,514 less for patients discharged to skilled nursing facilities. There was no difference in mortality or functional outcomes among the two groups.

The researcher said the results warrant further investigation among Medicare patients and others, given the high use and cost of post-acute care in the United States that's only expected to grow.

More information: Rachel M. Werner et al. Patient Outcomes After Hospital Discharge to Home With Home Health Care vs to a Skilled Nursing Facility, *JAMA Internal Medicine* (2019). DOI: 10.1001/jamainternmed.2018.7998

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