CHAPTER 8

Home health care services

RECOMMENDATIONS

8 For calendar year 2024, the Congress should reduce the 2023 Medicare base payment rate for home health agencies by 7 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 8

Home health care services

Chapter summary

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2021, about 3.0 million Medicare fee-for-service (FFS) beneficiaries received care, and the program spent $16.9 billion on home health care services. In that year, 11,474 HHAs participated in Medicare.

Assessment of payment adequacy

The indicators of Medicare payment adequacy for home health care are generally positive.

Beneficiaries' access to care—Access to home health care was adequate in 2021: Over 98 percent of Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 87.6 percent lived in a ZIP code served by five or more HHAs.

- ***Capacity and supply of providers***—Between 2020 and 2021, the number of HHAs fell by 0.8 percent, continuing a slow decline that began in 2013, but at a lower rate than in prior years. The slower decline in the supply of HHAs suggests that neither the coronavirus pandemic nor the major revisions to the home health prospective

In this chapter

payment system implemented in 2020 had a significant impact on HHA supply.

- ***Volume of services***—In 2021, the number of FFS beneficiaries receiving home health care fell by 1.1 percent, and the volume of 30-day periods also declined by 2.9 percent. However, the number of beneficiaries enrolled in FFS also declined as more beneficiaries enrolled in Medicare Advantage. As a result, the number of 30-day periods per 100 FFS beneficiaries increased by almost 1 percent in 2021, and the share of FFS beneficiaries using home health care increased to 8.3 percent. The average number of in-person visits per 30-day period declined by 4.7 percent, but some of the decline could have been offset by greater use of virtual visits through telehealth.
- ***Marginal profit***—In 2021, freestanding HHAs' marginal profit—that is, the rate at which Medicare payments exceed providers' marginal costs—was 26 percent, suggesting a significant financial incentive for freestanding HHAs with excess capacity to serve additional Medicare patients.

Quality of care—In 2021, the mean agency risk-adjusted rate of successful discharge to the community from HHAs was 52.2 percent and the mean agency risk-adjusted rate of hospitalizations was 18.2 percent. The pandemic and policies related to the public health emergency confound our assessment of trends in both quality measures. Further complicating assessment, the home health payment system now uses a shortened unit of payment (a 30-day unit rather than 60 days), which changes the period used in the postdischarge hospitalization measure.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs.

Medicare payments and providers' costs—In 2021, home health agencies' average cost per 30-day period decreased by 2.9 percent, in part reflecting a decline in the number of visits per 30-day period. As the number of visits per period declined, Medicare's payment per in-person visit increased by 17.7 percent. Medicare margins for freestanding agencies averaged 24.9 percent in 2021—a historic high—up from 20.2 percent in 2020 and 15.4 percent in 2019. These high margins indicate that the increase in payments in 2021 far exceeded the increase in costs. In aggregate, Medicare's payments have always been substantially more than costs: From 2001 to 2019, the Medicare margin

for freestanding HHAs averaged 16.4 percent. The projected margin for 2023 is 17.0 percent, reflecting both a statutory reduction to the base payment rate of 3.5 percent in 2023 (required to maintain budget neutrality following recent changes to the home health payment system) and expected cost growth indicated by the Medicare home health market basket. However, this rate of inflation is high relative to past experience, so margins in 2023 could be higher.

How should payments change in 2024?

Our review of payment adequacy for Medicare home health services indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and these excess payments diminish the service's value as a substitute for more costly services. On the basis of these findings, the Commission recommends that, for calendar year 2024, the Congress should reduce the 2023 base rate by 7 percent. ■

Background

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Also, unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2021, about 3.0 million Medicare beneficiaries received home care, and the program spent $16.9 billion on home health care services under the home health prospective payment system (PPS).

Medicare requires that a physician, nurse practitioner, clinical nurse specialist, or physician assistant certify a patient's eligibility for home health care.[1] Medicare also requires that a beneficiary have a face-to-face encounter with the practitioner ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. An encounter through telehealth services may be used to satisfy the requirement.

In 2020, CMS implemented major changes required by the Bipartisan Budget Act (BBA) of 2018: a new 30-day unit of payment and elimination of the number of in-person therapy visits as a factor in the payment system. CMS implemented the BBA of 2018 policies through a new case-mix system, the Patient-Driven Groupings Model (PDGM). Payments for a 30-day period are adjusted by the case-mix system to account for differences in patient severity. If beneficiaries need additional home health services at the end of the initial 30-day period, another period commences and Medicare makes an additional payment. Coverage for additional periods generally has the same requirements as the initial period (i.e., the beneficiary must be homebound and need skilled care). The PDGM applied to home health care services as of January 1, 2020 (an overview of the home health PPS is available at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_HHA_FINAL_SEC.pdf).

The coronavirus pandemic had a significant effect on home health care, just as it did on other sectors. The volume of services dropped in 2020, though most of this decline was confined to the first few months of the pandemic. CMS and the Congress made several policy changes in response to the pandemic that were intended to support or expand access to home health care (Centers for Medicare & Medicaid Services 2020). These new policies included expanding home health agencies' (HHAs') use of telehealth, allowing nurse practitioners and physician assistants to order the home health benefit, and suspending the 2 percent sequester on Medicare payments required by the Budgetary Control Act of 2011. These policy changes could also have affected the mix and amount of home health care services provided in 2021. In addition, HHAs, like other providers, were eligible for relief funds such as the Paycheck Protection Program.

Home health payments historically have been high

While the changes required by the BBA of 2018 substantially altered the home health PPS, they were not designed to reduce Medicare's payments for home health care services, which have substantially exceeded costs since the PPS was implemented in 2001. The Act required CMS to set the base rate for the PDGM at a level that was budget neutral relative to 2019, a year when the Commission reported high Medicare margins (over 15 percent) for freestanding agencies. (Medicare margins show the extent to which an agency's revenue from Medicare patients covers, exceeds, or falls below the cost of providing care for these patients.)

The BBA of 2018 requires that payments based on the PDGM be budget neutral (neither raising nor lowering aggregate home health care spending) relative to spending that would have occurred without the new model's implementation. For 2020 through 2026, CMS must determine how actual aggregate home health spending under the PDGM differs from spending that would have occurred in the absence of the payment system changes and must adjust the PPS base rate as needed to achieve budget neutrality. CMS is required to make permanent adjustments when it

TABLE 8–1 **Rate of decline in home health agencies participating in Medicare has slowed**

	Prepandemic			Pandemic		Average annual percent change	
	2013	2018	2019	2020	2021	2013–2019	2020–2021
Active HHAs	12,788	11,699	11,569	11,556	11,474	–1.7%	–0.8%
Number of HHAs per 10,000 Medicare beneficiaries	2.4	1.9	1.9	1.8	1.8	–4.2	–2.1

Note: HHA (home health agency). "Active HHAs" includes all agencies operating during a year, including agencies that closed or opened at some point during the year. Average annual changes were calculated on unrounded data.

Source: MedPAC analysis of CMS's Quality, Certification and Oversight file and 2021 annual report of the Boards of Trustees of the Medicare trust funds.

determines that an observed deviation from expected behavior will continue in future years. The statute requires temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year.

In the 2023 payment rule for the home health PPS, CMS determined that the base rate was 7.85 percent above the budget-neutral level required by statute. CMS implemented a permanent reduction to the base rate of 3.925 percent for 2023, half of the reduction it has identified as necessary. Assuming CMS's estimate of the budget-neutral level does not change, in future years CMS will have to implement another 3.925 percent reduction to keep spending at the level required by the BBA of 2018. CMS also found that spending in 2020 and 2021 was $2 billion above the budgetary targets for these years, but it has not yet indicated when or how it plans to implement a temporary reduction to recover these funds.

Medicare has always overpaid for home health services under the PPS and will continue to do so even after CMS adjusts the PPS base rate as needed to achieve budget neutrality with 2019 payments. Margins of 23 percent in the first year of the PPS suggest that the base rate CMS established in 2001 was well in excess of agencies' costs to treat Medicare beneficiaries. Between 2001 and 2019, freestanding HHA margins averaged 16.4 percent.

Are Medicare payments adequate in 2023?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2023. Specifically, we assess beneficiary access to care (by examining the supply of home health providers, annual changes in the volume of services, and marginal profit); quality of care; access to capital; and the relationship between Medicare's payments and providers' costs. In general, the payment adequacy indicators for home health care are positive.

Beneficiaries' access to care: Almost all beneficiaries live in an area served by HHAs

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2021, over 98 percent of fee-for-service (FFS) beneficiaries lived in a ZIP code served by two or more HHAs, and 87.6 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our prior reviews of access.[2]

Supply of providers: Agency supply declined slightly in 2021

In 2021, the supply of agencies declined by 0.8 percent. This decline is smaller than the trend in recent years; between 2013 and 2019, the number of agencies fell an average of 1.7 percent per year (Table 8-1). The small

TABLE 8–2

In 2021, the share of FFS beneficiaries using home health care increased, while the number of in-person home health visits per user declined

	Prepandemic			Pandemic		Average annual percent change	
	2017	2018	2019	2020	2021	2017–2019	2020–2021
Medicare FFS home health users (in millions)	3.4	3.4	3.3	3.1	3.0	–1.7%	–1.1%
Share of FFS beneficiaries using home health care	8.8%	8.7%	8.5%	8.1%	8.3%	–1.3	2.5
Total visits (in millions)	104.8	103.9	99.7	81.1	76.8	–2.5	–5.3
In-person visits per user	30.7	30.8	30.2	26.6	25.4	–0.8	–4.2
30-day periods (in millions)				9.6	9.3		–2.9
30-day periods per 100 FFS Medicare beneficiaries				25	26		0.7

Note: FFS (fee-for-service). Percentage change was calculated on unrounded data.

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.

decline in 2021 suggests that the industry has remained relatively stable in the aftermath of the coronavirus pandemic and the implementation of the PDGM in 2020.

HHA provider counts illustrate the overall size of the industry, but it is a limited measure of capacity. For example, HHAs can vary in size and the services they provide. Also, because home health care is not provided in a medical facility, HHAs can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because HHAs can use contract staff to meet their patients' needs.

The share of FFS beneficiaries using home health care increased in 2021

In 2021, the number of Medicare FFS beneficiaries using home health care declined by 1.1 percent, and the volume of 30-day periods declined 2.9 percent (Table 8-2). Though utilization and spending declined sharply during the coronavirus pandemic, home health care service volume was declining before the pandemic. Several factors likely account for the decline. More Medicare beneficiaries are enrolling in Medicare Advantage, reducing the demand for FFS Medicare services. In addition, aggregate and per capita hospitalizations, which are a common source of referrals to home health care, have declined in recent years. Since the onset of the pandemic, many home health care providers have reported that staffing shortages limit the volume of services they can provide.

However, notably, per capita use of the benefit increased 2.5 percent in 2021 (Table 8-2). In addition, the number of 30-day periods per Medicare FFS beneficiary also increased. Thus, despite the 2021 decline in aggregate use, the higher rate of home health users in 2021 indicates that HHAs are serving a rising share of the Medicare FFS population.

TABLE 8–3

The number of home health periods per FFS beneficiary is similar in urban and rural areas, 2021

	Number of 30-day periods per 100 FFS beneficiaries		
	Rural	**Urban**	**All**
Review Choice Demonstration states	29.0	31.4	31.0
All other states and territories	23.4	22.3	22.5
All states	24.5	24.6	24.5

Note: FFS (fee-for-service). Under the Review Choice Demonstration, home health agencies in Florida, Illinois, Ohio, North Carolina, and Texas are subject to additional review of their Medicare claims.

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 general, the Commission has found that, historically, per capita utilization of home health care services has been comparable between urban and rural areas (Medicare Payment Advisory Commission 2021). Data for 2021 indicate a continuing trend despite any effects of the coronavirus pandemic and changes to the case-mix system in 2020. In 2021, the number of periods per capita was almost equal in rural and urban areas, with beneficiaries in either area averaging about 24.5 thirty-day periods per 100 FFS beneficiaries (Table 8-3). This comparable utilization persists even when areas that are subject to program integrity concerns are excluded from the calculation. For example, when the five states subject to the Review Choice Demonstration for home health services—a demonstration focused on program integrity—are excluded, the rural areas had use rates of 23.4 thirty-day periods per 100 FFS beneficiaries, slightly higher than urban areas' rates, which averaged 22.3 thirty-day periods per 100 FFS beneficiaries.[3]

Increased use of telehealth during the coronavirus pandemic makes it difficult to interpret the decline in in-person visits In 2021, the number of in-person visits per 30-day period fell by 0.4 visits, or 4.7 percent, relative to 2020 (Table 8-4). Since 2019, there has been a decline of 1.4 in-person visits per 30-day period. The three therapy disciplines (physical, occupational, and speech–language pathology) account for about two-thirds of the decline in visits since 2019 (data not shown). Skilled nursing accounts for approximately 30 percent of the decline between 2019 and 2021.

Fewer in-person visits could, in part, reflect trends related to the coronavirus pandemic, such as the reluctance of beneficiaries to receive services in the home and the growth in the use of telehealth. Shortly after the onset of the pandemic, CMS expanded the use of telehealth in home health care, permitting agencies to provide virtual visits and other telehealth services under the benefit. The expanded coverage of telehealth was initially for the duration of the coronavirus pandemic but was later made permanent. A survey found that almost three-quarters of HHAs expanded their telehealth programs in 2020 (Shang et al. 2020). Several HHAs and industry experts we interviewed indicated that telehealth and virtual visits expanded substantially during the coronavirus pandemic, surging at the beginning and receding in later months. In 2023, CMS is requiring HHAs to report telehealth services, consistent with our recommendation in the March 2022 report to the Congress.[4]

Marginal profits

Another factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In determining whether to treat a patient, a provider with excess capacity compares the marginal

TABLE 8–4

In 2021, the number of in-person visits per 30-day period declined

	Prepandemic	Pandemic		2019–2021		2020–2021	
	2019	2020	2021	Change in number of visits	Average annual percentage change	Change in number of visits	Average annual percentage change
Skilled nursing	4.6	4.6	4.3	–0.3	–3.7%	–0.3	–8.0%
Physical therapy	3.5	2.9	3.0	–0.6	–10.0	0.1	1.1
Occupational therapy	1.1	0.9	0.8	–0.3	–18.3	–0.1	–1.5
Speech–language pathology	0.2	0.2	0.2	–0.1	–20.5	–0.1	–5.2
Medical social services	0.1	0.1	0.1	0.1	–20.8	–0.1	–8.4
Home health aide	0.7	0.6	0.5	–0.2	–18.5	–0.1	–14.5
Total	10.2	9.2	8.8	–1.4	–8.1	–0.4	–4.7

Note: Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the two years. Thirty-day periods are included in the year that the period ended. Components may not sum to totals due to rounding. Visit counts have been rounded. "Change in number of visits" and "average annual percentage change" columns were calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files for 2020 and 2021.

revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments exceed the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.[5] In 2021, the average marginal profit for freestanding HHAs was 26.1 percent, indicating that these HHAs have a strong incentive to serve Medicare beneficiaries.

Quality of care is difficult to assess during the pandemic

The quality of care in 2020 and 2021 is difficult to assess because of the effects of the coronavirus pandemic on beneficiaries and providers and because implementation of the 30-day unit of payment may have affected one of our measures. Data for these years likely reflect changes in the delivery of care and data limitations unique to the coronavirus pandemic rather than actual trends in quality. Changes in the use of other health care services, such as acute inpatient care or the increased use of telehealth by physicians, could also have affected home health care outcomes. In addition, the Commission's quality metrics rely on risk-adjustment models that use performance from previous years to predict beneficiary risk.

We evaluate quality of care using two measures: average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a spell of home health care. Successful discharges to the community include only beneficiaries who did not have an unplanned hospitalization and did not die in the 30 days after their spell. The hospitalization measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that occur during the spell of service (beneficiaries who died during a home health stay are excluded from the measure). Discharges to hospice or beneficiaries with the hospice benefit are excluded from the calculation of both measures.

In 2021, the share of Medicare beneficiaries hospitalized during their home health stay was 18.2 percent, about equal to the share in 2020 but more than 3 percentage points lower than in 2019 (Table 8-5, p. 246). Given the various disruptions to the health care

TABLE 8–5

HHAs' mean risk-adjusted rates of successful discharge to the community and all-cause hospitalizations between 2017 and 2021

		Prepandemic			Pandemic	
Measure	**Provider type**	**2017**	**2018**	**2019**	**2020**	**2021**
Successful discharge to the community	**All HHAs**	69.6%	70.4%	72.2%	61.8%*	52.2%*
	For profit	68.2	68.9	70.7	60.1*	50.7*
	Nonprofit	76.6	77.5	78.9	70.4*	59.7*
	Freestanding	69.0	69.8	71.6	61.1*	51.5*
	Hospital based	75.3	76.2	77.5	68.4*	58.2*
All-cause hospitalizations	**All HHAs**	21.3%	21.5%	21.4%	18.4%	18.2%
	For profit	22.0	22.1	22.0	18.8	18.6
	Nonprofit	18.8	18.9	19.0	17.0	16.4
	Freestanding	21.7	21.8	21.6	18.6	18.4
	Hospital based	19.0	19.1	19.3	16.9	16.5

Note: HHA (home health agency). "Successful discharge to the community" includes beneficiaries discharged to the community who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occurred during the stay. Both measures are uniformly defined and risk adjusted across the four post-acute care settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate. These measures report results for Medicare fee-for-service beneficiaries.
*A change to the home health payment system's unit of payment in 2020 affects the calculation of our discharge to community measure. Rates from 2020 and 2021 cannot be compared with those from prior years.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytic file.

delivery system in 2020, it is difficult to determine the factors that account for the stable hospitalization rate in 2021. Though the characteristics of beneficiaries receiving home health care in 2021 did not change significantly, our models may not have accounted for aspects of patient risk attributable to home health care beneficiaries during the coronavirus pandemic. The pandemic has changed how beneficiaries use inpatient and outpatient care, and these differences could have had some lasting impact on home health patients' hospitalization rates.

In 2021, the share of patients discharged successfully to the community was 52.2 percent. This rate appears to be almost 10 percentage points lower than in 2020 and 20 percentage points lower than in 2019. However, in addition to the many pandemic-related disruptions beginning in 2020, the implementation of the 30-day unit of payment has lowered our reported rate of discharge to community. Before 2020, home health care was provided in 60-day episodes. The implementation of 30-day periods in 2020 shortened the length of time beneficiaries received home health care, and time periods between the 31st and 60th day of home health care that were previously (before 2020) included as part of a home health spell of care became part of a postdischarge period. As a result, data on some hospitalizations that previously would have occurred within a home health stay could have been captured as occurring postdischarge, resulting in a decline in the community discharge rate. Correspondingly, the data for 2019 and prior years reflect the 60-day unit of payment and thus cannot be compared with the 2021 data.

TABLE 8–6

Most patient experience measures remained stable in 2021

HH–CAHPS® measure	2017	2018	2019	2021	Percentage point change, 2019–2021
Share of patients rating the home health agency a 9 or 10 out of 10	88%	88%	88%	88%	0
Share of patients that would definitely recommend the home health agency to friends or family	85	85	85	85	0
Share of patients who reported that their home health provider:					
Gave care in a professional way	83	83	83	81	–2
Communicated well with them	84	84	84	84	0
Discussed medicines, pain, and home safety with them	78	78	78	77	–1

Note: HH–CAHPS® (Home Health Care Consumer Assessment of Healthcare Providers and Systems®). HH–CAHPS is a standardized survey of patients' evaluations of home health. The survey items are combined to calculate measures of patient experience for each home health agency (HHA). Each year's results are based on a sample of surveys of HHAs' patients from January to December. CMS did not collect HH–CAHPS data for the first six months of 2020.

Source: CMS summary of HH–CAHPS public report of survey results tables.

We no longer include measures of patient functional improvement in our assessment of quality. The Commission contends that maintaining and improving functional status is a key goal of post-acute care, but has serious questions about the reliability of currently reported information (Medicare Payment Advisory Commission 2019). Because functional assessments are used in the case-mix system to establish payments, it is unlikely that this information can be divorced from payment incentives. In the June 2019 report to the Congress, the Commission discussed possible strategies to improve the assessment data, the importance of monitoring the reporting of these data, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019).

Most patient experience measures remained stable in 2021

HHAs collect Home Health Care Consumer Assessment of Healthcare Providers and Systems® (HH–CAHPS®) surveys from a sample of patients served, which CMS uses to calculate results for five measures of patient experience.[6] The HH–CAHPS measures key components of quality by assessing whether something that should happen during a stay (such as clear communication) actually happened.

HH–CAHPS ratings in 2021 were comparable to 2019 on most measures, with the same share of patients reporting positive responses for three of the measures. (Data for calendar year 2020 are unavailable because CMS waived the requirement to collect HH–CAHPS data for the first six months of 2020.) The share of beneficiaries reporting that (1) HHAs communicated in a professional way and (2) HHAs discussed medicines, pain, and home safety declined by 2 percentage points and 1 percentage point, respectively (Table 8-6). These measures were steady before 2020, suggesting that the disruptions related to the coronavirus pandemic may have had a small effect on these patient experience measures.

Providers' access to capital is adequate

In 2021, the all-payer margin for freestanding HHAs averaged 11.9 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and most are too small to attract interest from capital markets. Few HHAs access capital through publicly traded shares or through public debt, such as issuance of bonds. In 2021, FFS Medicare accounted for about 49 percent of revenue for freestanding HHAs.

Information on publicly traded home health care companies provides limited insight into access to capital. Publicly traded companies may have other lines of business in addition to home health care, such as hospice, Medicaid-covered services, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of HHAs in the industry. However, since they are the largest corporate entities in home health care, they provide some insight about the industry's financial status.

In 2022, some large for-profit firms reported that higher inflation and rising labor costs affected financial results (Seeking Alpha 2022). However, these firms also reported that increased Medicare Advantage (MA) enrollment was one of the most important factors affecting their operations (Enhabit Home Health & Hospice 2022). Since private Medicare plans reportedly pay less than traditional FFS Medicare for home health care services, the publicly traded HHAs contend that their financial returns are reduced by this shift in volume. These firms are working to secure higher payment from MA plans but noted that private plan rates remain lower than Medicare FFS rates.

Despite these factors, recent activity indicates that the large for-profit companies have capital to invest in expansion and are attractive investments for outside firms. For example, the three largest publicly traded firms reported acquiring new HHAs in 2022 to expand capacity (Amedisys 2022, Enhabit 2022, LHC Group 2022). In addition, UnitedHealth Group announced that it was acquiring LHC Group, a large publicly traded home health company, in March 2022 (Reuters 2022). Their forthcoming acquisition follows Humana's purchase of another large publicly traded home health care firm, Kindred at Home, in 2021.

Medicare payments and providers' costs: Reduced visits lowered costs in 2021

In 2021, as beneficiary enrollment in Medicare Advantage continued to rise, total Medicare FFS spending for home health care declined by 1.2 percent to $16.9 billion. The average payment per 30-day period (that did not receive a low-use payment adjustment) for freestanding agencies was $1,810. Though we typically report the annual increase in payments per home health period, new policies make that calculation more nuanced. For example, 2021 was the first full year with a new unit of payment. In 2020, a portion of claims were paid under the previous case-mix system and 60-day unit of payment, so PDGM data for this year do not reflect a full year of utilization under the new system. As an alternative, we compared the average payment per in-person visit in 2019 and 2021 since in-person visits are a primary unit of service in the home health benefit and data on the number of visits are available for both years. Between 2019 and 2021, Medicare's payment per visit increased by 17.7 percent, from about $180 per in-person visit to about $220 per in-person visit.[7] The per visit payment increase reflects the budget-neutrality requirement under the BBA of 2018, which required Medicare to set aggregate payments at a pre-PDGM baseline. The increase also reflects other payment policies in 2020 and 2021, including the annual payment updates, a percentage payment reduction that CMS implemented in 2020 in anticipation of coding changes under the PDGM, and the suspension of the sequester. Finally, a 4 percent increase in case-mix acuity also raised payments in 2020.

Fewer in-person visits per 30-day period is a substantial factor in the higher payment per visit under the PDGM. When setting the PDGM base rate, CMS assumed, consistent with the requirements of the BBA of 2018, that the number of in-person visits in a 30-day period would remain stable; thus, the rate is based on a higher level of utilization than occurred in 2021.[8] The base rate also does not reflect the shift to a less costly mix of services due to the drop in therapy services. If telehealth visits had been counted, the 2021 per visit payment increase would likely have been lower, but HHAs will not be required to report telehealth services until July 2023.

The decline in in-person visits under the PDGM was similar to the result of the industry's behavioral response in 2000, when Medicare switched from a

TABLE 8–7 **Historically high Medicare margins for freestanding home health agencies in 2021**

	Prepandemic	Pandemic		Share of home health agencies, 2021	Share of periods, 2021
	2019	2020	2021		
All	15.4%	20.2%	24.9%	100%	100%
Geography					
Majority urban	16.1	20.0	24.8	85.0	85.1
Majority rural	14.2	21.6	25.2	15.0	14.9
Type of ownership					
For profit	17.4	22.7	26.1	88.2	82
Nonprofit	11.4	12.4	20.2	11.8	18
Volume quintile					
First (smallest)	9.7	11.6	14.0	20	2.5
Second	11.4	14.0	15.9	20	5.8
Third	13.3	17.0	19.3	20	10.4
Fourth	14.1	18.8	22.8	20	18.6
Fifth (largest)	17.5	22.4	28.3	20	62.6

Note: Home health agencies were classified as majority urban if they provided more than 50 percent of 30-day periods to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties. These data do not include federal provider relief funds that HHAs received due to the public health emergency.

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

cost-based home health reimbursement system to a PPS that used 60-day episodes of care. In that year, the number of visits per 60-day episode fell below what CMS had assumed when it set the base payment for the newly established PPS. As a result, in 2001, the Medicare margin for freestanding HHAs exceeded 20 percent. Though the number of in-person visits per period could rebound in future years as the effects of the coronavirus pandemic recede, the pattern of visits and payments observed after the implementation of the PDGM in 2020 is similar to the early experience of the home health PPS that led to years of payments well in excess of costs.

In 2021, the average cost per 30-day period declined by 2.9 percent for freestanding HHAs, due in large part to reductions in the number of in-person visits provided. Reducing in-person visits allowed HHAs to offset reported price increases in labor and other services needed to deliver home health care, plus additional costs for personal protective equipment, along with economy-wide inflation. The reduction in the average cost per period contrasts with the 1.4 percent average annual increase in cost per 60-day episode between 2017 and 2019.

Medicare margins for freestanding HHAs reached an all-time high in 2021

In 2021, the aggregate Medicare margin for freestanding HHAs was 24.9 percent (Table 8-7). The margin ranged from 6.9 percent for those at the 25th percentile to 34.3 percent at the 75th percentile of the margin distribution (data not shown). For-profit HHAs

TABLE 8–8 **Performance of relatively efficient home health agencies in 2021**

Provider characteristics	Relatively efficient providers	All other providers
Number of home health agencies	409	2,443
Share that are for profit	74%	86.5%
Median		
Medicare margin	28.4%	23.2%
Hospitalization during home health spell	16.1%	19.6%
Successful discharge to community relative to expected	1.08	0.97
Standardized cost per 30-day period	$1,294	$1,346
Patient severity case-mix index	1.10	1.03
Visits per period		
Standardized average in-person visits per period	7.7	7.7
Share of in-person visits by type		
Skilled nursing	45%	48%
Aide	5%	5%
MSS	1%	1%
Therapy	49%	45%
HHA size		
Median number of 30-day payment periods	1,147	1,097
Share of 30-day periods		
Low-use 30-day periods	9.3%	7.2%
Outlier 30-day periods	4.4%	3.5%
Provided to rural beneficiaries	12.7%	22.5%

Note: MSS (medical social services), HHA (home health agency). Sample includes freestanding HHAs with complete data for three consecutive years. "Low-use 30-day periods" are those with low numbers of in-person visits, and these periods are paid on a per visit basis (the threshold for these payments depends on the payment group a period is assigned to, and it ranges from two to six in-person visits). "Outlier 30-day periods" are those that received a very high number of in-person visits and qualified for outlier payments. Share of in-person visits by type may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare cost reports and standard analytic file.

had higher margins than nonprofit HHAs, and rural HHAs had slightly higher margins than urban HHAs. Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, margins for HHAs in the bottom quintile of volume averaged 14.0 percent, compared with a 28.3 percent average margin for HHAs in the top quintile.

In 2020, HHAs received substantial payments through pandemic-related relief programs, such as the Paycheck Protection Program and the Small Business Administration Loan Forgiveness program. When these relief funds are included, the Medicare aggregate margin for freestanding HHAs in 2021 was 25.9 percent (data not shown).[9]

The Commission includes hospital-based HHAs in its calculation of acute care hospitals' Medicare margins because these agencies operate in the financial context of hospital operations. In 2021, margins for hospital-based HHAs were –18.1 percent (data not shown). The lower margins of hospital-based HHAs are attributable chiefly to their higher costs, some of which are a result of overhead costs allocated to the HHA from its parent hospital. Hospital-based HHAs help their parent institutions financially if they can shorten inpatient stays, lowering expenses in the more costly inpatient hospital setting.

Relatively efficient HHAs serve patients similar to those at other HHAs

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The analysis informs the Commission's update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of efficient providers. First, the provider must do relatively well on both cost and quality metrics. Second, performance must be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission's approach is to examine how many providers meet a preestablished set of criteria. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

To identify efficient HHAs, we examined cost efficiency and quality at freestanding HHAs to identify a cohort that demonstrated better performance on these metrics relative to its peers (Table 8-8). The cost measure was on a per 30-day-period basis, adjusted for risk (patient's health status) and local wages; the quality measures were risk-adjusted rates of hospitalizations during the home health spell and rate of successful discharge to the community after the home health spell. Our approach categorized an HHA as relatively efficient if it was in the best-performing third on at least one measure (low cost per episode, a low hospitalization rate, or a high rate of beneficiaries with a successful discharge to the community) and was not in the worst-performing third on any of these measures for three consecutive years (2017 to 2019). Providers also had to have complete claims, quality, and cost report data for 2017 to 2019 (as well as 2021). Because 2020 includes the effects of the PDGM implementation and coronavirus pandemic, we selected providers based on their performance in 2017 to 2019, a period without these two events. In 2021, about 14 percent of freestanding HHAs met the criteria to be classified as efficient.

In 2021, relative to other HHAs, efficient HHAs served a similar mix of patients and had a similar mix of nursing, therapy, aide, and social services visits but had a median cost per visit that was about 3.9 percent lower. Relatively efficient providers had a median hospitalization rate that was 3.5 percentage points lower (lower is better). Relatively efficient HHAs provided roughly the same number of in-person visits per period as other HHAs, and the former had a median margin that was 5.2 percentage points higher. Efficient providers were less likely to be for profit, tended to provide fewer 30-day periods in rural areas, and had a median Medicare margin of 28.4 percent.

Projected Medicare margin for 2023

In modeling 2023 margins, we incorporate policy changes that will go into effect between the year of our most recent data, 2021, and the year for which we are making the margin projection, 2023. Table 8-9 (p. 252) shows the major payment policy changes in 2022 and 2023, including a permanent reduction to the base payment rate of 3.5 percent, as required to maintain budget neutrality following the implementation of the PDGM classification system and associated changes to the PPS.[10] On the basis of these policies and assumptions, the Commission projects a margin of 17 percent in 2023.

The margin projection for 2023 assumes the rate of cost inflation indicated by the Medicare home health market basket for 2022 and 2023, 6.2 percent and 4.1 percent, respectively. However, this rate of inflation is high relative to past experience. As noted earlier, cost per period in 2021 has declined by 2.9 percent relative to 2020 (data not shown). In 2011 to 2019—the last nine years that the 60-day payment episode was in effect—the average increase in cost per episode was about 0.5 percent. The Commission's projection

TABLE 8–9

Payment policy changes in 2022 and 2023

	2022	2023
Home health policy changes:		
Market basket	3.1%	4.1%
Productivity	–0.5	–0.1
Budget-neutrality adjustment under BBA of 2018	N/A	–3.5
Outlier threshold adjustment	0.7	0.2
Total	**3.2**	**0.6**

Note: BBA (Bipartisan Budget Act). N/A (not applicable). Totals may not sum due to rounding and multiplicative relationship of payment factors.

assumes higher cost inflation than HHAs are likely to experience, so margins in 2023 could be higher.

How should Medicare payments change in 2024?

In considering how payments should change for 2024, we note that current law is expected to increase home health payment rates by 2.9 percent in 2024. CMS will revise its estimates before the publication of the final rule. However, our review of payment adequacy for Medicare home health services indicates that access is more than adequate in most areas and that payments continue to substantially exceed costs, as they have for many years. These excess payments do not accrue to the advantage of the beneficiary or the Medicare program. Further, the high aggregate margin indicates that the HH PPS provides few incentives for HHAs to furnish care efficiently.

As noted above, in 2023 CMS implemented a permanent reduction to the 30-day period base rate of 3.925 percent, half the amount required by law to maintain budget neutrality following the implementation of the PDGM classification system and associated changes to the PPS. Assuming this estimate does not change, in future years CMS will have to reduce the base rate for 30-day periods by an additional 3.925 percent to keep spending at the level required by law. We note that, even after such a reduction, payments to home health agencies would remain far above costs.

RECOMMENDATION 8

For calendar year 2024, the Congress should reduce the 2023 Medicare base payment rate for home health agencies by 7 percent.

RATIONALE 8

Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and the excess payments diminish the service's value as a substitute for more costly services. In addition, broad geographic variation in the use of the home health benefit indicates inefficiencies in some areas of the country.

A 7 percent reduction in 2024 would significantly address the magnitude of excess payments embedded in Medicare's home health payment rates. However, this reduction would likely be inadequate to align Medicare payments with providers' actual costs. Though the public health emergency was a disruption for HHAs, it did not significantly change the industry's financial

outlook or service delivery practices; in fact, Medicare margins in 2021 were much higher than in 2019.

IMPLICATIONS 8

Spending

- This recommendation would decrease federal program spending by $750 million to $2 billion in 2024 and by more than $10 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to high-quality home health care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness to deliver home health care. ■

Endnotes

1 The Medicare statute permits nurse practitioners, clinical nurse specialists, and physician assistants to order and supervise home health care services. State laws on medical scope of practice also govern the services these practitioners are permitted to deliver and may limit the ability of some nonphysician practitioners to order home health care.

2 As of November 2022, this measure of access is based on data collected and maintained as part of CMS's Home Health Compare database. The service areas listed are postal ZIP codes where an HHA has provided services in the past 12 months. This definition may overestimate access because HHAs need not serve the entire ZIP code to be counted as serving it. At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.

3 HHAs operating in Florida, Illinois, Ohio, North Carolina, and Texas are subject to additional review of their claims under the demonstration. HHAs subject to additional review can choose one of three options: prepayment claims review, postpayment claims review, or forgoing a review and accepting a 25 percent payment reduction. If an HHA that selects one of the first two options is found to have billed Medicare correctly for at least 90 percent of review claims, that HHA may elect a less burdensome review.

4 HHAs can voluntarily report telehealth services beginning on January 1, 2023, with mandatory reporting beginning July 1, 2023.

5 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

Marginal profit = (Medicare payments − (total Medicare costs − fixed costs)) / Medicare payment.

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.

6 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

7 These payment per visit amounts were computed by dividing the total Medicare PPS payments in each year by the total number of visits (for 2021, only payments and in-person visits for 30-day periods paid under the PDGM were included).

8 The BBA of 2018 required CMS to set spending under the PDGM so that it was equal to what Medicare would have spent under the predecessor payment system if the latter had been in effect in 2020.

9 The amount of the relief funds included in the calculation of Medicare margins was determined by applying the proportion of an HHA's revenues attributable to Medicare in 2019 to the total pandemic-related relief funds reported on the cost report.

10 The 3.925 percent reduction in the base rate in 2023 applies to about 92 percent of 30-day periods and does not apply to about 8 percent of 30-day periods that were paid on a per visit basis under the low-utilization payment adjustment. As a result, the aggregate reduction in 2023 is slightly lower at 3.5 percent.

References

Amedisys. 2022. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. https://d18rn0p25nwr6d.cloudfront.net/CIK-0000896262/d476c2c8-f5ee-4dd4-95b4-ce5e31f8bf8c.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. Home health agencies: CMS flexibilities to fight COVID-19. https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf.

Enhabit. 2022. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. https://d18rn0p25nwr6d.cloudfront.net/CIK-0001803737/2ded071f-cecc-4428-b492-fd339df584ec.pdf.

Enhabit Home Health & Hospice. 2022. Enhabit Home Health & Hospice second quarter 2022 earnings conference call. August 2. https://s201.q4cdn.com/374903510/files/doc_downloads/2022/08/Transcript_Enhabit-Home-Health-and-Hospice-Q2-2022-Earnings-Call_5248158_final.pdf.

LHC Group. 2022. LHC Group to acquire home health provider in Georgia. Press release. August 16. https://lhcgroup.com/newsroom/lhc-group-to-acquire-home-health-provider-in-georgia/.

Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Reuters. 2022. UnitedHealth to buy LHC Group for $5.4 billion in home healthcare push. March 29. https://www.reuters.com/business/healthcare-pharmaceuticals/unitedhealth-buy-lhc-group-about-54-billion-2022-03-29/.

Seeking Alpha. 2022. Amedisys Inc (AMED) CEO Chris Gerard on Q2 2022 results. Earnings call transcript. https://seekingalpha.com/article/4527133-amedisys-inc-amed-ceo-chris-gerard-on-q2-2022-results-earnings-call-transcript.

Shang, J., A. M. Chastain, U. G. E. Perera, et al. 2020. COVID-19 preparedness in US home health care agencies. *Journal of the American Medical Directors Association* 21, no. 7 (July): 924–927.