CHAPTER 7

Home health care services

RECOMMENDATIONS

7 For calendar year 2025, the Congress should reduce the 2024 Medicare base payment rates for home health agencies by 7 percent.

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

CHAPTER 7

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 2022, about 2.8 million fee-for-service (FFS) Medicare beneficiaries received care, and the program spent $16.1 billion on home health care services. In that year, 11,353 HHAs participated in FFS Medicare.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for home health care were positive in 2022.

***Beneficiaries' access to care*—**Access to home health care was adequate in 2022: Over 98 percent of FFS Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 88 percent lived in a ZIP code served by five or more HHAs. The share of home health stays reported as being initiated in a timely manner (within 3 days of hospital discharge or a signed physician order) was 96 percent for the 12-month period ending September 30, 2022, a slight increase from prior years. The share of inpatient prospective payment systems hospital discharges that were followed by at least one 30-day home health period declined slightly to 18.7 percent in the first 10 months of 2022 relative to the prior year but remained higher than the rate in 2019.

In this chapter

- ***Capacity and supply of providers*—**Between 2021 and 2022, the number of HHAs declined by 1.1 percent.
- ***Volume of services*—**In 2022, the volume of 30-day periods declined by 7.5 percent, but this decline reflects two changes that may be curbing home health utilization in FFS Medicare. First, the number of beneficiaries enrolled in FFS Medicare has declined as more beneficiaries enroll in Medicare Advantage. Controlling for the number of FFS beneficiaries, home health volume declined by 4.3 percent in 2022. Second, the decline in FFS beneficiaries' use of inpatient hospital services likely accounts for some of the reduction in home health volume observed in 2022, because a hospital stay is a common precursor to home health stays. The rate of inpatient hospital stays per 1,000 FFS beneficiaries declined 2.6 percent in 2022. For FFS beneficiaries who use home health care, the average number of in-person visits per 30-day period fell by 15.6 percent between 2019 (the year before CMS implemented major congressionally mandated changes to the HHA prospective payment system) and 2022, but some of the decline might have been offset by greater use of virtual visits through telehealth, which we are unable to observe with available data.
- ***FFS Medicare marginal profit*—**The Commission also assesses access by examining a measure of HHAs' ability to cover their variable costs, excluding certain fixed costs, referred to as the FFS Medicare marginal profit. In 2022, freestanding HHAs' FFS Medicare marginal profit—that is, the rate at which FFS Medicare payments exceeded providers' marginal costs—was 23 percent, indicating a significant financial incentive for freestanding HHAs with excess capacity to serve additional FFS Medicare beneficiaries.

***Quality of care*—**During the two-year period from January 1, 2021, to December 31, 2022, the median risk-adjusted rate of discharge to the community from HHAs was 79.2 percent, a decline of 3.3 percentage points relative to the median from the January 1, 2018, to December 31, 2019, period. Rates of successful discharge to the community varied by provider type, with lower rates and greater decline observed in for-profit and freestanding agencies. The median rate of potentially preventable readmissions after discharge was 3.88 percent from July 1, 2020, to December 31, 2022, and did not vary significantly across provider types. (Due to a change in the measure calculation, we cannot compare this to a prior period.) Most patient experience measures remained stable in 2022. The Commission continues to have concerns about the accuracy of provider-reported function data.

Providers' access to capital—Access to capital is a less important indicator of FFS Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. Recent years have seen substantial interest in HHAs by private equity and health insurance companies. According to industry reports, investor interest in home health care services slowed in 2023, but the slowdown came after a peak period for HHA mergers and acquisitions in 2021.

FFS Medicare payments and providers' costs—In 2022, there was an increase of 4.0 percent in the cost per 30-day period for freestanding HHAs, a reversal of the trend for 2021, when we observed cost per period decline by 2.9 percent. This increase in 2022 was due to higher cost per visit, but it was offset by a reduction in the number of in-person visits per 30-day period. However, even with this increase in cost, payments remained at high levels, with FFS Medicare margins for freestanding agencies averaging 22.2 percent in 2022. These margins indicate that FFS Medicare payments in 2022 far exceeded costs. In aggregate, FFS Medicare's payments have always been substantially more than costs: From 2001 to 2021, the FFS Medicare margin for freestanding HHAs averaged 16.8 percent. We project an aggregate FFS Medicare margin of 18 percent for 2024.

How should payments change in 2025?

The Commission's review indicates that FFS Medicare's payments for home health care are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered, but these excess payments diminish that value. The Commission recommends that, for calendar year 2025, the Congress reduce the 2024 base payment rate for home health agencies 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 2022, about 2.8 million FFS Medicare beneficiaries received home care, and the program spent $16.1 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 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.[2]

Home health payments historically have been high relative to costs

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 fee-for-service (FFS) Medicare margins (over 15 percent) for freestanding agencies. (FFS Medicare margins show the extent to which an agency's revenue from FFS 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 payment 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 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 2024 final rule for the home health PPS, CMS determined that spending would be above the BBA of 2018 statutory target in that year and future years unless a permanent adjustment equal to 5.779 percent was made. However, CMS implemented a permanent reduction equal to 2.890 percent for 2024, only half of the reduction it identified as necessary. Assuming CMS's estimate of the budget-neutral level does not change, in future years CMS is required to recover the balance of the excess spending above the level required by the BBA of 2018 with another reduction. In addition, CMS examined spending prior to 2024 (for 2020 through 2022) and found it was $3.4 billion above the budgetary targets. Under the BBA of 2018, CMS must implement temporary (one-time) reductions to cover

TABLE 7–1

Annual rate of decline for home health agencies participating in Medicare has been approximately 1 percent per year

					Average annual percent change	
	2019	2020	2021	2022	2019–2022	2021–2022
Active home health agencies	11,569	11,565	11,474	11,353	–0.6%	–1.1%
Number of home health agencies per 10,000 Medicare beneficiaries	1.88	1.83	1.79	1.75	–2.3	–2.7

Note: "Active home health agencies" 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 the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

this overage, but it has not yet indicated when or how it plans to recover these funds.

Are FFS Medicare payments adequate in 2024?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of a provider in 2024. 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 FFS Medicare's payments and providers' costs. Overall, the payment adequacy indicators for home health care are positive.

Beneficiaries' access to care: Good indicators of access in 2022

Supply and volume indicators show that almost all FFS beneficiaries have access to home health services. The share of inpatient prospective payment systems (IPPS) hospital discharges that were followed by at least one 30-day home health period declined slightly to 18.7 percent in the first 10 months of 2022 relative to the prior year but remained higher than the rate for 2019. Agencies reported that 96 percent of home health stays were initiated in a timely manner, a slight increase from prior years.

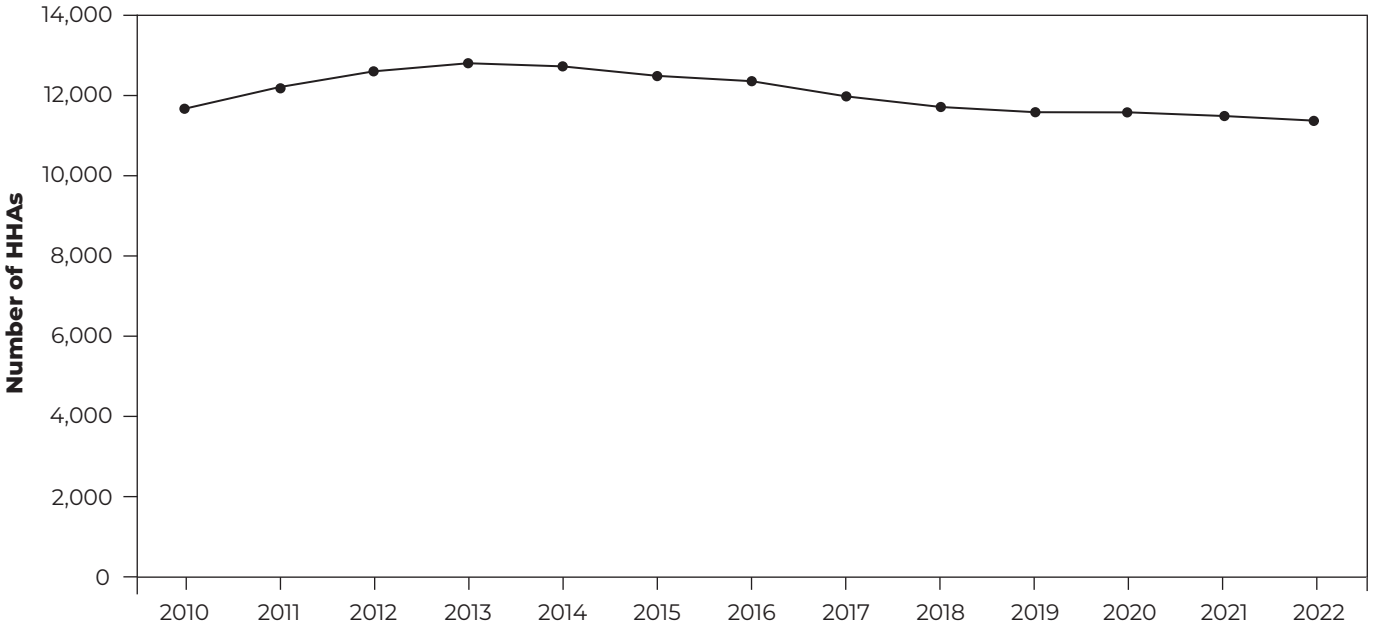
Though agency supply decreased slightly in 2022, almost all beneficiaries live in an area served by at least one home health agency

Home health agency (HHA) provider counts illustrate the overall size of the industry, but they are 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 to measure beneficiaries' access to home health care because HHAs can use contract staff to meet their patients' needs. However, even with these limitations, the number of HHAs is an important measure of industry capacity.

In 2022, 98 percent of FFS beneficiaries lived in a ZIP code served by two or more HHAs, and 88 percent lived in a ZIP code served by five or more agencies. The number of HHAs active in a ZIP code may not be a complete measure of access, but it does provide a baseline of how the supply of providers is distributed relative to the Medicare population. This definition may overestimate access because HHAs need not serve

FIGURE 7–1

Supply of HHAs has been in decline since 2013



Note: HHA (home health agency).

Source: Quality, Certification and Oversight Reports.

the entire ZIP code to be counted as serving it and because this measure does not assess the capacity of agencies relative to beneficiary demand (i.e., agencies may not have capacity to serve additional beneficiaries that require home health care). 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. These findings are consistent with our prior reviews of access.[3]

The supply of agencies peaked in 2013 and has slowly declined since then (Figure 7-1). Much of the decline has been concentrated in areas that experienced significant growth in agency supply in prior years. Prompted by concerns about fraud and abuse in home health care services, CMS implemented moratoriums in 2013 through 2019 prohibiting the entry of new HHAs in regions of Florida, Illinois, Michigan, and Texas.

The supply of agencies has remained relatively stable after the implementation of the PDGM in 2020, even through the coronavirus pandemic. In 2022, the supply of agencies declined by 1.1 percent (Table 7-1), slightly more than the decline observed from 2019 to 2022. The change in agency supply varied among states. For example, the supply in California increased by 186 agencies, or about 3.6 percent per year from 2019 to 2022. Florida, Texas, and Michigan, three states that had been a focus of fraud and abuse efforts, experienced a decline in agency supply of 2.3 percent per year from 2019 to 2022 (data not shown). Over the same period, all other areas experienced a decline in agency supply of 0.9 percent annually. On a per capita basis, the supply of agencies declined to 1.75 HHAs per 10,000 Medicare beneficiaries, including beneficiaries enrolled in both Medicare Advantage (MA) and FFS Medicare. Relative to the FFS Medicare population alone, the supply of agencies increased (to 2.3 HHAs per 10,000 FFS beneficiaries, data not shown) because

TABLE 7–2

In 2022, the share of FFS Medicare beneficiaries receiving home health care declined

					Average annual percent change	
FFS Medicare volume	**2019**	**2020**	**2021**	**2022**	**2019–2022**	**2021–2022**
Home health users (in millions)	3.3	3.1	3.0	2.8	–5.0%	–6.3%
Share of beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	–1.8	–3.0
30-day periods (in millions)	N/A	9.6	9.3	8.6	N/A	–7.5
30-day periods per 100 FFS Medicare beneficiaries	N/A	25.3	25.5	24.4	N/A	–4.3
30-day periods per FFS Medicare beneficiary who received home health care	N/A	3.13	3.08	3.04	N/A	–1.3

Note: FFS (fee-for-service), N/A (not available). Percentage changes were calculated on unrounded data. CMS implemented a 30-day period as the unit of payment in the home health prospective payment system in 2020; data for prior years in this unit of payment are not available.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

the 2022 decline in the number of FFS Medicare beneficiaries was greater than the decline in the number of agencies.

Decline in home health utilization in 2022 reflects several factors

The number of FFS Medicare beneficiaries using home health care and the volume of 30-day periods have decreased in recent years and continued to decline in 2022, falling 6.3 percent and 7.5 percent, respectively (Table 7-2). These declines have been driven by a reduction in the number of beneficiaries in FFS Medicare as a growing share of beneficiaries opt to enroll in Medicare Advantage. Controlling for the number of FFS beneficiaries, the volume of 30-day periods decreased by 4.3 percent in 2022, in part due to a 1.3 percent reduction in the number of 30-day periods delivered to FFS home health users.

But the share of FFS beneficiaries using home health care has been declining as well, falling 3.0 percent in 2022 (Table 7-2). Lower use of inpatient hospital care among FFS beneficiaries likely has contributed to this phenomenon because a hospital stay is a common precursor to home health care. The number of IPPS discharges per 1,000 FFS beneficiaries declined by 2.6 percent relative to 2021 (data not shown).[4] And even when FFS beneficiaries were hospitalized, they were somewhat less likely to be discharged to home health care in 2022 (18.7 percent of IPPS discharges) than in 2021 (19.6 percent of IPPS discharges), though the 2022 share remained higher than the share in 2019 (Table 7-3).

Some of the decline in home health care use in 2022 may also be attributable to a rebound in beneficiaries using skilled nursing facilities (SNFs). Before the pandemic, SNFs were the most frequent first post-acute care (PAC) destination among beneficiaries receiving formal PAC, with home health care services being the second most frequent PAC destination (Table 7-3). In 2020, the two services switched ranks in their share of use after an inpatient hospital stay. Home health care services became the most frequent first PAC service; the share receiving SNF services dropped to the second most frequent first PAC service. However, since 2020, the gap in shares between the two services has decreased. The annual frequency

TABLE 7–3

FFS Medicare beneficiaries' first post-acute service after an IPPS hospital stay, 2019–2022

	2019	2020	2021	First 10 months of 2022
Share of discharges with:				
No PAC service after discharge	60.8%	59.0%	58.6%	58.4%
At least one PAC service (skilled nursing facility, home health care, inpatient rehabilitation facility, or long-term acute care hospital)	39.1	41.0	41.4	41.6
Subtotal of discharges with at least one PAC service:				
Skilled nursing facility	18.7	15.9	16.6	17.4
Home health agency	15.8	20.1	19.6	18.7
Inpatient rehabilitation facility	3.7	4.1	4.4	4.6
Long-term acute care hospital	0.9	1.0	0.8	0.8
Total	100	100	100	100

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), PAC (post-acute care). IPPS discharges that were followed by more than one PAC service after discharge were classified by the initial type of PAC.

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

of discharges to SNFs has increased slightly, while discharges to home health care have declined slightly, indicating a rebound in SNF utilization. The recent change suggests a return to prepandemic PAC referral patterns for Medicare beneficiaries, and the rise in SNF utilization could account for some of the decline in home health care utilization observed in 2022.

One important measure of access is the timely initiation of home health care. CMS tracks this measure based on data reported by HHAs. The share of home health stays (including FFS Medicare and MA stays) that were reported as being initiated in a timely manner was 95.9 percent for the 12-month period ending June 30, 2022—a slight increase from prior years (Table 7-4). Though these data suggest that timely access to care remains strong, some caveats apply. For this measure, a home health stay is considered to have been initiated in a timely manner if the care begins within three days of hospital discharge or a signed physician

TABLE 7–4

The share of agencies reporting that home health care was initiated in a timely manner was steady in 2022

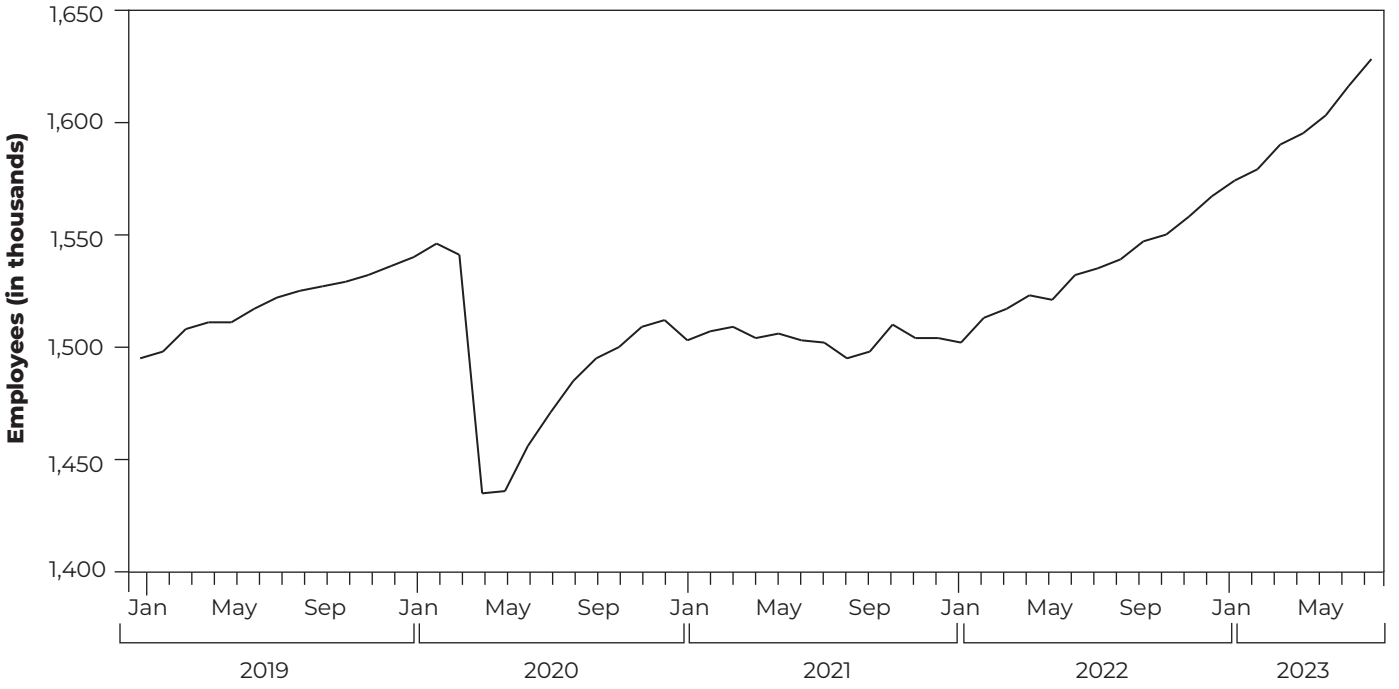
	July 1, 2017–June 30, 2018	July 1, 2018–June 30, 2019	July 1, 2020–June 30, 2021	July 1, 2021–June 30, 2022
Share of home health stays that were initiated in a timely manner	94.6%	95.5%	95.7%	95.9%

Note: Data include Medicaid, Medicare Advantage, and Medicare fee-for-service patients.

Source: Home Health Compare, 2023.

FIGURE 7–2

After a sharp decline in March 2020, employment rose above prepandemic levels for the sector of the economy that includes Medicare HHAs and other, non-Medicare home medical service providers



Note: HHA (home health agency). This figure includes employment for establishments classified by the North American Industry Classification System (NAICS) as home health care services (NAICS 6216). Under NAICS, home health care services comprise a broad array of home care establishments, including not only Medicare HHAs but also establishments that provide other in-home services such as personal care services, homemaker and companion services, medical equipment and supplies, counseling, 24-hour home care, dietary and nutritional services, audiology, and other specialized care, such as intravenous therapy.

Source: Bureau of Labor Statistics 2023.

order. The date of a physician order may reflect the administrative practices of specific physicians or home health agencies. If there are delays in the completion or receipt of physician orders, a delay of care may result that is not reflected in the data. In addition, a high rate might be expected under this measure as agencies would typically only begin care after an order is completed. However, a decline in the rate could still suggest an access issue and therefore should be examined in the context of other access indicators.

Employment in the broader home care sector in 2023 was higher than the prepandemic level

Since the pandemic, some HHAs have reported that staffing shortages limit the volume of services they can provide, which in some areas may also contribute to declining use (Filbin 2023). Many of these reports may reflect local labor market conditions or other factors not observed in national labor force measures. However, the Department of Commerce's employment data on the broader medical home care sector (using a definition that includes Medicare HHAs, hospice, private duty, pediatric agencies, and other home care providers) indicate that total employment was about 5 percent higher in July 2023 than it was in February 2020, prior to the pandemic (Figure 7-2). While these data measure employment for a broader category of home care services than Medicare HHAs, the latter comprise a significant share of this sector. However, these data may not reflect labor conditions in local

TABLE 7–5

Since 2020, the average number of home health in-person visits per 30-day period has declined

Volume measure	2019	2020	2021	2022	Total change in number of visits 2019–2020	Total change in number of visits 2020–2022	Percent change 2019–2022
Total visits per 30-day period	10.2	9.2	8.8	8.6	–1.0	–0.6	–15.6%
Visits per 30-day period by discipline:							
Physical therapy, occupational therapy, and speech–language pathology	4.9	3.9	3.9	4.0	–0.9	<0.1	–18.6
Skilled nursing	4.6	4.6	4.3	4.1	<0.1	–0.5	–10.5
Medical social services and home health aide	0.8	0.7	0.6	0.5	–0.1	–0.1	–32.3

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 later 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. "Total change in number of visits" column was calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files from 2019 through 2022.

geographic areas. Despite the rebound in employment since the pandemic, there have been concerns from home health care stakeholders that staffing remains a challenge (National Association for Home Care and Hospice 2023).

In aggregate, use of home health care in rural areas is comparable with urban areas In general, the Commission has found that, historically, per capita use of home health care services is comparable between urban and rural areas (Medicare Payment Advisory Commission 2021). In 2022, the number of 30-day periods per capita was slightly lower in rural than in urban areas, with beneficiaries in rural areas averaging 22.6 thirty-day periods per 100 FFS beneficiaries, while in urban areas the rate was 24.5 thirty-day periods per 100 FFS beneficiaries.

In-person visits during a 30-day period have declined since the PDGM was implemented, but data on telehealth services are necessary to assess services received by beneficiaries In 2022, the number of in-person visits per 30-day period was 1.6 visits fewer, or 15.6 percent lower, relative to 2019 (Table 7-5). The decline occurred in two phases: In 2020, the first year of the PDGM, the number of in-person therapy (physical, occupation, and speech-language pathology) visits per 30-day period declined by 0.9 visits (about 20 percent). A decline in therapy visits was expected following the implementation of the new PDGM, which eliminated the number of therapy visits as a factor in payment. Following this initial decline, the number of in-person therapy visits per 30-day period remained relatively steady through 2022. By contrast, there was little change in the number of skilled nursing visits per 30-day period in 2020, but the number of these visits per 30-day period decreased by 0.5 visits from 2020 to 2022. In total, therapy visits fell by 18.6 percent between 2019 and 2022, while skilled nursing visits fell by 10.5 percent. (As discussed below, the number of medical social services and home health aide services per 30-day period, which make up a small fraction of total visits, declined steadily between 2019 and 2022.)

Several factors may have contributed to the decline in visits per 30-day period since 2019. First, as noted above, changes to the incentives underlying the payment system likely resulted in changes in provider behavior. Second, fewer in-person visits could, in part, reflect trends related to the coronavirus pandemic, such as beneficiary reluctance to receive services in the home and provider staffing challenges. And growing use of telehealth services may have replaced some in-person visits. 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 coverage of telehealth was initially expanded for the duration of the public health emergency (PHE) 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 increased substantially during the coronavirus pandemic, surging at the beginning and receding in later months. Unfortunately, data were not available to assess the use of telehealth visits in 2020 through 2022. In 2023, CMS began requiring HHAs to report telehealth services, consistent with our recommendation in the March 2022 report to the Congress.[5]

Since the implementation of the home health PPS in 2000, the number of home health aide visits provided during a typical stay has declined (data not shown). In recent years, this decline continued, falling from 0.8 visits per 30-day period in 2019 to 0.5 visits per 30-day period in 2022. This decline has raised concerns that FFS Medicare beneficiaries are not receiving services they are entitled to under the Medicare home health benefit (Center for Medicare Advocacy 2019). In CMS's 2024 final rule, the agency highlighted industry and beneficiary stakeholder comments that discussed the reasons for the decline (Centers for Medicare & Medicaid Services 2023). Some commenters contended that FFS Medicare's payment policies do not adequately compensate HHAs for providing care to the patients with the highest need for aide services, and they cited challenges in hiring, training, and retaining aides. One comment to CMS noted that sometimes nurses or occupational therapists provide services typically furnished by a home health aide, raising the possibility that some of the decline in home health aide visits since 2000 represents a shift of these services to skilled nursing or therapist visits. In addition, commenters raised concerns that, to maximize financial performance, agencies were avoiding patients who need extensive aide services.

Like other Medicare PPSs, the home health PPS creates a financial incentive for agencies to limit the number of services they furnish per period. However, the average cost per visit of a home health aide is lower than the skilled nursing and therapy services provided during home health care. Like these other services, FFS Medicare's base payment rate includes the costs of home health aide services. Further, the average freestanding HHA has had a FFS Medicare margin in excess of 16 percent since 2001. The relatively low cost of home health aide services and high FFS Medicare margins for freestanding agencies indicate that FFS Medicare payment levels should be adequate to cover the costs of beneficiaries that need additional aide services.

Marginal profits

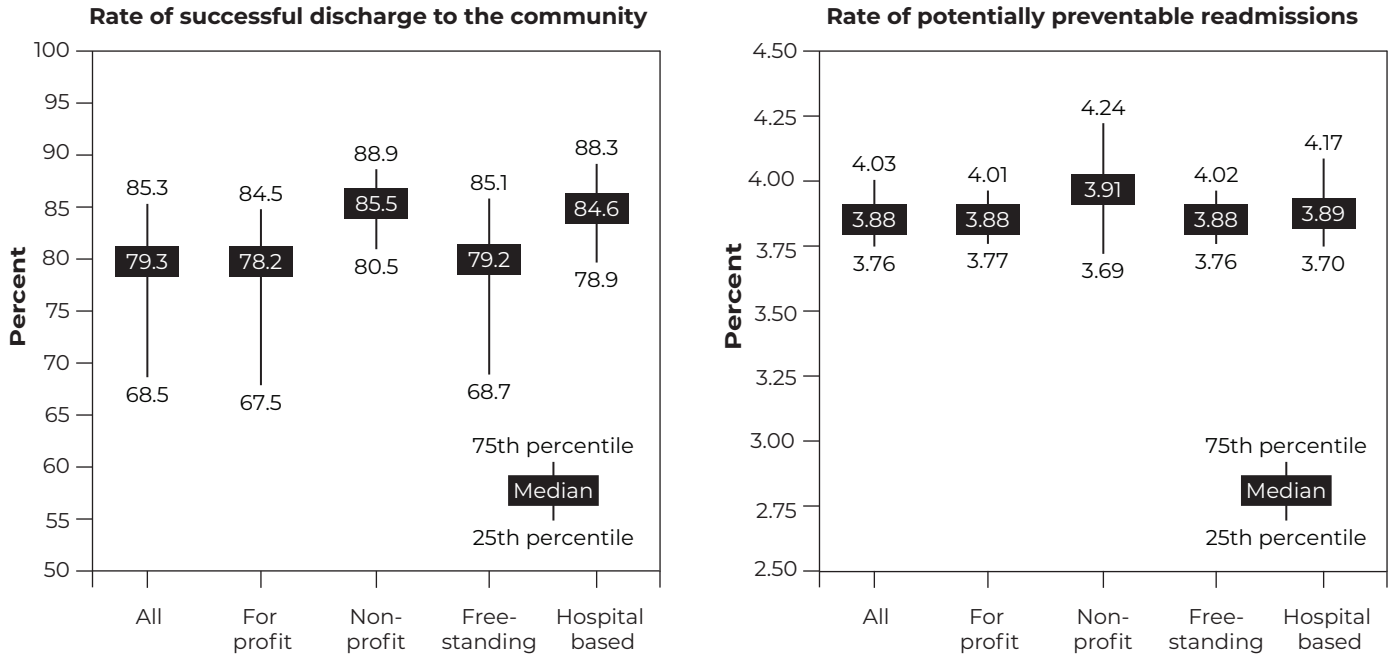
Another measure of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If FFS Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of FFS Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for FFS Medicare beneficiaries.[6] In 2022, the average marginal FFS Medicare profit for freestanding HHAs was 23 percent, indicating that these HHAs have a strong incentive to serve FFS Medicare beneficiaries.

Quality of care: Discharge to the community and potentially preventable readmissions

The Commission prioritizes quality measures tied to clinical outcomes in our assessment of payment adequacy. This year, we report two outcome measures for HHAs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community. We are replacing prototype cross-sector measures developed by the Commission, which we have previously used in our analysis of payment adequacy, with these similar

FIGURE 7–3

Median and interquartile ranges of HHAs' risk-standardized rates of successful discharge to community and potentially preventable readmissions



Note: HHA (home health agency). The measure of successful discharge to the community is an HHA's risk-standardized rate of fee-for-service (FFS) patients who were discharged to the community after a home health stay, did not have an unplanned admission to an acute care or long-term care hospital in the 31 days following discharge, and remained alive during those 31 days. All FFS Medicare patients, regardless of whether the home health stay was preceded by a hospitalization, are included in the calculation of the measure. Higher rates are better. The measure of potentially preventable readmission is calculated only for FFS home health patients who had an acute inpatient discharge within the five days before the start of their home health stay. For those patients, the measure is calculated as the risk-adjusted percentage who were readmitted to an acute care hospital during the 30 days following the start of the home health stay 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. Data for successful discharge cover the two-year period from January 1, 2021, to December 31, 2022; data for potentially preventable readmissions cover 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.

claims-based outcome measures developed by CMS. CMS outcome measures are the product of a transparent, expert-informed measure development process and have undergone public notice. They have and will be refined over time to incorporate improvements. CMS publicly reports facility-level measures after providers have the opportunity to review the data.

The return to the home or community quality measure shows the rate at which patients returned from the HHA and remained alive without any unplanned hospitalizations in the 31 days following discharge from the HHA (higher rates are better). This rate includes both community-admitted and posthospital home health beneficiaries. The median rate of discharge to the community declined from 82.6 percent in the period from January 1, 2018, to December 31, 2019, to 79.3 percent in the period from January 1, 2021, to December 31, 2022. 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 (Figure 7-3).

Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from home health care services who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages

TABLE 7–6 **Rate of hospitalization after the initiation of home health care declined slightly**

	January 1, 2019–December 31, 2019	July 1, 2020–June 30, 2021	January 1, 2022–December 31, 2022
Share of FFS Medicare beneficiaries hospitalized within 60 days of initiating home health care	15.4%	14.2%	14.2%

Note: FFS (fee-for-service). CMS's all-cause hospitalization measure covers a 60-day period of home health care, includes hospitalizations and rehospitalizations for any cause (not only potentially preventable conditions), and includes both community-admitted and posthospital home health stays.

Source: Medicare Compare, 2019–2022.

are better; a home health stay had to be preceded by a hospital stay to be included in this measure). 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 the July 1, 2020, to December 31, 2022, period, the HHAs at the 25th percentile and 75th percentiles had potentially preventable rehospitalization rates of 3.76 percent and 4.03 percent, respectively (Figure 7-3, p. 213).

While the rate of potentially preventable hospitalizations was relatively low overall, an all-cause measure of hospitalization indicates that about 14.2 percent of FFS Medicare beneficiaries experienced a hospitalization in the first 60 days of home health care in 2022 (Table 7-6). Compared with the potentially preventable rehospitalization measure, the all-cause hospitalization measure captures the care experience for a broader range of home health care services: The measure covers a 60-day period of care, includes hospitalizations and rehospitalizations for any cause (not only potentially preventable conditions), and includes both community-admitted and posthospital home health stays.

Most patient experience measures remained stable in 2022

HHAs collect Home Health Care Consumer Assessment of Healthcare Providers and Systems® (HH–CAHPS®) surveys from a sample that includes FFS Medicare, MA, and Medicaid patients served by HHAs.[7] The HH–CAHPS measures key components of quality by assessing whether something that should happen during a stay (such as clear communication) actually happened. These data include beneficiaries admitted to home health care from the community or after a stay at an inpatient hospital or inpatient PAC provider.

HH–CAHPS ratings in 2022 were comparable with prior years on most measures; the same share of patients in 2021 and 2022 reported positive responses for three of the measures (Table 7-7). (Data for 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) they would definitely recommend the HHA and (2) HHAs discussed medicines, pain, and home safety increased by 1 percentage point (Table 7-7).

Patient function is a key HHA outcome, but the Commission has questioned the accuracy of function information reported by post-acute care providers

Maintaining and improving patients' functional status is a key outcome of PAC. HHAs assess and record information on each beneficiary's level of function at admission and discharge from home health care using the Outcome and Assessment Information Set (OASIS). Provider-reported function data are used to assign patients to case-mix groups to adjust payments, and these data affect whether an HHA receives a penalty or a bonus under value-based purchasing (VBP). For these reasons, HHA-reported function data from OASIS

TABLE 7–7

Most patient experience measures did not change in 2022

HH–CAHPS® measure	2019	2021	2022	Percentage point change, 2021–2022
Share of patients rating the home health agency a 9 or 10 out of 10	84%	84%	84%	0
Share of patients who would definitely recommend the home health agency to friends or family	78	77	78	+1
Share of patients who reported that their home health provider:				
Gave care in a professional way	88	88	88	0
Communicated well with them	85	85	85	0
Discussed medicines, pain, and home safety with them*	83	81	82	+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 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. Data include FFS Medicare, Medicare Advantage, and Medicaid beneficiaries.
*This measure averages seven HH-CAHPS® questionnaire items that ask whether HHAs discussed prescription medicines, pain, and home safety with beneficiaries.

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

should be interpreted carefully. For example, a 2017 assessment of a Medicare home health VBP program found that agencies refined their assessment practices, raising the possibility that some of the better functional outcomes observed in the program reflected agency assessment practices and not improved outcomes (Pozniak et al. 2018). This finding contributes to the Commission's ongoing concerns about the integrity of function information reported by HHAs and other PAC providers. As we noted in our June 2019 report to the Congress, providers' recording of functional assessment information, such as change in mobility, appear to be influenced by incentives in the applicable payment systems rather than objective assessments of patients' function (Medicare Payment Advisory Commission 2019).

Because functional outcomes are critically important to patients receiving PAC, the Commission has discussed strategies to improve the assessment data, the importance of monitoring the reporting of these data, and the use of alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019). While current provider-reported patient function information is flawed, beneficiaries and policymakers have a strong interest in objective information about HHAs' effectiveness in improving or maintaining their patients' functional abilities. The ability to monitor patient function is especially important given the ongoing changes in delivery of care that have occurred since the implementation of the PDGM.

Providers' access to capital is adequate

In 2022, the all-payer margin for freestanding HHAs averaged 7.9 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 many 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 past years, the Commission examined public financial statements to assess access to capital, but since 2021, three of the largest publicly traded companies were acquired by MA insurance companies and no longer report detailed results for Medicare home health services. One of the largest remaining publicly traded home health companies, Enhabit Incorporated, reported that it is assessing strategic options which may include a "potential sale, merger, or other strategic transaction" (Enhabit Home Health & Hospice 2023).

The acquisition trends suggest that the home health industry has been attractive to outsider investors. In 2021, Humana completed its purchase of Kindred at Home (Waddill 2021). In 2023, Optum Health Care, a subsidiary of UnitedHealth Group, purchased LHC Group and entered into an agreement to purchase Amedisys (Pifer 2023). According to industry analysts, these acquisitions reflect several trends, including efforts to expand population-based health care services, better manage spending on and utilization of home health care services, and capture revenues that are paid to providers for services to plan beneficiaries (Irving Levin Associates 2023, Pifer 2023).

Private equity firms own many home health agencies, but measuring private equity's role in the sector is complicated by limitations in ownership data. As we noted in our June 2021 report to the Congress, Medicare providers can have complex ownership structures that make it challenging to identify the parent owner (Medicare Payment Advisory Commission 2021). As a result, efforts to identify private equity ownership may reflect analytic criteria unique to each analysis and may vary depending on the approach followed to resolve ambiguities in ownership structure. One recent analysis concluded that 5.7 percent of Medicare HHAs were owned by such firms in 2023 (Moss and Viera 2023). In recent years, private equity firms have accounted for a significant share of investment activity. An analysis by the Braff Group indicated that private equity's share of annual reported home health care and hospice transactions (buying or selling of agencies) increased from about 20 percent in 2013 to about 50 percent in 2021, though it appears that private equity's share of home health care transactions may have declined since 2021 (Braff Group 2022a, Braff Group 2022b). While the pace of private equity investment in health care appears to have slowed in 2022, the home health care sector is still viewed as likely to attract interest from private equity investors in the future (Irving Levin Associates 2023).

About 6 percent of HHAs were owned by a hospital or other provider (such as a skilled nursing facility) in 2022. Among health systems, ownership of a PAC service is common, with one study finding that 80 percent of health systems operate an HHA or SNF. Studies suggest that integration of home health and other PAC services can lead to better quality and lower costs (Hogan et al. 2020, Kalata et al. 2023).

In the last 10 years, freestanding HHAs' all-payer revenues have generally increased, but the share of revenues coming from FFS Medicare has declined. In 2013, the average freestanding HHA had total revenue of $3.7 million; the average increased to $4.8 million in 2022. FFS Medicare accounted for 58 percent of the average freestanding HHA's revenues in 2013, but by 2022 that share had declined to 49 percent for the average freestanding agency. Some of the decline in FFS Medicare's share of total revenue may reflect HHAs serving more Medicare beneficiaries through the MA program as enrollment in MA plans has increased. If the shift of beneficiaries from FFS Medicare to MA continues, freestanding agencies' share of revenues from FFS Medicare will continue to decline. While the costs and payments for MA enrollees are included in the all-payer data that HHAs report to CMS, HHAs are not required to report these financial measures for the MA population separately. As a result, it is not possible to compute HHAs' MA margins from the Medicare cost report. However, since HHAs' all-payer margins are significantly lower than FFS Medicare margins, it is likely that other payers, including MA plans, pay less than FFS Medicare. HHAs have stated that payment rates from MA plans are lower than HHAs' costs of providing home health care services (Dombi 2023).

Medicare payments and providers' costs: FFS Medicare margins remain high

In 2022, the aggregate Medicare FFS margin for freestanding HHAs was 22.2 percent, down from 24.9 percent in 2021—the historic high. FFS Medicare margins varied across providers but were positive for most.

TABLE 7–8

Total FFS Medicare expenditures for home health care services declined in 2022, but payments per in-person visit increased

					Average annual percent change		
	2019	2020	2021	2022	2019–2022	2021–2022	Cumulative change
Total FFS payments (in billions)	$17.9	$17.1	$16.9	$16.1	–3.4%	–4.4%	–10.0%
Total in-person visits (in millions)	99.7	81.1	76.8	69.5	–11.3	–9.6	–30.3
FFS payment per in-person visit	$180	$211	$220	$232	8.9	5.8	28.9
Payment per FFS Medicare beneficiary who received home health care	$5,437	$5,591	$5,588	$5,703	1.6	2.1	4.9

Note: FFS (fee-for-service). Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

HHAs continue to curb per period costs by reducing visits

In 2022, total FFS Medicare spending for home health care declined by 4.4 percent to $16.1 billion relative to the prior year (Table 7-8). The decline likely reflects several factors affecting utilization that were noted previously: decreased FFS Medicare enrollment, fewer hospitalizations leading to fewer post-acute admissions to home health, and increased SNF use by beneficiaries who have been hospitalized. Though total FFS Medicare payments for home health care declined between 2019 and 2022 by 10 percent, the average payment per FFS user of home health care has risen 4.9 percent over the period, while the average payment per in-person visit has climbed 28.9 percent, increasing from $180 per visit to $232.[8]

A decline in the number of in-person visits per 30-day period is a substantial factor in the higher payment per visit observed in 2020 and later years. When setting the PDGM base rate for 2020, 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 2022.[9] The base rate also does not reflect the shift to a less costly mix of services that occurred after 2019 due to the drop in therapy services. If telehealth visits had been counted, the 2022 per visit payment increase would likely have been somewhat lower, but HHAs were not required to report telehealth services until July 2023. The per visit payment increase also reflects other payment policies in 2020 through 2022, including 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.

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

TABLE 7–9

FFS Medicare margins for freestanding home health agencies declined in 2022 but remained high, 2021–2022

	2021	2022	Share of home health agencies, 2022	Share of periods, 2022
All	24.9%	22.2%	100%	100%
Geography				
Majority urban	24.8	22.2	85.4	86.0
Majority rural	25.2	21.8	14.6	14.0
Type of ownership				
For profit	26.1	23.5	92.5	86.4
Nonprofit	20.2	15.8	7.5	13.6
Volume quintile				
First (smallest)	14.0	13.4	20	2.7
Second	15.9	14.4	20	6.3
Third	19.3	17.0	20	11.0
Fourth	22.8	20.9	20	19.5
Fifth (largest)	28.3	24.7	20	60.5

Note: FFS (fee-for service). Home health agencies (HHAs) were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and 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 coronavirus pandemic. Percentages reflect rounding and may not sum to 100 percent.

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

of the home health PPS that led to years of payments well in excess of costs.

In 2022, the average cost per 30-day period increased by 4.0 percent for freestanding HHAs, a reversal of the trend we observed in 2021, when cost per period declined by 2.9 percent. This increase in 2022 was due to higher costs per visit, but the increase was offset by a reduction in the number of in-person visits provided. Historically, the increase in average cost per unit of payment for HHAs has been less than the rate indicated by the home health market basket. For example, between 2017 and 2019, the annual increase in cost per 60-day episode averaged 1.4 percent, while the home health market basket averaged 2.6 percent over the same period.

The aggregate FFS Medicare margin for freestanding HHAs was over 20 percent in 2022

In 2022, the aggregate FFS Medicare margin for freestanding HHAs was 22.2 percent (Table 7-9). The margin ranged from 5.6 percent for those at the 25th percentile to 31.8 percent at the 75th percentile of the margin distribution (data not shown). For-profit HHAs had higher margins than nonprofit HHAs, and urban HHAs had slightly higher margins than rural HHAs. Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, the margin for HHAs in the bottom quintile of volume averaged 13.4 percent, compared with a 24.7 percent margin for HHAs in the top quintile of volume. While there is variation in agency financial performance, FFS Medicare payments

TABLE 7–10

Home health PPS payment policy changes in 2023 and 2024

	2023	2024
Home health PPS policy changes:		
Home health market basket	4.0%	3.0%
Productivity	–0.1	–0.3
Budget-neutrality adjustment under BBA of 2018	–3.925	–2.890
Outlier threshold adjustment	0.2	0.2
Total	**0.1**	**0.2**

Note: PPS (prospective payment system), BBA (Bipartisan Budget Act). The effects of the home health PPS policy changes are multiplicative and do not sum to the total.
Source: MedPAC analysis of home health final rules for 2023 and 2024.

are well in excess of HHA costs. These overpayments have consequences for the Medicare program, as they increase the financial pressure on the Medicare trust funds and increase the Part B premium paid by Medicare beneficiaries.

The Commission includes hospital-based HHAs in its calculation of acute care hospitals' FFS Medicare margins because these agencies operate in the financial context of hospital operations. In 2022, FFS Medicare margins for hospital-based HHAs were –17.0 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.

FFS Medicare margin for 2024 projected to decline relative to 2022 but remain near 20 percent

In modeling 2024 FFS Medicare margins, we incorporate policy changes that will go into effect between the year of our most recent data, 2022, and the year for which we are making the margin projection, 2024. Table 7-10 shows the major payment policy changes in 2023 and 2024, including a permanent reduction to the base payment rate of 2.89 percent, as required to maintain budget neutrality following the implementation of the PDGM classification system and associated changes to the PPS. On the basis of these policies and assumptions, the Commission projects a FFS Medicare margin of 18 percent in 2024.

The annual increase in cost per 30-day period has fluctuated significantly since the PDGM was implemented. In 2021, the cost per 30-day period declined by 2.9 percent, while in 2022, the cost per 30-day period increased 4.0 percent. The Commission's projected margin assumes that the rate of cost inflation for 2023 will be 4.0 percent, equal to the increase observed in 2022. For 2024, the Commission assumes that costs will increase by 0.55 percent, the average of the increases in 2021 and 2022.

While our assumption of cost growth for 2024 is lower than the level of inflation projected by the home health market basket, it takes into consideration that, historically, annual cost increases in this industry have often been lower than anticipated. As noted earlier, cost per period in 2021 declined by 2.9 percent relative to 2020. In 2011 to 2019—the last 9 years that the 60-day payment episode was in effect—the average increase in cost per episode was about 0.5 percent per year.

How should FFS Medicare payments change in 2025?

In considering how payments should change, we note that current law is expected to increase home health payment rates by 2.7 percent in 2025 (an estimated

market basket increase of 2.9 percent minus a productivity adjustment of 0.2 percent). CMS will revise its estimates before the publication of the final rule. However, our payment adequacy indicators for FFS Medicare home health services are generally positive, and payments continue to substantially exceed costs, as they have for many years. These excess payments do not accrue to the advantage of beneficiaries or the Medicare program. Further, the high aggregate margin indicates that the home health PPS reduces the 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 2.890 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 2.890 percent to keep spending at the level required by law. We note that, even after such a reduction, payments to HHAs would remain far above costs.

RECOMMENDATION 7

For calendar year 2025, the Congress should reduce the 2024 Medicare base payment rates for home health agencies by 7 percent.

RATIONALE 7

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, FFS 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. Medicare has overpaid for home health care since the inception of prospective payment in 2000, and these overpayments create higher expenditures for the beneficiary and the Medicare program. The aggregate FFS Medicare margin was 22.2 percent in 2022, and we project that it will remain near 20 percent in 2024.

A 7 percent reduction to the FFS base payment in 2025 would significantly address the magnitude of excess payments embedded in FFS Medicare's home health payment rates. However, this reduction would likely be inadequate to align Medicare payments with providers' actual costs. Though the coronavirus public health emergency was a disruption for HHAs, it did not significantly change the industry's financial outlook; in fact, FFS Medicare margins in 2022 were much higher than in 2019.

IMPLICATIONS 7

Spending

- This recommendation would decrease federal program spending by $750 million to $2 billion in 2025 and by $5 billion to $10 billion over five years.

Beneficiary and provider

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

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 An overview of the home health PPS is available at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_HHA_FINAL_SEC.pdf.

3 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 in which an HHA has provided services in the past 12 months.

4 On a per capita basis, the use of inpatient hospital services in FFS Medicare has declined by 20 percent since 2018.

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

6 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 = (payments for FFS Medicare services – (total FFS Medicare costs – fixed building and equipment costs)) / FFS Medicare payments.

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

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

8 These amounts of payment per visit 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).

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

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