PointClickCare®

White Paper

The Cost of the Post-Acute Blind Spot

Why Transitions of Care Are Now the Deciding Factor in Quality and Cost Performance for Health Plans

Executive Summary

Post-acute care was long treated as a black box for health plans, important to outcomes but difficult to manage in any practical way. That assumption no longer holds. Today, the days surrounding discharge, from hospital to skilled nursing facility (SNF) and from SNF back to home or community, carry too much weight for cost, quality, and member outcomes to remain outside active intervention. When plans cannot see and act within those transitions, they are left absorbing avoidable readmissions, extended institutional stays, and worsening quality performance. New proprietary research makes the stakes clearer and, importantly, points to a more practical path forward. With real-time visibility and clinical intelligence, care teams can help members move safely to the right setting, sooner. This paper examines what is breaking, what it is costing, and what leading plans can now do differently.

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The Status Quo Now Comes at a Cost

Post-acute care has long been under-managed—not because plans doubted its importance, but because they doubted it was manageable. SNF and long-term care episodes were treated as a black box: the clinical data needed to act was assumed to be inaccessible, so plans concentrated care management where data was already visible, not necessarily where impact was highest. Post-acute became "important, but not a priority."

That logic has quietly become a liability. The risk it once allowed plans to work around has not diminished. It has become more concentrated, more consequential, and far more difficult to ignore. The highest-cost, highest-acuity members are often the ones moving through SNF stays and transitioning home. The moments that determine whether recovery holds or begins to unravel happen after discharge, often outside the plan's traditional line of sight. At this point, maintaining that blind spot is not a passive decision. It is an active acceptance of outcomes that more timely visibility and intervention could help prevent.[1]

> "You can't access SNF/LTC data, so you don't try."
>
> — President, Indiana Market (PointClickCare / Sage Growth Partners research)

The encouraging news is that the premise has changed. The data exists, it can be surfaced in real time, and the plans acting on it are turning one of the most fragile points in the member journey into one of their strongest levers for quality and cost performance.

Where the Money and the Measures Are Decided: Transitions of Care

There has never been a more direct line between care transitions and financial performance. Cost and quality pressures that could once be managed independently are now inextricably linked, and they converge at the handoff.

Medicare Advantage

For Medicare Advantage plans, risk-adjustment tightening under V28 is compressing revenue. At the same time, Star Ratings are graded on a steeper curve, so incremental improvement is no longer enough to hold position. Critically, CMS now triple-weights Plan All-Cause Readmissions (PCR). That means outcomes after discharge have outsized influence over bonus eligibility and revenue stability.

Medicaid

For Medicaid plans, the path differs but leads to the same place. Rising HEDIS thresholds, increasingly performance-based incentives, and persistent funding constraints mean avoidable utilization driven by poor post-discharge coordination erodes already-thin margins and pushes quality payments further out of reach.[2]

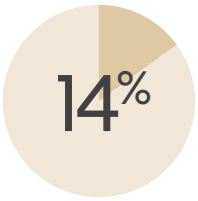
Meanwhile, the traditional cost-control playbook is losing its edge. Prior authorization and utilization management were designed to manage the front door of care. They remain necessary, but they are increasingly constrained by expanding gold-carding laws, heightened CMS oversight, and growing member frustration with delays and denials. Just as important, they do little to address where avoidable spend often takes shape now: in breakdowns in coordination, missed transitions, and delayed intervention after discharge. The most expensive utilization events, including readmissions, ED visits, and extended institutional stays, are rarely determined by whether care was authorized. More often, they are determined by whether the transition was managed well.[3]

The window for action is narrow, and much of it sits inside the post-acute stay itself. Risk builds while a member is in the SNF, and the move out of the SNF to home or community is where recovery most often either holds or breaks down. Identifying rising risk during the stay and coordinating a safe, well-prepared discharge is what changes the trajectory of care. The evidence is clear that structured, timely follow-up at the point of transition can reduce readmissions substantially. The opportunity is real. The problem is that, too often, the SNF stay ends before care managers have the visibility they need to act.[4]

The Evidence: A Post-Acute Blind Spot, Quantified

This is not a theoretical gap. To measure it, PointClickCare commissioned independent research conducted by healthcare market research firm Sage Growth Partners, surveying more than 150 health plan leaders in Q4 2025 on managing post-acute care and improving transitions. Respondents spanned national, regional, and provider-sponsored plans across Medicare Advantage, Medicaid, and Dual-Eligible Special Needs Plans.

The diagnosis is consistent: care management underperforms when visibility breaks down at transitions of care, precisely when timely intervention matters most. The findings below quantify where the breakdown occurs and why it directly limits a plan's ability to intervene, prevent avoidable utilization, and improve performance.



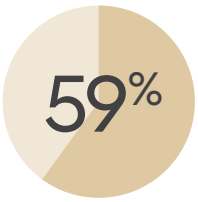
of health plans report real-time post-acute data exchange

What the data shows

Just 14% of health plans report real-time post-acute data exchange.

Why it matters

Real-time visibility remains rare. Most plans are managing a high-risk transition with delayed or incomplete information.



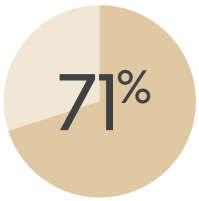
of plans describe their visibility into SNF and long-term care settings as "somewhat" or "very" limited

What the data shows

59% of plans describe their visibility into SNF and long-term care settings as "somewhat" or "very" limited.

Why it matters

Most plans openly acknowledge they are managing their highest-risk, highest-cost setting with limited line of sight.



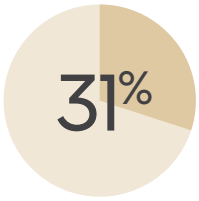
of plans' top improvement requests center on data availability, integration, or clarity for SNF/LTC settings

What the data shows

71% of plans' top improvement requests center on data availability, integration, or clarity for SNF/LTC settings.

Why it matters

The core barrier is not effort. It is the lack of usable data from the settings where costly transitions often unfold.



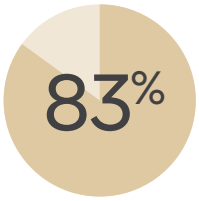
of plans receive timely data from post-acute providers within a day; the remaining 69% face multi-day or multi-week

What the data shows

Only 31% of plans receive timely data from post-acute providers within a day; the remaining 69% face multi-day or multi-week delays.

Why it matters

When information arrives late, the best opportunity to prevent deterioration may already be gone.



Plans rank SNF/LTC as their single greatest opportunity for both quality improvement (84%) and cost reduction (83%)

What the data shows

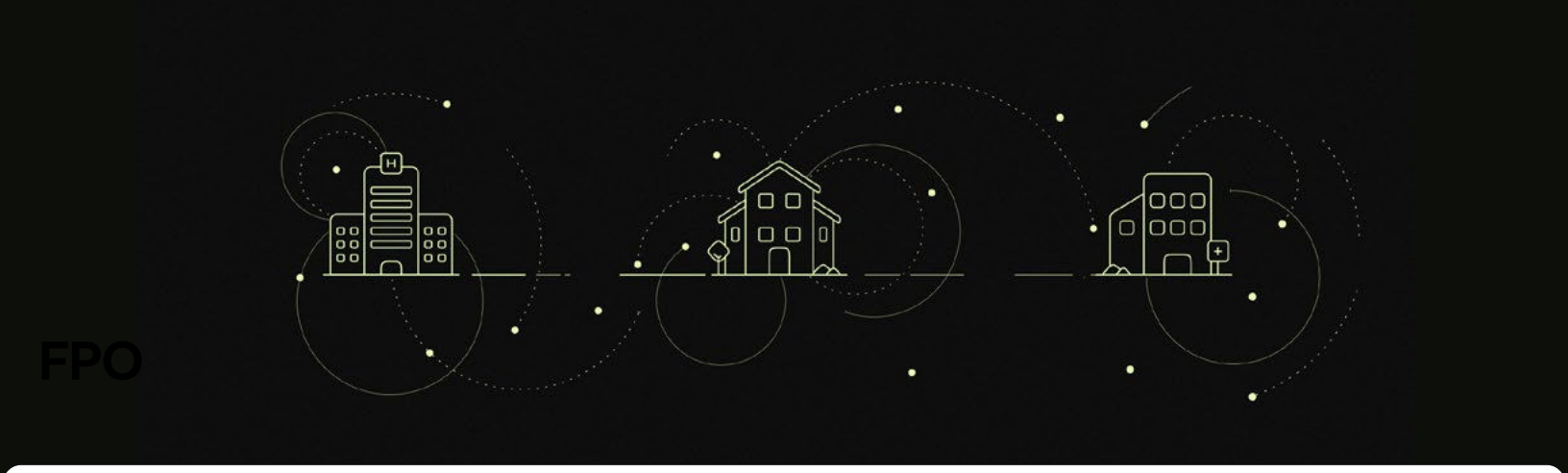
Plans rank SNF/LTC as their single greatest opportunity for both quality improvement (84%) and cost reduction (83%).

Why it matters

The opportunity is recognized at the leadership level. The gap is visibility and execution, not awareness.

The pattern is hard to miss. Care management may be positioned as a strategic lever, but in many organizations, it is still executed with tools built for retrospective coordination rather than real-time intervention. Information arrives late, fragmented, and scattered across systems. Even when the data exists, it rarely surfaces as an actionable signal inside the narrow window when it could still change the outcome.

> If we utilize the data in the right way, then we're going to move the needle. If it's sitting somewhere in some server or some database and not being pulled out, then there's nothing we can do.
>
> — Director of Healthcare Management (PointClickCare / Sage Growth Partners research)



The Post-Acute Black Box

The blind spot begins at acute discharge, but it widens dramatically once members enter post-acute care. SNF and long-term care settings remain among the least visible points in the entire continuum, even as they care for some of the highest-risk, highest-cost members, including Medicare Advantage, dual-eligible, and Medicaid populations. Without visibility into these stays, plans cannot influence length of stay, identify rising risk, or coordinate a timely, safe return to the community.[5]

> Plans have strong visibility into hospitals, but SNFs are fragmented and largely invisible. That's where patients—and opportunities—are getting overlooked.
>
> — Senior Vice President, Regional Managed Care Organization (PointClickCare / Sage Growth Partners research)

Plan leaders know exactly where the opportunity sits, and they consistently point to SNF and long-term care as the place to act. The challenge is that critical clinical events and changes in member status aren't surfaced in time to act on. Among the signals care managers say they need most, medication information ranks first. Nearly half of leaders identify it as the most valuable signal, reflecting both its impact on outcomes and the difficulty of reconciling regimens that change repeatedly across hospital and SNF stays. Inaccurate or conflicting medication data introduces immediate clinical risk at exactly the moment a member is most fragile.[6]

The core pain points plans must solve to move readmissions and quality are concrete. They include accurate and complete medication lists and reconciliation, clear care plans and discharge instructions, identification of the responsible follow-up provider, documentation of follow-up appointments and referrals, and reliable signals of rehospitalization risk. Each missing element narrows the window for effective intervention and pushes outcomes back toward the plan's cost line.

What This Is Costing You Right Now

These gaps are not abstractions on a dashboard. They appear as members readmitted within days of a discharge no one saw coming. They surface in first outreach calls after a SNF discharge that begin from square one because the care manager lacks the clinical context to guide the conversation. They show up in skilled stays that run longer than necessary because no one can confirm discharge readiness with confidence. And they are reflected in TRC and PCR performance that falls short because the handoff was not executed in time.

The economics are direct.

The average cost of a hospital readmission ranges from $15,000 to $17,500

$15,000 to $17,500/readmission

Preventing just one readmission per week yields annual savings approaching $1 million.

- $1 million/year

For a 50,000-member Medicare Advantage plan, a 5% reduction in readmissions can unlock multi-million-dollar savings per year.

= multi-million-dollar savings

Because these are broken utilization patterns rather than one-time events, the benefits compound annually.[7]

Every week the status quo holds, those avoidable events continue to recur, and the quality measures that influence revenue move further out of reach. That is the cost of waiting, and plans are already paying it.

The Path Forward: Real Post-Acute Care Management

The research describes an industry that knows where it's headed but is held back by the tools and data it has. The path forward isn't more dashboards or more effort from already-overwhelmed teams. It is giving care managers the right clinical information at the right moment, in a form they can act on immediately. That lets them anticipate risk and coordinate care before complications set in. Three shifts are achievable today and would meaningfully change a plan's trajectory:

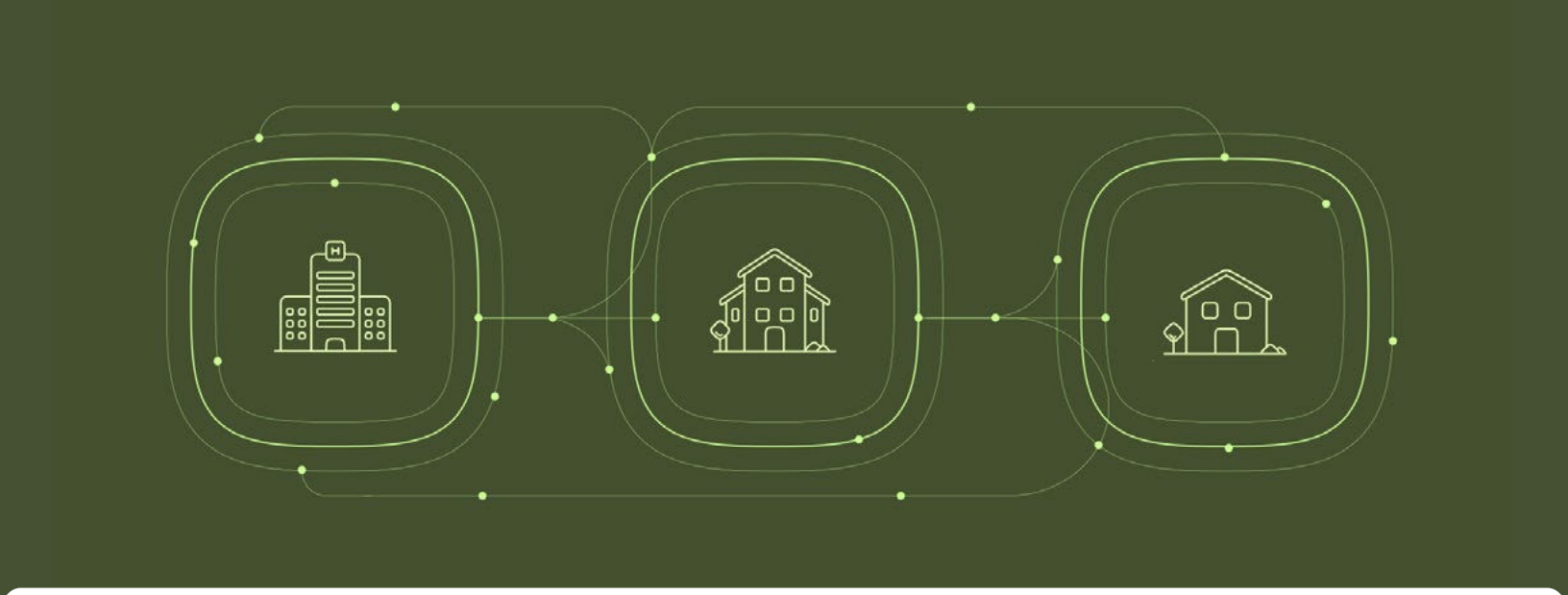
1. **Connect the story across care settings** instead of letting it end at discharge. Plans need real-time awareness of where members are and where they're going across acute and post-acute settings.

2. **Act on current-state clinical signals** rather than waiting for claims, which arrive far too late to influence the moment that matters.

3. **Equip care managers with clinical context before outreach.** Give them daily census, therapy notes, pending tests, medication updates, and discharge-readiness indicators instead of requiring chart-chasing.

> With my care management hat on, the biggest ask is to stop chasing charts. That is one of the most inefficient things between UM and CM that people have to do to coordinate care.
>
> — Senior Vice President, Regional Managed Care Organization (PointClickCare / Sage Growth Partners research)

Done well, this reframes care management from a reactive cost center into a strategic growth lever. Teams stop spending time finding information and start spending it intervening with full context. That is also how the same team can support more members without adding headcount.



PointClickCare: Supporting Safe Transitions to Home

For the first time, health plans can do real post-acute care management. PointClickCare delivers real-time visibility into members' SNF and long-term care stays. Teams can see live census, admissions and discharges, length of stay, vitals, medications, therapy notes, and estimated discharge dates without relying on phone calls or faxes. Built on the largest long-term and post-acute care dataset and trusted by more than 30,000 provider organizations and every major U.S. health plan, it surfaces the clinical context care teams have never had at the point they need it.

That visibility translates directly into the outcomes plans are measured on:

- **Identify high-risk members early and prevent readmissions.** PointClickCare's machine-learning Predictive Return to Hospital (pRTH) model flags members in SNF or long-term care with high or rising risk of hospitalization. It also highlights the contributing clinical factors, so teams can intervene during the stay rather than learning of a readmission after the fact. This is where Plan All-Cause Readmissions (PCR) are truly determined.
- **Transition members to lower-cost settings sooner and safer.** Comprehensive discharge-planning intelligence, including formal assessments and AI-curated discharge details, lets teams see discharge readiness and what the next setting requires before the stay ends. Members move to home or community-based care without bouncebacks. Transitions of Care (TRC) execution becomes more reliable, with timely 72-hour outreach, accurate medication reconciliation, and clean handoffs with the right clinical context. The goal is straightforward: ensure members receive care in the lowest-cost setting that is medically appropriate, and prevent avoidable returns to higher-cost care.
- **Increase efficiency by eliminating chart-chasing.** Real-time SNF/LTC clinicals, discharge details, and risk-based caseload prioritization live in one place, with targeted notifications and pre-discharge readiness signals. Care managers stop doing manual detective work and start working at the top of their license.

The result is measurable: lower Plan All-Cause Readmissions, stronger Transitions of Care performance, reduced avoidable days in SNF, and lower total cost of care are achieved through connected data and workflow integration across the continuum, not by asking teams to work harder.

The plans that invest in this visibility now will extend their advantage in quality, cost, and competitive position. Those that wait will keep paying for a blind spot they no longer have to accept.

References & Citations

1. Independent analysis underscores how much is at stake in this setting: the National Academies of Sciences, Engineering, and Medicine (Institute of Medicine) found that post-acute care accounts for roughly 73% of the geographic variation in Medicare spending—more than any other category—making it the single most variable, and therefore most addressable, component of total cost of care. Source: IOM, Variation in Health Care Spending: Target Decision Making, Not Geography (2013).

2. CMS increased the weight of the Part C Plan All-Cause Readmissions measure from 1x to 3x beginning with the 2025 Star Ratings; readmissions and transitions of care have been among the poorest-performing measures, with a majority of plans earning 3 stars or fewer. Star bonuses are material: KFF reports Medicare Advantage quality bonus payments reached at least $12.7 billion in 2025, more than quadrupling since 2015, and plans must reach 4 stars to qualify. Separately, CMS's V28 risk-adjustment model lowered average MA risk scores by roughly 3.12% in CY2024 as it phased in through 2025. Sources: CMS 2024/2025 MA & Part D Star Ratings Fact Sheets; KFF, Medicare Advantage Quality Bonus Payments (2025); Health Affairs (2025).

3. By late 2024, roughly eight states had enacted gold-card prior-authorization laws and more than ten additional states had introduced bills, with programs continuing to expand in 2025; UnitedHealthcare launched a national gold-card program in October 2024. Source: MultiState, Prior Authorization Reform (2025); AMA prior-authorization tracking.

4. The value of timely, informed follow-up is among the best-evidenced interventions in care delivery. Coleman and colleagues' randomized Care Transitions Intervention significantly reduced readmissions and was cost-effective, and systematic reviews of transitional-care programs report readmission reductions of up to ~45%. Sources: Coleman et al., Archives of Internal Medicine (2006); JAMA Network Open transitional-care review (2023).

5. The readmission risk is concentrated in exactly this setting. Roughly 20% of Medicare beneficiaries are readmitted within 30 days, and studies have found that about 23.5% of hospital discharges to a SNF return to the hospital directly from the SNF. MedPAC's potentially-avoidable SNF rehospitalization rate is about 10%, but the worst-performing quartile of facilities approaches 25%—wide variation that visibility lets plans act on. Sources: MedPAC, Skilled Nursing Facility Services (2025); Mor et al., Health Affairs / 'The Revolving Door of Rehospitalization from SNFs.'

6. Independent literature confirms medication reconciliation is the highest-yield, highest-risk gap at transitions. A systematic review found a median 53% rate of medication errors or unintentional discrepancies following discharge, and AHRQ notes that roughly two-thirds of post-discharge adverse events are medication-related. Sources: Alqenae et al., Drug Safety (2020); AHRQ PSNet, Readmissions and Adverse Events After Discharge.

7. A federal benchmark supports this range: AHRQ's analysis of the Nationwide Readmissions Database puts the average cost of a 30-day all-cause adult readmission at $15,200 (2018)—at the low end of the range cited here—with Medicare readmissions estimated at roughly $29.6 billion per year. Older analyses (MedPAC; the Center for Health Information and Analysis) have estimated that as much as three-quarters of 30-day readmissions are potentially preventable, representing tens of billions in avoidable spend. Sources: AHRQ HCUP Statistical Briefs #278 (2021) and #304 (2023); MedPAC; CHIA.

Explore PAC Management IQ

See how PAC Management IQ helps health plans close the post-discharge blind spot with real-time visibility into SNF stays, discharge readiness, and readmission risk.

PointClickCare is a leading health tech company with one simple mission: **to help every provider deliver exceptional care.**

Discover more

PointClickCare®