CHAPTER 7

Home health care services

RECOMMENDATION

7 For calendar year 2026, the Congress should reduce the 2025 Medicare base payment rate 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 2023, about 2.7 million fee-for-service (FFS) Medicare beneficiaries received home health care, and the program spent $15.7 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 2023.

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

- ***Capacity and supply of providers***—The number of HHAs participating in the Medicare program increased by 3.4 percent in 2023. However, this increase was due almost entirely to growth in the number of HHAs in Los Angeles County, California. Excluding this county, the number of participating HHAs declined by 2.8 percent. Still, in 2023 over 98 percent of FFS 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.

In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

- ***Volume of services*—**The number of 30-day periods per FFS Medicare beneficiary declined by 1.8 percent in 2023. This decline was driven by a decrease in the use of home health care after acute care hospital discharge, which increased in 2020 and then began to decline, although it remained higher in 2023 than in prepandemic years. 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 has declined since 2020, but the decline slowed in 2023.
- ***FFS Medicare marginal profit*—**Due to anomalies related to cost allocation on the home health cost report, we were unable to compute the FFS Medicare marginal profit for 2023.

***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*—**Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. In 2023, the all-payer margin for freestanding HHAs was 8.2 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. In recent years, private equity and health insurance companies have shown substantial interest in HHAs. 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 in previous years.

***FFS Medicare payments and providers' costs*—**The annual increase in cost per 30-day period has fluctuated substantially since 2020. 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. The increases resulted from higher costs per visit, but those costs were partially offset by fewer in-person visits per full 30-day period. Even with this cost increase, payments remained high: FFS Medicare margins for freestanding HHAs averaged 20.2 percent in 2023. These margins indicate that FFS Medicare payments in 2023 far exceeded costs. In aggregate, Medicare's payments have been substantially greater than costs for more than 20 years. From 2001 to 2022, the FFS Medicare margin for

freestanding HHAs averaged 17.1 percent. We project a FFS Medicare margin of 19 percent for 2025.

How should payments change in 2026?

Our 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 2026, the Congress should reduce the 2025 base payment rate by 7 percent. ■

Background

Medicare home health care services consist 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 2023, about 2.7 million fee-for-service (FFS) Medicare beneficiaries received home care, and the program spent $15.7 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 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 of 2018 (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 care 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 and accounted for about 93 percent of volume in 2023 (about 7 percent of 30-day periods were subject to the LUPA).

The BBA of 2018 requires the Commission to 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 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 will submit its final report on the impact of recent changes to the home health PPS in March 2026.

Home health payments have historically been high relative to costs

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first year of the PPS, average FFS Medicare margins for freestanding HHAs equaled 23 percent. (FFS Medicare margins reflect the extent to which an agency's revenue from FFS Medicare patients equals, exceeds, or falls below the cost of providing care for these patients.) FFS Medicare margins have remained high ever since the PPS was implemented, with HHAs often keeping cost growth lower than the rate of inflation projected in the home health market basket. The number of visits provided while a beneficiary has home health care has also declined over time. These factors have contributed to HHAs' high margins, which have averaged 17.1 percent over the period 2001 to 2022.

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, a year when the Commission reported high FFS Medicare margins (over 15 percent) for freestanding agencies.

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 BBA of 2018 changes. The statute requires temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year.

In the 2025 final rule for the home health PPS, CMS determined that a permanent reduction equal to 3.950 percent would be necessary to meet the BBA of 2018 budget-neutrality target for 2025 and future years. However, CMS implemented only half of the permanent reduction it identified as necessary, or a –1.975 percent adjustment for 2025. Assuming CMS's estimate of the budget-neutral level does not change, in future years CMS is required to recover the balance of any spending above the level required by the BBA of 2018 by implementing another reduction. CMS examined spending prior to 2024 (for 2020 through 2023) and found it was $4.461 billion above the budgetary targets. Future rulemakings are expected to implement the temporary adjustments to the home health base rate to cover this overage.

Are FFS Medicare payments adequate in 2025?

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, annual changes in the volume of services, and marginal profit); quality of care; access to capital; and the relationship between Medicare's payments and providers' costs. Overall, the payment adequacy indicators for home health care are positive.

Beneficiaries' access to care: Good indicators of access in 2023

Supply and volume indicators show that almost all FFS Medicare beneficiaries reside in an area with home health agencies that serve beneficiaries. 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 18.2 percent in the first 10 months of 2023 relative to the prior year but remained higher than the prepandemic rate in 2019. Data reported by HHAs to CMS indicate that 96.1 percent of home health services were initiated in a timely manner in 2023, a rate that was stable relative to 2022.

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

The number of home health agencies (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. For example, in 2023 the HHA at the 95th percentile of beneficiary census served 1,204 FFS Medicare beneficiaries, while the median HHA provided care to 114 FFS Medicare beneficiaries. 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 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. Because of these limitations, we also review other access-to-care indicators such as utilization and information on timely initiation of care reported by HHAs.

In 2023, 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 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).[3] At the same time, the definition may understate local supply if HHAs are willing to serve a ZIP code but did not

TABLE 7–1

Number of HHAs increased in 2023

	2019	2020	2021	2022	2023	Average annual percent change 2019–2023	Average annual percent change 2022–2023
Participating home health agencies	11,356	11,386	11,506	11,657	12,057	1.5%	3.4%

Note: HHA (home health agency).

Source: MedPAC analysis of the CMS Provider of Services file, home health standard analytic file, and the 2024 annual report of the Boards of Trustees of the Medicare trust funds. In previous years, MedPAC reported the number of HHAs using data from CMS survey and certification files, which are no longer available, so this report's count of HHAs in 2022 and previous years differs because of the use of the Medicare Provider of Services file.

receive a request to do so in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes. In 2023, the share of FFS Medicare beneficiaries living in a ZIP code with two or more HHAs and the share of FFS Medicare beneficiaries living in a ZIP code with five or more HHAs were similar to the rates we reported last year.

The supply of HHAs approved to operate in Medicare ("participating HHAs") increased in 2023 (Table 7-1). On a per capita basis, the number of HHAs per Medicare beneficiary (including both Medicare Advantage (MA) beneficiaries and FFS Medicare beneficiaries) has been relatively steady. A large spike in the number of HHAs in Los Angeles County, California, in 2023 drove an increase in the overall number of participating HHAs of 3.4 percent, but after excluding this county, the number of HHAs decreased by 2.8 percent relative to the prior year.

Declines in FFS Medicare home health volume and spending in 2023 reflect reductions in FFS enrollment, FFS hospitalizations, and per capita use of home health care

The total number of FFS Medicare beneficiaries using home health care and the total number of 30-day periods continued to decline in 2023, falling 4.4 percent and 3.9 percent, respectively (Table 7-2, p. 232). Much of the decline in FFS volume has been driven by a reduction in the number of beneficiaries in FFS Medicare, as a growing share of beneficiaries enroll in MA. Controlling for FFS enrollment, the number of 30-day periods in 2023 decreased by 1.8 percent. At the same time, the share of FFS beneficiaries using home health has also declined, falling 2.3 percent in 2023. Lower use of inpatient hospital care among FFS beneficiaries likely has contributed to the decline in use of home health care, since a hospital stay is a common precursor to home health care. The number of IPPS discharges per 1,000 Part A beneficiaries in FFS Medicare has generally declined since 2019, such that the per capita number of IPPS discharges in 2023 is 16.0 percent lower than in 2019 (data not shown). While fewer beneficiaries are receiving home health care services in 2023 relative to the prior year, the number of 30-day periods delivered per FFS home health user held steady at about 3.1.

Home health utilization was lower on a per capita basis in rural areas, averaging 22.1 thirty-day periods per 100 FFS Medicare beneficiaries in rural counties compared with 24.2 thirty-day periods per 100 FFS Medicare beneficiaries for urban counties in 2023 (Table 7-3, p. 233). The average use in rural counties in micropolitan statistical areas was comparable with rural counties outside these areas.

Decline in total home health care spending but increasing payments per home health user and home health visit Trends in overall FFS Medicare home health care spending tracked with utilization; spending decreased by 2.6 percent to $15.7 billion in 2023 (Table 7-2, p. 232). Medicare spending per FFS user of home

TABLE 7–2

In 2023, the share of FFS Medicare beneficiaries receiving home health care declined

FFS Medicare volume	2019	2020	2021	2022	2023	Average annual percent change 2019–2023	Average annual percent change 2022–2023
FFS users of home health (in millions)	3.3	3.1	3.0	2.8	2.7	–4.8%	–4.4%
Share of FFS beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.8%	–2.0	–2.3
30-day periods (in millions)	N/A	N/A	9.3	8.6	8.3	N/A	–3.9
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	25.5	24.3	23.9	N/A	–1.8
30-day periods per FFS Medicare beneficiary who received home health care	N/A	N/A	3.1	3.0	3.1	N/A	0.5
Visits per FFS user	2.6	2.1	2.1	2.0	1.9	–7.2	–2.5
Total payments (in billions)	$17.9	$17.1	$16.9	$16.1	$15.7	–3.2	–2.6
Payment per FFS Medicare user of home health care	$5,437	$5,591	$5,588	$5,703	$5,811	1.7	1.9
Medicare payment per in-person visit	$180	$211	$220	$232	$237	7.2	2.1

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 2024 annual report of the Boards of Trustees of the Medicare trust funds.

health care increased by 1.9 percent, reflecting slight increases in the average payment per 30-day period and in the number of 30-day periods per home health user.[4]

From 2019 to 2023, the total number of in-person home health visits delivered to FFS beneficiaries declined by 9.7 percent per year, on average. While some of this decline is due to lower rates of home health care use, another factor is the declining provision of in-person visits per full 30-day period (Table 7-6, p. 235). Though the aggregate number of in-person visits has declined, FFS Medicare spending per in-person visit has increased, climbing from $180 per visit in 2019 to $237 per visit in 2023 (Table 7-2).[5] While this FFS Medicare spending per visit calculation does not include visits provided via telehealth or remote patient-monitoring technologies (discussed on p. 235), including them would not change per visit Medicare expenditures substantially because data for 2023 (the only year of data available) indicate that only 1.2 percent of 30-day periods included telehealth or remote monitoring.

Share of beneficiaries receiving home health care after hospitalization declined in the first 10 months of 2023

The share of discharges to HHAs decreased to 18.2 percent in the first 10 months of 2023, but home health care remained the most frequent formal post-acute care (PAC) site used after discharge. Before the

TABLE 7–3

In 2023, use of home health by FFS Medicare beneficiaries was higher in urban counties

	30-day periods per 100 FFS Medicare beneficiaries
Urban counties	24.2
Rural counties	22.1
Rural counties in micropolitan statistical areas	22.2
All other rural counties (not in micropolitan statistical areas)	22.1
All counties	23.9

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.

pandemic, SNFs were the most frequent first PAC destination among beneficiaries receiving formal PAC, with home health care services being the second most frequent (Table 7-4). 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 IPPS discharges to SNFs has increased, and the share discharged to home health care has decreased. Even so, the share of FFS

TABLE 7–4

FFS Medicare beneficiaries' first post-acute care site after an IPPS hospital stay, 2019–2023

	2019	2020	2021	2022	First 10 months of 2023
Total IPPS discharges (in millions)	9.0	7.5	7.1	6.8	5.6
Share of discharges with:					
No PAC service after discharge	60.8%	59.0%	58.6%	58.4%	58.8%
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
First PAC site following IPPS discharge (as share of total discharges):					
Skilled nursing facility	18.7	15.9	16.6	17.4	17.3
Home health agency	15.8	20.1	19.6	18.6	18.2
Inpatient rehabilitation facility	3.7	4.1	4.4	4.7	5.0
Long-term acute care hospital	0.9	1.0	0.8	0.8	0.8

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), PAC (post-acute care). MedPAC reports the first 10 months of 2023 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.

TABLE 7–5

The share of home health services that were reported as initiated in a timely manner remained high in 2023

	2018	2019	2021	2022	2023
Share of home health stays that were initiated in a timely manner	94.6%	95.5%	95.7%	95.9%	96.1%

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

Source: Home Health Compare, 2024.

Medicare beneficiaries receiving home health care after IPPS discharge in the first 10 months of 2023 was 2.4 percentage points higher than the 2019 rate (Table 7-4, p. 233).

HHAs reported that most home health services were initiated in a timely manner, though measure limitations may affect results One important measure of access is the timely initiation of home health care. CMS tracks this measure based on data reported by HHAs, and the measure is included in CMS's 5-star quality rankings for HHAs. The share of home health services (including FFS Medicare and MA stays) that were reported as being initiated in a timely manner was stable at about 96 percent for the 12-month period ending June 30, 2023 (Table 7-5).[6] For this measure, home health services are considered initiated in a timely manner if the care begins on the start-of-care date ordered by the physician who referred the patient to home health care. If this date has not been indicated by the physician, care is considered timely if it begins within two days of the receipt of the referral by the HHA or, if the hospital discharge to home health care occurs after the receipt of the referral, within two days of inpatient discharge. Though these data suggest that timely access to care remains strong, the measure is subject to several limitations. The period of time in which care can begin and be considered timely is not fixed (e.g., two days after discharge), so if there are delays in sending a referral to an HHA, then care initiated with a substantial gap may be counted as timely. In addition, the date of a physician order may reflect the administrative practices of specific physicians or HHAs. 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 because agencies would typically only begin care after an order has been placed. Another limitation of this measure is that it does not reflect patients who were eligible for home health care but never received it. Nevertheless, a decline in the rate could suggest an issue with beneficiary access to home health care.

In-person visits during a full 30-day period have declined since 2019 In 2023, there were 1.7 fewer visits per full 30-day period, or 16.7 percent fewer, relative to 2019 (Table 7-6).[7] 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 visits (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. After this initial decline, the number of in-person therapy visits per full 30-day period remained relatively steady through 2023. 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 2023. In total, skilled nursing visits fell by 11.7 percent. (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 by 35.6 percent between 2019 and 2023.) The total number of in-person visits per full 30-day period declined by 1.2 percent in 2023.

Many factors may have contributed to the decline in visits per full 30-day period since 2019. As noted above,

TABLE 7–6

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

Volume measure	2019	2020	2021	2022	2023	Cumulative percent change 2019–2023	Percent change 2022–2023
Total visits per full 30-day period	10.2	9.2	8.8	8.6	8.5	–16.7%	–1.2%
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	–19.0	–0.9
Skilled nursing	4.6	4.6	4.3	4.1	4.1	–11.7	–1.3
Medical social services and home health aide	0.8	0.7	0.6	0.5	0.5	–35.6	–5.0

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. 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 (which ranges from two to six 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 through 2023.

changes in the incentives underlying the payment system likely changed provider behavior. Fewer in-person visits could also, in part, reflect trends related to the coronavirus pandemic, such as beneficiary reluctance to receive services in the home and provider staffing challenges.

Since the implementation of the home health PPS in 2000, fewer home health aide visits are provided during a typical stay. In recent years, this decline has continued, falling from 0.7 visits per 30-day period in 2019 to 0.5 visits per 30-day period in 2023 (data not shown). Some have questioned whether this decrease means that Medicare beneficiaries are not receiving services they are entitled to under the Medicare home health benefit (Center for Medicare Advocacy 2019). FFS Medicare margins for freestanding HHAs have been substantially higher than costs since the implementation of the PPS in 2000, so Medicare payments should be adequate to cover costs for needed aide services. Since aide services cost less than skilled nursing and therapy services, it is reasonable to expect agencies to maximize the use of lower-cost care.

Telehealth and remote patient-monitoring services are covered under the home health care benefit but were not used by many FFS Medicare beneficiaries in 2023

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 voluntary reporting of these services for 30-day periods beginning on or after January 1, 2023, and mandatory reporting for services initiated on or after July 1, 2023. In past years, we have noted that the lack of data has limited our ability to assess the recent changes in the number of in-person visits received by home health beneficiaries.

The claims data for 2023 (including both the voluntary and the mandatory reporting periods) indicate that 1.2 percent of 30-day periods included a telehealth visit or remote patient monitoring, and about 14 percent of HHAs provided at least one telehealth or remote patient-monitoring service to an FFS Medicare beneficiary. Skilled nursing care accounted for about 80 percent of the telehealth visits provided in 2023. The small number of beneficiaries receiving these services,

TABLE 7–7

Utilization, length of stay, and home health visits differed by home health stay type, 2021

	Community admitted	Posthospital	Difference (community admitted minus posthospital)
Total (millions)	1.8	2.0	–0.2
Average length of stay (in days)	93.9	57.9	35.9
Average visits per stay:	26.6	19.9	6.7
By discipline:			
Skilled nursing	14.9	9.0	5.9
Therapy	9.6	9.8	–0.3
Medical social work	0.1	0.1	<0.1
Home health aide	2.0	1.0	1.0
			Percentage point difference
Share of stays (in days):			
30 or less	33.0%	43.1%	–10.1
31–60	31.1	36.7	–5.6
61–120	17.9	12.3	5.7
121+	18.0	8.0	10.1
Total	100.0	100.0	N/A

Note: N/A (not applicable). A home health "stay" is a series of 30-day periods with a gap of no more than 10 days between consecutive 30-day periods. The gap is measured as the number of days between the last visit of a 30-day period and the first visit of a subsequent 30-day period. Stays with a hospital or skilled nursing facility stay preceding their longest home health stay were categorized as posthospital; stays not preceded by these services were categorized as community-admitted stays. "Length of stay" has been measured from the first visit of the first 30-day period in a stay to the last visit in the last 30-day period in a stay. Percentages were calculated on unrounded figures.

Source: Medicare Provider Analysis and Review 2021 and 2022, home health standard analytic file 2021 and 2022, Medicare Current Beneficiary Survey 2021.

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

Beneficiaries admitted to home health care from the community have longer stays While FFS Medicare pays for home health care in 30-day periods, many beneficiaries receive more than one 30-day period. The length of home health stays, which are back-to-back series of consecutive 30-day periods, varies widely; this variation likely reflects a myriad of factors. There were 3.9 million home health stays initiated in 2021, and the mean length of stay was 75.1 days. In 2021, 51.2 percent of stays were posthospital or postinstitutional PAC, and 49.8 percent were admitted from the community.

There were some differences in the length of stays and the mix of home health services beneficiaries received. Community-admitted stays were 63.8 percent longer on average than posthospital or postinstitutional PAC stays, with mean lengths of 93.9 days and 57.9 days, respectively (Table 7-7). Community-admitted stays averaged 6.7 more visits per stay, likely reflecting the longer length of stay. However, the mix of services was different across the two stay types, with skilled nursing being the most frequently provided service for community-admitted stays and therapy (primarily physical therapy) the most frequently provided service for posthospital stays.

There were similarities and differences in the demographic and clinical characteristics of community-admitted beneficiaries and posthospital or postinstitutional beneficiaries (Table 7-8).[8] Community-admitted beneficiaries were slightly older.

TABLE 7–8

Community-admitted and posthospital or postinstitutional PAC users of home health care had similarities and differences in select characteristics, 2021

	Community admitted	Posthospital	Percentage point difference
Number of FFS beneficiaries (millions)	1.4	1.7	N/A
Mean age	78.8	76.8	N/A
Share of beneficiaries:			
Male	37.9%	42.7%	–4.8%
Part D low-income subsidy or Medicare/Medicaid dually eligible beneficiary	32.7	23.3	9.5
Rural	19.0	17.8	1.2
Decedent in 2021	13.7	11.9	1.8
White/Caucasian	80.7	83.6	–3.0
Rates of selected conditions (ranked by percentage point difference):			
Alzheimer's disease, related disorders, and dementia	39.3	29.1	10.8
Pressure and chronic ulcers	23.8	18.3	5.5
Peripheral vascular disease	35.5	31.2	4.3
Rheumatoid arthritis/osteoarthritis	64.1	62.0	2.2
Depression	41.2	39.3	1.9
Hypothyroidism	28.6	28.4	0.2
Diabetes	43.9	43.8	0.1
Hypertension	87.9	90.2	–2.4
Chronic obstructive pulmonary disease	25.5	29.3	–3.8
Congestive heart failure	37.6	42.2	–4.6
Ischemic heart disease	49.0	55.7	–6.7
Hyperlipidemia	70.1	77.5	–7.4
Chronic kidney disease	52.8	60.2	–7.4
Anemia	50.4	62.6	–12.1

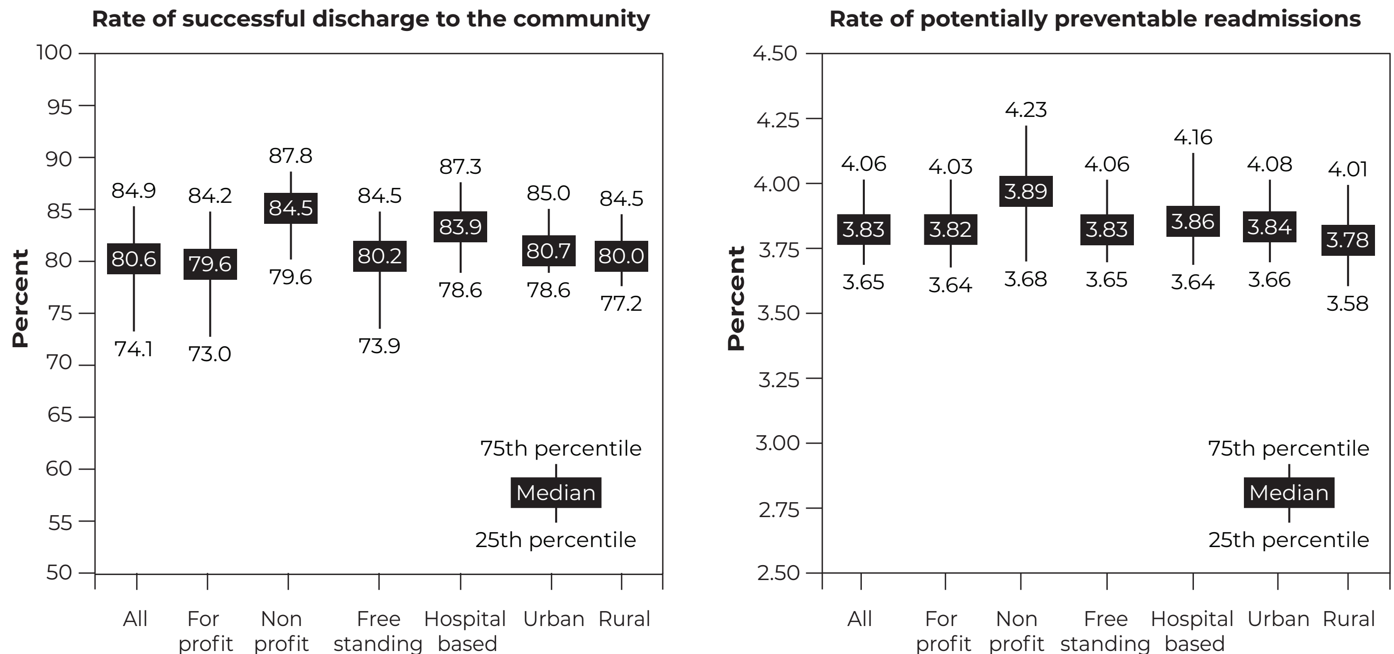
Note: FFS (fee-for-service), N/A (not applicable). FFS beneficiaries have been categorized based on the service use preceding their longest home health stay in 2021. Beneficiaries with a hospital or skilled nursing facility stay preceding their longest home health stay in 2021 were categorized as "posthospital." Beneficiaries without these services preceding their longest home health stay have been categorized as "community-admitted" beneficiaries. Incidence of clinical conditions are based on data from the Medicare Beneficiary Summary File Chronic Condition files and Other Conditions files. The classifications of conditions in those files reflect diagnoses recorded during either a one-year period (using 2021 claims) or a two-year period (using 2020 and 2021 claims). Percentage point changes were calculated on unrounded data.

Source: Home health standard analytic files 2020, 2021, and 2022; Master Beneficiary Summary File 2021; Medicare Provider Analysis and Review files 2021 and 2022.

Also among community-admitted beneficiaries, there was a lower share of male beneficiaries and a higher share who qualified for the Part D low-income drug subsidy or Medicaid. The two groups of beneficiaries had many common chronic conditions or serious clinical conditions, with the difference in the frequency between the two groups equal to or less than 3 percentage points for 20 of 35 conditions.[9] However, there were some substantial differences. For example, the rate of Alzheimer's disease and dementia was 10.8

FIGURE 7–1

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.

percentage points higher for community-admitted beneficiaries relative to posthospital beneficiaries, and the rate of anemia was 12.1 percentage points lower for community-admitted beneficiaries relative to posthospital beneficiaries.

Marginal profits

Another component of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to FFS Medicare patients. (Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional FFS beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Due to anomalies related to cost allocation on the home health cost report, we were unable to compute the FFS

Medicare marginal profit for 2023. We note, however, that because the FFS Medicare marginal profit excludes fixed costs included in our other financial measures, the FFS Medicare marginal profit for HHAs would be higher than the FFS Medicare margin reported later in this chapter.

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. There was over 10 percentage points of variation across the interquartile range where HHAs at the 25th percentile and 75th percentile had rates of 74.1 percent and 84.9 percent, respectively (Figure 7-1, first graph). For-profit HHAs had a lower median rate of discharge to 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). For January 1, 2021, to December 31, 2023, the median rate of home health stays with a potentially 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 7-1, second graph).

Most patient-experience measures remained stable

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. 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 2023 were relatively stable compared with prior years, and most patients reported high rates of positive responses.[10] (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) a high satisfaction rating with HHAs (9 or 10 on 10-point scale) and (2) that HHAs communicated well with them increased by 1 percentage point (Table 7-9, p. 240). The ratings for HHAs were high for major subgroups of HHAs, though there were some differences across groups. Rural agencies had higher rates of patient satisfaction compared with urban agencies (Table 7-10, p. 241).

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, Medicare Advantage, and other payers). In 2023, the all-payer margin for freestanding HHAs was 8.2 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Few HHAs access capital through publicly traded shares or through public debt such as issuance of bonds.

TABLE 7–9

Most patient-experience measures did not change in 2023

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

Note: HHA (home health agency), HH–CAHPS (Home Health 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 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.

While there has been significant acquisition activity by the larger for-profit firms in recent years, there 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 seeing no need to expand their footprint in the sector, and (3) challenges 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 slowdown in since 2023, some firms continue to expand their operations. For example, in 2024 the Pennant Group acquired an $80 million home health operation in Washington and Idaho, and Choice Health at Home, a multistate firm that operates home health care and hospice agencies, acquired a chain of HHAs in Oklahoma for $260 million (Donlan 2024, Famakinwa 2024). These acquisitions suggest that, while the overall volume of acquisitions has declined, access to capital is adequate for some agencies seeking 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 has a pending acquisition of Amedisys (Landi 2024, Pifer 2023). According to industry analysts, these acquisitions reflect several trends, including efforts to expand population-based health care services, better manage spending and utilization of home health care services, and capture 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.

TABLE 7–10

Patient-experience measures were higher for rural HHAs, 2023

HH–CAHPS measure	Urban	Rural
Share of patients rating the home health agency a 9 or 10 out of 10	84%	89%
Share of patients who would definitely recommend the home health agency to friends or family	78	84
Share of patients who reported that their home health provider:		
Gave care in a professional way	88	91
Communicated well with them	85	89
Discussed medicines, pain, and home safety with them	81	85

Note: HHA (home health agency), HH–CAHPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems). HH–CAHPS is a standardized survey of patients' evaluations of home health agencies. 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. Data include fee-for-service Medicare, Medicare Advantage, and Medicaid beneficiaries.

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

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

In 2023, the Medicare FFS margin for freestanding HHAs was 20.2 percent in aggregate, down from 22.1 percent in 2022. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) FFS Medicare margins varied across providers but were positive for most HHAs. As noted earlier, HHAs' FFS Medicare margins have averaged 17.1 percent from 2001 to 2022.

The annual increase in cost per 30-day full period has fluctuated since the PDGM was implemented. In 2021, the cost per full 30-day period declined by 2.9 percent, while in 2022 and 2023, the cost per full 30-day period increased by an average of 3.4 percent each year. Even with these fluctuations, the annual change in cost per 30-day period was 29 percent lower than the annual increases in inflation indicated by the home health market basket for these years. The increase in cost per full 30-day period in 2023 was due to higher costs per visit, but a small reduction in the number of visits slightly offset the growth in total cost per 30-day period.

The FFS Medicare margin for freestanding HHAs was over 20 percent in 2023

In 2023, the FFS Medicare margin for freestanding HHAs was 20.2 percent, with wide variation across HHAs (Table 7-11, p. 242). The margin ranged from 3.8 percent for the HHA at the 25th percentile to 30.8 percent for the HHA at the 75th percentile of the margin distribution (data not shown). For-profit HHAs had higher FFS Medicare margins than nonprofit HHAs, and urban HHAs had similar FFS Medicare margins compared with rural HHAs. 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 12.6 percent, compared with 22.4 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. These overpayments have consequences for the Medicare program since they increase the financial pressure on the Medicare trust fund and raise Part B premiums paid by Medicare beneficiaries.

TABLE 7–11

FFS Medicare margins for freestanding home health agencies, 2019–2023

	2019	2020	2021	2022	2023	Share of home health agencies, 2023	Share of periods, 2023
All	15.4%	20.2%	24.9%	22.2%	20.2%	100%	100%
Geography							
Majority urban	16.1	20.0	24.8	22.3	20.2	86	87
Majority rural	14.2	21.6	25.2	22.0	20.1	14	13
Type of ownership							
For profit	17.4	22.7	26.1	23.6	21.5	93	87
Nonprofit	11.4	12.4	20.2	16.4	13.3	7	13
Volume quintile							
First (smallest)	9.7	11.6	14.0	13.7	12.6	20	3
Second	11.4	14.0	15.9	14.5	13.9	20	7
Third	13.3	17.0	19.3	17.0	15.0	20	11
Fourth	14.1	18.8	22.8	21.0	19.4	20	20
Fifth (largest)	17.5	22.4	28.3	24.8	22.4	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.

In 2023, the average FFS Medicare margin for hospital-based HHAs was –16.5 percent (data not shown). 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 2025 projected to decline relative to 2023 but remain high

In modeling 2025 FFS Medicare margins, we incorporate policy changes that will go into effect between the year of our most recent data, 2023, and the year for which we are making the margin projection, 2025. Table 7-12 shows the major payment-policy changes in 2024 and 2025, including a permanent reduction to the base payment rate of –1.975 percent, as required to maintain budget neutrality following the implementation of the PDGM classification system and associated changes to the PPS. Based on these policies and assumptions, the Commission projects a FFS Medicare margin of 19 percent in 2025 for freestanding HHAs (data not shown).

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. The Commission's projected margin assumes

TABLE 7–12

Home health PPS payment policy changes in 2024 and 2025

	2024	2025
Home health PPS policy changes:		
Home health market basket	3.3%	3.2%
Productivity	–0.3	–0.5
Budget-neutrality adjustment under BBA of 2018	–2.890	–1.975
Outlier threshold adjustment	0.4	–0.4
Total	**0.8**	**0.5**

Note: PPS (prospective payment system), BBA (Bipartisan Budget Act). The impact of the budget-neutrality adjustment applies to all non–low-use payment adjustment (LUPA) periods, and so the net reduction on aggregate payments (which include both LUPA and non-LUPA periods) for 2024 and 2025 is less than the percentage indicated.

Source: MedPAC analysis of home health final rules for 2024 and 2025.

that for 2024 and 2025, the rates of cost increase will average 1.3 percent per year, the average for 2021 through 2023.

How should FFS Medicare payments change in 2026?

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 2026; however, CMS's third quarter 2023 projections indicate a 2.4 percent payment update in 2026 (an estimated market basket increase of 3.0 percent minus a productivity adjustment of 0.6 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 2025 CMS implemented a permanent reduction to the 30-day period base rate of 1.975 percent, half the amount required by law to maintain budget neutrality after 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 1.975 percent to keep spending at the level required by law. We note that, even after such a reduction, FFS Medicare payments to HHAs would remain far above costs.

RECOMMENDATION 7

For calendar year 2026, the Congress should reduce the 2025 Medicare base payment rate 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. FFS 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 FFS Medicare margin was 20.2 percent in 2023, and we project that it will be 19 percent in 2025.

As noted earlier, the BBA of 2018 requires reductions to home health care payments, but the recommendation is not intended to be additive to the BBA of 2018 adjustments. Under this recommendation, the base rate for 2026, net of all payment changes in 2026, would be 7 percent lower than the 2025 base rate.

IMPLICATIONS 7

Spending

- Current law is expected to increase payment rates by 2.4 percent in 2026. This recommendation would decrease federal program spending by $750 million to $2 billion in 2025 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_24_HHA_FINAL_SEC.pdf.

3 As of November 2024, 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.

4 The average payment per full 30-day period increased by 0.6 percent to $2,022 in 2023.

5 These payment amounts 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 Patient-Driven Groupings Model were included).

6 For the purpose of this measure, home health services are measured as a period of time that begins at the initiation of home health care services and continues to the end of services, typically discharge. Referred to as a "quality episode," this unit of measure may be a single 30-day period or several consecutive 30-day periods, depending on the length of service for FFS Medicare beneficiaries.

7 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 (which ranges from two to five in-person visits).

8 Beneficiaries were assigned to these categories based on the type of stay they had in 2021; beneficiaries with multiple stays were assigned to the category with the longest length of stay.

9 These 20 conditions include depression, osteoporosis, mobility impairments, cerebral palsy, epilepsy, hypothyroidism, diabetes, glaucoma, cystic fibrosis, endometrial cancer, fibromyalgia, leukemias and lymphomas, lung cancer, colorectal cancer, breast cancer, prostate cancer, cataracts, asthma, and hypertension (not all 20 conditions are included in the table).

10 CMS reported a 24 percent response rate for the HH–CAHPS in 2023.

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