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 2024

	2019	2020	2021	2022	2023	2024	Average annual percentage change 2019–2023	Average annual percentage change 2023–2024
Skilled nursing facilities	15,297	15,160	14,947	14,798	14,634	14,518	–1.1%	–0.8%
Home health agencies	11,356	11,386	11,506	11,657	12,057	12,234	1.5	1.5
Inpatient rehabilitation facilities	1,119	1,114	1,118	1,132	1,160	1,169	0.9%	0.8%
Long-term care hospitals	371	351	345	341	338	329	–2.3	–2.7

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

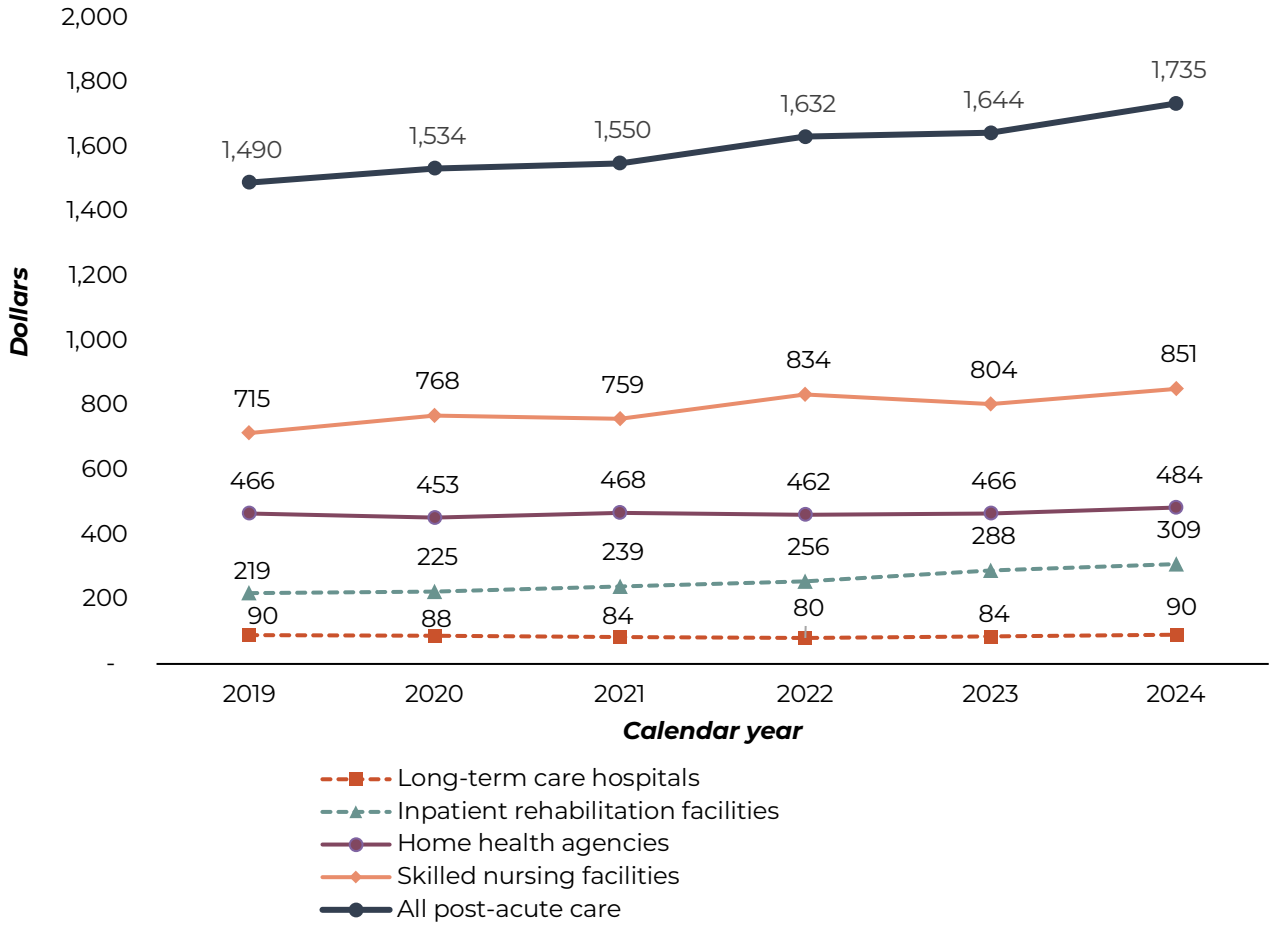
> The number of skilled nursing facilities decreased by about 1 percent per year between 2019 and 2024.

> The number of home health agencies increased between 2019 and 2024, but much of this growth has been concentrated in California, particularly Los Angeles County—an area previously identified by the California state auditor as a major hotspot for hospice fraud, waste, and abuse. Excluding California, the supply of home health agencies declined by about 1 percent between 2019 and 2024 (data not shown).

> After declining for several years, the total number of inpatient rehabilitation facilities increased between 2021 and 2024.

> 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.

Chart 8-2 An increase in SNF spending accounted for most of the growth in FFS Medicare spending per capita for post-acute care in 2019 to 2024

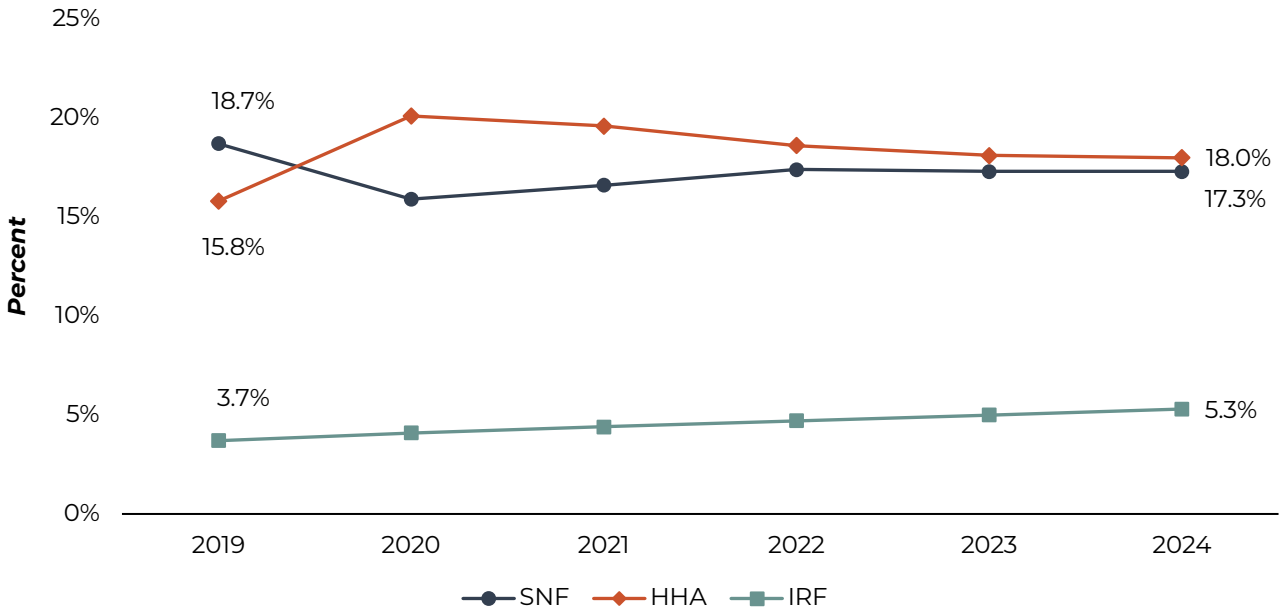


Note: SNF (skilled nursing facility), FFS (fee-for-service). These calendar year–incurred data represent program spending only; they do not include beneficiary cost sharing. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary, 2025.

> Between 2019 and 2024, FFS Medicare per capita spending on post-acute care rose from $1,490 to $1,735. Per capita spending growth was driven primarily by skilled nursing facility services and inpatient rehabilitation facility services. Per capita spending growth was slower over the period for home health agency services and declined for long-term care hospital services.

Chart 8-3 Between 2019 and 2024, 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 from CMS.

> Before the coronavirus public health emergency (PHE), SNFs were the most common PAC destination after discharge from an acute care hospital, with 18.7 percent of hospital discharges in 2019. 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.

> Overall, about 41 percent of acute care hospital discharges in 2020 through 2024 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 the treatment a patient received while hospitalized. For example, in 2024, the share of hospital discharges using PAC was 45 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 2024

Type of SNF	Facilities	FFS Medicare–covered stays	FFS Medicare payments
Totals	14,400	1,500,000	$26 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	86	88
Rural	27	14	12
For profit	74	76	81
Nonprofit	20	21	17
Government	6	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 may differ from 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 2024, freestanding facilities accounted for 98 percent of FFS Medicare–covered SNF stays and 98 percent of FFS Medicare's payments to SNFs.

> Urban facilities accounted for 73 percent of facilities in 2024, while accounting for 86 percent of FFS stays and 88 percent of FFS Medicare payments.

> For-profit facilities accounted for 74 percent of facilities in 2024, 76 percent of FFS stays, and 81 percent of FFS Medicare payments.

Chart 8-5 Per capita FFS SNF admissions decreased in 2024, but covered days per admission continued to rise

Volume measure	2019	2020	2021	2022	2023	2024	Average annual percentage change 2019–2023	Average annual percentage change 2023–2024
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	47	45	–4.6%	–3.8%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,498	1,383	1,396	–0.8%	1.0%
Covered days per admission	26.1	28.5	28.0	28.0	29.2	30.7	4.1%	4.9%

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

Source: MedPAC analysis of 2019–2024 Medicare Provider Analysis and Review file and enrollment data from CMS.

> Between 2019 and 2023, SNF admissions per 1,000 FFS beneficiaries decreased 4.6 percent per year, on average, and declined another 3.8 percent in 2024. Covered days per 1,000 beneficiaries decreased 0.8 percent per year, on average, between 2019 and 2023 but increased 1.0 percent in 2024. Meanwhile, covered days per admission rose 4.1 percent per year, on average, between 2019 and 2023 and climbed almost 5 percent in 2024 as the average length of stay grew to 30.7 days.

Chart 8-6 FFS Medicare margins in freestanding SNFs remained high in 2024

	2021	2022	2023	2024
All	22.8%	23.5%	22.5%	24.4%
Rural	22.1	22.5	20.8	21.2
Urban	22.9	23.6	22.8	24.8
Nonprofit	9.9	9.2	8.2	10.8
For profit	25.5	26.1	25.5	27.2

Note: FFS (fee-for-service), SNF (skilled nursing facility). FFS Medicare margins do not reflect federal provider relief funds that SNFs received due to the coronavirus pandemic.

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

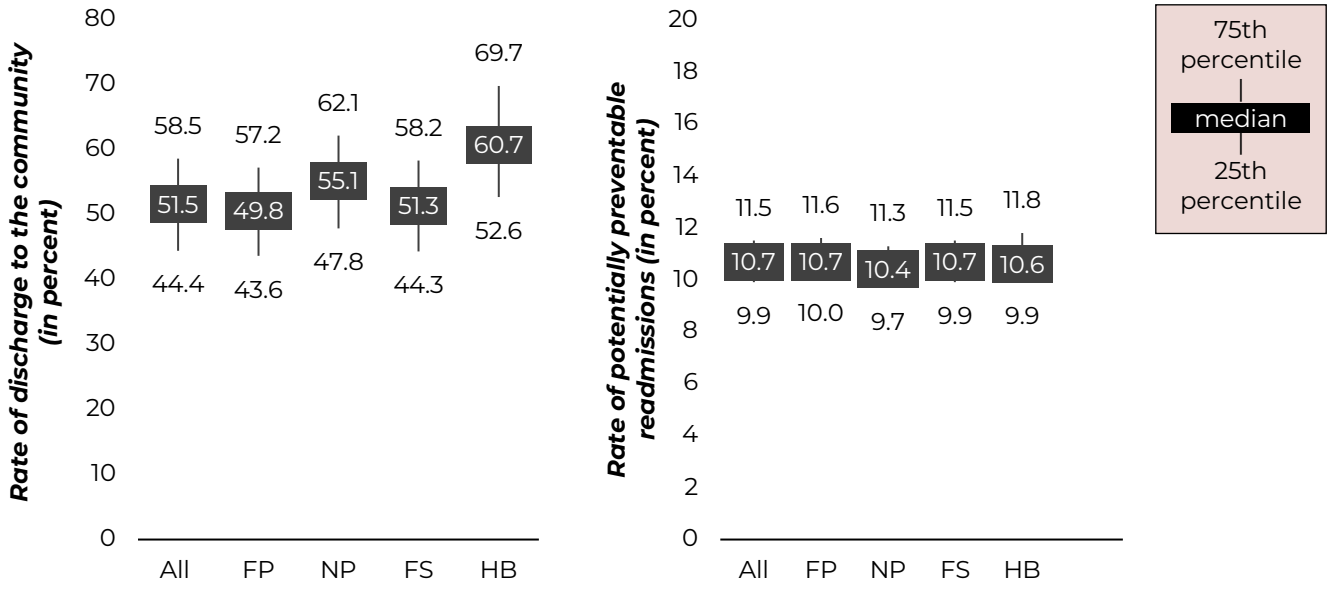
> The aggregate FFS Medicare margin for freestanding SNFs in 2024 (24.4 percent) exceeded 10 percent for the 25th consecutive year (not all years are shown). Had we considered an allocated share of the federal relief funds that providers received due to the public health emergency, we estimate the aggregate FFS margin during these years would have been even higher.

> The aggregate FFS Medicare margin increased in 2024 because the average payment per day in freestanding SNFs increased 4.9 percent while costs per day increased 2.3 percent (data not shown). Growth in costs per day in 2024 slowed as wage growth in the sector slowed compared with previous years, and ancillary costs (which include therapy) stabilized after rising in 2023 (data not shown).

> Aggregate FFS Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had FFS Medicare margins that were 34 percent or higher, and one-quarter had margins that were 13 percent or lower (data not shown). Consistent with the prepandemic years, urban SNFs had a higher aggregate FFS Medicare margin than rural SNFs in 2024 (prepandemic margins not shown). 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 2023 and 2024 (data not shown).

> In 2024, the average total margin (the margin across all payers and all lines of business) for freestanding SNFs was 2.1 percent, up from 0.4 percent in 2023 (data not shown). The increase 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 2023 and FY 2024



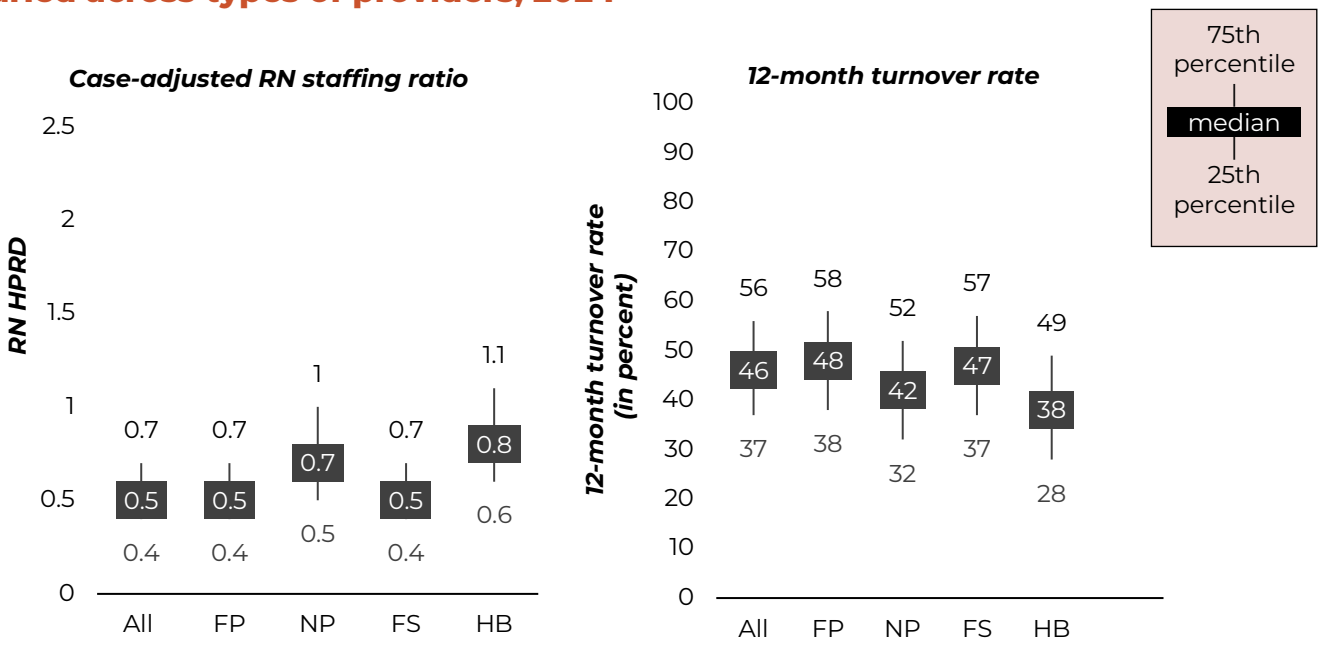
Note: SNF (skilled nursing facility), FY (fiscal year), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2023 and FY 2024 combined). Rates are computed from Medicare claims for eligible Medicare 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 CMS's provider data catalog, FY 2023 through FY 2024.

> In FY 2023 and FY 2024 (combined), the median rate of discharge to the community from SNFs was 51.5 percent, similar to the combined FY 2022 and FY 2023 rate of 50.9 percent (latter data not shown). In FY 2023 and FY 2024, one-quarter of SNFs had rates above 58.5 percent and one-quarter had rates below 44.4 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 2023 and FY 2024 (combined), SNFs' median rate of potentially preventable readmissions to the hospital was 10.7 percent. (Lower rates indicate better quality.) One-quarter of SNFs had rates above 11.5 percent and one-quarter had rates below 9.9 percent.

Chart 8-8 SNFs' RN staffing ratios and total nursing staff turnover rates varied across types of providers, 2024



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 2024, the median SNF provided 0.5 RN HPRD, similar to 2023 (latter data not shown). One-quarter of SNFs provided 0.7 or more HPRD, while one-quarter provided 0.4 or fewer 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 urban 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 2024, the 12-month nursing staff turnover rate was 46 percent for the median SNF. Although a methodology change in the turnover calculation makes the 2024 rate not directly comparable with previous years, the 2023 rate of 49 percent represents an improvement from 2021 and 2022, when the rate was around 53 percent (data not shown). One-quarter of facilities had turnover rates greater than 56 percent, meaning that over half 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 (47 percent) were similar to turnover rates at very rural facilities (46 percent), although RN-specific turnover was higher in urban facilities (43 percent) than in rural facilities (40 percent) (data not shown).

Chart 8-9 Fee-for-service home health care use was steady in 2024

	2019	2020	2021	2022	2023	2024	Average annual change 2019–2023	Average annual change 2023–2024
FFS Medicare home health users (millions)	3.3	3.1	3.0	2.8	2.7	2.7	–4.7	–2.1
Share of FFS Medicare beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.9%	7.9%	–2.1	1.0
30-day periods (millions)	N/A	N/A	9.3	8.6	8.3	8.3	N/A	–0.5
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	26	24	24	25	N/A	2.6
Total in-person visits (millions)	99.7	81.1	76.8	69.5	66.8	65.4	–9.5	–3.2
In-person visits per user	30.2	26.6	25.4	24.6	24.6	24.6	–5.0	<0.1

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 that 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 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2024, the number of FFS beneficiaries using home health care declined by 2.1 percent, reflecting, at least in part, a decrease in the number of beneficiaries enrolled in FFS Medicare. 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 2024, at 25 per 100 FFS beneficiaries. The number of in-person visits per home health user remained relatively steady in 2024, at 24.6.

> In 2024, about 2.2 percent of FFS-covered 30-day home health periods included a telehealth visit or remote patient monitoring, and about 12 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 2024. 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	2023	2024
Period by source of referral		
Preceded by hospitalization or institutional PAC	25.3%	25.0%
Community admitted	74.7	75.0
Period by timing of 30-day period		
Early	30.8	30.3
Late	69.2	69.7

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 and 2024 home health standard analytic files from CMS.

> Most FFS-covered home health periods were 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 2023 and 2024.

> 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 2024 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 2024

	2019	2020	2021	2022	2023	2024	Share of home health agencies, 2024	Share of 30-day periods, 2024
All	15.4%	20.2%	24.9%	22.2%	19.8%	21.2%	100%	100%
Geography								
Majority urban	16.1	20.0	24.8	22.3	20.0	21.3	86	87
Majority rural	14.2	21.6	25.2	22.0	18.6	20.5	14	13
Type of ownership								
For profit	17.4	22.7	26.1	23.6	21.2	23.1	93	86
Nonprofit	11.4	12.4	20.2	16.4	13.3	12.2	7	14
Volume quintile								
First (smallest)	9.7	11.6	14.0	13.7	12.5	14.4	20	3
Second	11.4	14.0	15.9	14.5	13.7	15.1	20	7
Third	13.3	17.0	19.3	17.0	14.5	17.6	20	11
Fourth	14.1	18.8	22.8	21.0	19.0	20.3	20	19
Fifth (largest)	17.5	22.4	28.3	24.8	22.1	23.2	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. FFS Medicare margins do not reflect federal provider relief funds that HHAs received due to the coronavirus pandemic.

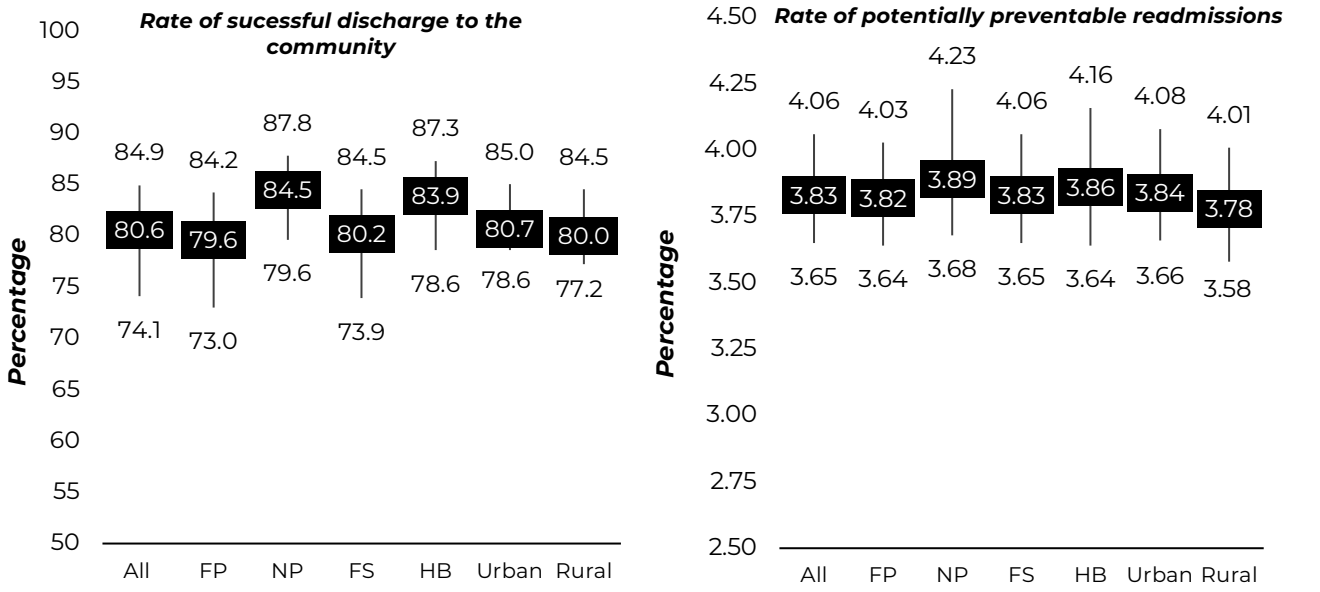
Source: MedPAC analysis of Medicare home health cost-report files from CMS.

> In 2024, freestanding HHAs (about 95 percent of all HHAs; data not shown) had an aggregate FFS Medicare margin of 21.2 percent. The 2024 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 2023 averaged 17.2 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 23.1 percent in 2024, compared with 12.2 percent for nonprofit agencies. There was little difference in the aggregate FFS Medicare margins of urban HHAs (21.3 percent) and rural HHAs (20.5 percent).

> Agencies with higher volumes of 30-day periods had higher FFS Medicare margins. The agencies in the lowest-volume quintile in 2024 had an aggregate FFS Medicare margin of 14.4 percent, compared with 23.2 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 of successful discharge are for the 24-month period from January 1, 2022, to December 31, 2023; rates of 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 CMS's 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 the 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 percentile had potentially preventable rehospitalization rates of 3.65 percent and 4.06 percent, respectively.

Chart 8-13 In FY 2024, the number of FFS Medicare IRF stays grew substantially compared with growth in 2019 to 2023

	2019	2020	2021	2022	2023	2024	Average annual percentage change 2019–2023	Percentage change 2023–2024
IRF inpatient stays (thousands)	404	374	373	376	404	435	0.0%	7.7%
IRF inpatient stays per 10,000 beneficiaries	107	101	104	109	120	132	2.8	10.0
Average length of stay (days)	12.6	12.9	12.9	12.8	12.5	12.4	–0.2	–0.7

Note: FY (fiscal year), 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 2023 to 2024, the number of FFS-covered IRF cases rose by 7.6 percent, to about 435,000 cases. When controlling for the number of FFS beneficiaries, the increase was even greater (10.0 percent).

> The average length of stay decreased slightly in 2024 to 12.4 days, a 0.7 percent reduction from 12.5 days in 2023.

Chart 8-14 Stroke, neurological conditions, and debility remained the most common conditions for FFS beneficiaries in IRFs in FY 2024

	2019	2020	2021	2022	2023	2024
Stroke	19.8%	19.1%	18.1%	17.5%	15.9%	15.1%
Fracture of the lower extremity	10.0	11.3	11.2	11.7	11.4	11.4
Debility	12.3	13.5	14.0	14.7	14.2	14.7
Neurological conditions	14.4	14.0	14.9	15.7	14.7	15.0
Brain injury	11.0	11.2	11.3	11.8	11.5	11.9

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). "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, 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 continued to be the most common condition among IRF stays, accounting for 15.1 percent of FFS stays in 2024. However, that share has declined almost 5 percentage points since 2019. Between 2019 and 2024, IRF stays for debility increased from 12.3 percent to 14.7 percent of IRF FFS stays.

Chart 8-15 IRFs' aggregate FFS Medicare margin increased to 17.1 percent in FY 2024

IRF category	*2019*	*2020*	*2021*	*2022*	*2023*	*2024*
All	14.1%	13.5%	16.7%	13.7%	14.8%	17.1%
Type						
Freestanding	24.7	23.6	25.7	23.0	24.3	25.0
Hospital based	1.3	1.5	5.2	0.9	0.6	4.1
Ownership						
For profit	24.2	23.6	25.2	22.4	23.5	24.6
Nonprofit	0.7	–0.3	4.6	–0.1	–0.2	2.9
Geography						
Urban	14.5	13.8	17.0	14.1	15.0	17.3
Rural	7.3	8.5	11.7	7.7	10.6	12.5
Number of beds						
1 to 10	–9.6	–6.2	–3.3	–7.0	–6.4	–4.9
11 to 24	1.3	2.0	5.0	0.8	1.1	5.1
25 to 64	15.9	15.6	18.6	15.3	16.4	18.6
65 or more	21.0	18.6	21.9	19.4	20.5	22.0
FFS Medicare share of days						
<50%	4.0	6.3	11.4	7.0	7.0	10.2
50% to 75%	18.0	17.0	20.0	17.6	19.1	20.8
≥75%	17.9	21.1	20.5	21.7	21.8	22.1
Low-income patient share						
0% to <5%	18.2	15.7	20.0	16.8	18.4	21.3
5% to <10%	18.3	18.8	20.1	18.1	18.3	22.2
10% to <15%	13.7	12.6	16.9	13.8	14.5	14.3
15% to <20%	15.3	14.9	16.6	12.6	14.7	15.0
20% to <25%	2.3	8.3	14.1	6.6	12.5	12.7
25% or more	5.9	5.0	9.6	10.0	5.5	5.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), FY (fiscal year). FFS Medicare margins do not reflect federal provider relief funds that IRFs received due to the coronavirus pandemic.

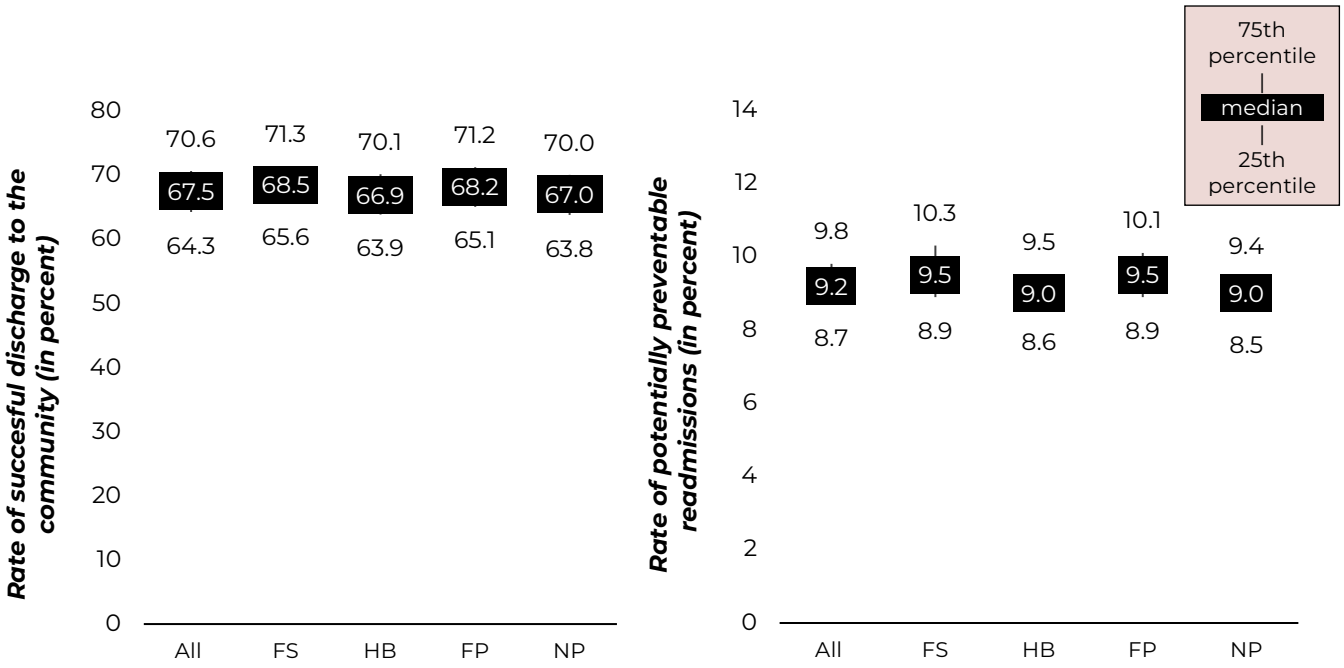
Source: MedPAC analysis of cost-report data from CMS.

> In 2024, growth in IRFs' per case payments was slow but outpaced growth in costs (data not shown); as a result, the FFS Medicare margin increased to 17.1 percent.

> FFS Medicare margins vary by IRF type. In 2024, freestanding IRFs and for-profit IRFs had substantially higher aggregate margins (25.0 percent and 24.6 percent, respectively) than hospital-based IRFs and nonprofit IRFs (4.1 percent and 2.9 percent, respectively).

> There are large differences in FFS Medicare margins by IRF size. In 2024, the aggregate FFS Medicare margin for IRFs with 10 or fewer beds was –4.9 percent. By contrast, the FFS Medicare margin for IRFs with 65 or more beds was 22.0 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 2023 and FY 2024



Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FS (freestanding), HB (hospital based), FP (for profit), NP (nonprofit). Data include IRFs in the 50 states and the District of Columbia and cover 24 months (FY 2023 and FY 2024 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 2023 and FY 2024, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.5 percent, similar to the 67.2 percent from FY 2022 and FY 2023 (latter data not shown).

> The median facility risk-adjusted rate of potentially preventable readmission was 9.2 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers.

Chart 8-17 FFS Medicare LTCH stays that qualified for the standard LTCH payment rate remained steady in FY 2024, while nonqualifying cases dropped sharply

	2019	2020	2021	2022	2023	2024	Percentage change 2023–2024
Stays (in thousands)							
All	91	78	70	60	59	47	–20%
Nonqualifying	23	19	20	19	17	5	–70
Qualifying	68	59	50	41	42	42	1
Share of qualifying	75%	76%	71%	68%	71%	89%	26
Stays per 10,000 FFS beneficiaries							
All	24	21	20	17	17	14	–17
Nonqualifying	6	5	6	6	5	2	–68
Qualifying	18	16	14	12	12	13	6
Payment per stay (in thousands)							
All	$41	$46	$49	$49	$49	$51	5
Nonqualifying	$26	$32	$39	$39	$35	$24	–32
Qualifying	$47	$50	$53	$53	$53	$55	3
Length of stay (in days)							
All	27	28	28	28	27	28	4
Nonqualifying	23	24	26	26	25	25	0
Qualifying	28	29	28	29	28	28	3

Note: FFS (fee-for-service), LTCH (long-term care hospital), FY (fiscal year). A "qualifying" stay is a Medicare case that meets the criteria specified in the Pathway for SGR Reform Act of 2013 for full payment under the LTCH prospective payment system. "Nonqualifying" LTCH stays are paid a (generally lower) "site-neutral" rate that is the lesser of Medicare's acute care hospital payment for the case type or 100 percent of the costs of the stay. 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.

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

> 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 (generally lower) "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 January 2020 through May 2023, the application of site-neutral payment rates was waived due to the coronavirus public health emergency (PHE).

> The number of FFS Medicare–covered LTCH stays—both qualifying and nonqualifying—fell in FY 2020. Total stays continued to decline during the PHE, driven by a reduction in the number of qualifying LTCH stays, both on an absolute and per capita basis. The number of nonqualifying stays was relatively steady through the PHE.

> In FY 2024, the pattern changed, with the number of qualifying LTCH stays increasing while nonqualifying stays dropped sharply, falling about 70 percent on an absolute and a per capita basis. The drop in nonqualifying stays coincided with the reapplication of site-neutral payment rates for such cases.

During the PHE, the average LTCH payment rate per FFS stay increased as nonqualifying stays received higher LTCH payment rates. In FY 2024, payment per nonqualifying stay fell as site-neutral rates were reapplied, while payment per qualifying stay increased.

Chart 8-18 FFS Medicare LTCH stays continued to be concentrated in two MS–LTC–DRGs in FY 2024

MS–LTC–DRG	Description	Share of FFS Medicare LTCH stays					
		2019	2020	2021	2022	2023	2024
189	Pulmonary edema and respiratory failure	20.5%	19.4%	18.7%	22.9%	22.5%	24.3%
207	Respiratory-system diagnosis with ventilator support >96 hours	13.2	14.5	15.6	14.3	13.0	17.6
871	Septicemia without ventilator support >96 hours with MCC	5.5	5.1	3.9	3.2	3.1	2.7
208	Respiratory-system diagnosis with ventilator support ≤96 hours	2.7	3.1	3.5	3.3	2.7	2.6
166	Other respiratory system OR procedures with MCC	2.3	2.5	2.8	2.6	2.6	3.7
177	Respiratory infections and inflammations with MCC	1.9	3.7	9.1	3.9	2.5	2.6
981	Extensive OR procedure unrelated to principal diagnosis with MCC	2.0	2.0	2.2	2.3	2.3	3.1
539	Osteomyelitis with MCC	1.8	1.5	1.7	1.9	2.2	1.5
949	Aftercare with CC/MCC	2.2	2.0	1.9	2.0	2.1	2.4
682	Renal failure with MCC	1.7	1.7	1.4	1.5	1.7	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 in two MS–LTC–DRGs: pulmonary edema and respiratory failure (accounting for 24.3 percent of FFS Medicare stays in FY 2024) and respiratory-system diagnosis with ventilator support for more than 96 hours (accounting for 17.6 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 17 percent of FFS nonqualifying stays in FY 2024 (data not shown).

Chart 8-19 LTCHs' aggregate FFS Medicare margin decreased in FY 2024

	LTCH FFS Medicare margin, by fiscal year					
	2019	2020	2021	2022	2023	2024
All LTCHs	–2.0%	3.6%	6.0%	–1.8%	–0.7%	–3.1%
Nonprofit	–12.0	–11.3	–11.7	–23.2	–21.0	–20.0
For profit	–0.1	6.0	8.5	1.4	2.3	–0.7
Margin percentile						
25th percentile	–12.8	–6.9	–4.7	–13.6	–12.2	–21.8
Median	0.2	5.0	6.1	–3.5	–1.1	–6.6
75th percentile	8.5	12.3	15.2	8.2	8.9	5.4
Facility share of qualifying stays						
High share	3.0	6.3	5.2	–1.5	0.6	–1.8
Low share	–8.2	0.3	6.4	–2.1	–1.3	–14.0

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 less of a provider's cases were qualifying cases in the year. FFS Medicare margins do not reflect federal provider relief funds that LTCHS received due to the coronavirus pandemic.

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

> When CMS implemented lower site-neutral payment rates for certain types of LTCH cases in FY 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. 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).

> FY 2024 was the first full year after the expiration of the site-neutral payment-rate waiver, which had paid site-neutral stays the higher full payment rate, and LTCHs' FFS Medicare margin dropped to –3.1 percent.

> 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 expanded after the waiver of site-neutral payment rates expired. High-share facilities had a margin of –1.8 percent, but low-share facilities had a margin of –14.0 percent. However, the number of low-share facilities also dropped dramatically since facilities billed far fewer nonqualifying cases than in previous years (see Chart 8-17).

Chart 8-20 LTCH PPS costs per stay increased faster than LTCHs' payments per stay in FY 2024

	Percentage change from prior fiscal year					
	2019	2020	2021	2022	2023	2024
Payments per stay						
All LTCHs	4.3%	9.2%	7.0%	0.3%	–0.2%	7.5%
Share qualifying						
LTCHs with >85% qualifying stays	0.6	7.9	11.9	1.3	2.2	–8.4
LTCHs with ≤85% qualifying stays	1.4	10.4	11.5	2.6	–1.5	–10.3
Cost per stay						
All LTCHs	5.4	3.3	4.3	8.6	–1.3	10.0%
Share qualifying						
LTCHs with >85% qualifying stays	2.1	4.2	13.2	8.5	0.1	–6.2
LTCHs with ≤85% qualifying stays	4.2	1.8	4.7	11.9	–2.2	1.0

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. Percentages reflect changes in nominal dollars, not adjusted for inflation.

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

> 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' costs per stay were about $49,000 per case (data not shown).

> In FY 2023, payments per stay grew 2.2 percent among LTCHs with a higher share (greater than 85 percent) of stays meeting the qualifying criteria for LTCH PPS standard rates, while payments per stay declined 1.5 percent, on average, among all other 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).

> In FY 2024, overall payments and costs per stay showed large increases, but these increases were attributable to the large drop in nonqualifying stays, which changed the overall mix of cases, as LTCHs trended toward higher-payment and higher-cost qualifying stays. LTCHs with high shares of qualifying stays saw payments drop by 8.4 percent to $54,000, while costs dropped 6.2 percent to about $55,000 (data not shown). The few LTCHs left with low shares of qualifying stays (roughly 15 percent of LTCHs) saw growth in cost per stay outpace growth in payments per stay.