MEDPAC

Advising the Congress on Medicare issues

Post-acute care: Trends and key issues

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Presentation overview

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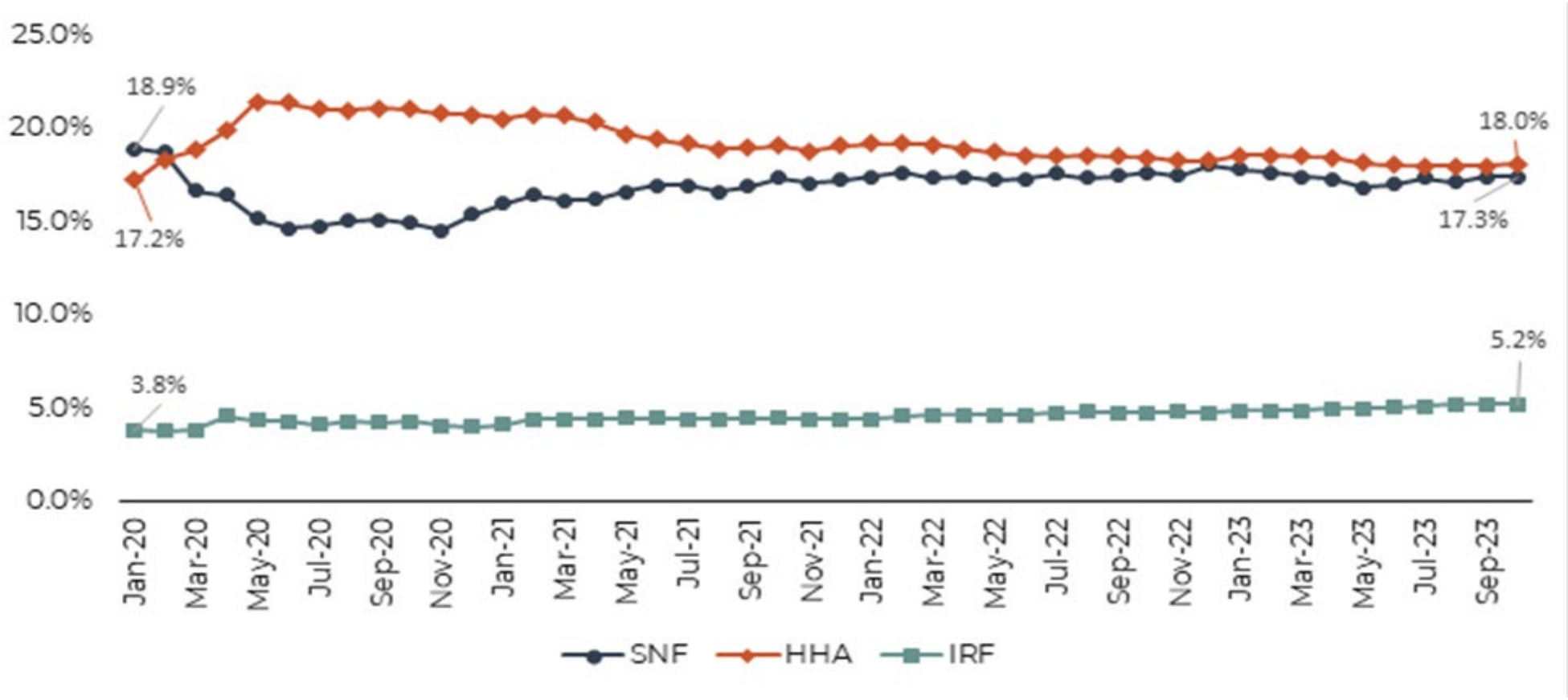
Note: PAC (post-acute care), FFS (fee for service), APMs (alternative payment models), MA (Medicare Advantage)

Spending and FFS Medicare utilization for SNFs, HHAs, and IRFs, 2024

Setting	Number of providers	Total spending	Average payment	Average length of stay
SNF	14,500	$30 billion	$20,970 per stay	30.7 days
HHA	12,200	$15.7 billion	$1,852 per 30-day period	75 days
IRF	1,170	$11 billion	$25,300 per stay	12.4 days

Note: HHA (home health agency), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility). Spending includes cost sharing.
Source: All data are from 2024 MedPAR files except the home health average length of stay (2021 MedPAR).

Shifts in the shares of FFS hospital discharges going to PAC between January 2020 and October 2023



Note: FFS (fee-for-service), PAC (post-acute care), SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). This chart shows where beneficiaries enrolled in FFS Medicare received PAC after hospitalization.

Source: MedPAC analysis of Medicare claims data.

Differences across settings in levels of care, eligibility, benefits and cost sharing requirements

- Levels of therapy provided, staffing, and physician presence
- Eligibility for Medicare coverage
  - SNF: Must have a prior hospital stay and require daily skilled care
  - HHA: Must need part-time or intermittent skilled care and be unable to leave the home without considerable help; no prior hospital stay required
  - IRF: Must be able to participate and benefit from intensive therapy; no prior hospital stay required
- Benefits: Day limits for SNF and IRF, no limits on home health care
- Cost-sharing requirements
  - None for HHA
  - Some for SNF and IRF

Note: SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility)

Reasons for the overlap in the types of patients treated in post-acute care settings

- MedPAC and others have documented that similar types of patients are treated in different settings
- Reasons for the overlap:
  - Variation in provider supply across markets
  - Lack of evidence-based guidelines to guide placements (except for treatment of stroke)
  - Differences in clinical judgment
  - Variation in providers' referring and admitting practices
  - Patient preferences for a specific provider or setting

Source: Gage (2012), MedPAC (2014, 2024), RTI International (2022)

Data limitations continue to undermine comparisons of quality across settings

- Information used in the case-mix systems to adjust payments and calculate star ratings may not be accurate
- Patient experience measures missing for beneficiaries treated in SNFs and IRFs
  - In 2021, MedPAC recommended that CMS develop and report measures for SNFs
  - In 2022, MedPAC noted that patient experience measures should be developed for all PAC users

Note: SNF (skilled nursing facilities), IRF (inpatient rehabilitation facilities), PAC (post-acute care)

Comparing outcomes of beneficiaries treated in SNFs, HHAs, and IRFs is complicated

- To draw conclusions about the "best" setting for treating a certain condition, analyses must control for differences in the patients treated
- But information from claims and patient assessments is unlikely to fully account for patient selection
- Admitting practices and Medicare rules also shape a provider's patient mix
- Studies often differ in the conditions and outcome measures they compare
- Except for stroke, studies of other conditions do not have consistent conclusions for similar outcome measures or across different measures

Note: SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). Studies of conditions other than stroke examined joint replacement, hip fracture, total knee arthroscopy, and conditions that do not contribute to the IRF compliance threshold.

Source: Stroke conclusions: Alcusky 2018, Chan 2013, Hong 2019, Springer 2022). Studies of other conditions: MedPAC 2024, Cogan 2020, Cogan 2021, Mallison 2014, Osundolire 2024, Padget 2028, Riester 2023, Burke 2021, Werner 2019

High FFS Medicare payment rates, FFS incentives, and Medicare benefit designs may promote inefficient care

- Medicare FFS margins for HHAs, SNFs, and IRFs have mostly been above 10% for 20+ years
- FFS payment incentives may encourage inefficient care
- Medicare's PAC benefit designs may encourage volume and intensity
  - No limit on duration of home health care use
  - Limited or no cost-sharing requirements
  - Prior 3-day hospital stay requirement for SNF coverage may encourage IRF use by beneficiaries without a preceding hospitalization

Note: FFS (fee for service, HHA (home health agencies, SNF (skilled nursing facilities), IRF (inpatient rehabilitation facilities)

Improvements to the designs of the FFS payment systems for HHAs and SNFs

- Original PPS designs for HHA and SNF included the amount of therapy as a factor in the case-mix classification systems
  - Created incentives to furnish therapy so that cases would be assigned to higher-payment case-mix groups
- MedPAC recommended that both PPSs use patient characteristics, not the amount of therapy, to set payment rates (in 2008 for SNF and 2011 for HHA)
- CMS redesigned the SNF (2019) and HHA PPSs (2020) to exclude therapy as a factor
- The revised SNF PPS expanded the clinical conditions considered in the case-mix system to more fully capture a patient's medical complexity

Note: FFS (fee for service), HHA (home health agency), SNF (skilled nursing facility), PPS (prospective payment system)
Source: MedPAC June 2008 Report to the Congress, MedPAC March 2011 Report to the Congress

CMS's efforts to improve FFS purchasing of PAC

Programs that target FFS improper payments

- An improper payment does not meet program requirements but is not itself fraud
- For PAC claims, the most frequent reasons are insufficient documentation and lack of medical necessity
- Ongoing CMS demonstrations for IRFs and HHAs require 100% claims review in states with high rates of improper payments
- A program targeting improper payments to SNFs ended in June 2025

Programs that tie FFS payments to quality

- SNF VBP program: Since 2018, incentive payments have not changed quality; Incentive payments are too small to change behavior
- HHA VBP program: Too new to be evaluated; estimated impacts for 2026 suggest incentive payments will be too small to change behavior

Note: FFS (fee for service), PAC (post-acute care), IRF (inpatient rehabilitation facilities), HHA (home health agencies), SNF (skilled nursing facilities), VBP (value-based purchasing)

Sources: CMS 2024 improper payment report, MedPAC 2021, Burke 2025, GAO 2021, HHA proposed rule for CY 2026.

Narrowing FFS Medicare price differences across PAC settings for similar patients would be complex to implement

- MedPAC's work on narrowing prices between PAC settings spans 9 years
- The Congress mandated reports by MedPAC and the Secretary on a unified PPS across settings
- MedPAC concluded that accurate payments could be set but associated issues would be complicated to implement
- The Secretary outlined a prototype unified PPS design and discussed implementation-related issues
- MedPAC examined a targeted policy that would lower IRF prices for cases that could have been treated in a SNF and decided there was not a solid evidence basis for selective price reductions

Note: FFS (fee for service, PAC (post-acute care), SNF (skilled nursing facilities), PPS (prospective payment system), IRF (inpatient rehabilitation facilities)
Sources: MedPAC reports in 2016, 2017, 2018, 2019, 2023, 2024. RTI report in 2022.

Note: FFS (fee for service), PAC (post-acute care), SNF (skilled nursing facilities), PPS (prospective payment system), IRF (inpatient rehabilitation facilities), SNF (skilled nursing facilities)
Sources: MedPAC 2016, MedPAC 2023, MedPAC 2024, RTI 2022.

Alternative payment models counter FFS volume incentives

- APMs are entities that are at risk for the cost of care for their attributed beneficiaries
- To lower costs, APMs have an incentive to avoid PAC use altogether, use less PAC, and shift PAC use to lower-cost providers
- Evaluations found that APMs used less SNF and IRF services while generally maintaining or improving quality
- Building on the successes of the bundled payment initiatives, in January 2026 CMS will begin a mandatory demonstration for 5 high-cost procedures for hospitals in 188 markets (the TEAM model)

Note: FFS (fee for service), APM (alternative payment model), ACO (accountable care organization), PAC (post-acute care), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility) TEAM (Transforming Episode Accountability Model)

MA counters FFS volume incentives

- MA plans are paid per member per month; plans have an incentive to lower their costs
- To lower costs, MA plans may:
  - Avoid PAC altogether
  - Use lower-cost PAC and use less PAC
- MA plans often use utilization management tools such as prior authorization and provider networks
  - Potential effects on providers: Burdensome prior authorization and documentation requirements; networks may shift volume across providers
  - Potential effects on beneficiaries: Limited choice of providers; denials or delays in getting care; postponed treatments that may worsen beneficiaries' conditions

Note: MA (Medicare Advantage), FFS (fee for service), PAC (post-acute care).

Discussion

- Future planned and possible work
  - Evaluate the new HHA and SNF case-mix systems
  - Monitor the TEAM alternative payment model
  - Compare MA and FFS use of PAC
  - Examine MA effects on the financial performances of SNFs and IRFs
  - Other ideas?

Note: MA (Medicare Advantage), FFS (fee for service), PAC (post-acute care), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility)

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