SECTION

8

Post-acute care

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

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

	2018	2019	2020	2021	2022	2023	Average annual percent change 2018–2023	Percent change 2022–2023
Skilled nursing facilities	15,359	15,305	15,173	15,098	14,973	14,800	–0.7%	–1.0%
Home health agencies	11,556	11,356	11,386	11,506	11,657	12,057	0.9	3.4
Inpatient rehabilitation facilities	1,170	1,152	1,159	1,181	1,181	1,206	0.6	2.1
Long-term care hospitals	386	371	351	345	341	338	–2.6	–0.9

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

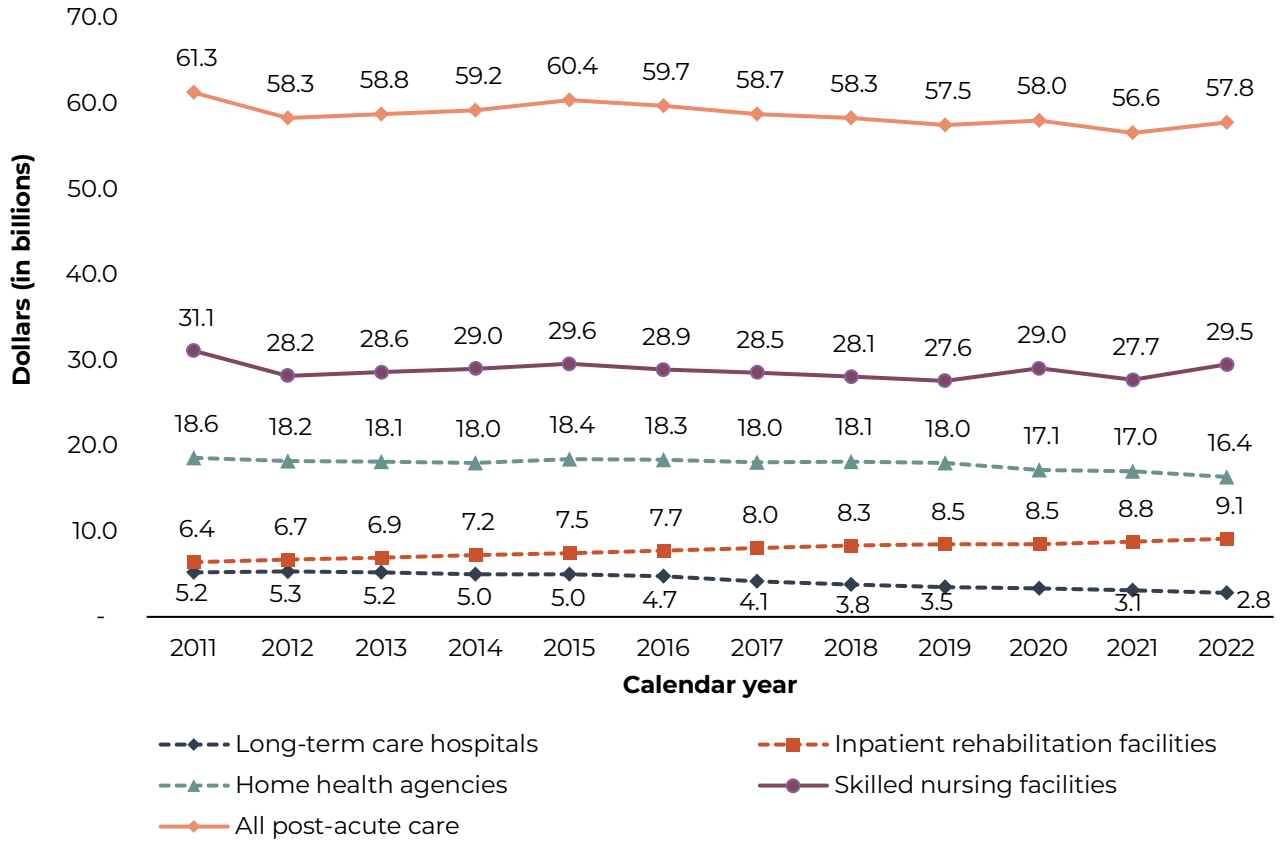
> The number of skilled nursing facilities decreased less than 1 percent per year between 2018 and 2023.

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

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

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

Chart 8-2 Aggregate Medicare fee-for-service spending for post-acute care declined between 2015 and 2022



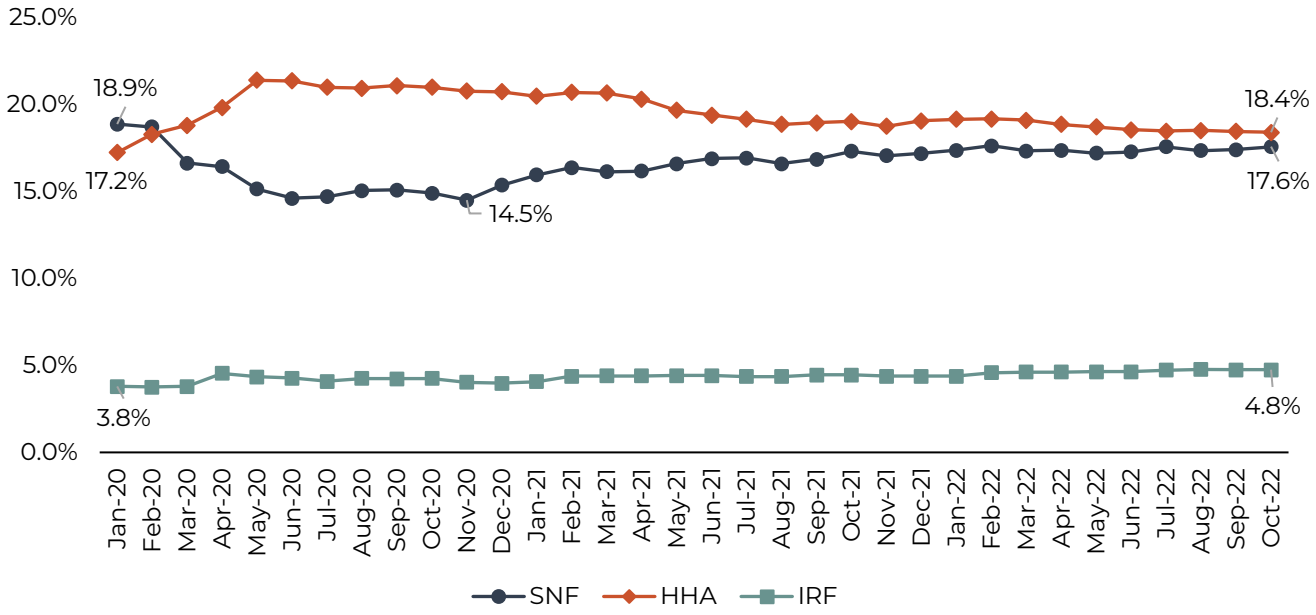
Note: These calendar year–incurred data represent program spending only; they do not include beneficiary cost sharing. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary, 2024.

> Aggregate fee-for-service (FFS) spending on all post-acute care sectors combined increased between 2021 and 2022 on a nominal basis despite decreased enrollment in FFS.

> Between 2021 and 2022, spending for skilled nursing facility care increased due to an increase in volume. Spending declined for home health care and long-term care hospitals, while spending on IRFs increased slightly.

Chart 8-3 Between January 2020 and October 2022, SNFs lost and then gradually regained some of the share of IPPS discharges to PAC, and the shares going to HHAs and IRFs increased



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

Source: MedPAC analysis of Medicare claims data.

> In January 2020, immediately prior to the pandemic, SNFs were the most common PAC destination after discharge from the acute care hospital, with 18.9 percent of discharges. That same month, 17.2 percent of inpatient discharges received home health care. As the number of inpatient discharges began to fall in March 2020 due to the pandemic, the share of beneficiaries discharged from a hospital to a SNF also declined. At the same time, the share receiving services from HHAs and IRFs increased, making home health the most commonly used PAC setting. Home health remained the most frequent PAC setting postdischarge throughout 2021 and 2022. Although SNFs had not regained their prepandemic share of discharges, by September 2022, SNFs had gradually recovered some of the share of IPPS discharge volume lost during the pandemic.

> Overall, about 41 percent of inpatient hospital discharges in both 2021 and 2022 were followed by services from a SNF, HHA, IRF, or long-term acute care hospital (data not shown). Use of PAC after hospital discharge varied depending on the condition or treatment a patient received while hospitalized. For example, in 2022, the share of hospital discharges using PAC was 47 percent for postsurgical patients compared with about 40 percent for patients who received mostly medical services during their inpatient stay (data not shown).

Chart 8-4 Freestanding SNFs, urban SNFs, and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending in 2022

Type of SNF	Facilities	Medicare-covered FFS stays	Medicare FFS payments
Totals	14,691	1,842,676	$27 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	84	86
Rural	27	16	14
For profit	72	76	79
Nonprofit	22	21	18
Government	5	3	3

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

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

> In 2022, freestanding facilities accounted for 98 percent of Medicare-covered SNF stays and 98 percent of Medicare's payments to SNFs.

> In 2022, urban facilities accounted for 73 percent of facilities, 84 percent of stays, and 86 percent of Medicare payments.

> In 2022, for-profit facilities accounted for 72 percent of facilities, 76 percent of stays, and 79 percent of Medicare payments.

Chart 8-5 Fee-for-service SNF admissions increased in 2022

Volume measure	2019	2020	2021	2022	Average annual change 2019–2022	Average annual change 2021–2022
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	–3.1%	10.3%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,500	3.6	10.2
Covered days per admission	26.1	28.5	28.0	28.0	7.0	–0.1

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

Source: Calendar year data from CMS, Office of Information Products and Data Analytics, 2019–2022.

> To control for changes in fee-for-service (FFS) enrollment, we examine service use per 1,000 FFS beneficiaries. Between 2021 and 2022, SNF admissions per 1,000 FFS beneficiaries increased 10.3 percent. Compared with 2019, covered admissions per FFS beneficiary were 3.1 percent lower, but covered days were 7 percent higher due to longer lengths of stay.

Chart 8-6 Freestanding SNF Medicare margins remained high in 2022

	2018	2019	2020	2021	2022
All	10.8%	12.1%	18.1%	17.6%	18.4%
Rural	8.6	10.2	19.3	17.1	17.5
Urban	11.2	12.5	18.0	17.1	18.5
Nonprofit	0.8	1.7	3.2	2.7	1.1
For profit	13.6	15.2	21.5	21.1	22.0

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports, 2017–2022.

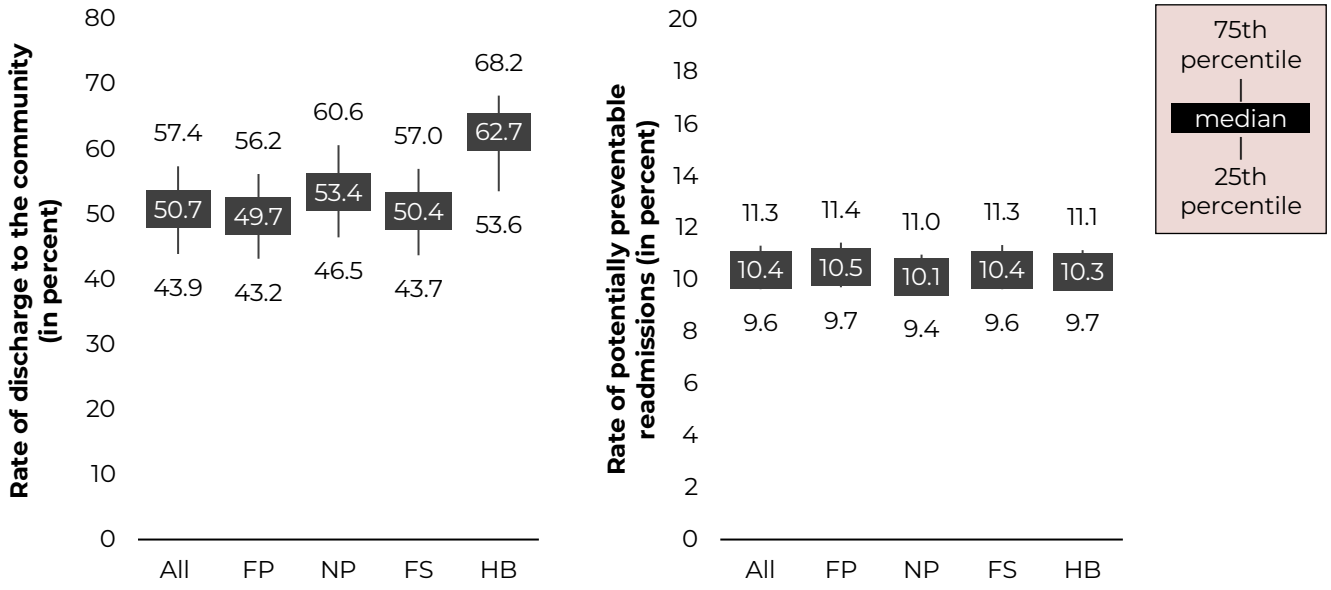
> The aggregate Medicare margin for freestanding SNFs in 2022 (18.4 percent) exceeded 10 percent for the 23rd consecutive year (not all years are shown). Had we considered an allocated share of the federal relief funds providers received due to the coronavirus pandemic, we estimate the aggregate margin in 2022 would have been even higher, at 20 percent (not shown).

> The aggregate Medicare margin increased in 2022 because the average payment per day in freestanding SNFs increased 2.2 percent, while costs per day increased just 1.7 percent (data not shown). The relatively lower growth in costs per day reflects more covered days over which to spread fixed costs. Another factor was the decline in ancillary costs per day. Between 2021 and 2022, SNFs provided 11 percent fewer minutes of rehabilitation therapy per discharge (data not shown). In addition, a greater share of the minutes was provided in group therapy or concurrently, both of which are lower-cost modalities compared with individual therapy.

> Aggregate Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had Medicare margins that were 28.9 percent or higher, and one-quarter had margins that were 4.4 percent or lower (data not shown). Consistent with several years before the pandemic, urban SNFs had a higher aggregate Medicare margin than rural SNFs in 2022. For-profit SNFs had a considerably higher aggregate 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 2021 and 2022 (data not shown).

> In 2021, the average total margin (the margin across all payers and all lines of business) for freestanding facilities was –1.4 percent, down from 3.4 percent in 2021 (data not shown). One contributing factor to the lower total margin in fiscal year 2022 was the reduced amount of provider relief funds. These funds were reported that year, but the amounts in aggregate were about half of what they were in 2020 and 2021.

Chart 8-7 SNF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2021 and FY 2022



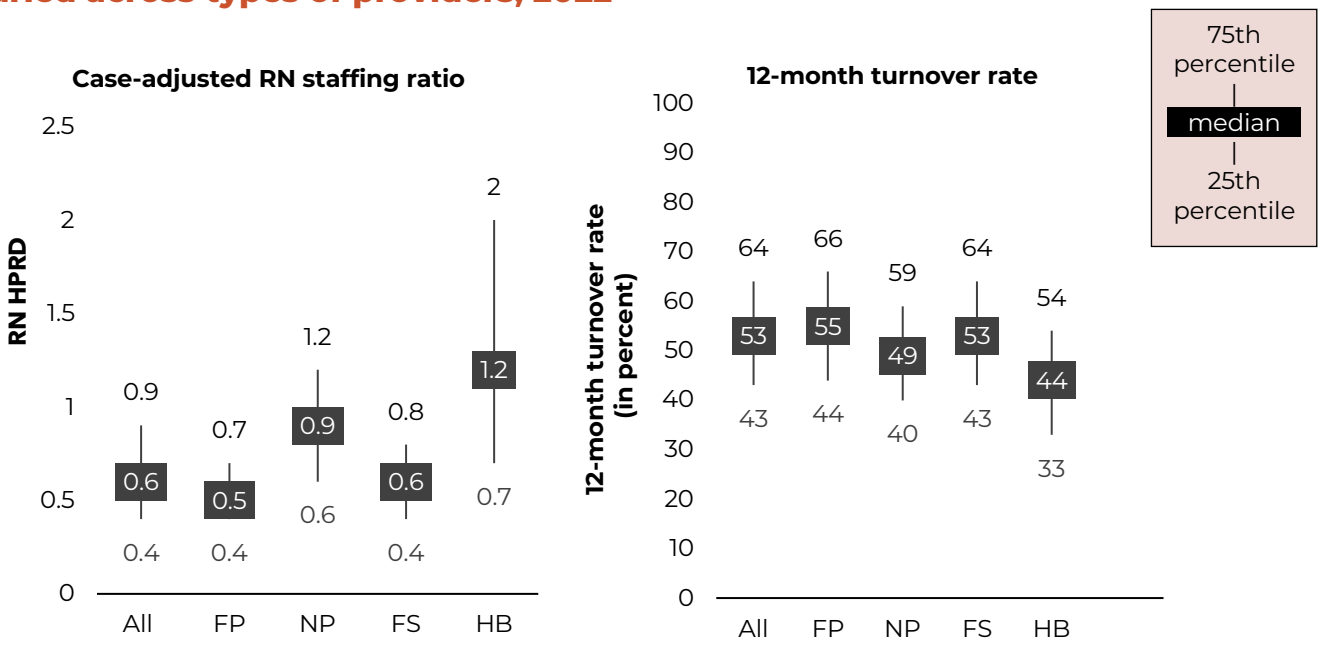
Note: SNF (skilled nursing facility), FY (fiscal year), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (fiscal years 2021 and 2022 combined). Rates are computed from Medicare claims for eligible Medicare Part A–covered SNF stays and do not include swing-bed stays. The measure of discharge to the community is a SNF's risk-standardized rate of fee-for-service Medicare residents who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of potentially preventable readmissions after discharge is calculated as the risk-adjusted percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better.

Source: MedPAC analysis of SNF claims-based outcome measures from the Provider Data Catalog, fiscal year 2021 through fiscal year 2022.

> In FY 2021 and FY 2022 (combined), the median rate of discharge to the community from SNFs was 50.7 percent, which was a slight decline compared with the FY 2018 and FY 2019 combined rate of 51.7 percent (latter data not shown; higher rates are better). In FY 2021 and FY 2022, one-quarter of SNFs had rates above 57.4 percent and one-quarter had rates below 43.9 percent. The median rates for nonprofit SNFs and hospital-based SNFs were higher than the median rates for for-profit SNFs and freestanding SNFs.

> In FY 2021 and FY 2022, SNFs' median rate of potentially preventable readmissions to the hospital was 10.4 percent. (Lower rates indicate better quality.) One-quarter of SNFs had rates above 11.3 percent and one-quarter had rates below 9.6 percent.

Chart 8-8 SNFs' RN staffing ratios and total nursing staff turnover rates varied across types of providers, 2022



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 2022, the median SNF provided 0.6 RN HPRD. One-quarter of SNFs provided 0.9 or more HPRD, while one-quarter provided 0.4 or less HPRD. Freestanding SNFs had lower median case-mix-adjusted RN staffing than hospital-based SNFs, and for-profit SNFs had lower median case-mix-adjusted RN staffing than nonprofit SNFs. 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 2022, the 12-month nursing staff turnover rate as of the fourth quarter of 2022 was 53 percent for the median SNF. One-quarter of facilities had turnover rates greater than 64 percent—meaning that nearly two-thirds of their nursing staff left the facility in the 12-month period. For-profit SNFs and freestanding SNFs had higher turnover rates than nonprofit SNFs and hospital-based SNFs.

Chart 8-9 Fee-for-service home health care use and spending declined in 2022

	2019	2020	2021	2022	Average annual change 2019–2022	Average annual change 2021–2022
Medicare FFS home health users (millions)	3.3	3.1	3.0	2.8	–5.0%	–6.3%
Share of Medicare FFS beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	–1.8	–3.0
30-day periods (millions)	N/A	9.6	9.3	8.6	N/A	–4.3
30-day periods per 100 FFS Medicare beneficiaries	N/A	25	26	24	N/A	–1.3
Total in-person visits (millions)	99.7	81.1	76.8	61.5	–11.3	–9.6
Visit per user	30.2	26.6	25.4	24.6	–6.7	–3.5

Note: FFS (fee-for-service), N/A (not available). Average annual changes are calculated using unrounded values and then rounded to the nearest tenth. Payment amounts shown here are lower than those displayed in Chart 8-2 due to the use of different data sources. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2022 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2022, the number of beneficiaries using FFS-covered home health care declined by 6.3 percent, reflecting both a decrease in the number of beneficiaries enrolled in FFS Medicare and a decline in the share of FFS beneficiaries who used home health care. FFS home health utilization and spending have 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 declined 1.3 percent in 2022.

> The number of in-person visits per home health user fell 3.5 percent from 2021 to 2022. During the public health emergency, CMS expanded the use of telehealth in home health care, permitting agencies to provide virtual visits and other telehealth services under the benefit. (These changes were later made permanent.) No data are available on the number and type of telehealth services that home health agencies provided in 2020 through 2022. It is not known, therefore, whether the decline in visits represents a real reduction in service provision or some or all of those visits were replaced with telehealth services. Since July 1, 2023, home health agencies have been required to report telehealth visits on Medicare claims, similar to what is required for in-person visits.

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

Type of 30-day period	2021	2022
Periods by source of referral		
Preceded by hospitalization or institutional PAC	24.3%	25.2%
Community admitted	75.6%	74.8%
Periods by timing of 30-day period		
Early	29.3%	30.9%
Late	70.7%	69.1%

Note: 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 2022 home health standard analytic file.

> Most home health periods are not preceded by a hospitalization or institutional PAC stay. "Community-admitted" home health periods accounted for about three-quarters of PAC stays in 2021 and 2022.

> Under the 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 2022 compared with the prior year. The mix of cases by clinical payment group also did not change significantly (data not shown).

Chart 8-11 Medicare margins for freestanding home health agencies, 2021 and 2022

	2021	2022	Share of freestanding agencies 2022
All	24.9%	22.1	100%
Geography			
Mostly urban	24.8	22.2	85
Mostly rural	25.2	21.8	15
Type of control			
For profit	26.1	23.5	92.5
Nonprofit	20.2	15.8	7.5
Volume quintile (lowest to highest)			
First	14.0	13.4	20
Second	15.9	14.4	20
Third	19.3	17.0	20
Fourth	22.8	20.9	20
Fifth	28.3	24.7	20

Note: Agencies are characterized as urban or rural based on the residence of the majority of their patients.

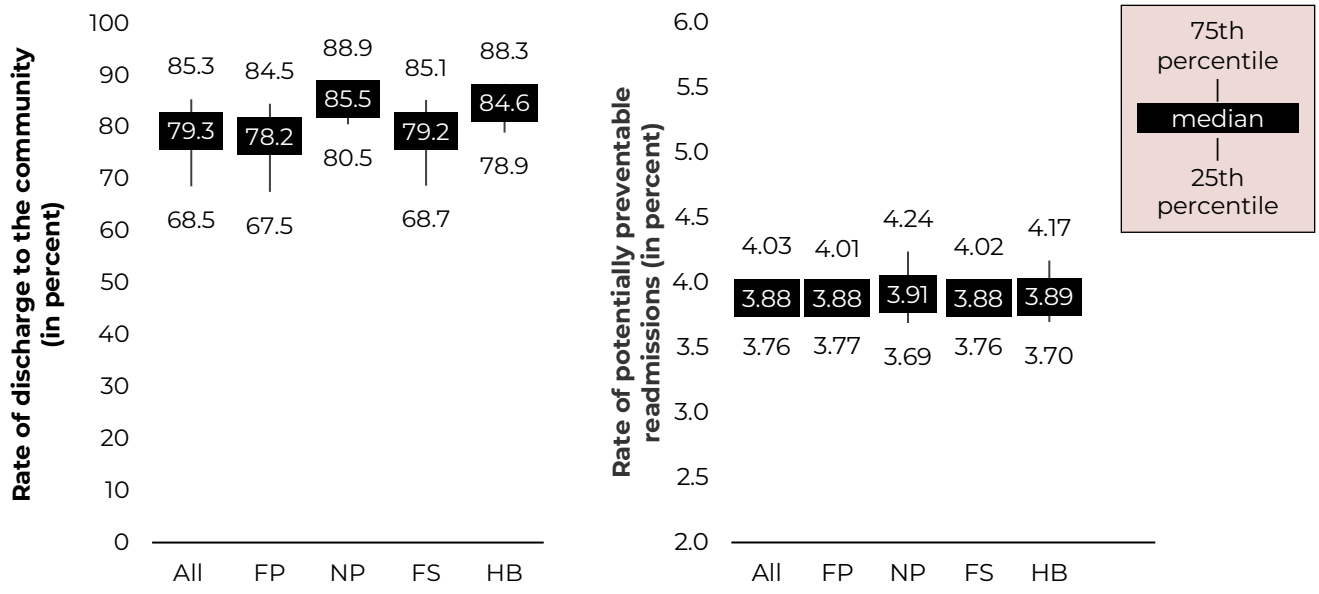
Source: MedPAC analysis of Medicare Cost Report files from CMS.

> In 2022, freestanding home health agencies (HHAs) (87 percent of all HHAs; data not shown) had an aggregate Medicare margin of 22.1 percent. The 2022 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 2019 averaged 16.4 percent (data not shown), indicating that most agencies have been paid well in excess of their costs for more than 20 years.

> Freestanding HHAs that served mostly urban patients in 2022 had an aggregate margin of 22.2 percent; HHAs that served mostly rural patients had an aggregate margin of 21.8 percent. Over 90 percent of these agencies are for profit; these agencies had an average margin of 23.5 percent in 2022, compared with an average margin of 15.8 percent for nonprofit agencies.

> Agencies with higher volumes of 30-day periods had higher margins. The agencies in the lowest-volume quintile in 2022 had an aggregate margin of 13.4 percent, while those in the highest quintile had an aggregate margin of 24.7 percent.

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



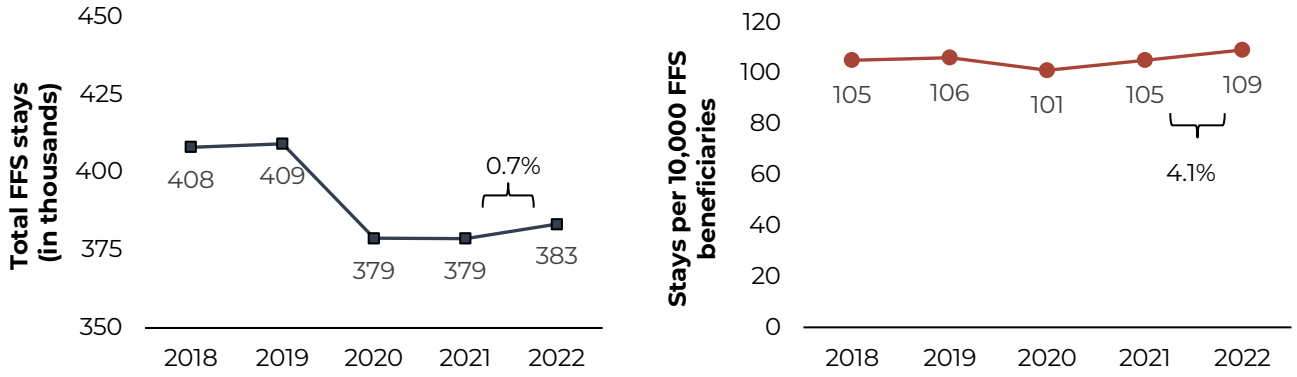
Note: HHA (home health agency), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). The measure of discharge to the community is an HHA's risk-standardized rate of fee-for-service (FFS) Medicare patients who were discharged to the community after a home health stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of potentially preventable readmissions after discharge is calculated as the risk-adjusted percentage of patients discharged from an HHA who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A–covered home health stays in the 50 states and the District of Columbia, regardless of whether the home health stay was preceded by a hospitalization. Rates for successful discharge are for the 24-month period from January 1, 2021, to December 31, 2022; rates for potentially preventable readmissions are for the 30-month period from July 1, 2020, to December 31, 2022.

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

> The median rate of discharge to the community from home health was 79.3 percent in the period from January 1, 2021, to December 31, 2022 (higher rates indicate better quality). For-profit providers had the lowest median rates of discharge to community in both periods, while hospital-based providers had the highest rates. From January 1, 2021, to December 31, 2022, the HHAs at the 25th percentile and 75th percentile had rates of 68.5 percent and 85.3 percent, respectively.

> For the 30-month period from July 1, 2020, to December 31, 2022, the share of home health stays with a potentially preventable readmission was 3.88. The average rates of potentially preventable rehospitalization did not differ significantly across ownership categories or facility type. In this same period, the HHAs at the 25th percentile and 75th percentiles had potentially preventable rehospitalization rates of 3.76 percent and 4.03 percent, respectively.

Chart 8-13 In 2022, the number of IRF stays grew for the first time since the start of the pandemic



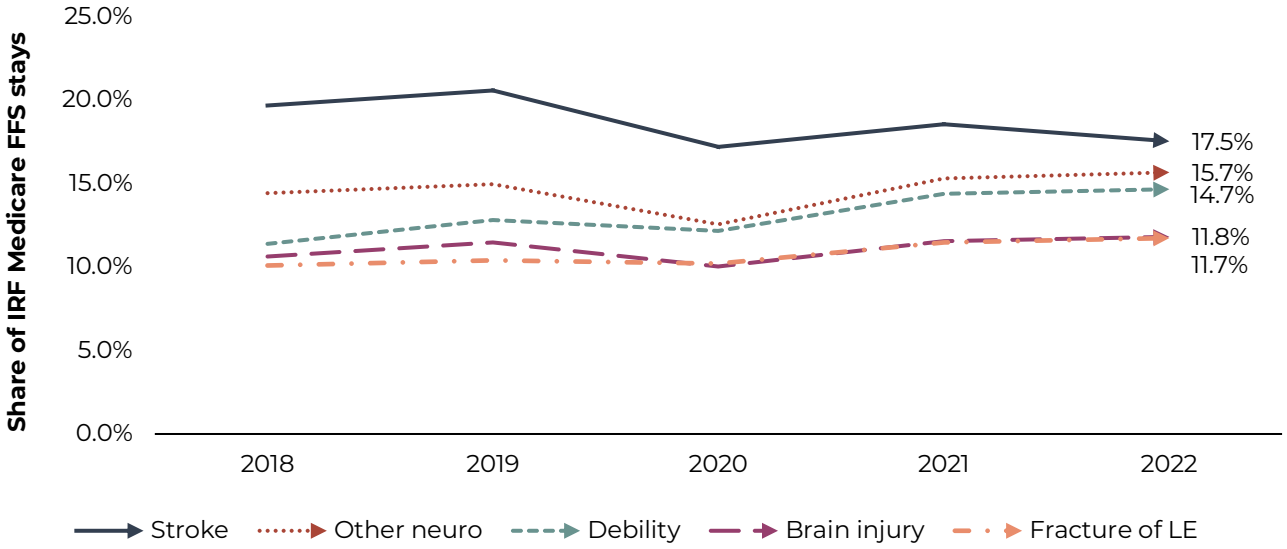
Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). The number of FFS stays and the number of beneficiaries are rounded.

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

> From 2021 to 2022, the number of FFS cases slightly rose, to about 383,000 cases. However, when controlling for the number of FFS beneficiaries, the number of cases increased 4.1 percent in 2022, from 105 to 109.

> The average length of stay remained relatively stable at 12.8 days, a 0.7 percent reduction from 12.9 days in 2021 (data not shown).

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



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

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

> Although the share of stroke cases slightly decreased from 2021 to 2022 (18.5 percent in 2021), stroke continues to be the most frequently occurring case type among FFS beneficiaries admitted to IRFs, accounting for 17.5 percent of Medicare FFS cases in 2022.

> Between 2021 and 2022, the share of IRF cases with a diagnosis of "other neurological conditions" increased slightly from 15.3 percent to 15.7 percent of IRF discharges, while the share of cases with debility increased from 14.4 percent to 14.7 percent.

Chart 8-15 IRFs' aggregate FFS Medicare margin decreased to just under 14 percent in 2022

	2018	2019	2020	2021	2022
All IRFs	14.4%	14.1%	13.3%	16.9%	13.7%
Hospital based	2.0	1.7	1.4	5.7	0.9
Freestanding	25.3	24.6	23.4	25.9	23.3
Urban	14.7	14.5	13.6	17.3	14.1
Rural	9.1	7.6	9.0	11.7	7.8
Nonprofit	2.5	1.1	−0.3	5.3	−0.4
For profit	24.4	24.2	23.4	25.3	22.7
Number of beds					
1–10	–9.1	−9.1	−7.3	−2.7	−6.3
11–24	1.4	1.6	2.2	5.7	1.2
25–64	16.8	15.8	14.8	18.6	15.0
65+	21.1	20.9	19.3	22.2	19.8

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

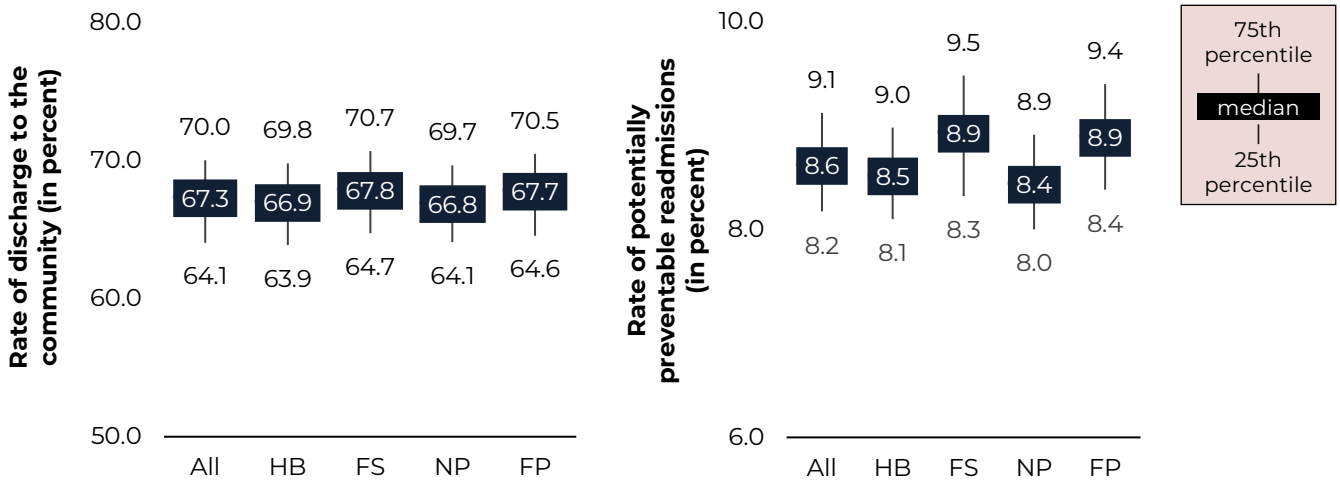
Source: MedPAC analysis of cost report data from CMS.

> In 2022, IRFs' per case payments grew much more slowly than costs; as a result, the aggregate Medicare margin decreased but remained strong at 13.7 percent (14.2 percent when including Medicare's share of federal relief funds; data not shown).

> Medicare margins vary by IRF type. In 2022, freestanding IRFs and for-profit IRFs had substantially higher aggregate margins (23.3 percent and 22.7 percent, respectively) than hospital-based IRFs and nonprofit IRFs (0.9 percent and –0.4 percent, respectively).

> There are large differences in Medicare margins by IRF size. In 2022, the aggregate Medicare margin for IRFs with 10 or fewer beds was –6.3 percent. By contrast, the Medicare margin for IRFs with 65 or more beds was 19.8 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 2021 and FY 2022



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

Source: Medicare IRF claims from CMS.

> In 2021 and 2022, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.3 percent, about 2 percentage points higher (better) than the rate for the period from 2018 to 2019 (latter data not shown).

> The median facility risk-adjusted rate of potentially preventable readmission was 8.6 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers. (Because of a change in the measure calculation, we cannot compare this rate to a prior time period.)

Chart 8-17 In 2022, fee-for-service LTCH volume continued to decline compared with 2021

		2021	Average annual percent change 2018–2021	2022	Percent change 2021–2022
Cases	All	70,021	–11.8%	60,278	–13.9%
	Nonqualifying cases	20,072	–11.9	19,386	–3.4
	Qualifying cases	49,949	–11.3	40,892	–18.1
	Share of qualifying cases	71%	0.6	68%	–4.9
Cases per 10,000 FFS beneficiaries	All	19.4	–10.0	17.3	–10.9
	Nonqualifying cases	5.6	–9.9	5.6	0.0
	Qualifying cases	13.8	–9.6	11.7	–15.2
Payment per case	All	$48,557	6.6	$48,582	0.1
	Nonqualifying cases	$39,063	17.5	$38,839	–0.6
	Qualifying cases	$52,745	4.1	$53,201	0.9
Length of stay (in days)	All	27.6	1.3	27.8	0.7
	Nonqualifying cases	25.7	3.4	26.3	2.2
	Qualifying cases	28.3	0.4	28.5	0.8

Note: LTCH (long-term care hospital), FFS (fee-for-service). "Qualifying cases" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. All counts are for stays covered by FFS Medicare and do not include those in private plans. Dollar amounts are nominal figures, not adjusted for inflation.

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

> Beginning in fiscal year 2016, only certain LTCH cases qualify for the higher standard LTCH prospective payment system (PPS) rate. Cases that do not meet LTCH-qualifying criteria are paid a lower site-neutral rate—the lower of (1) an amount based on Medicare's inpatient hospital PPS rate or (2) 100 percent of the cost of the case.

> The number of LTCH cases per 10,000 FFS beneficiaries declined, on average, by 10.0 percent per year between 2018 and 2021 (data not shown). In contrast, the number of cases meeting the LTCH-qualifying criteria declined more slowly, falling 9.6 percent per year during the same period.

> In 2022, the volume of all LTCH cases fell nearly 14 percent. The volume of qualifying cases fell 18.1 percent that year. The volume of nonqualifying cases also decreased by 3.4 percent, likely owing to the expiration of the waiver of site-neutral payments for nonqualifying cases.

> During the public health emergency (PHE), all cases were paid the higher, standard LTCH PPS rate. As a result of this temporary PHE-related payment change, the average payment per nonqualifying case between 2020 and 2021 increased by 20.6 percent on a nominal basis (not shown) but remained the same from 2021 to 2022.

Chart 8-18 Ten MS–LTC–DRGs accounted for over half of LTCH fee-for-service discharges in 2022

MS–LTC–DRG	Description	Discharges	Share of cases
189	Pulmonary edema and respiratory failure	13,774	22.9%
207	Respiratory system diagnosis with ventilator support 96+ hours	8,629	14.3
177	Respiratory infections and inflammations with MCC	2,343	3.9
871	Septicemia without ventilator support 96+ hours with MCC	1,920	3.2
208	Respiratory system diagnosis with ventilator support <96 hours	1,969	3.3
166	Other respiratory system OR procedures with MCC	1,556	2.6
981	Extensive OR procedure unrelated to principal diagnosis with MCC	1,413	2.3
949	Aftercare with CC/MCC	1,205	2.0
539	Osteomyelitis with MCC	1,128	1.9
592	Skin ulcers with MCC	944	1.6
	Top 10 MS–LTC–DRGs	34,881	57.9
	Total	60,278	100.0

Note: MS–LTC–DRG (Medicare severity long-term care–diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), OR (operating room), CC (complication or comorbidity). MS–LTC–DRGs are the case-mix system for LTCHs. Shares for each MS–LTC–DRG presented in the table are rounded, but the sum of the top 10 was calculated using unrounded values.

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

> Cases in LTCHs are concentrated in a relatively small number of MS–LTC–DRGs. In 2022, the top 10 MS–LTC–DRGs accounted for about 58 percent of LTCHs' fee-for-service cases. Cases in LTCHs have grown less concentrated over time. In 2021, the top 10 MS–LTC–DRGs accounted for 60.9 percent of fee-for-service cases in LTCHs (data not shown).

> The share of fee-for-service LTCH cases in MS–LTC–DRG 177 (respiratory infections and inflammations with major complication or comorbidity) decreased from 9.1 percent of cases in 2021 (not shown) to 3.9 percent of cases in 2022. The share of cases in MS–LTC–DRG 207 (respiratory system diagnosis with ventilator support for 96+ hours) also decreased, from 15.6 percent of cases in 2021 (not shown) to 14.3 percent of cases in 2022.

Chart 8-19 Aggregate LTCHs' Medicare margins decreased in 2022

LTCH	2018	2019	2020	2021	2022
All	–0.5%	–1.6%	3.8%	7.5%	–1.3%
Type of control					
Nonprofit	–13.3	–13.2	–13.1	–8.9	–24.0
For profit	1.5	0.6	6.5	9.9	2.2
Facility share of qualifying cases					
High share	2.0	2.2	4.5	5.4	–1.5
Low share	0.1	–2.4	3.0	7.1	–2.0

Note: LTCH (long-term care hospital). "Qualifying cases" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. "High share" means more than 85 percent of a provider's cases were qualifying cases in the year. "Low share" means 85 percent or fewer of a provider's cases were qualifying cases in the year.

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

> In fiscal year 2016, CMS began implementing a dual payment-rate system under which LTCH cases not meeting criteria specified in law are paid a lower site-neutral rate—the lower of an amount based on (1) Medicare's inpatient hospital prospective payment system rate or (2) 100 percent of the cost of the case. As a result, the aggregate Medicare margin fell to –2.2 percent in 2017 (data not shown) and remained negative through 2019.

> Due to the public health emergency waiver of site-neutral payment rates, all cases were paid the higher standard LTCH prospective payment system rates starting January 27, 2020. That year, the Medicare aggregate margin (excluding relief funds) for all LTCHs increased to 3.8 percent. In 2021, when LTCHs were paid the higher LTCH rate for the entire year, the aggregate margin nearly doubled to 7.5 percent. With reported Provider Relief Fund revenue allocated to Medicare payments, the aggregate margin in 2021 was 9.8 percent (data not shown).

> In 2022, LTCHs had a negative aggregate Medicare margin (of –1.3 percent) for the first time since the implementation of the public health emergency waiver of site-neutral payment rates. LTCHs with a high share (greater than 85 percent) of qualifying cases had an aggregate Medicare margin of –1.5 percent, while LTCHs with a low share (85 percent or less) of qualifying cases had an aggregate margin of –2.0 percent, excluding relief funds.

Chart 8-20 LTCH Medicare PPS payments per case declined in 2022, while LTCH Medicare PPS costs per case increased for all LTCHs

	Percent change			
	2018–2019	2019–2020	2020–2021	2021–2022
Payments per case				
All LTCHs	3.1%	9.7%	7.9%	–0.4%
LTCHs with >85% qualifying cases	2.6	9.1	7.7	0.2
Cost per case				
All LTCHs	4.5	4.5	4.1	9.2
LTCHs with >85% qualifying cases	2.6	6.5	7.8	7.3

Note: LTCH (long-term care hospital), PPS (prospective payment system). "Qualifying cases" 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. Percentages reflect changes in nominal dollars, not adjusted for inflation.

Source: MedPAC analysis of cost report data from CMS.

> Between 2021 and 2022, aggregate Medicare payments per case for all LTCHs decreased 0.4 percent on a nominal basis to more than $48,000 per case (latter data not shown). For LTCHs with high shares (more than 85 percent) of qualifying cases, payments per case increased 0.2 percent to more than $58,000 per case (not shown) during the same period.

> In 2022, reduced case volume and coronavirus pandemic–related costs likely contributed to aggregate growth in costs per case. Between 2021 and 2022, aggregate cost per case for all LTCHs rose 9.2 percent to more than $49,000 per case (latter data not shown). For LTCHs with high shares of qualifying cases, costs increased 7.3 percent to more than $59,000 per case (latter data not shown) during the same period.