CHAPTER 6

Post-acute care: Trends and key issues

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Chapter summary

Beneficiaries who require recuperative or rehabilitative care may be treated in skilled nursing facilities (SNFs), by home health agencies (HHAs), and in inpatient rehabilitation facilities (IRFs). While all three settings provide rehabilitation, skilled nursing, and personal care, the level of care varies. Generally, IRFs can provide the most intensive level of care, while HHAs provide the least, and SNF care falls between the two. The three settings differ in terms of Medicare benefits and cost-sharing requirements under fee-for-service (FFS) Medicare, which can shape service use.

Aggregate FFS spending on post-acute care (PAC) declined slightly over the past decade, due in part to the shift in enrollment from FFS to Medicare Advantage (MA). In addition, declines in acute care hospital stays, which precede much PAC, have reduced referrals to PAC. Staffing shortages have also constrained the supply of open and staffed SNF beds and home health visits.

For a host of reasons, there is some overlap in the types of patients treated in the three settings. But comparing the patients treated and their outcomes is complicated by several factors, such as the unobserved differences in the patients treated across providers. Data limitations—including inaccurate reporting of patient-assessment information that

In this chapter

may reflect payment and other incentives rather than actual differences in patients and the lack of patient-experience data for SNFs and IRFs—undermine comparisons within and across settings. Reflecting these limitations, studies examining outcomes by setting have reached mixed conclusions.

By its nature, FFS has incentives for providers to increase volume: SNFs may extend stays, HHAs may trigger second 30-day periods, and IRFs may admit patients who qualify for the care but could be treated in a less intensive setting. Medicare's cost-sharing rules for SNF and HHA services may also encourage unnecessary care. FFS incentives may be stronger when margins are high, and Medicare FFS margins for SNFs, HHAs, and IRFs have been in the double digits for 20 years. Because updates to prospective payment system rates are in statute, CMS does not have the authority to rebase payment rates without congressional action. The Commission has routinely recommended reductions to base payment rates across Medicare's PAC payment systems.

The Commission has explored two policies that could improve the efficiency of PAC: value-based purchasing (VBP) programs and establishing site-neutral payment rates across PAC settings. By adjusting payment rates based on the quality of care provided, VBP programs create incentives for providers to furnish high-quality care. But the current financial incentives of the SNF and HHA VBP programs are too small to encourage providers to improve quality. Policies that would establish more equivalent FFS Medicare payments for similar cases treated in different settings, such as a unified payment system for providers in the three settings, could establish reasonably accurate payment rates but would be complex to implement. The Commission has also considered more targeted alignment of Medicare's prices for certain types of cases treated in IRFs and SNFs but has been stymied by a lack of solid evidential basis to lower prices for a select group of conditions.

Alternative payment models (APMs), such as accountable care organizations and bundled-payment initiatives, create incentives to shift higher-cost IRF use to SNFs, to shorten SNF stays, and to shift care to HHAs for beneficiaries who could go home, as well as to avoid some PAC use altogether. Such changes in PAC use could reflect more efficient service use but could also mean that some beneficiaries do not get the care they need. However, APMs have shown promise in lowering program spending without compromising quality. The Commission will continue to monitor the impact of APMs on PAC use.

The shift in enrollment away from FFS Medicare to Medicare Advantage (MA) has important implications for PAC providers and beneficiaries. Because

MA plans are paid a monthly per member amount, they have an incentive to lower their costs by using lower-cost PAC, shortening SNF stays, and prolonging hospital stays to avoid PAC altogether. MA plans typically use prior authorization and provider networks to manage service use by their enrollees. These utilization-management tools may be beneficial for enrollees to the extent that they result in improved transitions between care settings, better coordination of care, and elimination of unnecessary care. However, such management tools can also create hurdles for providers and beneficiaries that could delay the start of needed PAC or deny it altogether. The Commission plans to continue examining the use of PAC in MA, including examining differences in FFS and MA use of SNF and IRF services for beneficiaries who did and those who did not have a prior hospital stay. ■

Beneficiaries who require recuperative or rehabilitative care may be treated in skilled nursing facilities (SNFs), by home health agencies (HHAs), and in inpatient rehabilitation facilities (IRFs).[1] The care is referred to as "post-acute care" (PAC) because it often follows inpatient hospital care.[2] In 2023, about 41 percent of fee-for-service (FFS) Medicare hospital discharges were followed by PAC, though the share varies by condition.[3] Under FFS Medicare, each setting has its own coverage rules, cost-sharing requirements, conditions of participation, and payment system to establish payment rates.

Background

SNFs, HHAs, and IRFs all provide rehabilitation, skilled nursing, and personal care, but the level of care varies, with each having distinct features.[4] HHAs care for beneficiaries who can be safely treated at home and do not require facility-based care. Under FFS Medicare, HHA users are a mix of beneficiaries who had a prior hospital stay and those who did not. SNFs provide facility-based care to beneficiaries who require daily skilled care but do not need the intensity of rehabilitation care offered in IRFs or cannot meet IRF admission criteria.[5] Most SNFs are a part of a nursing home that also provides long-term care (which Medicare does not cover). The mix of short-term PAC and long-term care and the availability of specialized services such as ventilator care vary by provider. One study found that nursing homes that specialize in short-term PAC (rather than long-term care) reported better patient outcomes for their PAC users (Templeton et al. 2023). There is wide variation in the improvement in patient health (using a composite measure of health outcomes) across SNFs within and across markets (Einav et al. 2025). IRFs offer the most intensive rehabilitation services and care must be supervised by a rehabilitation physician. To be paid as an IRF, 60 percent of a facility's admissions must be for patients with 1 of 13 conditions that typically require intensive rehabilitation (known as the 60 percent rule or the "compliance threshold").

Medicare's benefit and cost-sharing requirements differ by PAC setting

The three settings differ in terms of benefits and cost-sharing requirements under FFS Medicare (Table 6-1, p. 192). To qualify for care in HHAs or SNFs, beneficiaries must require skilled nursing or rehabilitation services. Medicare covers up to 100 days of SNF care per spell of illness as long as the beneficiary has had a prior 3-day hospital stay, with daily copayments beginning on Day 21 of the stay.[6] A beneficiary can receive covered home health services for an unlimited period so long as beneficiaries meet coverage rules (such as being homebound). There is no cost sharing for home health use. To qualify for IRF care, a beneficiary is expected to participate in and benefit from an intensive rehabilitation program (typically three hours of therapy a day, five days a week) involving at least two therapy disciplines and requiring supervision by a rehabilitation physician. IRFs are licensed as hospitals, and beneficiaries are responsible for the inpatient deductible if they have not already met it with a preceding hospital stay.

PAC spending and use under FFS Medicare

HHAs and SNFs are the most numerous PAC providers, with over 12,200 HHAs and 14,500 SNFs in 2024 (Table 6-2, p. 193). There are far fewer IRFs (1,170). In 2024, far more beneficiaries used home health care than SNF or IRF services. Almost all beneficiaries (96 percent) live in markets with at least two SNFs, and similar shares live in markets with two HHAs (data not shown). In contrast, less than one-third of hospital markets have an IRF. Beneficiaries needing IRF-level care living in those markets either remain in an acute care hospital for longer periods of time, travel to an IRF, or get their rehabilitation care in a SNF.

In 2024, FFS Medicare spending on PAC was $57.7 billion, including $5.6 billion in beneficiary cost sharing (the majority being SNF copayments). Spending was the highest for SNF care ($31 billion), followed by home health care ($15.7 billion), and IRF services ($11 billion). (Not included in these figures is spending for skilled nursing services provided in hospital "swing beds," which was $2 billion in 2024.) Differences in the level and cost of services across settings are reflected in the average payment per stay. Home health care has the lowest FFS Medicare payments per unit of service ($1,937 per 30-day period in 2024) and IRFs have the highest ($25,300 per stay).

Home health stays were the longest (49.3 days in 2023), indicating multiple 30-day periods for many beneficiaries. The SNF average length of stay was

TABLE 6–1

Eligibility, benefits, and cost sharing for care in skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities

Setting	Eligibility	Benefits	Cost sharing
SNF	• Beneficiary must need daily skilled nursing or therapy care • Beneficiary must have a prior 3-day hospital stay (unless waived)	• Benefit covers up to 100 days per spell of illness	• Beneficiary must pay daily copayments ($217 in 2026) beginning on Day 21
HHA	• Beneficiary must need part-time or intermittent skilled care (nursing or therapy) • Beneficiary must be unable to leave their home without considerable effort	• Benefit covers part-time or intermittent care; no limits on the number of visits	• None
IRF	• Beneficiary must be able to actively participate in intensive rehabilitation services (e.g., 3 hours per day, 5 days a week) • Beneficiary is expected to benefit from intensive therapy • Beneficiary requires 2+ therapy modalities • Beneficiary requires supervision by a rehabilitation physician	• Benefit covers 90 days per spell of illness, with an additional 60-day lifetime reserve	• Beneficiary must pay the inpatient hospital deductible ($1,736 in 2026) per spell of illness (most are transferred from an acute hospital and have already met this deductible) • Beneficiary must pay daily copayments ($434 for any inpatient hospital days 61–90; the daily copayment for lifetime-reserve days is $838)

Note: SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). A skilled service is one that requires the skills of technical or professional personnel, such as registered nurses and physical therapists. A spell of illness begins with the first day of a hospital or SNF stay and ends when there have been 60 consecutive days during which a patient was not in a hospital or a SNF.

more than double that for IRF stays (30.7 days in 2024 vs. 12.4 days).

Aggregate FFS spending on PAC declined slightly (0.6 percent) over the past decade due partly to the shift in enrollment from FFS to Medicare Advantage (MA). In addition, declines in acute care hospital stays, which precede much PAC, have reduced referrals to PAC. In 2019, before the coronavirus public health emergency (PHE), there were 244 inpatient hospital stays per 1,000 FFS beneficiaries. Hospitalizations declined sharply during the PHE and remained well below the prepandemic rate in 2023, at 205 stays per 1,000 FFS beneficiaries. During the PHE, PAC spending decreased 2.3 percent but has since rebounded.[7]

Staffing shortages have constrained the supply of open and staffed SNF beds and home health visits, and they can delay placement of patients into PAC. Delays in institutional PAC placement can result in beneficiaries occupying hospital beds that could be used by other patients who require acute medical services. For beneficiaries, the delays could be harmful or beneficial, depending on the patient's care needs and the services provided while awaiting placement. On the one hand, delays may contribute to further impairment if the beneficiary does not receive needed rehabilitation care. On the other hand, delays could facilitate the provision of certain medical services while still in the hospital, such as dialysis or specialized wound care. While placement in home

TABLE 6–2

Number of providers, spending, and mean lengths of stay in skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities under FFS Medicare, 2024

Setting	Provider counts	FFS users	Total FFS Medicare spending	Average payment	Mean length of stay
SNF	14,500	1.1 million	$31 billion, including $5.4 billion cost sharing	$20,970 per stay	30.7 days
HHA	12,220	2.6 million	$15.7 billion	$1,937 per 30-day period	49.3 days
IRF	1,170	377,000	$11 billion, including $0.2 billion cost sharing	$25,300 per stay	12.4 days

Note: FFS (fee-for-service), SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). The average payment includes beneficiary cost sharing. Medicare pays SNFs on a per diem basis and pays HHAs for 30-day periods. The "mean length of stay" for SNFs refers to Medicare-covered days. The figure for the mean length of stay in HHAs is from 2023.

Source: Medicare Provider Analysis and Review and Standard Analytic Files, 2023, 2024.

health care may not be delayed, the start of care can be, which may increase the risk of hospitalization and emergency department (ED) use (Kaltwasser 2022). The nursing home industry reported in 2024 that, of the 441 nursing homes included in its survey, over half had trouble hiring staff such that their occupancy rates were affected (American Health Care Association 2024). At the same time, high staffing turnover rates in HHAs and SNFs place additional burdens on an already taxed workforce. While our analyses indicate that access is generally positive (see later chapters in this report on the adequacy of Medicare's FFS payments to SNFs and HHAs), there can be markets where delays in placement exist (Massachusetts Health & Hospital Association 2025).

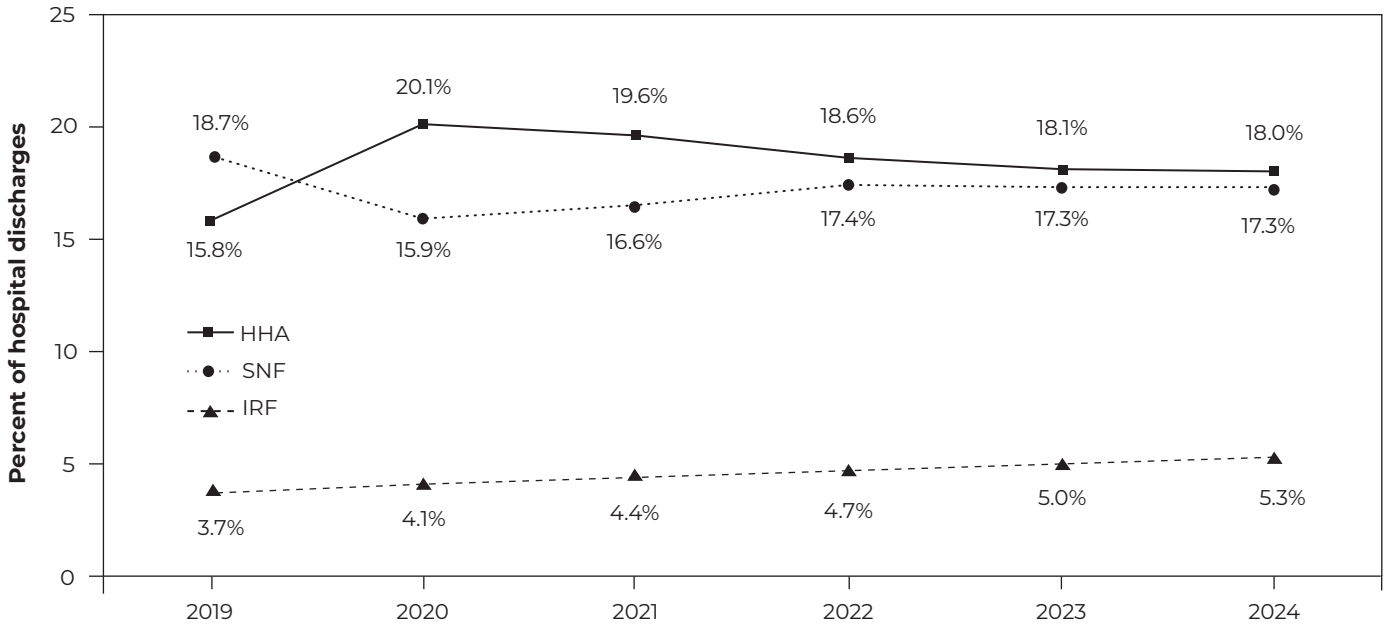
Between 2015 and 2024, spending per FFS beneficiary on PAC increased about 11 percent, partly reflecting rate increases over time. There were large differences by setting, ranging from a 1 percent decline in home health per capita FFS spending to an 8 percent increase in SNF per capita spending and a 56 percent increase in IRF per capita spending. During the same period, there was also wide variation in volume changes. SNF volume (measured as admissions per FFS beneficiary) declined 35 percent, while IRF volume rose 31 percent. The growth in IRF spending and use are partly explained by an increase in providers (4 percent), predominantly for-profit providers. Like SNF volume, home health volume also declined over the period (a 6 percent decline in episodes per FFS beneficiary between 2015 and 2019 and a 4 percent decline in 30-day periods per FFS beneficiary between 2020 and 2024).

Hospital referrals to PAC

Before the coronavirus PHE, SNFs were the most common PAC destination after discharge from an acute care hospital, with 18.7 percent of hospital discharges in 2019 (Figure 6-1, p. 194). HHAs accounted for 15.8 percent of discharges. However, SNF use dropped during the PHE, concurrent with the drop in hospital admissions, and while SNF volume rose in 2021 and 2022, it has not returned to prepandemic levels. During the PHE, HHAs' share of hospital discharges increased to 20.1 percent, and though it has declined since 2020, it remains the most common PAC setting. The share of hospital discharges going to IRFs has steadily increased since 2019 and in 2024 accounted for 5.3 percent of hospital discharges.

FIGURE 6–1

Shifts in the shares of FFS hospital discharges going to different post-acute care settings between 2019 and 2024



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

Source: MedPAC analysis of Medicare claims data.

Overlap in the types of patients treated in different PAC settings

Although the level of services differs across the PAC settings, the Commission and others have documented the overlap in some of the types of patients treated (Gage 2012, Medicare Payment Advisory Commission 2024a, Medicare Payment Advisory Commission 2014a, RTI International 2022). In general, if beneficiaries can be safely treated at home, they prefer home to an institutional setting. Nevertheless, there is some overlap in the types of patients treated in SNFs and HHAs. Beneficiaries with adequate home support may be referred to HHAs, while similar beneficiaries without such support may be referred to SNFs. There is also overlap in the types of patients going to IRFs and SNFs. Some beneficiaries could be referred to an IRF or a SNF, depending on many factors (see discussion below). Because IRFs are licensed as hospitals, their requirements for registered nurse and physician supervision are higher than the supervision available in most SNFs. Thus, clinically complex beneficiaries who require close medical supervision may be referred to an IRF rather than a SNF, if they meet admission criteria. Some IRF admissions are beneficiaries who do not have a prior three-day hospital stay and do not qualify for a covered SNF stay. Reflecting the potential overlap, the Congress mandated that the Commission submit two reports on the design of a single payment system for all PAC providers in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) (see p. 202).

One indicator of the substitutability of PAC is the lower use of high-cost PAC in alternative payment models (APMs), such as accountable care organizations (ACOs) and episode-based bundled-payment models. APM participants have pursued cost savings in part by substituting SNF care for IRF care and substituting home health care for SNF care, in addition to

shortening SNF stays and avoiding PAC altogether (see discussion, p. 203).

There are many reasons for the overlap in the types of patients treated across PAC settings: the variation in the supply and use of PAC across the country, the lack of clear criteria identifying which patients require what level of PAC, and a lack of evidence-based research that could be used to direct beneficiaries to the setting with the best outcomes. (One exception is the stroke guidelines established by the American Heart Association/American Stroke Association (Winstein et al. 2016).) While many providers, clinicians, and caregivers use some sort of guidelines to make placement recommendations, these guidelines may be based on Medicare coverage rules rather than on evidence of what practices result in the best outcomes for a given clinical condition. At the same time, local referral recommendations will be informed by the availability of providers in each market as well as the quality of care and service capabilities of each. A beneficiary may be referred to a SNF if there is one in the market that can meet their care needs; otherwise, they might be referred to an IRF (if they meet admission criteria).

Differences in clinical judgment and experience can also lead to variation in referral decisions, such as the appropriateness of an IRF admission for any given patient. Such variation is expected. For example, one IRF industry stakeholder said there can be differences of opinion regarding the need for medical supervision by a rehabilitation physician (American Medical Rehabilitation Providers Association 2025). Interpretation (and adequate documentation) of the need for intensive versus moderate assistance for some activities of daily living can also lead to differences in whether an IRF stay meets admission criteria (Snecinksi 2025). Reflecting the wide range in practices, the directors of hospital stroke centers we interviewed told us they each had clear decision rules about how IRFs were used (Medicare Payment Advisory Commission 2015b). Yet, those rules were very different across facilities except that the patient had to be able to tolerate intensive therapy and be expected to be discharged home within the typical time frame of an IRF stay (two weeks). There could also be differences of opinion about whether a beneficiary has the potential to significantly benefit from an intensive rehabilitation program, a requirement for Medicare coverage.

In our work on IRF and SNF use, hospital discharge planners we spoke with talked about differing approaches taken by IRFs when considering potential admissions (L & M Policy Research 2023). While only 60 percent of an IRFs' total inpatient population must require treatment for specified conditions to be paid under the IRF PPS, some IRFs were strict about admitting only patients with conditions that contribute to the compliance threshold, while other IRFs admitted patients who did not have such conditions. Some hospital discharge planners reported having a hard time predicting whether beneficiaries who did not have a condition that contributes to the 60 percent threshold would be accepted for admission by an IRF. Some IRFs were flexible about providing bedside therapy to accommodate the changing care needs of a patient and enable the IRF to meet the intensive therapy requirement. Some discharge planners referred beneficiaries to SNFs to gain strength, with an expected subsequent transfer to an IRF once the beneficiary can tolerate and participate in intensive therapy.

No easy algorithm can predict whether a beneficiary requires intensive therapy and meets IRF admission criteria. Discharge planners told us that the list of conditions used to qualify IRFs for payments under the IRF prospective payment system (PPS) was imperfect at identifying patients who require IRF-level care, often saying that the list was too restrictive. For example, they said that patients with conditions such as cancer, congestive heart failure, chronic obstructive pulmonary disease, or post-COVID acute respiratory failure may require intensive services but are not counted toward meeting the compliance threshold. On the other hand, we heard that not all patients recovering from a stroke (a condition that does count toward the compliance threshold) require the intensity of services furnished by IRFs. We also heard that on any given day, placement decisions could be influenced by how close the IRF was to meeting the compliance threshold. Hospital discharge planners also told us that IRFs were less likely than SNFs to admit patients who were not expected to go home after the PAC stay. The lack of clear guidelines and an imperfect list of conditions that count toward compliance make for ambiguous guardrails for the appropriate use of IRFs. In addition, hospital discharge planners said that travel time for family members was a key consideration for beneficiaries when deciding between an IRF and a SNF. Some beneficiaries who

qualified for IRF care wanted to be treated in a SNF if it was closer to home.

Concerns about measuring and improving quality in nursing homes

To assess the value of Medicare's PAC purchases and help consumers make informed decisions about where to get care, it is important to be able to meaningfully compare quality of care across providers and settings. Information gathered from patient assessments is central to such comparisons, but the tools historically were different enough that, for many years, comparisons were not possible. The assessment tools differed in their time frames, methods of collecting the data, the assessment scales, and definitions of common dimensions of care assessed (such as walking or cognitive status) (Medicare Payment Advisory Commission 2005).

Since 1999, the Commission has discussed the importance of being able to compare PAC patients and their outcomes (Medicare Payment Advisory Commission 2014b, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2010, Medicare Payment Advisory Commission 2007, Medicare Payment Advisory Commission 2006, Medicare Payment Advisory Commission 1999). The Commission noted that the lack of comparable data undermined the program's ability to purchase high-quality care in the least costly setting (Medicare Payment Advisory Commission 2007). In 2014, the Commission recommended the collection of common patient-assessment information across PAC providers (Medicare Payment Advisory Commission 2014b).

When the Congress enacted IMPACT, it required the Secretary to collect uniform patient-assessment items in each setting and develop quality measures that would be used in each setting. CMS developed uniform measures for discharge function, changes in skin integrity (new or worsened pressure sores), Medicare spending per beneficiary, discharge to community, hospital readmissions, medication reconciliation, incidence of falls with major injury, and transfer of health information and care preferences when an individual transitions home or to another setting; all SNFs, HHAs, and IRFs report them as part of the quality-reporting programs. The Commission uses a subset of these measures (all claims-based outcome measures) to examine quality of care as part of its annual assessment of the adequacy of Medicare's FFS payments for PAC providers.

Although Medicare now requires PAC providers to report certain patient-assessment information and several outcome measures to facilitate comparisons of care within and across settings, challenges remain in measuring quality and comparing it across settings, as discussed below. First, payment and other incentives may encourage providers to inaccurately report information. Second, a key dimension of quality, patient experience/patient satisfaction, is not collected in each setting. Third, controlling for underlying differences in patient populations across and within settings remains an issue, due in part to the service capabilities and admission requirements that vary across settings. Perhaps because of these data limitations, studies comparing outcomes across settings have reached different conclusions.

Inaccurate reporting of patient-assessment information may reflect payment and other incentives

The Commission and others have raised concerns about the accuracy of the information gathered by patient assessments (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2019, Office of Inspector General 2012, Sanghavi et al. 2020). An Office of Inspector General (OIG) study found that nursing homes failed to report 43 percent of falls with major injury and hospitalization for Medicare beneficiaries, resulting in misinformation reported on Care Compare (Office of Inspector General 2025). OIG also found that falls with major injury were underreported in the patient assessments completed by HHAs (Office of Inspector General 2023). Researchers found that nursing homes underreported the use of antipsychotic medications but overreported the conditions that qualify nursing homes for an exemption from the star-rating measure (Chen and Grabowski 2023).

Providers may record certain patient-assessment information inaccurately because they have a financial incentive to do so. Some patient-assessment

information is used by Medicare's case-mix systems to establish payment rates for a SNF day, a home health period, or an IRF stay. For example, functional status at admission is included in the case-mix systems for all three settings, and a small difference in the function score can shift the assignment of the patient to a different case-mix group, thus giving providers a financial incentive to record patients' functional status as worse than it is. In 2016, the Commission reported that high-margin IRFs had patients who were, on average, less severely ill in their preceding acute care hospital stay but were coded as more functionally disabled upon admission to the IRF. This discrepancy suggests that assessment and coding practices might contribute to greater profitability in some IRFs (Medicare Payment Advisory Commission 2016b). In other work, the Commission compared assessments of patients who transferred between PAC settings and found that functional status recorded at discharge from one setting and admission to another were often different, and the differences favored reporting function levels that would raise payments (Medicare Payment Advisory Commission 2019).

Inaccurate recording of patient-assessment information may also be influenced by the star ratings. Providers pay attention to their star ratings because they are used by consumers, MA plans, and participants in APMs to select PAC providers (see discussion of the star ratings for nursing homes in Chapter 7 of this report). The Commission supports public reporting of provider quality. However, inaccurate reporting of information may result in overstatements of quality for some providers. One study found that the correlation between provider-level hospitalization rates (a fairly objective measure based on claims) and nursing home star ratings was weaker after the ratings were made available to the public (Ryskina et al. 2018). Another study found evidence that some nursing homes increased their staffing, reduced admissions, increased discharges, and improved patient care around the time of their inspections, but the changes were temporary (Chen and Dillender 2025). The Commission compared setting-specific functional assessment items used for payment rather than the uniform item used for quality reporting (Medicare Payment Advisory Commission 2019). We found that the items used for quality reporting were likely to indicate a higher level of independence than the functional-status information that was used to establish payment. (A lower level of independence generally results in higher payment, all else equal.) A study of HHA outcome measures before and after the introduction of the star ratings for HHAs found improvements in provider-reported patient-assessment measures but not in claims-based measures of hospitalizations and timely initiation of care (Chen et al. 2024).

The Commission has discussed strategies to improve the quality of the patient-assessment information, including monitoring and auditing assessment information that PAC providers submit, requiring hospitals to collect patient-assessment information at discharge, and gathering patient-reported outcomes (Medicare Payment Advisory Commission 2019). CMS has taken steps to improve the quality of the data collected in the patient assessments and outcome measures it reports. The Consolidated Appropriations Act, 2021, requires CMS to validate the patient-assessment information used in the SNF VBP and quality-reporting programs (including functional status). The limited validation process (it will review up to 10 records for a random sample of 10 percent of SNFs each year) will begin in January 2026. In response to OIG's 2025 report on nursing homes' underreporting of falls, CMS now uses data from Medicare and Medicaid claims and encounter data, in addition to patient assessments, to capture major injuries resulting from falls in nursing homes (Office of Inspector General 2025). In 2023, OIG recommended that CMS take steps to ensure the completeness and accuracy of the HHA-reported Outcome and Assessment Information System data used to calculate the falls (Office of Inspector General 2023). In July 2025, CMS convened an expert panel to discuss a common approach to measuring falls across PAC settings that could include adding claims data and revisions to the diagnosis codes to identify falls and major injuries (RTI International 2025). In the HHA VBP program, the calculation of the rates of discharge to community are now based on claims, rather than the patient-assessment information.

Patient-experience data are not collected in all PAC settings

Medicare does not collect data on patient experience for beneficiaries treated in SNFs or IRFs, even though their experience is a key dimension of quality. The Commission has recommended that the Secretary

finalize the development of and begin to report patient experience in nursing homes (Medicare Payment Advisory Commission 2021). For fiscal year 2024, CMS proposed but did not implement a SNF patient-experience measure, citing comments it received about the small number of questions the tool included (four), the exclusions allowed in calculating the satisfaction rates, and the need for SNFs to contract with a vendor to submit weekly survey-response data (Centers for Medicare & Medicaid Services 2023b). The following year, CMS requested information about a patient-experience/patient-satisfaction measure and said it would consider comments in future measure development (Centers for Medicare & Medicaid Services 2024c).

CMS also explored patient-experience/patient-satisfaction measures for IRFs. Under contract to CMS, RTI tested a patient-experience survey for IRFs in 2017 and found ceiling effects (too many IRFs had high scores to differentiate performances) and that the measures were reliable if the facility had a minimum of 240 responses (RTI International 2018). In 2023, CMS solicited comments on patient-experience/patient-satisfaction measures and received mixed support, including concerns about the administrative and financial costs associated with data collection (Centers for Medicare & Medicaid Services 2023a). An industry stakeholder commented that the number of survey responses required for reliable results would be problematic for most IRFs (Encompass Health 2024). To date, CMS has not required IRFs to collect this information.

HHAs are required to collect information about patient experiences using the Home Health Consumer Assessment of Healthcare Providers and Systems, and this information is scored in the home health care VBP program.

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

To accurately compare patient outcomes in SNFs, HHAs, and IRFs, analyses must control for differences in patient populations within and across settings. Yet, even with robust risk adjustment, using information from claims and patient assessments is unlikely to fully capture patient selection. Differences in outcomes could reflect unmeasured differences in the patients treated in each setting and across providers. In addition, providers are not required to admit every beneficiary who is referred to them and can avoid patients with certain care needs that they do not have the staffing or equipment to treat. For example, Medicare's coverage rules require that IRFs admit only patients who can tolerate intensive therapy. Industry stakeholders told us that IRFs admit less than 40 percent of the patients referred to them (American Medical Rehabilitation Providers Association 2023). Among patients who meet this requirement, hospital discharge planners we spoke with told us that IRFs avoid certain types of patients, such as those unlikely to go home after their IRF stay or those with behavioral health issues (L & M Policy Research 2023). One study concluded that the discharging hospital had a large effect on the probability of whether patients were discharged to IRFs or SNFs (Simmonds et al. 2024). In addition, the three settings have varying service capabilities that result from licensure requirements and Medicare's conditions of participation for each setting. For example, IRFs are licensed as hospitals and are equipped to treat the worsening of many clinical conditions that many SNFs would not be able to treat. As a result of these factors, we would expect IRFs to have lower hospital readmission rates than HHAs or SNFs—and in fact they do. The median hospital readmission rate for the period 2023 to 2024 was 9.2 percent for IRFs and 10.7 percent for SNFs.

In addition to the complications of controlling for patient selection, studies comparing outcomes across settings have had mixed results in part because they differed in the settings, the clinical conditions, and the outcomes examined (Cogan et al. 2021, Cogan et al. 2020, Mallinson et al. 2014, Medicare Payment Advisory Commission 2024a, Osundolire et al. 2024, Padgett et al. 2018, Riester et al. 2023). The studies typically examined patients recovering from joint replacement, hip fracture, total knee arthroplasty, and/or conditions that do not contribute to the IRF compliance threshold. In terms of outcome measures, the studies examined some combination of functional improvement and rates of hospital readmissions, discharge to community, and mortality. Studies do not have consistent conclusions for similar measures or across measures.

Two studies comparing outcomes for SNFs and HHAs included patients with all conditions, though

one included only patients who had dementia (in addition to their reason for rehabilitation care) (Burke et al. 2021, Werner et al. 2019). The studies found that HHAs and SNFs had similar mortality rates but drew different conclusions about readmission rates. Werner et al. also found that HHAs and SNFs had similar functional outcomes (Werner et al. 2019). Another study comparing outcomes after total knee arthroplasty for HHAs, SNFs, and IRFs found that HHAs had lower readmission and complication rates, even after controlling for demographics and comorbidities (Whitaker et al. 2024).

The one exception to the mixed outcomes is the study of outcomes for patients recovering from strokes. Studies found that IRFs had better outcomes than SNFs (as measured by functional improvement, discharge to community, and mortality) (Alcusky et al. 2018, Chan et al. 2013, Hong et al. 2019, Prvu Bettger et al. 2019). Another study analyzing outcomes for stroke patients included HHAs, and it also concluded that IRF outcomes had the lowest mortality rates, followed by HHAs, then SNFs, but noted that the severity of the stroke is a factor in PAC placement (Springer et al. 2022).

Chronic quality problems in some nursing homes persist despite regulatory and quality initiatives

Despite numerous regulatory and quality initiatives over many years, the quality of care provided to many nursing home residents and PAC users remains poor (Medicare Payment Advisory Commission 2025b). Continued quality problems partly reflect the low Medicaid payment rates that, on average, do not cover the cost of care (Medicaid and CHIP Payment and Access Commission 2023). Low payment rates appear to affect nursing home staffing levels, which in turn affect the quality of care (Medicaid and CHIP Payment and Access Commission 2022). In addition, low Medicaid payment rates create financial incentives for providers to hospitalize their long-stay residents to requalify those with Medicare coverage for a higher-payment Medicare-covered stay once they return to the facility. While inpatient hospital stays are financially advantageous to the nursing home, they are disorienting to beneficiaries and unnecessarily expose them to risks associated with hospitalizations.

Nursing homes must meet federal requirements regarding many dimensions of quality of care, quality of life, residents' rights, and the safety of the physical environment. There are also federal staffing minimums regarding the availability of on-duty registered nurses and licensed nurses as well as requirements for sufficient staffing to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Nevertheless, overall quality problems remain, though select outcomes have improved (National Academies of Sciences Engineering and Medicine 2022). While inspections play a key role in ensuring that minimum quality standards are met, they often fall short for a variety of reasons, including timeliness and variation across states in conducting the inspections and citation of serious deficiencies (KFF 2024, Office of Inspector General 2022a). Even with the staffing requirements, workforce shortages and high turnover rates are major factors that undermine the quality of care in nursing homes (National Academies of Sciences Engineering and Medicine 2022). The majority of states (38 plus the District of Columbia) have implemented stricter minimum staffing requirements than the federal requirements (Medicaid and CHIP Payment and Access Commission 2022).

CMS has several programs focused on improving quality, but only the star-rating program has had some success. The Quality Reporting Program posts provider performance on a variety of quality measures, and a subset of these measures are used to rate providers using 1 to 5 stars (for more information, see the discussion of nursing home star ratings in Chapter 7). Researchers found that some consumers appear to use the ratings to select higher-quality facilities and that providers try to improve their ratings (Konetzka et al. 2021). By contrast, the Quality Improvement Organization (QIO) Program offers resources to help providers improve their quality, but there is a lack of evidence showing that the program is effective (National Academies of Sciences Engineering and Medicine 2022). In addition, as discussed below, we and others have concluded that the SNF value-based purchasing program has not been effective at lowering hospitalization rates (the single performance measure through 2025).

The lackluster results of regulatory and quality initiatives over many years suggest that significant improvement in nursing home quality will require

substantial changes to the way Medicare (and Medicaid, for long-term care) oversees and pays for care. MedPAC has examined accountable care organizations that focus on beneficiaries in nursing homes (the High Needs ACOs) and MA plans that serve beneficiaries in nursing homes (the institutional special-needs plans, or I–SNPs) (Medicare Payment Advisory Commission 2025b). Both models offer more patient monitoring, hands-on care, and assistance with care transitions. Though limited in their current enrollment of beneficiaries, the models have shown some potential to improve care for beneficiaries. The Commission will continue to monitor these models.

High FFS Medicare payments, FFS incentives, and Medicare benefits may encourage inefficient care

By its nature, FFS has incentives that encourage volume, and those incentives may be stronger when FFS margins are high, as they are in SNFs, HHAs, and IRFs. The incentives of the VBP programs are too small to encourage providers to improve quality. Policies to narrow the prices that Medicare pays for similar cases treated in different settings would be complex to implement.

FFS incentives and Medicare benefits may encourage unnecessary care

FFS incentives may encourage unnecessary volume: SNFs may extend stays, HHAs may trigger second 30-day periods, and IRFs may admit patients who qualify for the care but could be treated in a less intensive setting. As noted above, determining whether an admission is appropriate without medical-record review is hard to discern and, even then, clinicians could disagree.

Within each payment bundle of service (the IRF stay, the SNF day of care, or the home health 30-day period), providers have incentives to control their costs (and the services they provide). The original designs of the HHA and SNF PPSs encouraged providers to furnish unnecessary therapy that boosted payment because rates were based on, among other factors, the amount of therapy provided.[8] The Commission recommended that those PPSs be redesigned without a therapy adjustment (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2008). In payment year 2020, CMS revised both PPSs and removed therapy as an adjuster. Providers responded to the revised PPSs, wth SNFs reducing the number of minutes of therapy and HHAs reducing the number of therapy visits (Medicare Payment Advisory Commission 2025c, Medicare Payment Advisory Commission 2023b). Despite beneficiaries getting fewer therapy services, our indicators of quality showed either no change or slight improvement, suggesting that the therapy declines were "right sizing" the amount of therapy based on a patient's care needs. Studies of the revised SNF case-mix groups found that spending increased, which could be the result of increased patient complexity, improved coding of patient complexity, or increased coding that does not correspond to changes in patient complexity (Geng et al. 2025, Wang et al. 2025). Future work could examine whether the redesigned payment systems have resulted in more accurate payments.

The three PPSs rely on provider-reported functional status data that may not always reflect patient care needs. Because this information is key to differentiating patients' care needs and the design of case-mix groups, it is important that CMS do all it can to ensure its accuracy. The Commission outlined strategies that CMS could undertake, including the monitoring of provider-reported assessments, requiring hospital discharge assessments (to corroborate the PAC assessment data), and gathering patient-reported outcomes for SNFs and IRFs (Medicare Payment Advisory Commission 2019). As noted above, CMS will undertake a limited validation program for SNFs but has not planned similar efforts for IRFs and HHAs.

In 2024, the Commission examined the accuracy of IRF payments and found that payments do not track costs per stay (Medicare Payment Advisory Commission 2024b). Higher-severity cases are more profitable than lower-severity cases, and the relationship between costs per stay and case mix (that raise or lower payments) has deteriorated over time. The Commission concluded that replacing the way CMS calculates the IRF case-mix weights (it uses hospital-specific relative value weights) with cost-based weights (used in other settings) would result in more uniform profitability across case types.[9] Cost-based weights could help

dampen providers' incentives to inaccurately record the severity of patients.

Medicare benefits may also encourage the provision of unnecessary care if beneficiaries meet coverage rules (such as needing a skilled service or, in the case of home health care, being homebound). The home health benefit is unlimited, and there is no cost sharing. Both features could extend care that may be of marginal value. For SNFs, there is no cost sharing until Day 21, which may dampen beneficiaries' and providers' interest in shortening stays.

FFS Medicare margins indicate FFS payments are considerably higher than the cost of PAC

FFS Medicare margins for SNFs, HHAs, and IRFs have been high for more than two decades—above 10 percent for more than 20 years, with only minor exceptions (between 2008 and 2011, IRF margins dipped to between 8 percent and 9 percent). Because updates to PPS payment rates are in statute, CMS does not have the authority to rebase payment rates without congressional action. The Commission has routinely recommended that the Congress reduce the base payment rates across Medicare's PAC payment systems.

CMS's efforts to lower improper payments to PAC providers

Each year, CMS estimates the share of claims that were improperly paid under Medicare's coverage, coding, and billing rules, or the share of claims with insufficient documentation to support the submitted claim.[10] In 2024, across all FFS Medicare, the improper-payment rate was 7.7 percent, but for SNFs and IRFs the rates were substantially higher (17 percent and 29 percent, respectively) (Centers for Medicare & Medicaid Services 2024a). The most common reason for improper payment to SNFs was insufficient documentation, whereas for IRFs it was lack of medical necessity. Compared with SNFs, IRFs have more eligibility rules that could contribute to the denials. HHAs had a rate comparable with the FFS Medicare average, and the key reasons were insufficient documentation (51 percent) and lack of medical necessity (34 percent).

CMS currently has two demonstrations that target improper payments to HHAs and IRFs in states with high rates.[11] Each IRF and HHA in the selected states is subjected to 100 percent claims review until it reaches acceptable approval rates. Providers must submit documentation supporting the medical necessity of the admission. The HHA demonstration aims to reduce the number of Medicare appeals and improve provider compliance with Medicare program requirements without delaying care to beneficiaries or altering the home health benefit. Beginning in 2016 and recently extended an additional five years (through May 2029), the demonstration includes HHAs in Florida, Illinois, Ohio, Oklahoma, North Carolina, and Texas. The five-year IRF demonstration began in May 2023 in Alabama and was expanded to Pennsylvania in 2024, with plans to expand to Texas and California in 2026. Its goal is to test improved methods for the identification, investigation, and prosecution of potentially medically unnecessary admissions and to decrease appeals.

In 2023, CMS launched a 5-Claim Probe and Educate Review Program for SNF claims that audited five claims per SNF and educated providers about proper billing. In June 2025, CMS ended the augmented auditing.

Current value-based purchasing programs are unlikely to change provider behavior

By adjusting payment rates based on the quality of care provided, VBP programs are intended to create incentives for providers to furnish high-quality care. As required by the Congress, CMS implemented a VBP program in SNFs (in fiscal year 2019). To date, the SNF VBP has not reduced hospital readmissions (Burke et al. 2025). Since 2018, the readmission rate has increased from 19.6 percent to 20.5 percent in 2024 (Centers for Medicare & Medicaid Services 2025c). The Commission and others have concluded that the incentives of the SNF VBP program (a 2 percent withhold) are too small to incentivize changes in care (Burke et al. 2025, Government Accountability Office 2021, Medicare Payment Advisory Commission 2021). We also have noted that the scoring approach (requiring providers in the lowest 40 percent of rankings to have their payments lowered by the program each year) does not provide enough financial incentive for providers to improve. In 2021, the Commission recommended that the SNF VBP program be eliminated and replaced with one that meets its principles for a value incentive program (Medicare Payment Advisory Commission 2021).

The HH VBP model is an expansion of a previous multiyear model test that saw improvements in the quality of the HHAs in the nine states that participated in the original model (Centers for Medicare & Medicaid Services 2024b). The original model resulted in an average 4.6 percent improvement in the participating HHAs' composite performance, as well as reductions in unplanned acute care hospitalizations and SNF stays, with no evidence of adverse risks and with average annual program savings of $141 million (Centers for Medicare & Medicaid Services 2025a). Based on these results, the model was expanded to include all HHAs beginning in 2025 and includes payment adjustments ranging from −5 percent to +5 percent. The nationwide VBP is too new to draw conclusions about its results. For 2026, CMS estimated that the average payment adjustment would be about −0.09 percent. The top and bottom 10 percent of HHAs' performances are estimated to have their payments adjusted upward or downward by about 2.5 percent (Centers for Medicare & Medicaid Services 2025a). As with the SNF VBP program, the size of these adjustments in the HH VBP model may not be large enough to prompt HHAs to improve their care.

There is no VBP for IRFs.

Site-neutral Medicare FFS payment policies across PAC settings for similar patients would be complex to implement

The overlap in some of the types of patients treated in different settings and the broad similarities in the services offered raise questions about whether Medicare's FFS payment rates could be made more equivalent for providers in different settings that treat similar patients. The Congress mandated that the Commission and the Secretary evaluate a prototype design for a unified PPS that would use patient characteristics to establish payments across SNFs, HHAs, IRFs, and long-term care hospitals (Medicare Payment Advisory Commission 2016a). In the first of two required reports, the Commission concluded that a reasonably accurate PAC PPS could be designed using patient and stay characteristics. A unified PPS would use a common set of parameters to adjust payments across the settings, with an additional adjuster to lower payments for home health care, given its much lower costs. (Otherwise, home health care stays would be highly overpaid and institution-based care would be severely underpaid.[12]) Our modeling indicated several design features that should be considered in a unified PPS (such as outlier policies for high-cost stays and short stays). Building on this work, the Commission subsequently explored various implementation issues, including the length of a phase-in period and the level of payments, the need to lower payment rates for later stays in sequential PAC stays (such as when a home health stay follows a SNF), and an episode-based design (including only PAC, excluding hospital and physician and other Part B services) (Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2017).

In a mandated report to the Congress, the Secretary outlined a prototype PPS design that was broadly consistent with the features identified by the Commission. One key difference was that the design included adjusters that would set different payment rates by setting. The report discussed other important considerations, including unified benefits, cost sharing, and value-based payment (RTI International 2022).

In our second report, the Commission confirmed that a reasonably accurate design was possible (Medicare Payment Advisory Commission 2023a). However, we concluded that, while designing a unified PAC PPS would be relatively straightforward, implementing one would not be. In addition to designing a unified PPS, CMS would need considerable resources to develop and implement the requisite accompanying policies, such as a common set of conditions of participation, aligned cost sharing, and a value-incentive program. Changes to the individual PPSs would require congressional action. Given the complexities associated with implementing a PAC PPS, the Commission stated that policymakers could look for opportunities to adopt smaller-scale policies that would narrow price differences for similar patients treated in different settings.

One example of more targeted alignment of Medicare's prices for PAC is the overlap of some patients treated in IRFs and SNFs. The Commission considered alternative pricing that would lower FFS Medicare payments to IRFs for patients who could have been treated in SNFs (Medicare Payment Advisory Commission 2024a). To identify case types that would be candidates for price

reductions, we focused on conditions that do not contribute to the IRF compliance threshold. (These are conditions that CMS determined do not typically require intensive therapy.) However, as discussed above (p. 195), the list of conditions that contribute to the compliance threshold (or any list) does not necessarily identify patients who require IRF-level care. Implementing price reductions for select conditions that do not contribute to the compliance threshold could result in IRFs avoiding patients with these conditions (even if the patients required IRF-level care). Further, because our research found that cases that do and do not contribute to the compliance threshold were equally profitable, it was not clear why rates would be lowered for only some conditions. Moreover, unmeasured differences in the patients treated in IRFs and SNFs undermined our ability to draw conclusions about the characteristics and outcomes of the patients treated in each setting. These factors persuaded the Commission that there was not a solid evidentiary basis to lower prices for a select group of conditions and that our standing recommendation to lower prices for all cases (a recommendation that is reassessed each year) was the best course of action.

Alternative payment models create incentives to lower FFS spending by using less post-acute care

APMs—such as ACOs and bundled-payment initiatives—hold participating entities at risk for the total cost of care, with limited exceptions. Entities are typically paid under FFS Medicare for the care provided and, at the end of the performance period, their spending is compared with a benchmark. If their spending is below the benchmark, the entities share in any program savings. In some models, entities must also maintain or improve quality to qualify for any program savings. ACOs are accountable for a defined group of beneficiaries during a performance period (such as a year), whereas entities participating in bundled-payment initiatives are typically at financial risk for episodes of care (30, 60, or 90 days) for beneficiaries with specific conditions (such as hip fracture).

To lower spending, entities participating in APMs have an incentive to avoid unnecessary PAC use altogether or shift higher-cost IRF use to SNFs and SNF care to HHAs for beneficiaries who could go home. Because SNFs are paid on a per diem basis, entities also have an incentive to shorten SNF stays. It is important to note that shifts in PAC use could reflect more efficient service use, but it could also mean that some beneficiaries do not get the care they need. Given their financial incentives, the models could increase providers' incentives to selectively admit certain types of patients, which could worsen racial disparities; bundled-payment initiatives also could encourage volume (Liao et al. 2020). The models could also lead to narrower referral networks, which could affect beneficiaries' care, depending on the quality of the PAC providers.

Older ACO models (ACO Investment Model, Next Generation, and Global and Professional Direct Contracting (now known as the ACO REACH model)) did not consistently lower program spending after accounting for reconciliation payments (Abt Associates 2020, NORC at the University of Chicago 2024a, NORC at the University of Chicago 2024b). All models used less PAC—some combination of fewer SNF admissions and shorter stays and fewer HHA and IRF days. Despite the service reductions, quality scores—as measured using a mix of mortality, hospital admissions, hospital readmission, ED use, and patient experiences—were maintained or improved. Next Generation ACO model participants also improved prevention and screening (fall risk, breast cancer, colorectal cancer, and clinical depression) and management of chronic conditions such as diabetes, hypertension, and cardiovascular disease (NORC at the University of Chicago 2024b). More recent results of the Medicare Shared Savings Program ACOs (performance year 2024) show that the program achieved net savings by lowering hospital, ED, and SNF use (Centers for Medicare & Medicaid Services 2025b). Compared with similar physician groups, the ACOs had higher rates of screening for depression, controlling blood pressure, and patient satisfaction.

ACOs can apply for a waiver from the required three-day hospital stay for Medicare coverage of SNF care, but such waivers are used relatively infrequently. A study of waiver use by ACOs between 2014 and 2019 found that less than 5 percent of ACO stays were waiver stays (Centers for Medicare & Medicaid Services 2023c).

CMS has tested three versions of bundled-payment initiatives—Bundled Payments for Care Improvement (BPCI), BPCI–Advanced (BPCI–A), and the Comprehensive Care for Joint Replacement (CJR) models. The BPCI–A and CJR models held entities accountable for maintaining or improving quality when calculating incentive payments to participants. The CJR model was mandatory for hospitals in certain areas. The original BPCI lowered spending but did not achieve net savings once reconciliation payments were made, while BPCI–A (especially for surgical cases and in later years) and the CJR models achieved net savings to Medicare, though the results varied depending on the year (Lewin Group et al. 2025, Lewin Group et al. 2024, Lewin Group et al. 2021). Each iteration of the models offered important lessons on risk adjustment and setting the target prices so that the benchmarks were realistic. All initiatives curbed PAC use by shortening SNF stays and lowering SNF and IRF use. Despite less PAC use, quality was generally maintained or improved—gauged by a mix of measures including ED visits, functional outcomes, or rates of readmissions, mortality, and complications. The BPCI and BPCI–A models had less success in maintaining positive patient experiences. A review of 20 studies of CMS's Acute Care Episode Demonstration, the BPCI, and the CJR model confirmed these findings (Agarwal et al. 2020). Some of the studies did not find differences in the case mixes of hospitals that did and did not participate in the initiatives, suggesting that participating hospitals did not avoid higher-risk patients. Some of the studies concluded that initiatives did not increase the volume of episodes. A study of hospital referrals to SNFs found that the BPCI did not change the number or concentration of SNFs used by the participating hospitals (Lin et al. 2024, Zhu et al. 2019). A study of the BPCI model for lower-extremity joint replacement found that patient selection accounted for over one-quarter of the model's savings (Navathe et al. 2020).

Beginning in January 2026, CMS is testing a mandatory bundled-payment model for five high-cost procedures for hospitals in 188 markets—the Transforming Episode Accountability Model (TEAM). The procedures include lower-extremity joint replacement, surgical hip/femur fracture treatments, coronary artery bypass graft, spinal fusion, and major bowel surgery. The bundle includes all services during the initial hospitalization and the 30 days after discharge. Participating hospitals will earn an extra payment if they keep their spending below a target price and score well on clinical and patient-experience measures, while other hospitals may be subject to a repayment amount for spending over the target price.

MA plans have an incentive to lower their costs by using less PAC

As beneficiaries increasingly enroll in MA plans, FFS Medicare volume in PAC has declined. This shift could have important implications for PAC providers and beneficiaries. In the future, we plan to review the literature comparing MA and FFS use of PAC, but we offer a preview of possible trends for PAC providers here.

MA plans are another way to counter FFS volume incentives. Because plans are paid a monthly per member amount, they have an incentive to lower their costs by lowering unnecessary service use. MA plans may use physicians and nurse practitioners to coordinate care and furnish preventive care to lower the use of more expensive services.

MA plans have a financial incentive to prolong hospital stays and avoid PAC altogether, use lower-cost PAC, and shorten SNF stays. By extending a hospital stay, a plan can avoid making a referral to (and incurring the cost of) a separate PAC stay or enabling a referral to a lower-intensity (and lower-cost) PAC setting. A study conducted by NORC at the University of Chicago found that MA enrollees' observed hospital lengths of stay were 40 percent longer than stays for beneficiaries enrolled in FFS Medicare and that a smaller share of MA enrollees' hospitalizations were discharged to PAC (NORC at the University of Chicago 2025). The Commission has found that, after a hospital discharge, MA enrollees used HHAs more often than beneficiaries in FFS Medicare, but that the MA home health stays included fewer visits (Medicare Payment Advisory Commission 2025b). Among MA plans, those with cost-sharing requirements had lower use compared with other plans. This pattern likely reflects the utilization-management tools that MA plans employ to control service use. Over the coming year, we plan to examine differences in FFS and MA use of SNF and IRF services for beneficiaries who did and did not have a prior hospital stay, controlling for differences in beneficiary characteristics.

Potential effects on providers

MA plans typically use prior authorization and provider networks to manage service use by their enrollees. For providers, these management tools can mean burdensome processes and requirements to get initial approval and to extend care if additional care is needed. Plans often establish networks of providers that steer volume toward some providers and away from others. A provider's volume could be affected by whether it is included in a network and would be more likely to receive referrals.

Some industry representatives report that MA plans' payment rates to HHAs and SNFs may be lower than FFS Medicare rates (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2025c). Therefore, the total financial performance (that considers all sources of revenues and expenses for all patients) may be affected by a provider's share of MA revenues and lower MA rates, all else equal. In the future, we plan to examine the impact of MA on the financial performance of PAC providers.

Potential effects on beneficiaries

Utilization-management tools may also affect beneficiaries. Some plans manage the PAC of their enrollees (such as helping beneficiaries with their transition home or coordinating the initiation of home health services), and beneficiaries may benefit from this oversight. Provider networks can restrict beneficiary choice of setting and/or provider. As a result, a beneficiary's preferences may not factor into a placement decision and could increase travel times if the approved location is further away from the beneficiary's home.

Prior authorization for initial or subsequent care (such as recertification of home health care) can delay the start of PAC or deny it altogether. It is not clear whether these tools delay or deny needed care or result in service delivery that is more efficient. Denials could simply indicate that the documentation accompanying the initial request for care was insufficient. OIG found that SNF and IRF services were among the most frequently denied, even though requests met Medicare coverage rules and MA billing rules (Office of Inspector General 2022b). OIG noted that the denials could delay or prevent beneficiaries from getting medically necessary care. A Senate investigation of three large MA plans found that between 2019 and 2022, the use of prior authorization increased and their denial rates of PAC were higher than for other services (U.S. Senate Permanent Subcommittee on Investigations 2024). During this period, the Senate Committee reported that the companies' use of algorithms to review requests increased. In a class action lawsuit against one large plan, plaintiffs alleged that the use of an artificial intelligence model wrongfully denied PAC by overriding physicians' determinations about medically necessary care (U.S. District Court for the Western District of Kentucky 2023).

Delays in approving PAC can result in beneficiaries staying in hospitals longer as they await approval for PAC placement. A recent study comparing hospital lengths of stay for FFS Medicare and MA found that MA enrollees had a higher probability of hospital stays that were 14 days or longer (McGarry et al. 2025). The authors said that longer hospital stays could be due to MA plans' approval requirements and could increase beneficiaries' risk of hospital-acquired infections and delay timely rehabilitation. Hospital discharge planners we spoke with about IRF and SNF placement told us that MA enrollees often were hard to place in IRFs and that delays in getting the plan's determination could mean that some beneficiaries' functional status deteriorated such that they no longer qualified for IRF care (L & M Policy Research 2023). A recent survey of nursing homes found that two-thirds of respondents said they had experienced denials or delays of medically necessary care daily or weekly and had instances where care was shortened against medical advice (American Health Care Association 2025). These limitations could affect beneficiaries' treatment plans and families' arrangements for care at home. We will continue to monitor MA enrollees' use of PAC. ■

Endnotes

1 Some chronically critically ill beneficiaries receive care in long-term care hospitals (LTCHs). Because there are few providers and beneficiaries who use this service, we have not included LTCHs in this chapter. A small number of hospitals provide SNF services in hospital beds normally used for acute care services. The use of "swing beds" is discussed in Chapter 7 of this report.

2 Earlier work by the Commission found that about one-third of PAC use involved combinations of PAC stays, including transitions within a setting (the most common was from one HHA to another) and discharges from IRFs or SNFs to home health care (Medicare Payment Advisory Commission 2019).

3 Though the number of FFS discharges from acute care hospitals has declined in recent years, the share of beneficiaries discharged from an acute hospital to PAC has been fairly stable over time (Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2020).

4 Although SNFs, IRFs, and HHAs all have nurses and therapists, their skills may differ depending on the patients they treat. For example, an IRF that routinely treats spinal cord injury patients will have therapists who have the training and skills to treat this specialized population.

5 A skilled service is one that requires the skills of technical or professional personnel, such as registered nurses and physical therapists.

6 A spell of illness begins with the first day of a hospital or SNF stay and ends when there have been 60 consecutive days during which a patient was not in a hospital or a SNF. In 2015, the Commission recommended that the Congress revise the three-day requirement to allow for up to two outpatient observations days to count toward meeting the requirement (Medicare Payment Advisory Commission 2015a). SNFs with at least a 3-star rating that participate in certain accountable care organizations may apply for a waiver from CMS for the three-day hospital-stay requirement. We previously reported that although many accountable care organizations obtain waivers, very few SNF stays use them (Medicare Payment Advisory Commission 2025b).

7 During the coronavirus public health emergency, the three-day hospital-stay requirement for SNFs was waived.

8 The Commission tracked the accuracy of the SNF PPS between 2006 and 2014 and concluded that payments were not aligned with costs of care and that the inaccuracies had grown over time (Urban Institute and Medicare Payment Advisory Commission 2015). The inaccuracies were due in part to the growth in the provision of therapy, which increased costs but raised payments even more.

9 The range in the payment-to-cost ratios using the current case-mix weights range from 1.07 to 1.29 (where 1.0 means that payments equal costs). Under cost-based weights, the weights would range from 1.15 to 1.18.

10 Improper payments may include payments for an ineligible good or service; duplicate payments; and payment for a good or service not received; but they also include payments made when the information is not sufficient to determine whether payment is proper. Thus, an improper payment should not itself be considered evidence of fraud, which involves willful misrepresentation (Government Accountability Office 2023).

11 A third program was in effect between 2016 and 2019 to combat fraud and the growth in the number of new agencies. CMS set a temporary enrollment moratorium on new HHAs in four states (Texas, Florida, Illinois, and Michigan). The moratorium ended when CMS expanded its anti-fraud capabilities with new rules regarding provider enrollment, expanded reporting of provider information, the use of analytics to identify potential problems, data sharing across providers, and staff training.

12 Home health stays were defined as 30-day episodes.

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