Setting a New Agenda for Medicare's Post-Acute Care Payment Policy

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The Hopkins Business of Health Initiative hosted a panel on October 8, 2025, titled *"Setting a New Agenda for Medicare's Post-Acute Care Payment Policy"* as part of the *Future of Health Care Delivery Nexus Convening Series*. The panel brought together leading researchers, David Grabowski, PhD (Harvard Medical School), R. Tamara Konetzka, PhD (University of Chicago), and Anne Deutsch, RN, PhD (RTI International/ Northwestern University), and was moderated by Kathryn Linehan, MPH. They discussed how Medicare's post-acute care payment systems can better balance fiscal sustainability and patient needs as Medicare Advantage continues to reshape the delivery landscape.

Background

Post-acute care, or PAC, refers to the short-term skilled services patients receive after a hospitalization. These services support recovery and help millions of Medicare beneficiaries regain or maintain function at a critical point in their care. About four in ten Medicare hospital discharges go to a PAC setting—skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), or long-term care hospitals.

Over the past decade, policymakers have sought to refine how Medicare pays for PAC. Revisions to Medicare's prospective payment systems (PPSs) have aimed to reduce incentives to provide more services simply to increase reimbursement, while value-based purchasing programs have introduced modest accountability for outcomes. At the same time, policy interest in site-neutral PAC payment, paying similar rates for comparable outcomes across settings, has waned.

In addition to changes to the PAC PPSs, Medicare has sought to influence provider decisions and patient pathways with alternative payment models (APMs). APMs, such as bundled payment initiatives, have reduced PAC use in some cases, but scaling these successes remains an ongoing challenge. Meanwhile, the rapid growth of Medicare Advantage (MA) has reshaped care delivery. MA plans often rely on prior authorization and selective provider networks to manage post-acute utilization and length of stay, but limited transparency in MA data leaves policymakers with little insight into how these strategies affect access, quality, or spending.

Against this backdrop, the panel explored what is known about provider responses to payment incentives, where critical evidence gaps remain, and how policymakers can chart a more coherent and sustainable path forward for Medicare's PAC payment policy.

Measuring What Matters: Function, Quality, and Data Gaps

Dr. Deutsch emphasized the need to measure what truly matters to patients. "The goals of care vary tremendously," she said. For some, avoiding readmissions is paramount; for others, regaining function and independence defines recovery. She noted that emerging technologies—such as wearable sensors that track activity and recovery—have the potential to generate 'automated, actionable data' to guide care, offering a more nuanced picture of functional improvement and patient progress as these tools evolve.

> *"We need to measure what matters most to patients—their function, their recovery, and their return to independence."*
> — Anne Deutsch, RN, PhD

Dr. Deutsch noted that Medicare's value-based purchasing (VBP) programs for SNFs and HHAs have drawn attention to outcomes but have only achieved modest effects. Konetzka called the evidence "underwhelming," and Dr. Grabowski added that "we didn't move the needle," cautioning that focusing narrowly on readmissions may widen disparities between well-resourced and under-resourced facilities.

Dr. Konetzka also questioned the nursing home Five-Star Quality Rating System. "Families often rely on the stars, but they're a very imperfect signal," she said. Though payroll-based staffing data improved accuracy, she urged CMS to weight staffing more heavily and inspections less, arguing that turnover, stability, and skill mix matter as much as nursing hours worked per patient.

Site-Neutral Payment: Appealing in Principle, Difficult in Practice

Dr. Konetzka described site-neutral payment as "conceptually really appealing, almost self-evident," the idea that comparable care with comparable outcomes should be reimbursed at the same rate regardless of setting. Yet she cautioned that the principle is far easier to articulate than to operationalize. Differences in patient frailty, motivation, and family support—factors that strongly influence both discharge decisions and outcomes—make equitable comparisons across settings and patients challenging. Without stronger evidence and better patient-level data, she warned, site-neutral PAC payment could inadvertently restrict access to intensive rehabilitation for those who need it most.

She pointed to inpatient rehabilitation facilities (IRFs) as "a really interesting case study" in both the conceptual appeal and practical challenges of site-neutral payment. Although IRFs represent a relatively small share of PAC, their use has increased markedly in recent years, driven largely by growth among freestanding, for-profit facilities, a highly consolidated segment of the market. Freestanding and for-profit IRFs have high Medicare margins [around 24 percent in 2023, according to MedPAC]. This profit potential, combined with somewhat loosely defined admission

criteria, can fuel unnecessary use of these relatively costly PAC services. Yet the absence of robust data on which patients are clinically appropriate for IRF versus SNF care makes it difficult to assess appropriate use or define truly comparable cases across settings. She noted that this evidence gap "is the big problem for site-neutral payment," a valid goal, she said, "but one we're not yet ready to implement well."

"Site neutrality is a valid goal—but one we're not yet ready to implement well."
— R. Tamara Konetzka, PhD

Trade-offs Under SNF and HHA Payment System Reforms

Dr. Grabowski reflected on the rollout of Medicare's Patient-Driven Payment Model for SNFs in October 2019 and Patient-Driven Groupings Model for HHAs in January 2020, reforms meant to curb incentives for unnecessary therapy. He noted that evidence suggests the overuse of therapy has declined—but new incentives around coding and case-mix classification have emerged. Early evaluations show little change in readmissions or mortality, though available claims data do not allow for measuring meaningful outcomes such as function and recovery. Konetzka noted that despite the mixed evidence, it remains worthwhile to test and iterate on new payment systems and solutions.

"We've right-sized therapy—but we've replaced therapy incentives with coding incentives."
— David Grabowski, PhD

Medicare Advantage: Lower Use, Unclear Outcomes

As Medicare Advantage enrollment passes 50 percent, panelists discussed its growing influence on PAC. "Every study shows less post-acute care [in MA]—fewer admissions and shorter stays," said Dr. Grabowski. Prior authorization may curb overuse but risks underuse. Dr. Konetzka described the landscape as a "grand experiment." MA plans appear to deliver PAC more efficiently, but "we see lower intensity, and we don't know if that's appropriate or harmful." Dr. Deutsch added that while standardized patient-assessment tools are improving, gaps in MA encounter data still limit meaningful comparisons of PAC use in MA and Traditional Medicare.

Workforce: Foundational to Quality

Dr. Grabowski pointed to growing research evidence linking workforce stability and quality of care across post-acute and long-term care settings. He described the current staffing shortage as a crisis, noting that facilities with more consistent staffing and lower turnover achieve better outcomes. Immigrant workers, he said, play a critical role in sustaining the workforce. Dr. Grabowski emphasized that addressing pay, working conditions, and immigration policy must be part of any serious reform effort. "We need to expand the pool, both native-born and immigrant, through better pay, working conditions, and immigration policy."

A New Agenda: Policy and Research Priorities

When asked to identify priorities for policy makers, Dr. Grabowski called for expanding alternative payment models (APMs) that integrate PAC rather than treating it as "the piggy bank for savings." Dr. Deutsch urged targeting APMs to predictable populations like joint replacement patients while improving measurement of function and community discharge. Dr. Konetzka highlighted Institutional Special Needs Plans, a bridge between long-term and post-acute care, that might align incentives and reduce hospitalizations.

Ms. Linehan reminded the audience that even as new models evolve, traditional Medicare payment remains the backbone of the system and too often an afterthought in reform debates. She argued that policymakers cannot build coherent post-acute care policy that ignores this foundation. Refining the core PPS frameworks—how rates are set, updated, and adjusted for case mix and costs—still determines how providers respond to incentives. She noted that policy energy often focuses on new model testing, but the biggest levers remain in how traditional Medicare pays. Ms. Linehan observed that all Medicare payment policy, from bundled payment and Medicare Advantage, is built on those underlying PPS payment systems and patient and provider responses to them.

Panelists agreed that advancing the field will depend on stronger evidence about quality and functional outcomes—areas where data remain limited. Continued work to improve measurement, transparency, and analytic tools will be essential to understanding how post-acute care contributes to recovery and independence.