SECTION

8

Post-acute care

Skilled nursing facilities
Home health services
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1 Change in the number of post-acute care providers in Medicare differed across sectors in 2023

	2018	2019	2020	2021	2022	2023	Average annual percent change 2018–2022	Percent change 2022–2023
Skilled nursing facilities	15,359	15,305	15,173	15,098	14,973	14,800	–0.6%	–1.0%
Home health agencies	11,556	11,356	11,386	11,506	11,657	12,057	0.2	3.4
Inpatient rehabilitation facilities	1,170	1,152	1,159	1,181	1,181	1,206	0.2	2.1
Long-term care hospitals	386	371	351	345	341	338	–3.1	–0.9

Source: MedPAC analysis of active provider counts from CMS Survey and Certification's Quality, Certification, and Oversight Reports (skilled nursing facilities) and CMS Provider of Services files (home health agencies, inpatient rehabilitation facilities, and long-term care hospitals).

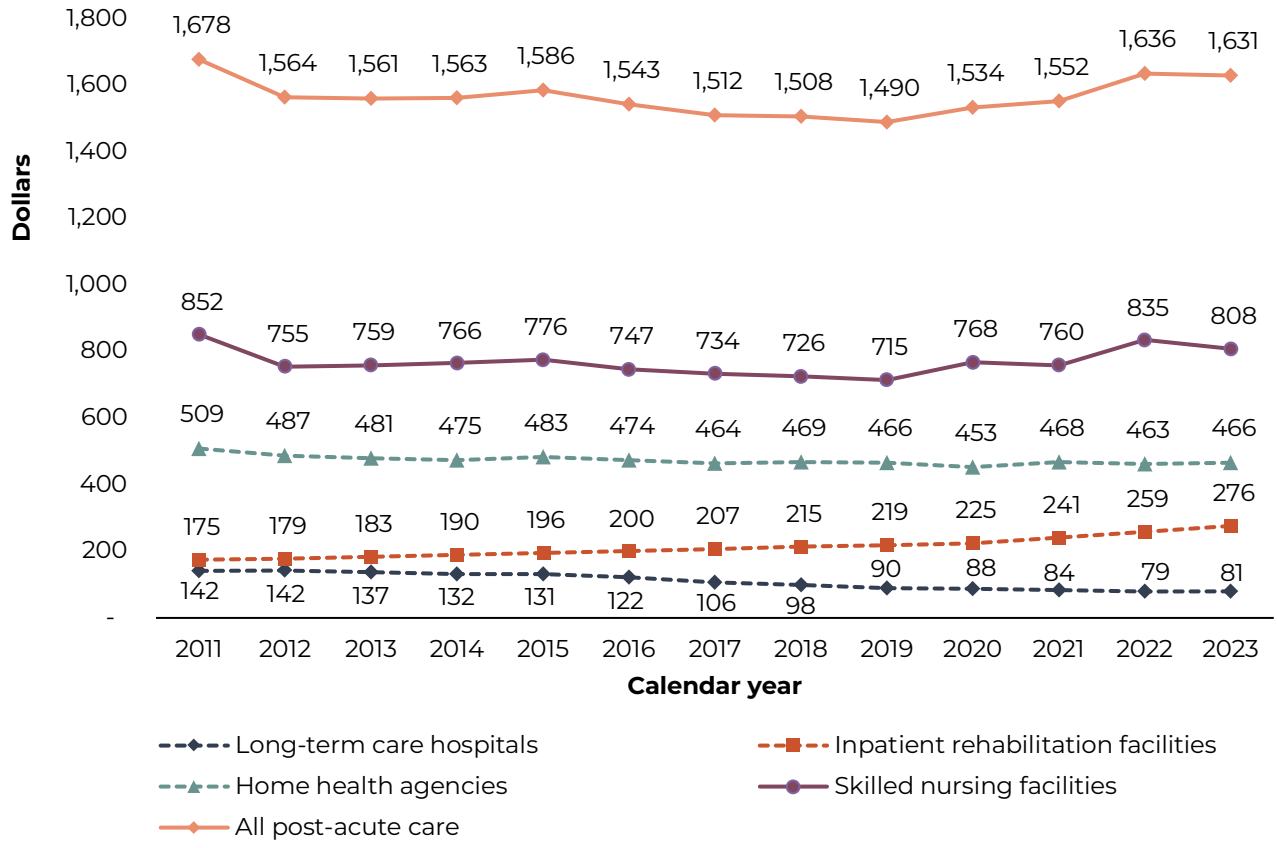
> The number of skilled nursing facilities decreased less than 1 percent per year between 2018 and 2022.

> The number of home health agencies has increased since 2018, but much of this growth has been concentrated in California; excluding that state, the supply of agencies declined by about 2 percent between 2018 and 2023 (data not shown).

> After declining for several years, the total number of inpatient rehabilitation facilities started to increase slightly in 2020 and increased again in 2023.

> After peaking in 2012 (data not shown), the number of long-term care hospitals (LTCHs) decreased. The decline became more rapid after the implementation of a dual payment-rate system that reduced payments for certain Medicare discharges from LTCHs beginning in fiscal year 2016, but the decline slowed in 2022 and 2023.

Chart 8-2 FFS Medicare spending per capita for post-acute care was relatively steady between 2011 and 2023 for skilled nursing facilities and home health agencies

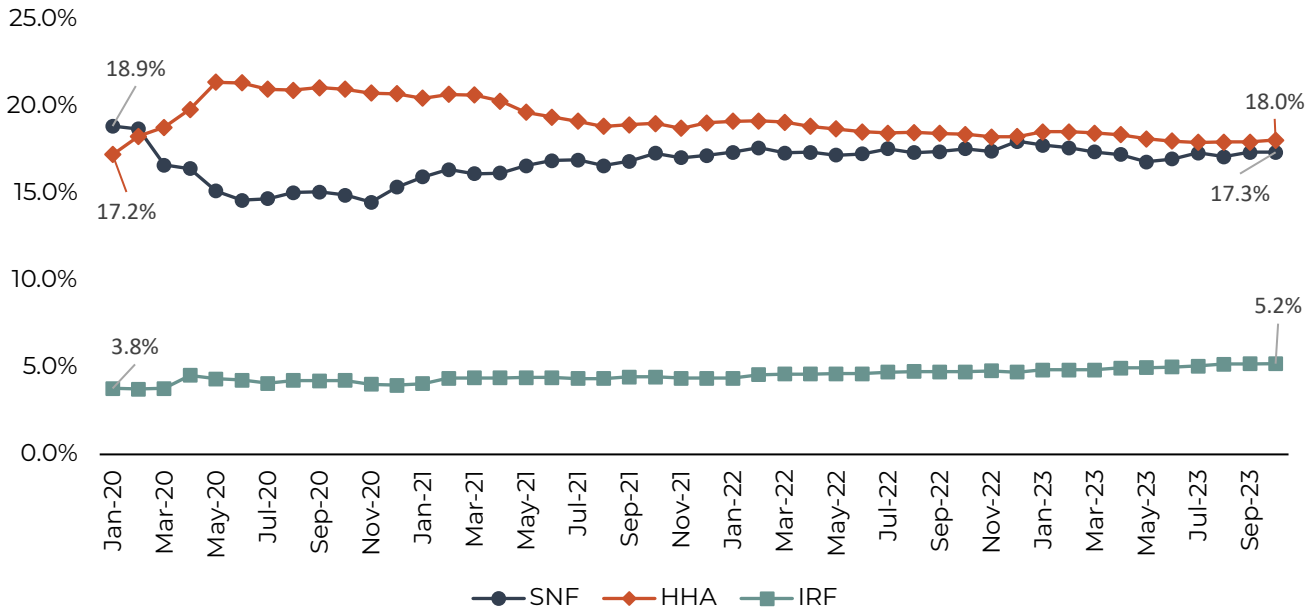


Note: FFS (fee-for-service). These calendar year–incurred data represent program spending only; they do not include beneficiary cost sharing. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary, 2024.

> Between 2011 and 2023, per capita spending for FFS Medicare beneficiaries was relatively steady for skilled nursing facilities and home health agencies. Per capita spending for inpatient rehabilitation services increased, particularly in 2023; while per capita spending for long-term care hospitals has declined.

Chart 8-3 Between January 2020 and October 2023, SNFs lost and then gradually regained some of the share of IPPS discharges to PAC, while the share going to HHAs increased and then gradually declined



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

Source: MedPAC analysis of Medicare claims data.

> In January 2020, immediately prior to the pandemic, SNFs were the most common PAC destination after discharge from an acute care hospital, with 18.9 percent of discharges. That same month, 17.2 percent of inpatient discharges received home health care. As the number of inpatient discharges began to fall in March 2020 due to the pandemic, the share of beneficiaries discharged from a hospital to a SNF fell. At the same time, the share receiving services from HHAs and IRFs increased, with home health becoming the most commonly used PAC setting. Since then, the share of hospital discharges receiving home health care has declined steadily while the share using SNFs has increased, though home health remained the most commonly used PAC setting as of October 2023. The share of hospital discharges receiving IRF care, by contrast, remained higher than it was before the pandemic.

> Overall, about 41 percent of inpatient hospital discharges in 2021 through the first 10 months of 2023 were followed by services from a SNF, HHA, IRF, or long-term acute care hospital (data not shown). Use of PAC after hospital discharge varied depending on the condition or treatment a patient received while hospitalized. For example, in the first 10 months of 2023, the share of hospital discharges using PAC was 47 percent for postsurgical patients compared with about 40 percent for patients who received mostly medical services during their inpatient stay (data not shown).

Chart 8-4 Freestanding SNFs, urban SNFs, and for-profit SNFs accounted for the majority of facilities, FFS Medicare–covered stays, and FFS Medicare spending in 2023

Type of SNF	Facilities	FFS Medicare–covered stays	FFS Medicare payments
Totals	14,500	1,583,000	$25 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	85	87
Rural	27	15	13
For profit	73	75	79
Nonprofit	22	22	18
Government	5	3	3

Note: SNF (skilled nursing facility), FFS (fee-for-service). Components may not sum to 100 percent due to rounding and missing values. The number of facilities and the FFS Medicare spending amounts shown here are lower than those displayed in Charts 8-1 and 8-2 due to the use of different data sources. Table includes covered stays and program spending in SNFs and does not include swing beds.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files from CMS.

> In 2023, freestanding facilities accounted for 98 percent of Medicare-covered SNF stays and 98 percent of FFS Medicare's payments to SNFs.

> In 2023, urban facilities accounted for 73 percent of facilities, 85 percent of FFS stays, and 87 percent of FFS Medicare payments.

> In 2023, for-profit facilities accounted for 73 percent of facilities, 75 percent of FFS stays, and 79 percent of FFS Medicare payments.

Chart 8-5 Per capita FFS SNF admissions increased in 2022 but fell in 2023

Volume measure	2019	2020	2021	2022	2023	Average annual change 2019–2022	Average annual change 2022–2023
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	47	–2.1%	–12%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,500	1,385	2.7	–8
Covered days per admission	26.1	28.5	28.0	28.0	29.0	0.2	5

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data are for calendar years and include 50 states and the District of Columbia. Changes are calculated using unrounded values and then rounded to the nearest percentage.

Source: MedPAC analysis of 2019–2023 Medicare Provider Analysis and Review and Common Medicare Environment data.

> To control for changes in FFS enrollment, we examined service use per 1,000 FFS beneficiaries. Between 2022 and 2023, SNF admissions per 1,000 FFS beneficiaries decreased 12 percent. Between 2019 and 2022, SNF admissions decreased an average of 2.1 percent per year, while days per 1,000 beneficiaries increased an average of 2.7 percent per year. Compared with 2019, covered admissions per 1,000 FFS beneficiaries in 2023 were 14 percent lower, but covered days per admission were 11 percent higher due to longer stays.

Chart 8-6 FFS Medicare margins in freestanding SNFs remained high in 2023

	2021	2022	2023
All	22.1	22.9	21.9
Rural	21.8	22.1	20.3
Urban	22.2	23.0	22.2
Nonprofit	8.5	7.2	7.3
For profit	25.1	25.9	25.1

Note: FFS (fee-for-service), SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports and Minimum Data Set data.

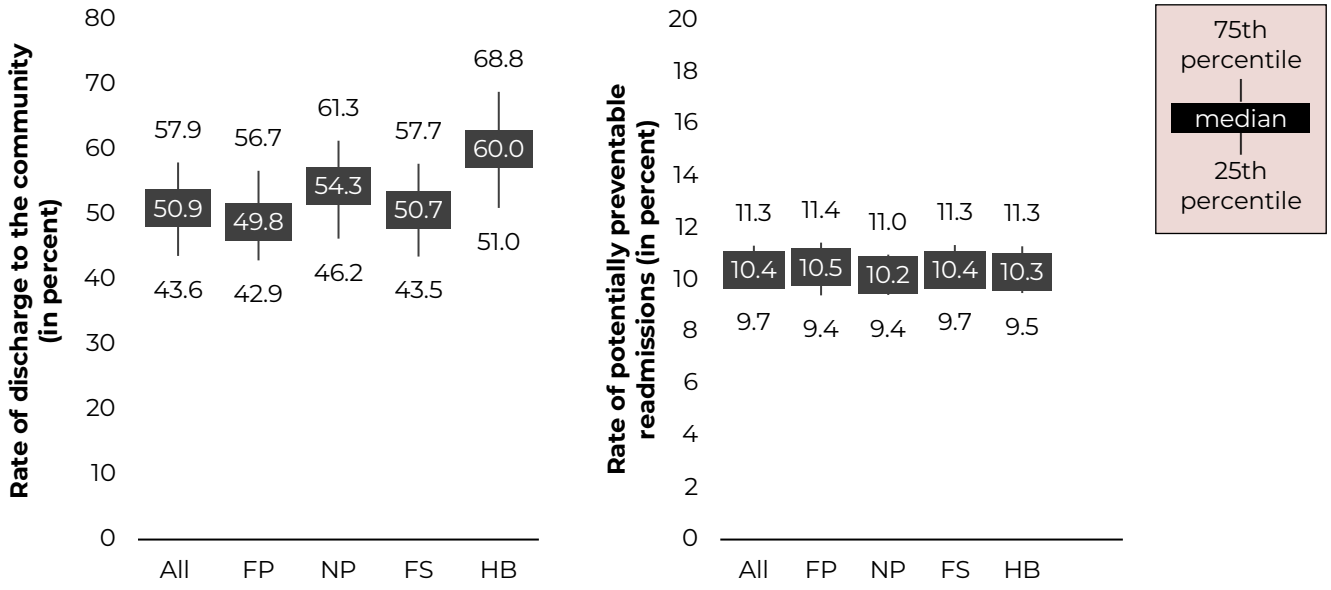
> The aggregate FFS Medicare margin for freestanding SNFs in 2023 (21.9 percent) exceeded 10 percent for the 24th consecutive year (not all years are shown). Had we considered an allocated share of the federal relief funds that providers received due to the coronavirus pandemic, we estimate the aggregate FFS margin in 2023 would have been even higher.

> The aggregate FFS Medicare margin decreased in 2023 because the average payment per day in freestanding SNFs increased 2.4 percent, while costs per day increased 3.8 percent (data not shown). The larger growth in costs per day in 2023 reflected growth in both routine and ancillary costs. This year was the first since the implementation of the Patient-Driven Payment Model that ancillary costs grew, driven by overall increases in per day costs of physical therapy, occupational therapy, and drugs.

> Aggregate FFS Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had FFS Medicare margins that were 32 percent or higher, and one-quarter had margins that were 10.6 percent or lower (data not shown). Consistent with the prepandemic years, urban SNFs had a higher aggregate FFS Medicare margin than rural SNFs in 2023. For-profit SNFs had a considerably higher aggregate FFS Medicare margin than nonprofit SNFs. Compared with for-profit SNFs, nonprofit facilities were smaller (fewer beds and lower volume) and had lower payments per day, higher costs per day, and higher growth in costs per day between 2022 and 2023 (data not shown).

> In 2023, the average total margin (the margin across all payers and all lines of business) for freestanding SNFs was 0.4 percent, up from –1.3 percent in 2022 (data not shown). The improvement reflects an aggregate increase in Medicaid base rates.

Chart 8-7 SNF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2022 and FY 2023



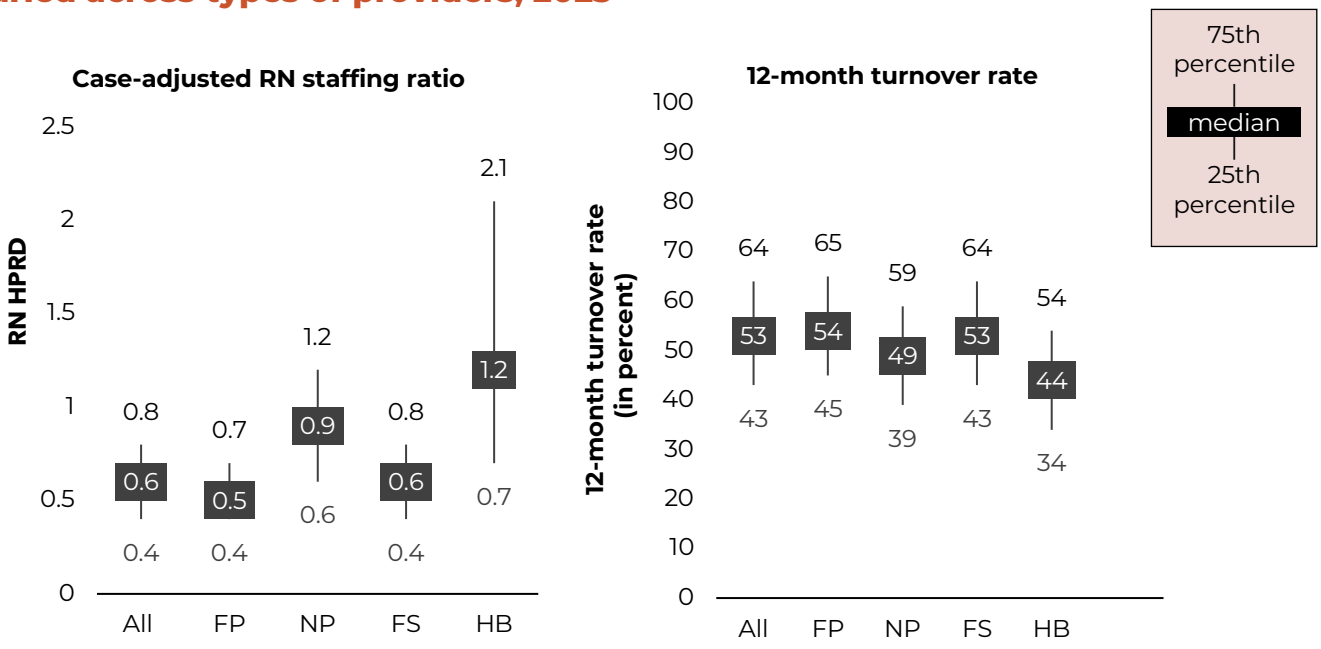
Note: SNF (skilled nursing facility), FY (fiscal year), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2022 and FY 2023 combined). Rates are computed from Medicare claims for eligible Medicare Part A–covered SNF stays and do not include swing-bed stays. The measure of "discharge to the community" is a SNF's risk-standardized rate of fee-for-service Medicare residents who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of "potentially preventable readmissions" after discharge is calculated as the risk-adjusted percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better.

Source: MedPAC analysis of SNF claims-based outcome measures from the Provider Data Catalog, FY 2022 through FY 2023.

> In FY 2022 and FY 2023 (combined), the median rate of discharge to the community from SNFs was 50.9 percent, similar to the combined FY 2021 and FY 2022 rate of 50.7 percent (latter data not shown). In FY 2022 and FY 2023, one-quarter of SNFs had rates above 57.9 percent and one-quarter had rates below 43.6 percent. The median rates of discharge to the community for nonprofit SNFs and hospital-based SNFs were higher than the median rates for for-profit SNFs and freestanding SNFs. Urban SNFs had higher rates of community discharge than rural SNFs (data not shown).

> In FY 2022 and FY 2023 (combined), SNFs' median rate of potentially preventable readmissions to the hospital was 10.4 percent. (Lower rates indicate better quality.) One-quarter of SNFs had rates above 11.3 percent and one-quarter had rates below 9.7 percent.

Chart 8-8 SNFs' RN staffing ratios and total nursing staff turnover rates varied across types of providers, 2023



Note: SNF (skilled nursing facility), RN (registered nurse), HPRD (hours per resident day), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Staffing ratios for the year are determined by averaging the quarterly values for each provider for the calendar year. All Medicare- and Medicare/Medicaid–certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's provider data catalog.

> In 2023, the median SNF provided 0.6 RN HPRD, identical to 2022 (latter data not shown). One-quarter of SNFs provided 0.8 or more HPRD, while one-quarter provided 0.4 or less HPRD. Freestanding SNFs had lower median case-mix-adjusted RN staffing than hospital-based SNFs, and for-profit SNFs had lower median case-mix-adjusted RN staffing than nonprofit SNFs. Rural facilities had ratios similar to those of metropolitan facilities (data not shown). Although the staffing ratios are adjusted for acuity, some of the differences could reflect the mix of long-stay and short-stay patients in a facility.

> In 2023, the 12-month nursing staff turnover rate was 53 percent for the median SNF, identical to 2022 (latter data not shown). One-quarter of facilities had turnover rates greater than 64 percent, meaning that nearly two-thirds of their nursing staff left the facility in the 12-month period. For-profit SNFs and freestanding SNFs had higher turnover rates than nonprofit SNFs and hospital-based SNFs. Turnover rates at urban facilities (53 percent) were similar to turnover rates at very rural facilities (51 percent), although RN-specific turnover was higher in urban facilities (51 percent) than in very rural facilities (44 percent) (data not shown).

Chart 8-9 Fee-for-service home health care use and spending declined in 2023

	2019	2020	2021	2022	2023	Average annual change 2019–2022	Average annual change 2022–2023
FFS Medicare home health users (millions)	3.3	3.1	3.0	2.8	2.7	–5.0	–4.4%
Share of FFS Medicare beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.8%	–1.9	–2.3
30-day periods (millions)	N/A	N/A	9.3	8.6	8.3	N/A	–3.9
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	26	24	24	N/A	1.8
Total in-person visits (millions)	99.7	81.1	76.8	69.5	66.3	–11.3	–4.6
In-person visits per user	30.2	26.6	25.4	24.6	24.5	–6.7	–0.2

Note: FFS (fee-for-service), N/A (not available). Average annual changes are calculated using unrounded values and then rounded to the nearest tenth. The 30-day period was established as the unit of payment for home health care services on January 1, 2020, and consequently 30-day period data are not available for 2019 and 2020 (data for 2020 are affected because a portion of services in this year were paid under the prior unit of payment during the transition period).

Source: MedPAC analysis of home health standard analytic files from CMS and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2023, the number of FFS beneficiaries using covered home health care declined by 4.4 percent, reflecting both a decrease in the number of beneficiaries enrolled in FFS Medicare and a decline in the share of FFS beneficiaries using home health care. FFS home health utilization has been declining for several years as more beneficiaries enroll in Medicare Advantage and per capita FFS hospitalizations—a common source of referral to home health care—have fallen. Controlling for the decline in FFS Medicare enrollment, the number of 30-day home health periods remained relatively steady in 2023, at 24 per 100 FFS beneficiaries. The number of in-person visits per home health user remained relatively steady in 2023, at 24.5.

> In 2023, about 1.2 percent of FFS-covered 30-day home health periods included a telehealth visit or remote patient monitoring, and about 14 percent of home health agencies (HHAs) provided at least one telehealth or remote patient-monitoring service to a FFS beneficiary (data not shown). Skilled nursing care accounted for about 80 percent of the telehealth visits provided in 2023. The small number of beneficiaries receiving these services, and the limited number of HHAs providing them, indicates that most clinical care in the home health benefit is still provided in person.

Chart 8-10 Most FFS Medicare home health periods are not preceded by a hospitalization or PAC stay

Type of 30-day period	2022	2023
Period by source of referral		
Preceded by hospitalization or institutional PAC	25.2%	25.3%
Community admitted	74.8	74.7
Period by timing of 30-day period		
Early	30.9	30.8
Late	69.1	69.2

Note: FFS (fee-for-service), PAC (post-acute care). Periods "preceded by hospitalization or institutional PAC" refer to periods that occurred less than 15 days after a stay in a hospital (including a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. "Community admitted" refers to periods for which there was no hospitalization or PAC stay in the previous 15 days. "Early" periods are periods for beneficiaries who have not received any home health care in the prior 60 days; "late" periods are the second or later in a series of consecutive periods.

Source: MedPAC analysis of 2023 home health standard analytic file.

> Most FFS-covered home health periods are not preceded by a hospitalization or institutional PAC stay. "Community-admitted" home health periods accounted for about three-quarters of PAC 30-day periods in 2022 and 2023.

> Under FFS Medicare's home health payment system, home health periods for beneficiaries who have not received any home health care in the prior 60 days are classified as "early," while periods that are the second or later in a series of consecutive periods are classified as "late." The share of periods by timing or source of referral did not change substantially in 2023 compared with the prior year. The mix of cases by clinical payment group also did not change significantly (data not shown).

Chart 8-11 FFS Medicare margins for freestanding home health agencies remained high in 2023

	2019	2020	2021	2022	2023	Share of home health agencies, 2023	Share of periods, 2023
All	15.4%	20.2%	24.9%	22.2%	20.2%	100%	100%
Geography							
Majority urban	16.1	20.0	24.8	22.3	20.2	86	87
Majority rural	14.2	21.6	25.2	22.0	20.1	14	13
Type of ownership							
For profit	17.4	22.7	26.1	23.6	21.5	93	87
Nonprofit	11.4	12.4	20.2	16.4	13.3	7	13
Volume quintile							
First (smallest)	9.7	11.6	14.0	13.7	12.6	20	3
Second	11.4	14.0	15.9	14.5	13.9	20	7
Third	13.3	17.0	19.3	17.0	15.0	20	11
Fourth	14.1	18.8	22.8	21.0	19.4	20	20
Fifth (largest)	17.5	22.4	28.3	24.8	22.4	20	60

Note: FFS (fee-for service). Home health agencies (HHAs) were classified as "majority urban" if they provided more than 50 percent of episodes to beneficiaries in urban counties, and they were classified as "majority rural" if they provided more than 50 percent of episodes to beneficiaries in rural counties. These data do not include federal provider relief funds that HHAs received due to the coronavirus pandemic. Percentage changes were calculated on unrounded data.

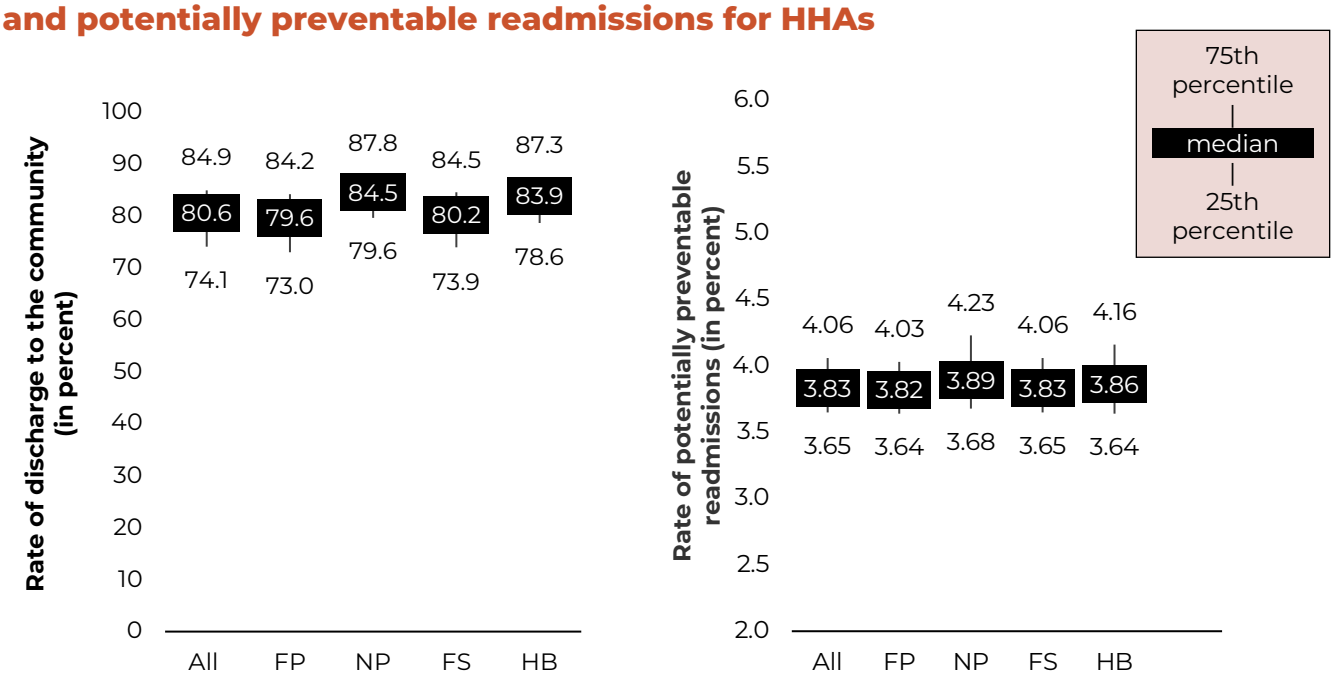
Source: MedPAC analysis of Medicare home health cost-report files from CMS.

> In 2023, freestanding HHAs (87 percent of all HHAs; data not shown) had an aggregate FFS Medicare margin of 20.2 percent. The 2023 margin is consistent with the historically high margins the home health industry has experienced since the prospective payment system (PPS) was implemented in 2000. The margins from 2001 to 2022 averaged 17.1 percent (not all data shown), indicating that most agencies have been paid well in excess of their costs for more than 20 years.

> For-profit agencies had an average FFS Medicare margin of 21.5 percent in 2023, compared with 13.3 percent for nonprofit agencies. There was little difference in the aggregate FFS Medicare margins of urban HHAs (20.2 percent) and rural HHAs (20.1 percent).

> Agencies with higher volumes of 30-day periods had higher FFS Medicare margins. The agencies in the lowest-volume quintile in 2023 had an aggregate FFS Medicare margin of 12.6 percent, compared with 22.4 percent for those in the highest-volume quintile.

Chart 8-12 Risk-standardized rates of successful discharge to the community and potentially preventable readmissions for HHAs



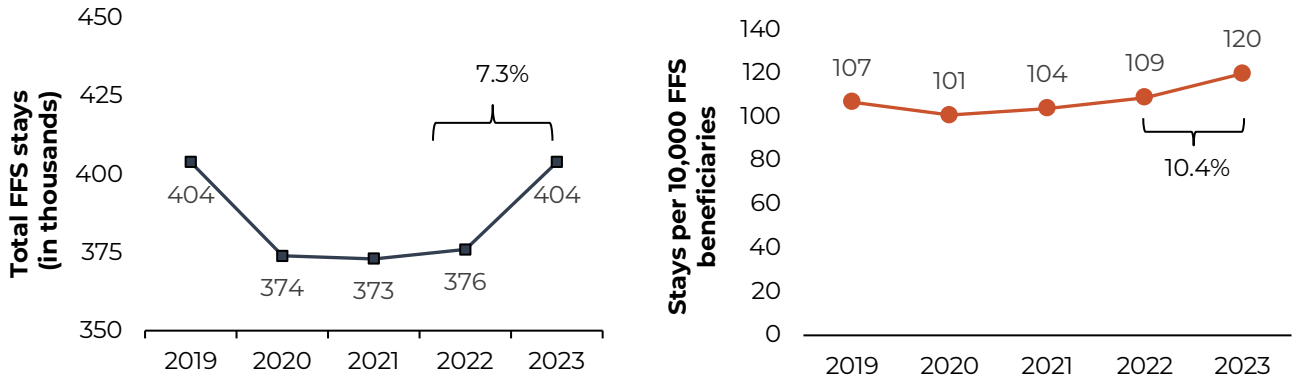
Note: HHA (home health agency), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). The measure of "discharge to the community" is an HHA's risk-standardized rate of fee-for-service (FFS) Medicare patients who were discharged to the community after a home health stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of "potentially preventable readmissions" after discharge is calculated as the risk-adjusted percentage of patients discharged from an HHA who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A–covered home health stays in the 50 states and the District of Columbia, regardless of whether the home health stay was preceded by a hospitalization. Rates for successful discharge are for the 24-month period from January 1, 2022, to December 31, 2023; rates for potentially preventable readmissions are for the 36-month period from January 1, 2021, to December 31, 2023.

Source: MedPAC analysis of claims-based outcome measures from the Provider Data Catalog.

> The median rate of discharge to the community from home health was 80.6 percent in the period from January 1, 2022, to December 31, 2023 (higher rates indicate better quality). For-profit providers had the lowest median rates of discharge to community during the period, while nonprofit providers had the highest rates. From January 1, 2022, to December 31, 2023, HHAs at the 25th percentile and 75th percentile had rates of 74.1 percent and 84.9 percent, respectively.

> For the 36-month period from January 1, 2021, to December 31, 2023, the median rate of home health stays with a potentially preventable readmission was 3.83. The median rates of potentially preventable rehospitalization did not differ significantly across ownership categories or facility type. In this same period, the HHAs at the 25th percentile and 75th percentiles had potentially preventable rehospitalization rates of 3.65 percent and 4.06 percent, respectively.

Chart 8-13 In 2023, the number of FFS Medicare IRF stays grew substantially compared with prior years



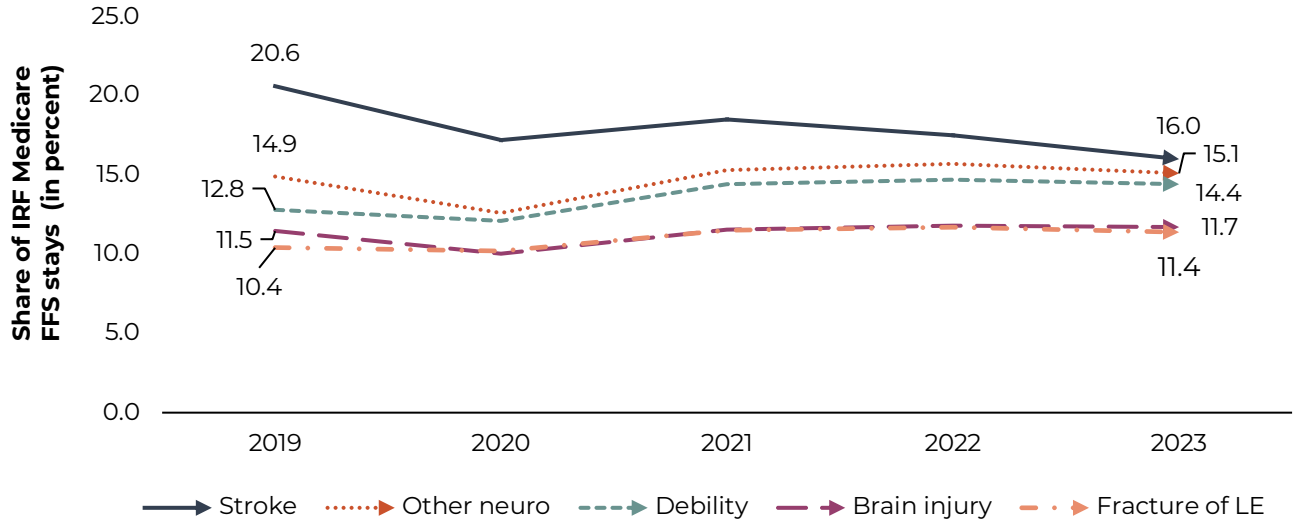
Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). The number of FFS stays and the number of beneficiaries are rounded.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> From 2022 to 2023, the number of FFS-covered IRF cases rose by 7.3 percent, to about 404,000 cases. When controlling for the number of FFS beneficiaries, the increase was even greater (10.4 percent).

> The average length of stay decreased slightly in 2023 to 12.5 days, a 2.3 percent reduction from 12.8 days in 2022 (data not shown).

Chart 8-14 Stroke, other neurological conditions, and debility remained the most common conditions for FFS beneficiaries in IRFs in 2023



Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), LE (lower extremity). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with "debility" have generalized deconditioning not attributable to other conditions. "Brain injury" includes both traumatic and nontraumatic injuries. All FFS Medicare IRF stays with valid patient assessment information were included in this analysis. Yearly percentages presented in this table are rounded. (The cases shown in 2023 represent about 70 percent of all FFS cases.)

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

> Stroke, "other neurological conditions" (such as multiple sclerosis and neuromuscular disorders), debility, brain injury, and fracture of the lower extremity continue to be the most common conditions among IRF stays. Since 2019, these conditions have steadily composed about 70 percent of IRF stays.

> Stroke continues to be the most common condition among IRF stays, accounting for 16.0 percent of FFS stays in 2023. However, the share of stroke stays has declined from 20.6 percent of stays in 2019. Between 2019 and 2023, IRF stays for debility have increased from 12.8 percent to 14.4 percent of IRF FFS stays.

Chart 8-15 IRFs' aggregate FFS Medicare margin increased to 14.8 percent in 2023

	2019	2020	2021	2022	2023
All IRFs	14.1%	13.3%	16.9%	13.7%	14.8%
Hospital based	1.7	1.4	5.7	0.8	1.0
Freestanding	24.6	23.4	25.9	23.3	24.2
Urban	14.5	13.6	17.3	14.1	15.0
Rural	7.6	9.0	11.7	7.7	11.2
Nonprofit	1.1	−0.3	5.3	−0.5	−0.2
For profit	24.2	23.4	25.3	22.7	23.5
Number of beds					
1–10	−9.1	−7.3	−2.7	−6.5	−5.3
11–24	1.6	2.2	5.7	1.1	1.0
25–64	15.8	14.8	18.6	15.0	16.6
65+	20.9	19.3	22.2	19.8	20.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups where applicable (e.g., "all IRFs").

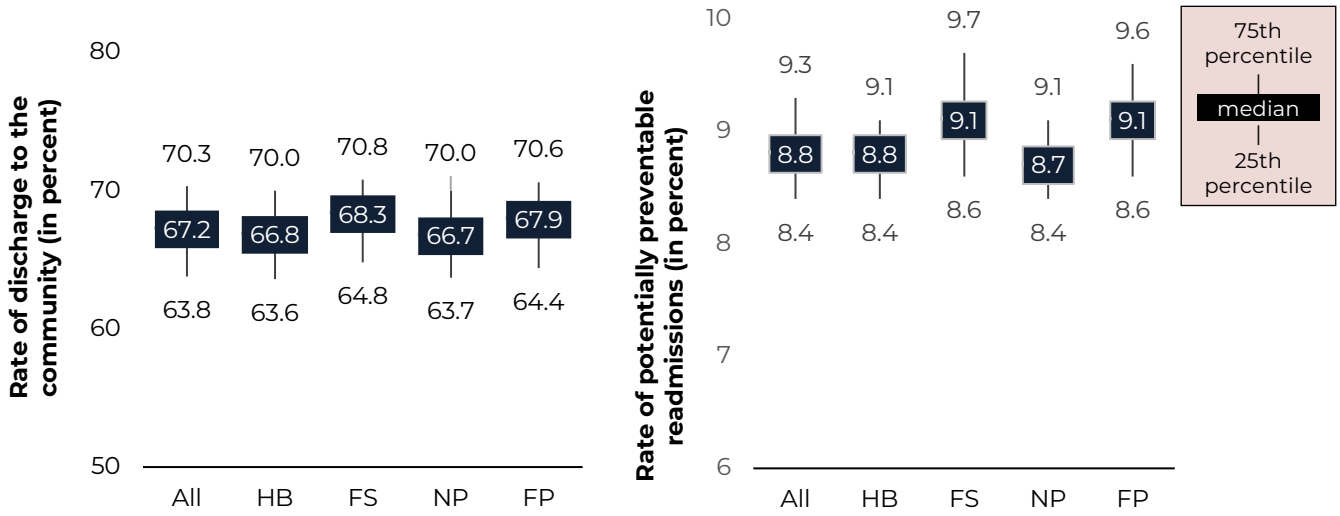
Source: MedPAC analysis of cost-report data from CMS.

> In 2023, IRFs' per case payments grew slightly while costs declined; as a result, the aggregate FFS Medicare margin increased, remaining strong at 14.8 percent (14.9 percent when including Medicare's share of federal relief funds; data not shown).

> FFS Medicare margins vary by IRF type. In 2023, freestanding IRFs and for-profit IRFs had substantially higher aggregate margins (24.2 percent and 23.5 percent, respectively) than hospital-based IRFs and nonprofit IRFs (1.0 percent and –0.2 percent, respectively).

> There are large differences in FFS Medicare margins by IRF size. In 2023, the aggregate FFS Medicare margin for IRFs with 10 or fewer beds was –5.3 percent. By contrast, the FFS Medicare margin for IRFs with 65 or more beds was 20.4 percent. These differences are in large measure due to economies of scale since smaller facilities have higher unit costs.

Chart 8-16 IRF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2022 and FY 2023



Note: IRF (inpatient rehabilitation facility), FY (fiscal year), HB (hospital based), FS (freestanding), NP (nonprofit), FP (for profit). Data include IRFs in the 50 states and the District of Columbia and cover 24 months (FY 2021 and FY 2022 combined). The measure of "discharge to the community" includes beneficiaries discharged from an IRF to the community who did not have an unplanned hospitalization and/or die in the 31 days following discharge. Higher rates are better. The measure of "potentially preventable readmissions after discharge" is calculated as the risk-adjusted percentage of patients discharged from an IRF who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Providers with at least 25 stays in the year were included in calculating the average facility rate.

Source: Medicare IRF claims from CMS.

> In FY 2022 and FY 2023, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.2 percent, similar to the 67.3 percent from FY 2021 and FY 2022 (latter data not shown).

> The median facility risk-adjusted rate of potentially preventable readmission was 8.8 percent (similar to last year) and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers.

Chart 8-17 FFS Medicare inpatient stays at LTCHs remained relatively steady in FY 2023 and well below FY 2019 level

	LTCH FFS Medicare stays and payments, by fiscal year				
	2019	2020	2021	2022	2023
Stays (in thousands)					
All	91	78	70	60	59
Nonqualifying	23	19	20	19	17
Qualifying	68	59	50	41	42
Share of qualifying	75%	76%	71%	68%	71%
Stays per 10,000 FFS beneficiaries					
All	24	21	20	17	17
Nonqualifying	6	5	6	6	5
Qualifying	18	16	14	12	12
Payment per stay (in thousands)					
All	$41	$46	$49	$49	$49
Nonqualifying	$26	$32	$39	$39	$37
Qualifying	$47	$50	$53	$53	$53
Length of stay (in days)					
All	27	28	28	28	27
Nonqualifying	23	24	26	26	25
Qualifying	28	29	28	29	28

Note: FFS (fee-for-service), LTCH (long-term care hospital), FY (fiscal year). "Qualifying stay" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. All counts are for stays covered by FFS Medicare and do not include stays paid for by private plans. Dollar amounts are nominal figures, not adjusted for inflation. Results differ from those published in prior years because of newer data and methodological updates, such as enrollment counts.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and the 2024 report of the Boards of Trustees of the Medicare trust funds.

> Since FY 2016, FFS Medicare has differentiated between two types of stays at LTCHs: (1) those meeting criteria specified in law, which are paid at the standard LTCH prospective payment system rate, and (2) others, which are paid at a site-neutral rate. Stays that qualify for the standard rate are nonpsychiatric, nonrehabilitation stays that either:

>> immediately follow an acute care hospital stay that included three or more days in an intensive care unit or

>> include mechanical ventilation for at least 96 hours.

> From FY 2019 through FY 2022, the number of FFS Medicare–covered LTCH stays continued to decline, both on an absolute and per capita basis. In addition, the share of qualifying stays declined.

> In FY 2023, the volume of LTCH stays remained relatively steady but shifted toward qualifying stays.

> From January 2020 through May 2023, the application of site-neutral payment rates was waived due to the coronavirus public health emergency. As a result, the average LTCH payment rate per FFS stay increased part way through FY 2020 and further increased in FY 2021, when LTCHs were paid the higher LTCH rate for the entire fiscal year.

Chart 8-18 FFS Medicare LTCH stays continued to be concentrated in two MS–LTC–DRGs in FY 2023

MS–LTC–DRG	Description	DRG share of FFS Medicare LTCH stays, by fiscal year				
		2019	2020	2021	2022	2023
189	Pulmonary edema and respiratory failure	20.5%	19.4%	18.7%	22.9%	22.5%
207	Respiratory system diagnosis with ventilator support >96 hours	13.2	14.5	15.6	14.3	13.0
871	Septicemia without ventilator support >96 hours with MCC	5.5	5.1	3.9	3.2	3.1
208	Respiratory system diagnosis with ventilator support ≤96 hours	2.7	3.1	3.5	3.3	2.7
166	Other respiratory system OR procedures with MCC	2.3	2.5	2.8	2.6	2.6
177	Respiratory infections and inflammations with MCC	1.9	3.7	9.1	3.9	2.5
981	Extensive OR procedure unrelated to principal diagnosis with MCC	2.0	2.0	2.2	2.3	2.3
539	Osteomyelitis with MCC	1.8	1.5	1.7	1.9	2.2
949	Aftercare with CC/MCC	2.2	2.0	1.9	2.0	2.1
682	Renal failure with MCC	1.7	1.7	1.4	1.5	1.7

Note: FFS (fee-for-service), LTCH (long-term care hospital), MS–LTC–DRG (Medicare severity long-term-care diagnosis related group), FY (fiscal year), MCC (major complication or comorbidity), OR (operating room), CC (complication or comorbidity). MS–LTC–DRGs are used in the case-mix system for LTCHs. Shares for each MS–LTC–DRG presented in the table are rounded.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> FFS Medicare categorizes each inpatient stay at an LTCH into an MS–LTC–DRG, primarily based on the patient's principal diagnosis and the care provided.

> FFS Medicare inpatient stays at LTCHs continued to be concentrated into two MS–LTC–DRGs: pulmonary edema and respiratory failure (accounting for 22.5 percent of FFS Medicare stays in FY 2023) and respiratory system diagnosis with ventilator support >96 hours (which accounted for 13.0 percent of stays).

> Among nonqualifying stays—stays paid under the site-neutral rate when it is in effect (see Chart 8-17)—pulmonary edema and respiratory failure was still the most common MS–LTC–DRG, accounting for about 15 percent of FFS nonqualifying stays in FY 2023 (data not shown).

Chart 8-19 LTCHs' aggregate FFS Medicare margin increased in FY 2023 but remained negative

	LTCH FFS Medicare margin, by fiscal year				
	2019	2020	2021	2022	2023
All LTCHs	–2.0%	3.6%	6.0%	–1.8%	–0.7%
Nonprofit	–12.0	–11.3	–11.7	–23.2	–21.0
For profit	–0.1	6.0	8.5	1.4	2.3
Margin percentile					
25th percentile	–12.8	–6.9	–4.7	–13.6	–12.2
Median	0.2	5.0	6.1	–3.5	–1.1
75th percentile	8.5	12.3	15.2	8.2	8.9
Facility share of qualifying stays					
High share	3.0	6.3	5.2	–1.5	0.6
Low share	–8.2	0.3	6.4	–2.1	–1.3

Note: LTCH (long-term care hospital), FFS (fee-for-service), FY (fiscal year). "Qualifying stay" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. "High share" means more than 85 percent of a provider's cases were qualifying cases in the year. "Low share" means 85 percent or fewer of a provider's cases were qualifying cases in the year. Data are for LTCHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Results differ from those published in prior years because of newer data and methodological updates, such as the incorporation of outlier reconciliation amounts.

Source: MedPAC analysis of hospital cost-report data and LTCH final-rule data files.

> When CMS implemented lower site-neutral payment rates for certain types of LTCH cases in fiscal year 2016, LTCHs' aggregate FFS Medicare margin fell from nearly 4 percent in FY 2016 to less than −2 percent in FY 2017 (data not shown). LTCH's FFS Medicare margin remained negative through FY 2019. The aggregate FFS Medicare margin jumped to 3.6 percent during the first year of the pandemic, when LTCH site-neutral payment rates were waived and all LTCH cases were paid at the higher, standard LTCH prospective payment rates. The aggregate FFS Medicare margin climbed further, to 6.0 percent in FY 2021.

> In FY 2022, LTCHs' FFS Medicare margin declined sharply, falling to −1.8 percent, despite the continued waiver of site-neutral payment rates. This decline was driven by large increases in LTCHs' cost per stay (see Chart 8-20).

> In FY 2023, LTCHs' FFS Medicare margin remained negative but increased about 1 percentage point to −0.7 percent, as costs per stay declined more than payments per stay (see Chart 8-20).

> FFS Medicare margins varied significantly across LTCHs. For-profit LTCHs consistently had a substantially higher FFS Medicare margin than nonprofit LTCHs. The difference in the FFS Medicare margin between LTCHs with a high share of qualifying stays and a low share narrowed during the waiver of site-neutral payment rates.

Chart 8-20 LTCH PPS payments per stay and LTCHs' costs per stay were relatively steady in FY 2023

	Percentage change from prior fiscal year				
	2019	2020	2021	2022	2023
Payments per stay					
All LTCHs	4.3%	9.2%	7.0%	0.3%	–0.2%
Share qualifying					
LTCHs with >85% qualifying stays	0.6	7.9	11.9	1.3	2.2
LTCHs with ≤85% qualifying stays	1.4	10.4	11.5	2.6	–1.5
Cost per stay					
All LTCHs	5.4	3.3	4.3	8.6	–1.3
Share qualifying					
LTCHs with >85% qualifying stays	2.1	4.2	13.2	8.5	0.1
LTCHs with ≤85% qualifying stays	4.2	1.8	4.7	11.9	–2.2

Note: LTCH (long-term care hospital), PPS (prospective payment system), FY (fiscal year). "Qualifying stay" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS. Data are for LTCHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Results differ from those published in prior years because of newer data and methodological updates, such as the incorporation of outlier reconciliation amounts. Percentages reflect changes in nominal dollars, not adjusted for inflation.

Source: MedPAC analysis of hospital cost-report data and LTCH final-rule data files.

> LTCHs' PPS payments per stay increased rapidly in FY 2020 and FY 2021, reflecting the first year of the public health emergency–related waiver of site-neutral payment rates, and then payments held relatively steady in FY 2022 and FY 2023. In both FY 2022 and FY 2023, LTCHs' PPS payments per stay were about $48,000 per stay (data not shown).

> LTCHs' costs per stay increased more rapidly in FY 2022, reflecting higher-than-expected inflation and reduced volume. In both FY 2020 and FY 2023, LTCHs' cost per stay were about $49,000 per case (data not shown).

> In FY 2023, payments per stay grew faster among LTCHs with a higher share (>85 percent) of stays meeting the qualifying criteria for LTCH PPS standard rates than among all LTCHs. Among LTCHs with a higher share of qualifying stays, both payments and costs per stay were about $58,000 in FY 2023 (data not shown).