CHAPTER 8

Home health care services

RECOMMENDATION

8 For calendar year 2027, the Congress should reduce the 2026 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 2024, about 2.7 million fee-for-service (FFS) Medicare beneficiaries received home health care, and the program spent $16.0 billion on those services. In that year, there were over 12,000 HHAs certified to participate in Medicare.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for home health care were positive in 2024.

***Beneficiaries' access to care*—**Supply and volume indicators show that FFS Medicare beneficiaries have good access to home health care.

- ***Capacity and supply of providers*—**In 2024, over 97 percent of FFS Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 86 percent lived in a ZIP code served by five or more HHAs. The share of general acute care hospital discharges that were followed by at least one 30-day home health period jumped to 20.1 percent in the first year of the coronavirus pandemic and then declined, reaching 18.0 percent in the first 10 months of 2024, but the share remains higher than the rate for 2019 (15.8 percent). The number of HHAs

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participating in the Medicare program increased by 1.5 percent in 2024. However, this increase was due almost entirely to growth in the number of HHAs in California, with the highest growth in HHAs in Los Angeles County. Many stakeholders, including the California state auditor, have suggested that the aberrant pattern of HHA supply and utilization in Los Angeles County raises program-integrity concerns. Excluding California, the number of participating HHAs declined by 1.0 percent in 2024.

- ***Volume of services*—**The number of 30-day periods per 100 FFS Medicare beneficiaries increased slightly in 2024, by 2.6 percent, and the number of full 30-day periods per FFS user of home health was stable at 3.1. The average number of in-person visits per 30-day period was steady at 8.3 in 2024.

***Quality of care*—**During the two-year period from January 1, 2022, to December 31, 2023, the median risk-adjusted rate of discharge to the community from HHAs was 80.6 percent, an increase (improvement) of 1.3 percentage points relative to the median from January 1, 2021, to December 31, 2022. The median rate of potentially preventable readmissions after discharge was 3.8 percent from January 1, 2021, to December 31, 2023.

***Providers' access to capital*—**Home health care agencies are generally not as capital intensive as many other provider types because they do not require extensive physical infrastructure. In 2024, the all-payer margin for freestanding HHAs was 5.0 percent, indicating that many HHAs yielded positive financial results that should appeal to capital markets. According to industry reports, investor interest in home health care services has slowed since 2023, but the slowdown comes after a peak period for HHA mergers and acquisitions.

***FFS Medicare payments and providers' costs*—**The FFS Medicare margin for freestanding HHAs averaged 21.2 percent in 2024. This margin indicates that FFS Medicare payments in 2024 far exceeded costs, as they have for more than 20 years; the FFS Medicare margin for freestanding agencies averaged 17.2 percent from 2001 to 2023. The average payment per full 30-day period increased 1.6 percent in 2024. Cost per 30-day period was relatively stable in 2024, rising just 0.2 percent because growth in costs per visit were offset by a reduction in the number of in-person visits per 30-day period. We project a FFS Medicare margin of 19 percent for freestanding HHAs in 2026.

How should payments change in 2027?

Our review indicates that FFS Medicare 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 payments need to be reduced to align aggregate payments more closely with aggregate costs. The Commission recommends that, for 2027, the Congress reduce the 2026 Medicare base payment rate for home health agencies by 7 percent. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include home health agencies (HHAs) that furnish skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work to beneficiaries in their homes.

Background

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 (SNF) 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 2024, about 2.7 million FFS Medicare beneficiaries received home care, and the program spent $16.0 billion on home health care services under the home health prospective payment system (PPS).

FFS Medicare requires that a physician, nurse practitioner, clinical nurse specialist, or physician assistant certify a patient's eligibility for home health care.[1] FFS Medicare also requires that a beneficiary have a face-to-face encounter with a doctor or other allowed practitioner that is related to the primary reason for 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 case-mix 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).[2] Thirty-day periods with relatively few visits are paid on a per visit basis through a low-use payment adjustment (LUPA); the threshold for the LUPA varies from two to five in-person visits, depending on the payment group to which a 30-day period has been assigned. Full 30-day periods—periods that meet or exceed the LUPA threshold—receive the full case-mix-adjusted 30-day payment under the PDGM. These periods accounted for about 93 percent of volume in 2024 (about 7 percent of 30-day periods were subject to the LUPA).

The BBA of 2018 requires that the Commission assess the impact of the changes to the home health PPS on agency payments and costs and on the delivery and quality of care. The Act also requires the Commission to provide interim and final reports to the Congress. In March 2022, the Commission submitted its interim report, which described recent changes in use and costs of care that occurred in 2020 but noted that any observed initial impact of the new payment system was confounded by the disruptions associated with the coronavirus public health emergency (Medicare Payment Advisory Commission 2022). The Commission's final report examining the impact of the BBA of 2018 changes is in Chapter 14 of this report to the Congress.

Home health payments have historically been high relative to costs

Since the implementation of the home health PPS, FFS Medicare payments for home health care have consistently exceeded costs. In 2001—the first year of the PPS—freestanding HHAs reported an average FFS Medicare margin of 23 percent.[3] (The FFS Medicare margin measures how an agency's revenue from FFS Medicare patients compares with the cost of providing their care.) Although the PPS payment update has been reduced multiple times since 2001, these adjustments have not fully addressed the excess payment levels. In addition, HHAs have been able to mitigate cost increases by reducing the number of in-person visits provided. From 2001 through 2023, the average FFS Medicare margin remained high at 17.2 percent.

While the changes required by the BBA of 2018 substantially altered the home health PPS, they

were not designed to change the overall level of FFS Medicare's payments for home health care services. The Act requires CMS to set the base rate for the PDGM at a level that is budget neutral relative to 2019, when the FFS Medicare margin for freestanding agencies was 15.4 percent.

Are FFS Medicare payments adequate in 2026?

To examine the adequacy of FFS Medicare's payments for home health care, we assess beneficiary access to care (by examining the supply of home health providers and annual changes in the volume of services); quality of care; access to capital; and the relationship between Medicare's payments and providers' costs. Overall, the payment-adequacy indicators for home health care are positive.

Beneficiaries' access to care: Supply of agencies and utilization did not change substantially in 2024

The number of HHAs is one indicator of the overall size of the industry, but it is a limited measure of capacity. 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 and capacity as local conditions change. Even the number of staff directly employed by an HHA may not be an effective measure of the supply of home health care because HHAs can use contract staff to meet their patients' needs. The presence of a provider also does not measure an HHA's ability to take additional patients. For other Medicare providers, such as inpatient hospitals and skilled nursing facilities (SNFs), administrative data are available to measure occupancy, such as the share of their beds that are occupied for a given period, to assess their available capacity. However, a similar measure is not available for home health care.

Supply of HHAs did not change substantially, and almost all beneficiaries live in an area served by at least one home health agency

In 2024, 97 percent of FFS beneficiaries lived in a ZIP code served by two or more HHAs, and 86 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 FFS Medicare population. This definition may overestimate the local supply of agencies because HHAs need not serve the entire ZIP code to be counted as serving it, and this measure does not assess the capacity of agencies relative to beneficiary demand (i.e., agencies may not have capacity to serve additional beneficiaries who require home health care).[4] At the same time, the definition may understate local supply if HHAs are willing to serve a ZIP code but did not receive a request to do so in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.

From 2019 to 2024, the number of HHAs certified to participate in Medicare increased by over 870 HHAs, or almost 8 percent, climbing about 1.5 percent per year, on average; but this increase was driven entirely by growth in the number of HHAs in California, which nearly doubled over the time period (Table 8-1). The number of HHAs in California climbed 14.6 percent per year, on average, from 2019 to 2023, and an additional 269 HHAs were certified to participate in Medicare in 2024. Meanwhile, HHA supply for states and territories excluding California declined by about 1 percent per year, on average, from 2019 to 2024.

The Commission's examination of HHAs includes all providers approved by CMS to participate in Medicare, but not all approved HHAs necessarily serve FFS Medicare beneficiaries. Approval means the HHA meets federal requirements and is eligible to bill FFS Medicare, yet participation depends on the agency's business model and patient mix. Certain agencies may focus on private-pay clients or those covered by other insurance plans, even though they hold Medicare certification. As a result, some of the HHAs included in our counts do not serve FFS Medicare beneficiaries.

Most of the growth in HHAs in California has been concentrated in Los Angeles County—an area previously identified as a major hotspot for fraud, waste, and abuse in hospice services under Medicare. A 2022 report by the California State Auditor found that "growth in the number of hospice agencies in Los Angeles County has vastly outpaced the need for

TABLE 8–1 **Recent increase in home health agencies reflects significant growth in California**

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
Participating home health agencies								
Nation (all states and territories)	11,356	11,386	11,506	11,657	12,057	12,234	1.5%	1.5%
States and territories excluding California	9,823	9,691	9,665	9,257	9,412	9,320	–1.1	–1.0
California only	1,533	1,695	1,841	2,400	2,645	2,914	14.6	10.2

Source: MedPAC analysis of the CMS Provider of Services file.

hospice services" (Auditor of the State of California 2022, Centers for Medicare & Medicaid Services 2023). The sustained, multiyear increase in HHAs in the same county may raise similar concerns.

The California state auditor's report on hospice noted that home health agencies were operating in the same areas of Los Angeles County that were identified as having a "suspiciously high number of hospice agencies" (Auditor of the State of California 2022). For example, the report highlighted a 22,500-square-foot office building that housed the corporate offices of 112 hospice agencies and 49 HHAs. The auditor concluded that "based on the size of the building and our observations from visiting the building, there does not appear to be space for more than a total of 150 hospice agencies, home health agencies, and other businesses in the building." The report also flagged irregularities in inspections of HHAs conducted by the California Department of Public Health in Los Angeles County. These inspections revealed issues such as HHA staff being unavailable and patients being admitted without their knowledge or without meeting eligibility requirements for services. Industry stakeholders have also expressed concern about potential home health fraud in Los Angeles County and have urged CMS to investigate aberrant trends and take appropriate action to address program-integrity issues (Berger 2025, LeadingAge 2025, National Alliance for Care at Home 2025).

Home health care spending in Los Angeles County has risen alongside rapid HHA growth. In 2024, the county accounted for $1.4 billion—about 9 percent of total FFS home health care expenditures—even though it represents only about 2 percent of FFS Medicare beneficiaries. That year, approximately 16 percent of FFS Medicare beneficiaries in Los Angeles County received home health services—more than double the national average. It is unclear whether higher FFS Medicare home health spending reflects substitution for more costly care. For example, SNF care may be an alternative for some posthospital home health users, yet the share of FFS Medicare beneficiaries with a SNF stay in Los Angeles County was 4.9 percent in 2023, compared with a national average of 4.0 percent.

Another unusual trend in Los Angeles County is the significant number of HHAs that serve only FFS Medicare beneficiaries. Typically, HHAs serve a mix of Medicare Advantage (MA) and FFS Medicare beneficiaries, reflecting local enrollment patterns. But in Los Angeles County, more than 400 HHAs in 2022 served only FFS Medicare beneficiaries—about 38 percent of HHAs in the county (the remaining 62 percent served a mix of FFS and MA beneficiaries).[5] Nationwide, HHAs serving only FFS Medicare beneficiaries accounted for just 8 percent of agencies. This finding is particularly striking because the share of beneficiaries enrolled in MA in Los Angeles County was 61.5 percent in 2023, higher than the national average.

TABLE 8–2

In 2024, the share of FFS Medicare beneficiaries receiving home health care was steady

FFS Medicare volume	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
FFS users of home health (in millions)	3.3	3.1	3.0	2.8	2.7	2.7	–4.7%	–2.1%
Share of FFS Medicare beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.9%	7.9%	–2.1	1.0
30-day periods (in millions)	N/A	N/A	9.3	8.6	8.3	8.3	N/A	–0.5
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	25.5	24.3	24.1	24.7	N/A	2.6
30-day periods per FFS Medicare beneficiary who received home health care	N/A	N/A	3.1	3.0	3.1	3.1	N/A	1.6

Note: FFS (fee-for-service), N/A (not applicable). CMS implemented a 30-day period as the unit of payment in 2020, so no data on 30-day periods are available for 2019. Not all claims in January and February of 2020 were paid under the new Patient-Driven Groupings Model, so we do not have a full year of data on 30-day periods for 2020. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

While many factors can affect the mix of beneficiaries an HHA serves, it is unclear why the rate of FFS-only HHAs is so high in this county.

The substantial growth in HHAs within an area associated with hospice-related fraud, the higher-than-average home health utilization and spending, findings from the California State Auditor and the Department of Public Health, and concerns raised by industry stakeholders all indicate an aberrant pattern of home health care supply and utilization in Los Angeles County. Further investigation may be warranted to determine whether these trends stem from program-integrity issues.

In prior years, CMS has addressed rapid growth in HHAs by establishing a moratorium on enrollment of new HHAs, but no moratoriums are in effect in Los Angeles County or other areas. In addition, a moratorium does not address activities by HHAs that have already begun operation, but another program—the Review Choice Demonstration (RCD)—may offer an alternative. Under the RCD, HHAs are subject to a review of their claims and can select either prepayment or postpayment review. Agencies that maintain high compliance can transition to less frequent reviews. The RCD currently applies to HHAs operating in Florida, Illinois, North Carolina, Ohio, Oklahoma, and Texas through 2029.

Utilization of home health care did not change substantially in 2024

Between 2019 and 2023, the number of FFS users of home health declined almost 5 percent per year, on average, as enrollment shifted from FFS to MA and fewer FFS beneficiaries used home health services (Table 8-2). However, in 2024, the share of FFS beneficiaries using home health increased slightly, rising 1.0 percent. Accounting for changes in FFS enrollment, the average number of thirty-day periods

TABLE 8–3

In 2024, use of home health by FFS Medicare beneficiaries was higher in urban counties

	30-day periods per 100 FFS Medicare beneficiaries
Urban counties	24.8
Rural counties	
All rural counties	21.7
In micropolitan statistical areas	22.1
Not in micropolitan statistical areas	23.1
Frontier (population density less than 6 people per square mile)	11.7

Note: FFS (fee-for-service). Rural counties are classified based on the boundaries of micropolitan statistical areas established by the U.S. Census Bureau. Under the Census Bureau's definition, micropolitan statistical areas are labor-market and statistical areas in the U.S. centered on an urban cluster (urban area) with a population of at least 10,000 but fewer than 50,000 people. Micropolitan statistical areas consist of the county or counties containing the core plus any other counties with strong commuting ties to the core counties.

Source: MedPAC analysis of home health standard analytic files and Common Medicare Environment file.

also increased slightly in 2024 to 24.7 thirty-day periods per 100 FFS Medicare beneficiaries. The intensity of use among those who received home health care remained relatively stable, with each user receiving approximately 3.1 thirty-day periods of care annually from 2021 to 2024 (Table 8-2). Understanding the trends in timely access to home health care after hospitalization is important, as some studies have demonstrated that delays in the initiation of home health care can lead to adverse outcomes (Smith et al. 2021, Topaz et al. 2022). The Commission plans to analyze these trends in future analyses.

Home health utilization was lower on a per capita basis in rural areas, averaging 21.7 thirty-day periods per 100 FFS Medicare beneficiaries in rural counties compared with 24.8 thirty-day periods per 100 FFS Medicare beneficiaries for urban counties in 2023 (Table 8-3). The average use in rural counties in micropolitan statistical areas was comparable with nonmicropolitan rural counties outside these areas. While rural frontier counties had the lowest use rate compared with other areas, it is notable that rural areas also include some of the highest-utilization counties in the country. For example in 2024, 22 of the 25 counties with the highest frequency of 30-day periods per 100 FFS beneficiaries were classified as rural, demonstrating that rural areas, like urban areas, are a mix of high-utilization and low-utilization counties (data not shown).

In-person visits during a full 30-day period have declined since 2019 In 2024, there were 0.1 fewer visits per full 30-day period, or 1.6 percent fewer, relative to 2023 (Table 8-4, p. 262).[6] Since 2019, the number of visits per full 30-day period declined 18.0 percent, or 1.8 visits. The decline occurred in two phases: In 2020, the first year of the PDGM, the number of in-person therapy (physical, occupational, and speech–language pathology) visits per full 30-day period declined by 1.0 visit (almost 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, but utilization in this year was also disrupted by the coronavirus pandemic. After this initial decline, the number of in-person therapy visits per full 30-day period remained relatively steady through 2024. By contrast, there was little change in the number of skilled nursing visits per full 30-day period in 2020 relative to the prior year, but the number of these visits per 30-day period decreased by 0.5 visits from 2020 to 2024. (The number of medical

TABLE 8–4

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

Volume measure	2019	2020	2021	2022	2023	2024	Cumulative percent change 2019–2024	Percent change 2023–2024
Total in-person visits (in millions)	99.7	81.1	76.8	69.5	66.8	65.4	–34.4%	–2.1%
Total in-person visits per full 30-day period	10.2	9.2	8.8	8.6	8.5	8.4	–18.0	–1.6
In-person visits per full 30-day period by discipline:								
Physical therapy, occupational therapy, and speech–language pathology	4.9	3.9	3.9	4.0	3.9	3.8	–21.5	–2.2
Skilled nursing	4.6	4.6	4.3	4.1	4.1	4.1	–11.8	–0.6
Medical social services and home health aide	0.8	0.7	0.6	0.5	0.5	0.5	–41.6	–5.9

Note: FFS (fee for service). 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. A 30-day period is classified as "full" when the number of in-person visits meets or exceeds the threshold established for the payment group to which the 30-day period has been assigned (a number that ranges from two to five in-person visits). Visit counts have been rounded. Percentages were calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files, 2019–2024.

social services and home health aide services per 30-day period, which make up a small fraction of total visits, declined by 0.3 between 2019 and 2024.)

Share of beneficiaries receiving home health care after hospitalization declined in the first 10 months of 2024 The share of hospital discharges to HHAs decreased to 18.0 percent in the first 10 months of 2024, but home health care remained the most frequent formal post-acute care (PAC) site used after discharge (Table 8-5). Before the coronavirus pandemic, SNFs were the most frequent first PAC destination among beneficiaries receiving formal PAC, with home health care services being the second-most frequent. In 2020, the two sites of care switched ranks in their share of use after an inpatient hospital stay: Use of SNF services after hospitalization fell, and use of home health care after hospitalization climbed. Since then, the share of inpatient prospective payment systems (IPPS) discharges to SNFs has increased, and the share discharged to home health care has decreased. Even so, the share of FFS Medicare beneficiaries receiving home health care after IPPS discharge in the first 10 months of 2024 was 2.2 percentage points higher than the 2019 rate (Table 8-5).

Telehealth and remote patient-monitoring services are covered under the home health care benefit but were not used by many FFS Medicare beneficiaries in 2024 Under the Medicare home health benefit, HHAs are permitted to provide two types of digital services: audio or video telehealth visits and remote patient monitoring. Though these services have been covered for several years, HHAs began mandatory reporting for digital services initiated on or after July 1, 2023.

The claims data for 2024 indicate that 2.2 percent of 30-day periods included a telehealth visit or remote patient monitoring. About 12 percent of HHAs reported providing at least one telehealth visit to a FFS Medicare beneficiary.[7] There were about 375,000 telehealth visits in 2024, with skilled nursing care accounting for about 80 percent of the visits. The small number of telehealth services furnished (less than 1 percent of all visits), and

TABLE 8–5

FFS Medicare beneficiaries' first post-acute site after an IPPS hospital stay, 2019–2024

	2019	2020	2021	2022	2023	First 10 months of 2024
Total IPPS discharges (in millions)	9.0	7.5	7.1	6.8	6.8	5.6
Share of discharges with:						
No PAC service after discharge	60.8%	59.0%	58.6%	58.4%	58.8%	58.7%
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	41.2	41.3
First PAC site following IPPS discharge (as share of total discharges):						
Skilled nursing facility	18.7	15.9	16.6	17.4	17.3	17.3
Home health agency	15.8	20.1	19.6	18.6	18.1	18.0
Inpatient rehabilitation facility	3.7	4.1	4.4	4.7	5.0	5.3
Long-term acute care hospital	0.9	1.0	0.8	0.8	0.8	0.7

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), PAC (post-acute care). MedPAC reports the first 10 months of 2024 because some home health claims that followed the IPPS discharges in the last two months of that year are not available for analysis.

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

the limited number of HHAs providing them, indicates that most clinical care in the home health benefit is still provided in person.

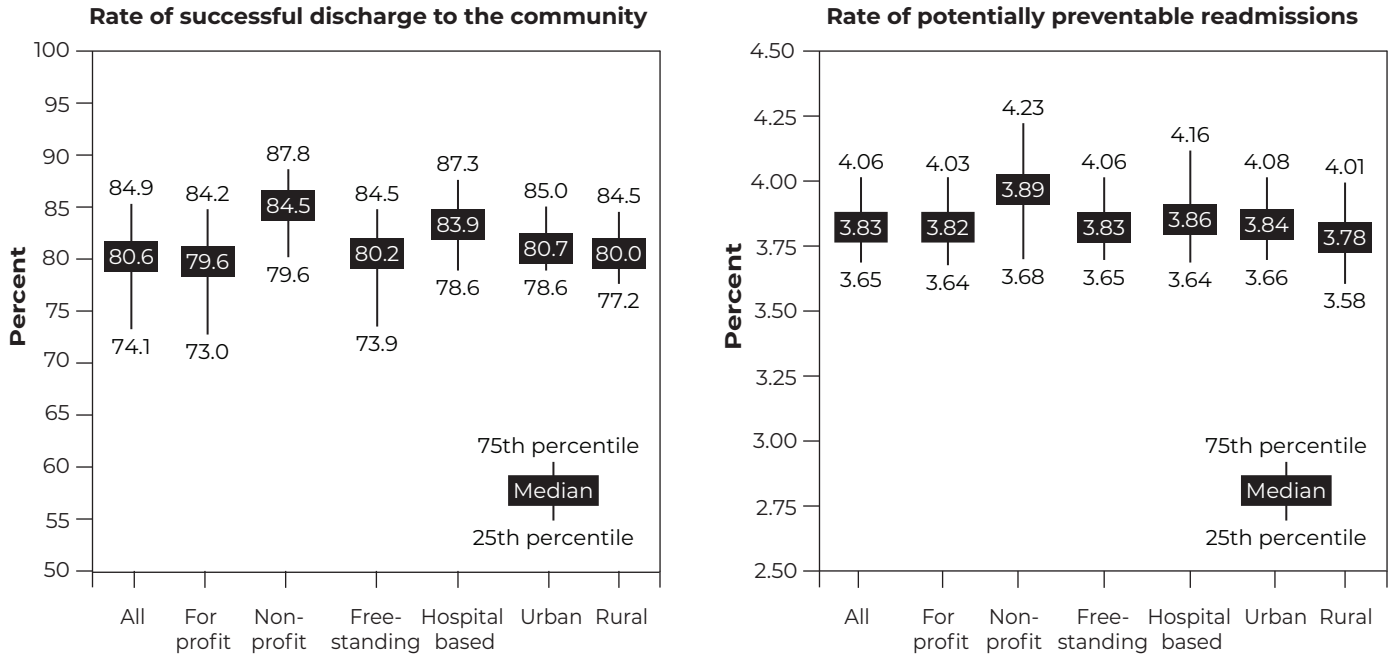
Quality of care: Discharge to the community and potentially preventable readmissions

The Commission prioritizes quality measures tied to clinical outcomes in our assessment of payment adequacy. We report two outcome measures for HHAs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community. The quality measure of the return to home or community shows the rate at which patients stay home and remain 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 increased from 79.3 percent in the period from January 1, 2021, to December 31, 2022 (data not shown), to 80.6 percent in the period from January 1, 2022, to December 31, 2023 (Figure 8-1, p. 264). The interquartile range varied more than 10 percentage points: HHAs at the 25th percentile and 75th percentile had rates of 74.1 percent and 84.9 percent, respectively (Figure 8-1, first graph). For-profit HHAs had a lower median rate of discharge to the community in 2023 compared with nonprofit HHAs.

Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from home health care services who were readmitted to a hospital for a medical condition that might have been prevented in the 30-day period beginning 2 days after the end of home health care services (lower percentages are better; a home health stay had to be preceded by a hospital stay to be included in this measure). From January 1, 2021, to December 31, 2023, the median rate of home health stays with a potentially

FIGURE 8–1

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-adjusted 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. The measure is calculated as the risk-adjusted percentage of those patients who were readmitted to an acute care hospital for a medical condition that might have been prevented in the 30-day period that begins 2 days after the end of the home health stay. Lower rates are better. Data for "successful discharge" cover the two-year period from January 1, 2022, to December 31, 2023; data for potentially preventable readmissions cover the 36-month period from January 1, 2021, to December 31, 2023.

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

preventable readmission was 3.83 percent. The median rates of potentially preventable rehospitalization did not differ substantially across ownership categories or facility type. In the January 1, 2021, to December 31, 2023, period, potentially preventable rehospitalization rates varied across the 25th and 75th percentiles with rates of 3.65 percent and 4.06 percent, respectively (Figure 8-1, right figure).

Maintaining and improving patients' function is a key outcome of post-acute care. HHAs assess and record information on each beneficiary's level of function at admission to and discharge from an HHA using the Outcome and Assessment Information Set (OASIS) patient-assessment instrument. However, because provider-reported function data are used to assign patients to case-mix groups to adjust payment, the Commission and others have raised concerns about the validity of the provider-reported patient-assessment information (see discussion in Chapter 6 of this report).

Patient-experience measures remained stable

HHAs collect Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH–CAHPS)

TABLE 8–6

Most patient-experience measures did not change in 2024

HH–CAHPS measure	2019	2020	2021	2022	2023	2024	Percentage point change 2019–2023	Percentage point change 2023–2024
Share of patients rating the HHA a 9 or 10 out of 10	84%	N/A	84%	84%	85%	85%	1	0
Share of patients who would definitely recommend the home health agency to friends or family	78	N/A	77	78	78	79	0	1
Share of patients who reported that their home health provider:								
Gave care in a professional way	88	N/A	88	88	88	89	0	1
Communicated well with them	85	N/A	85	85	86	86	1	0
Discussed medicines, pain, and home safety with them	83	N/A	81	82	82	82	–1	0

Note: HH–CAHPS (Home Health Consumer Assessment of Healthcare Providers and Systems), HHA (home health agency), N/A (not applicable). 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 due to the coronavirus public health emergency. Data include fee-for-service Medicare, Medicare Advantage, and Medicaid beneficiaries.

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

surveys from a sample that includes FFS Medicare, MA, and Medicaid patients served by HHAs. 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 both posthospital and community-admitted home health beneficiaries.

HH–CAHPS ratings in 2024 were relatively stable compared with prior years, and most patients reported high rates of positive responses.[8] (Data for 2020 are unavailable because CMS waived the requirement to collect HH–CAHPS data for the first six months of 2020 due to the coronavirus public health emergency.) The share of patients reporting (1) that they would definitely recommend their HHA to friends or family and (2) that their HHA provided care in a professional way increased by 1 percentage point in 2024 (Table 8-6).

Providers' access to capital is adequate

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. Yet indicators suggest that HHAs have adequate access to capital. One measure the Commission assesses is the overall profitability of HHAs, which examines the profitability for all health care payers that HHAs serve (including FFS Medicare, MA, and other payers). In 2024, the all-payer margin for freestanding HHAs was 5.0 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. Few HHAs access capital through publicly traded shares or through public debt such as issuance of bonds.

While there has been significant acquisition activity by the larger for-profit firms in recent years, there

TABLE 8–7

FFS Medicare spending for home health care was steady in 2024

FFS Medicare volume	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
Total payments (in billions)	$17.9	$17.1	$16.9	$16.2	$15.9	$16.0	–3.0%	1.1%
Payment per FFS Medicare user of home health care	5,437	5,591	5,587	5,703	5,839	6,031	1.8	3.3
Average payment per full 30-day period	N/A	N/A	1,945	2,010	2,024	2,057	N/A	1.6
Medicare payment per in-person visit	180	211	220	232	237	245	7.2	3.3

Note: FFS (fee-for-service), N/A (not applicable). CMS implemented a 30-day period as the unit of payment in 2020, so no data on 30-day periods are available for 2019. Not all claims in January and February of 2020 were paid under the new Patient-Driven Groupings Model, so we do not have a full year of data on 30-day periods for 2020. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files

have been notable swings in the number of HHAs purchased by investors since 2020. In 2021 and 2022, the reported number of investor purchases increased relative to prior years, with the number of transactions lower in 2023 and 2024 (Braff Group 2024). This change may reflect several factors, such as (1) higher interest rates reducing demand from investors for acquisition, (2) large insurers having completed substantial acquisitions that met their needs for capacity in this sector, and (3) changes in the home health market such as increasing MA enrollment or the BBA of 2018 budget-neutrality adjustments to FFS Medicare payments.

Even with the decrease in interest since 2023, some firms continue to expand their operations. For example, in 2025, Addus Homecare completed a $21.3 million acquisition of home health and hospice agencies in Pennsylvania (Mertz-Taggart 2025). The Pennant Group also acquired several new agencies in California and completed a $146.5 million acquisition of HHAs from UnitedHealth Group (Marselas 2025). These acquisitions suggest that, while the overall volume of acquisitions has declined, access to capital is adequate for companies that seek to expand.

Some of the largest publicly traded HHA companies have been acquired in recent years. In 2021, Humana completed its purchase of Kindred at Home (Waddill 2021). In 2023, Optum Health Care, a subsidiary of UnitedHealth Group, completed its purchase of LHC Group, and in 2025, Optum Health Care finalized its purchase of Amedisys (Emerson 2025). According to industry analysts, these acquisitions reflect several trends, including efforts to expand population-based health care services, better management of spending and utilization of home health care services, and capturing revenues that are paid to providers for services to plan beneficiaries (Irving Levin Associates LLC 2023, Pifer 2023). The acquisitions suggest that large investors viewed the publicly traded for-profit HHAs, which receive a significant share of their revenues from FFS Medicare, as attractive investments.

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

The FFS Medicare margin for freestanding HHAs rose to 21.2 percent in 2024, up 1.4 percentage points since 2023. This increase reflects growth in the average

TABLE 8–8

FFS Medicare margins for freestanding home health agencies, 2019–2024

	2019	2020	2021	2022	2023	2024	Share of home health agencies, 2024	Share of 30-day periods, 2024
All	15.4%	20.2%	24.9%	22.2%	19.8%	21.2%	100%	100%
Geography								
Majority urban	16.1	20.0	24.8	22.3	20.0	21.3	86	87
Majority rural	14.2	21.6	25.2	22.0	18.6	20.5	14	13
Type of ownership								
For profit	17.4	22.7	26.1	23.6	21.2	23.1	93	86
Nonprofit	11.4	12.4	20.2	16.4	13.3	12.2	7	14
Volume quintile								
First (smallest)	9.7	11.6	14.0	13.7	12.5	14.4	20	3
Second	11.4	14.0	15.9	14.5	13.7	15.1	20	7
Third	13.3	17.0	19.3	17.0	14.5	17.6	20	11
Fourth	14.1	18.8	22.8	21.0	19.0	20.3	20	19
Fifth (largest)	17.5	22.4	28.3	24.8	22.1	23.2	20	60

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 they 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. Percentage changes were calculated on unrounded data. Percentages may not sum to 100 due to rounding.

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

payment per 30-day period since costs remained relatively stable. These margins indicate that FFS Medicare payments in 2024 far exceeded costs, as they have for more than 20 years.

Trends in FFS spending and cost growth

In 2024, aggregate FFS Medicare payments for home health care totaled $16.0 billion, remaining essentially unchanged from the previous year (Table 8-7). This stability marks a shift from 2019 to 2023, when total FFS Medicare payments declined. However, when adjusting for changes in FFS enrollment and the number of beneficiaries receiving home health care, payments have generally increased since 2019, with the average payment per full 30-day period increasing by 1.6 percent in 2024. As the number of in-person visits per 30-day period has declined, the average Medicare FFS payment per in-person home health visit has grown substantially, rising from $180 per visit in 2019 to $245 per visit in 2024.

Cost per full 30-day period increased by just 0.2 percent in 2024, lower growth than in previous years, as higher average costs per visit were largely offset by the reduction in the number of visits per 30-day period (data not shown).

The FFS Medicare margin for freestanding HHAs was over 20 percent in 2024

In 2024, the FFS Medicare margin for freestanding HHAs was 21.2 percent, with wide variation across HHAs (Table 8-8). The margin ranged from 5.7 percent for the HHA at the 25th percentile to 31.0 percent for the HHA at the 75th percentile of the

TABLE 8–9

Home health PPS payment policy changes in 2025 and 2026

	2025	2026
Home health PPS policy changes:		
Home health market basket	3.2%	3.2%
Productivity	–0.5	–0.8
Budget-neutrality adjustment under BBA of 2018	–1.975	–3.6
Outlier threshold adjustment	–0.4	–0.5
Total	**0.4**	**–1.4**

Note: PPS (prospective payment system), BBA (Bipartisan Budget Act). The impact of the budget-neutrality adjustment applies to all 30-day periods without the low-use payment adjustment (LUPA), and so the net reduction on aggregate payments (which include both LUPA and non-LUPA periods) for 2025 and 2026 is less than the reduction to the base rate.

Source: MedPAC analysis of home health final rule for 2025 and final rule for 2026.

margin distribution (data not shown). Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, the FFS Medicare margin for HHAs in the bottom quintile of volume averaged 14.4 percent, compared with 23.2 percent for HHAs in the top quintile of volume. While agencies' financial performance varies, FFS Medicare payments are generally well in excess of HHA costs. While home health care is a valuable service when provided appropriately and efficiently, these overpayments have consequences for the Medicare program since they increase the financial pressure on the Medicare trust funds and raise Part B premiums paid by Medicare beneficiaries.

In 2024, the average FFS Medicare margin for hospital-based HHAs was –15.2 percent. The lower FFS Medicare 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 costs in the inpatient hospital setting.

FFS Medicare margin for 2026 projected to decline relative to 2024 but remain high

In projecting 2026 FFS Medicare margins, we incorporate policy changes that will go into effect between the year of our most recent data, 2024, and the year for which we are making the margin projection, 2026. Table 8-9 shows the major payment-policy changes finalized in 2025 and 2026, including the reductions mandated by the BBA of 2018.

Under the BBA of 2018, CMS is required to make permanent adjustments (increases or decreases) when it estimates that home health care spending will deviate from the level expected absent changes made by the BBA of 2018. The statute requires temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year. In the 2026 home health final rule, CMS implemented a permanent 1.023 percent reduction to the base rate to align with the BBA of 2018 budget-neutrality target for 2026 and future years, and a temporary 3 percent reduction for the 2026 rate year to address spending above the target from 2020 to 2024.

In projecting the 2026 FFS Medicare margin, we also make an estimate of cost growth between 2024 and 2026. 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 and 2023, the cost per 30-day period increased by about 3.4 percent each year. As noted earlier, the cost per full 30-day period increased by just 0.2 percent in 2024.

We project that the FFS Medicare margin for freestanding HHAs in 2026 will be 19 percent.

How should FFS Medicare payments change in 2027?

Under current law, FFS Medicare's payment rates to HHAs are increased annually based on the projected increase in the HHA market basket, less an amount for productivity improvement. CMS will revise its estimates before setting rates for 2027; however, CMS's third-quarter 2025 projections indicate a 2.3 percent payment update in 2027 (an estimated market basket increase of 3.1 percent minus a productivity adjustment of 0.8 percent). The payment-adequacy indicators for Medicare home health services are positive and show that FFS Medicare 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 FFS Medicare program. Further, excessive FFS Medicare payments reduce the incentives for HHAs to furnish care efficiently.

As discussed above, for 2026 CMS implemented the BBA of 2018–required reduction to the 30-day period base rate to maintain budget neutrality after implementation of the PDGM classification system and associated changes to the PPS required by the BBA of 2018. Our margin estimate for 2026 includes the effects of this policy; even after this reduction, FFS Medicare payments to HHAs would remain far above costs.

RECOMMENDATION 8

For calendar year 2027, the Congress should reduce the 2026 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. Home health care can be provided at lower costs than institutional care, and Medicare beneficiaries often prefer to receive care at home. However, FFS Medicare's payments for home health services are too high, and payments need to be reduced to align aggregate payments more closely with aggregate costs. FFS Medicare has overpaid for home health care since the inception of the prospective payment system in 2000, and these overpayments create higher expenditures for the taxpayers and the Medicare program. The FFS Medicare margin was 21.2 percent in 2024. We project that, after CMS implements the BBA of 2018–required adjustments to the base payment rate, the FFS Medicare margin will be 19 percent in 2026.

This recommendation is not intended to be additive to the BBA of 2018 adjustments. Under this recommendation, the base rate for 2027, net of all payment changes, would be 7 percent lower than the 2026 base rate.

IMPLICATIONS 8

Spending

- Current law is expected to increase payment rates by 2.3 percent in 2027. This recommendation would decrease federal program spending by $750 million to $2 billion over one year and by $10 billion to $25 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 Medicare 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/2024/10/MedPAC_Payment_Basics_25_HHA_FINAL_SEC.pdf.

3 Freestanding HHAs, which constituted about 95 percent of HHAs in 2024, are not owned or operated by a hospital or other health care facility. The Commission's analysis of financial performance focuses on freestanding agencies because the cost structure of facility-based HHAs may include overhead costs from parent facilities that do not reflect the cost of providing care.

4 As of November 2025, 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 ZIP codes in which an HHA has provided services in the past 12 months.

5 MedPAC assessed the trends in volume by analyzing the Outcome and Assessment Information Set, Medicare Advantage, and FFS Medicare data for each provider, similar to the approach in our June 2024 report to the Congress (Medicare Payment Advisory Commission 2024).

6 A 30-day period is classified as "full" when the number of in-person visits meets or exceeds the threshold established for the payment group to which the 30-day period has been assigned (a number that ranges from two to five in-person visits).

7 Remote patient monitoring is also covered under the FFS Medicare home health benefit, though these services were provided in only 0.1 percent of 30-day periods in 2024.

8 CMS reported a 23 percent response rate for the HH–CAHPS in 2024.

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