Matching Post-Acute Care to Clinical Need: Reducing Unnecessary Skilled Nursing Facility Use

$1.56 billion
of Medicare Spending (0.03% of Total Health Spending)

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Issue Summary: In 2024, skilled nursing facility (SNF) care accounted for over half ($31 billion) of total post-acute care (PAC) spending ($57.7 billion) in the fee-for-service (FFS) Medicare program. SNFs offer important recuperative and rehabilitative care for patients after an acute illness. For many people, this care could safely be offered at a lower cost. However, Medicare eligibility and payment rules may incentivize more SNF use than necessary, driving excessive Medicare spending without commensurate benefit for patients.

Policy Recommendation: Congress and CMS should expand mandatory bundled payment initiatives and other risk-sharing financial approaches to conditions that commonly use PAC to incentivize providing care in lower cost settings, such as the home. Congress and CMS could also pair these policies with increased caregiver support and a more generous Medicare home health benefit, as a way of offering something that more closely resembles SNF at home.

Potential Savings: Substituting 10% of SNF stays with home health care could have saved Medicare roughly $898 million in 2024. Reducing each of the remaining SNF stays by one day could have saved an additional $664 million, totaling about $1.56 billion in potential Medicare savings in 2024.

Related Literature and Evidence:

Werner, R. M., Coe, N. B., Qi, M., & Konetzka, R. T. (2019). "Patient outcomes after hospital discharge to home with home health care vs to a skilled nursing facility." *JAMA Internal Medicine*, 179(5), 617-623.

Werner, R. M., Coe, N., Qi, M., & Konetzka, R. T. (2023). "The value of an additional day of post-acute care in a skilled nursing facility." *American Journal of Health Economics*, 9(1), 1-21.

Background

Post-acute care (PAC) is care for individuals who need additional rehabilitation or support after an acute illness or procedure, most often after hospital stays. PAC can be delivered in institutional settings, such as skilled nursing facilities (SNFs) or inpatient rehabilitation facilities (IRFs), or in outpatient settings, such as at a patient's home by home health agencies.

Medicare is the primary payer for PAC, with fee-for-service (FFS) spending on PAC totaling $57.7 billion in 2024 (MedPAC 2026a). SNFs are the most common site of PAC and comprise nearly 54% of that spending ($31 billion, including beneficiaries' cost sharing) (MedPAC 2026a).

SNF admissions among FFS beneficiaries have been declining over the years, which may partly stem from rising Medicare Advantage enrollment and declining acute care hospital stays (MedPAC 2026a). Despite these shifts, SNF stays continue to constitute a substantial amount of traditional Medicare's costs, totaling roughly 6% of Parts A and B spending in 2025 (Medicare Trustees 2026). In addition, the growth in Medicare's FFS payments to SNFs is outpacing growth in the facilities' costs: from 2023 to 2024, the average payments per day to freestanding SNFs increased 4.9% while daily costs increased 2.3% (MedPAC 2026b).

While SNFs offer important recuperative and rehabilitative care for patients, SNF eligibility and payment rules under FFS Medicare may lead to more frequent SNF use and longer stays than is optimal, driving up Medicare spending without commensurate benefit for patients. With pressure on acute care hospitals to shorten hospital lengths of stay, discharging patients to SNFs provide a way to further shorten hospital stays. In addition, SNFs are paid a per diem (i.e., daily) rate, which may encourage them to hold patients for more days on the margin. Medicare covers a maximum of 100 SNF days per acute care episode; the first 20 days are fully covered by the program, with a daily copayment kicking in for beneficiaries on day 21 ($217 per day in 2026; MedPAC 2026b). Full Medicare coverage for the first 20 days, combined with a daily payment, gives SNFs little financial incentive to discharge the average patient sooner through more efficient care delivery.

Most patients and caregivers would much rather receive high-quality PAC at home instead of an institutional setting (Geng et al. 2024). As policymakers continue to pursue and refine alternative payment models that affect PAC, they should understand how current policy incentivizes SNF vs. home health care—and the trade-offs of each in terms of patient and caregiver satisfaction, health outcomes, and Medicare spending.

Evidence Base

We use Medicare claims and assessment data from 2010-2016 to explore two policy questions (Werner et al. 2019, Werner et al. 2023). First, are there benefits to using SNFs versus home health care? Second, once someone is in a SNF, how long should they stay, and what is the value of an additional day?

Discharge to Home Health Care vs. a SNF

We estimate differences in patient outcomes and Medicare payments for patients discharged to home health versus SNF, accounting for the fact that healthier patients are more likely to be sent home (Werner et al. 2019). We focus on patients who could reasonably be cared for in either setting and whose discharge is effectively determined by whether they happen to live closer to a home health agency or a SNF. These are also the patients most likely to be moved by payment reforms that nudge providers toward one setting or another.

We find a trade-off between the two settings: home health care costs less but leads to more hospital readmissions. Sending marginal patients home with home health care rather than to SNFs saved Medicare an average of $4,514 per patient over the 60-day episode covering the hospital admission, PAC, and any readmissions. Discharge to home health care came with no detectable difference in 30-day mortality rates or functional outcomes (i.e., activities of daily living, like bathing and dressing) but resulted in a 5.6 percentage point higher 30-day hospital readmission rate. Those added readmissions were concentrated among "discretionary" cases—conditions where the need for hospitalization is less clear and, therefore, admission rates vary more, rather than cases with urgent, unambiguous need for hospital care.

SNFs appear to prevent some of these readmissions, likely through closer monitoring and more intensive care. Fewer readmissions do save Medicare money, but not enough to offset the higher cost of SNF care itself compared to home health care. Total Medicare spending over the 60-day episode is still lower for patients discharged to home.

For policymakers, the results point to genuine savings from shifting marginal patients out of SNFs—but at the cost of more readmissions. They also point to a tension in current Medicare incentives: readmission penalties push hospitals toward higher-acuity settings like SNFs, while bundled payments and accountable care organizations (ACOs) push toward lower-cost, home-based care. Where these patients end up depends on which incentive dominates.

The Value of an Additional SNF Day

In a subsequent paper, we assess the value of staying an additional day in a SNF (Werner et al. 2023). To separate the effect of an extra day from the fact that sicker patients stay longer, we use areas with higher Medicare Advantage penetration—which puts downward pressure on the length of all SNF stays—as a natural experiment.

We find that an additional SNF day does lower short-term hospital readmission rates, but the effect is small and fades fast—it is detectable at 7 and 14 days post-discharge but near zero by 30 days. The effect also varies across patients: those with the greatest clinical complexity (and longest predicted stays) benefit the most from an additional day.

For the average patient, the cost savings from fewer readmissions are small and do not offset the costs of an extra SNF day—roughly $371 in added Medicare spending per day. The implication is that reducing SNF length of stay can lower Medicare spending without clear harm to patients—particularly healthier, short-stay patients, while the most clinically complex may warrant more caution.

Bundled Payment and ACOs' Effect on PAC

A growing body of evidence shows that bundled payment and ACOs reduce institutional PAC use without detectable harm to patients' clinical outcomes. The clearest example is the mandatory Comprehensive Care for Joint Replacement (CJR) Model: over its first two years (2015-2017), institutional spending per episode fell 3.1%, driven by a 5.9% relative decline in discharges to PAC facilities as patients shifted from institutional care to home-based care, with no rise in complications (Barnett et al. 2019). Nearly a decade later, CJR is found to have generated an estimated $112.7 million in net Medicare savings across roughly 98,000 joint replacement episodes at 323 hospitals in 2021-2023, with no change in quality of care (Lewin Group 2025). ACOs lower institutional PAC use in a similar way. For ACOs entering the Medicare Shared Savings Program in 2012, PAC spending fell about 9%, with fewer facility discharges, shorter SNF stays, and no change in readmissions or mortality (McWilliams et al. 2017). Patients sent from ACO-affiliated hospitals to ACO-affiliated SNFs saw lower readmissions, shorter SNF stays, and lower Medicare costs (Agarwal and Werner 2018). Hospitals reported adopting strategies to strengthen relationships with SNFs, such as by sharing access to electronic medical records or hiring care coordination staff (Zhu et al. 2018).

Policy Recommendation

To promote post-acute care in the most clinically appropriate setting and achieve Medicare savings, Congress and CMS should expand mandatory bundled payment initiatives and other risk-sharing financial approaches to conditions that commonly use PAC. Holding hospitals financially accountable for the total cost of an episode encourages them to match patients to the right PAC setting—home versus facility—based on clinical need, and to monitor and influence the quality and cost of SNF care for the patients they refer. This approach counteracts SNFs' per diem incentive described above.

Congress and CMS could also pair these payment reforms with stronger support for home-based care—a more generous Medicare home health benefit and direct support for family caregivers—as a way of offering something that more closely resembles SNF at home. As SNF use has fallen, the need for help at home has risen, with older adults relying more on family caregivers and unpaid aides after discharge

(Bressman et al. 2021). That burden is likely to grow as payment reform expands. The CJR Model caused a 9 to 15% relative increase in both the need for and receipt of help with activities of daily living at the end of a home health episode (Werner et al. 2025). Strengthening home-based supports and supporting caregivers directly can help offset these effects. Reinvesting part of the bundled payment savings in caregiver support and a more robust home health benefit could help ensure the shift to home-based PAC improves care rather than simply redistributing its burden onto families. Survey evidence reinforces the stakes: most patients and caregivers strongly prefer high-quality care at home, but that preference shifts toward facility-based care when caregiving demands are too heavy or families face financial strain (Geng et al. 2024).

Potential Savings

Substituting home health care for a SNF stay would have saved $5,987 per stay in 2024 (based on Werner et al. 2019's $4,514 estimate in 2013 dollars, inflated by the medical care component of the Consumer Price Index). To offer a conservative estimate, substituting home health care for 10% of the 1.5 million SNF stays under traditional Medicare in 2024 (150,000 stays) would have saved Medicare an estimated $898 million (MedPAC 2026b).

Shortening a SNF stay by one day would have saved $492 per stay in 2024 (Werner et al. (2023)'s $371 estimate (2013 dollars), inflated the same way). Applying that one-day reduction to the remaining 1.35 million stays would have saved Medicare an additional $664 million.

Combined, these marginal reductions to SNF stays could have saved Medicare about $1.56 billion in 2024. Through alternative payment models like bundled payment and ACOs, Medicare could achieve savings by shifting marginal patients from SNFs toward home health and trimming the length of remaining stays. $1.56 billion represents the scale of potential savings if utilization shifted across all SNF stays; how much is actually captured depends on how broadly these models are applied.

As noted above, while patients generally prefer to receive care at home, shifting care to the home can also increase burdens on family caregivers and offset some of these savings (Werner et al. 2025). Medicare savings estimates do not account for the full costs of increased caregiving needs, in terms of lost wages and effects on physical and mental health.

Existing Policy Proposals

CMS proposed the CJR-X Model in its Fiscal Year 2027 Hospital Inpatient Prospective Payment Systems (IPPS) proposed rule released on April 10, 2026. This mandatory nationwide model would expand the CJR Model, which concluded in 2024 and only applied to 34 select metropolitan areas. CJR-X would focus on traditional Medicare patients undergoing hip, knee, and ankle replacements (also called lower extremity joint replacements (LEJR)) in the inpatient and outpatient hospital settings. If the rule is finalized, CJR-X would begin on October 1, 2027.

The 5-year mandatory Transforming Episode Accountability Model (TEAM) runs from 2026 through 2030. TEAM uses episode-based payments to cover surgery through 30 days post-hospitalization for five surgical procedures: LEJR, hip fracture, spinal fusion, coronary artery bypass graft (CABG), and major bowel procedures.

These current proposals move in the right direction; CMS should continue to explore other conditions or procedures that commonly use PAC and could serve as good candidates for bundled payment.

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