THE HAMILTON PROJECT

Rethinking Medicare home health

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Abstract

Home health care is an important component of the Medicare system, yet Medicare home health lacks a clear, agreed-upon objective. The program appears to try to serve multiple purposes—substituting for institutional post-acute care, covering the costs of treatment and recovery from acute health events for home-bound patients, and providing in-kind, long-term services and supports (LTSS) to frail older adults. Current program design reflects an unresolved compromise among these objectives. In this essay, we clarify the objectives that Medicare home health might potentially serve, assess how well current program design aligns with those objectives, and discuss reforms that might help the program better meet each of these objectives.

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1. Introduction

Home health care is an important component of the Medicare system. In 2023, about 2.7 million beneficiaries in Traditional (i.e., fee-for-service) Medicare received home health care from more than 12,000 home health providers, at a total cost of $15.7 billion. Home health makes up 28.6 percent of Medicare spending on post-acute care, with the remainder attributed to institutional care at skilled nursing facilities (SNFs) (49.5 percent), inpatient rehabilitation facilities (16.9 percent), and long-term care hospitals (5.0 percent; Medicare Payment Advisory Commission [MedPAC] 2025b).

Home health is often viewed as clinically appropriate (Werner et al. 2019), patient preferred (Geng et al. 2024), and less costly than institutional alternatives. At the same time, the presence of robust profit margins (MedPAC 2025a) and persistent concerns about overuse and fraud (Einav et al. 2026; Government Accountability Office [GAO] 2017; Leder-Luis and Malani 2025) have fueled debates about whether and/or how to reform program design (MedPAC 2026; National Alliance for Care at Home 2026). Yet there is little consensus on how the program is performing or how it should evolve.

In this essay, we argue that these debates stem in part from a more fundamental issue: Medicare home health lacks a clear, agreed-upon objective. The program appears to try to serve multiple purposes: Medicare home health substitutes for institutional post-acute care, insures the costs of treatment and recovery from acute health events, and provides in-kind LTSS to frail older adults. Current program design reflects an unresolved compromise among these objectives.

Herein we clarify the potential objectives that Medicare home health might serve, assess how well current program design aligns with those objectives, and discuss reforms that might help the program better meet each of these objectives. We begin in section 2 by briefly reviewing the structure and history of Medicare home health. Section 3 discusses three possible objectives for Medicare home health, while section 4 discusses the key elements of program design and considerations for each in light of different objectives. The final section briefly synthesizes some key lessons.

2. Medicare home health

2.1. Program features: Eligibility, coverage, providers, and payments

Medicare home health services consist of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work delivered in patients' homes. Eligibility requires that a physician certify that the patient needs intermittent skilled care and is unable to leave their home without considerable effort. Unlike Medicare SNF coverage, Medicare home health coverage does not require a preceding hospital stay.

Medicare home health is provided through Medicare-certified home health agencies (HHAs), which must be primarily engaged in providing skilled nursing services and therapeutic services, and must employ at least one physician and one registered professional nurse to oversee its services. There are roughly 12,000 Medicare-certified HHAs, 83.5 percent of which are for-profits; this is higher than the for-profit share of nursing homes (72.4 percent) and much higher than the for-profit share of hospitals (36.1 percent; Centers for Disease Control and Prevention [CDC] 2026a, 2026b; Welch et al. 2023).

Since 2000, Medicare has reimbursed HHAs under a prospective, case-mix-adjusted payment system. Payments were originally based on 60-day episodes of care, but this period was shortened to 30 days in 2020. If beneficiaries continue to require services at the end of the episode, a new payment period commences and Medicare makes an additional payment. Episodes with relatively few visits are paid through a low-use payment adjustment, and extremely costly episodes may qualify, ex-post, for an additional outlier payment.[1] Medicare home health payments appear to be high relative to costs, with margins averaging 17.1 percent over the 2001–22 period (MedPAC 2025a).

Three features of Medicare home health coverage are notable. First, unlike almost any other service covered by Medicare, home health services do not have any patient cost sharing (e.g., in the form of deductibles or copayments). As a result, patients who receive Medicare home health services are not responsible for *any* out-of-pocket payments; by contrast, Medicare SNF coverage requires patient co-pays of $209.50 per day for days 21 through 100 and requires patients to pay the full cost of the SNF after day 100 (MedPAC 2025a).

Second, also unlike most Medicare-covered services, home health is unusual in providing aspects of care that even relatively healthy individuals might want. An individual with a well-functioning hip is unlikely to want a hip replacement, but an elderly individual with limited mobility might well appreciate physical therapy in the home and related services.

Third, although the Medicare home health benefit is framed as skilled medical care, the populations served and the patterns of use may have more overlap with LTSS than most Medicare-covered services.

All three of these features are central to the policy challenges we discuss below.

2.2. Characteristics of enrollees and services provided

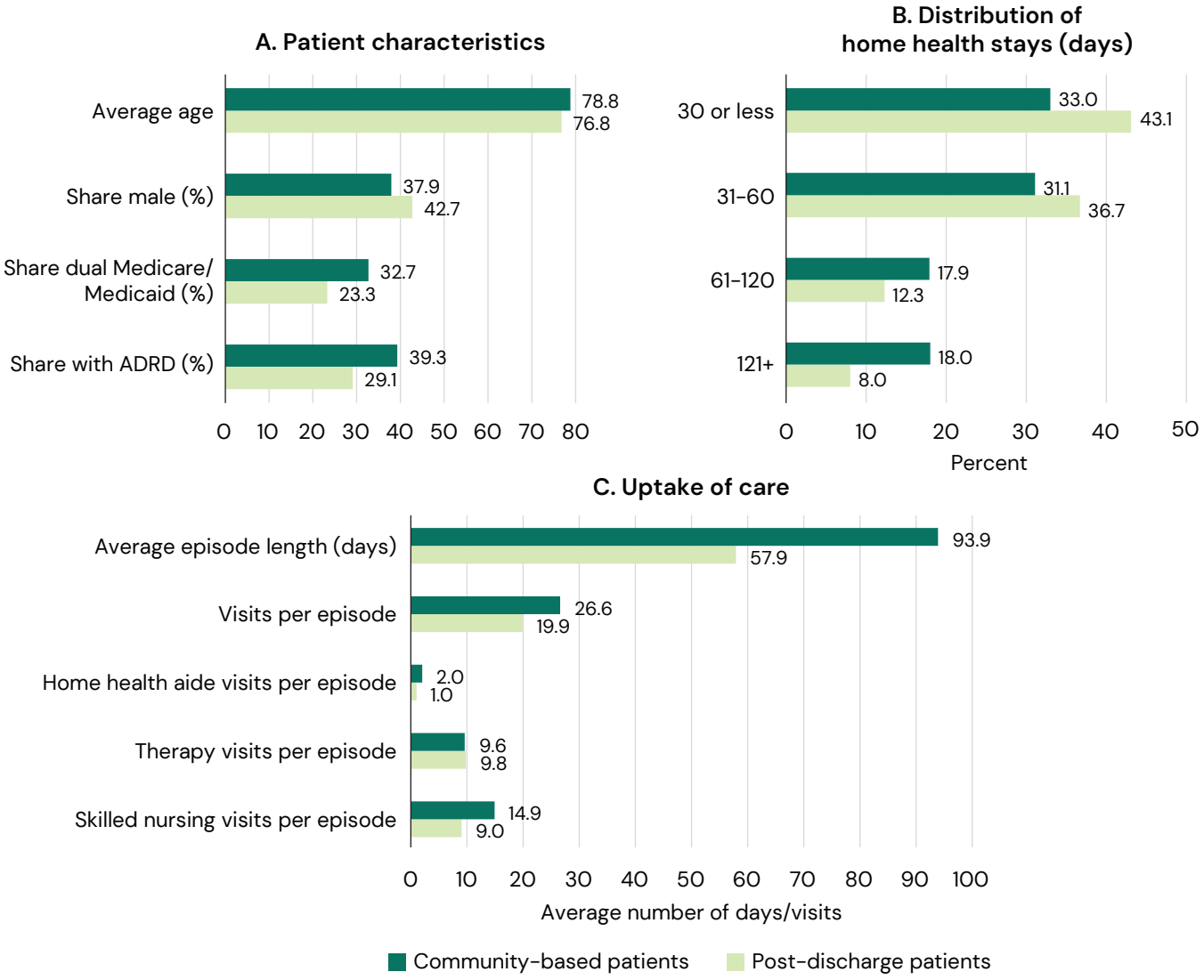
A natural starting point for understanding what Medicare home health does in practice is to examine who receives it and what types of services are delivered. Medicare home health episodes are split fairly evenly between two distinct types: those that are initiated post-discharge from a hospital or SNF, and community-based episodes that begin without any recent institutional care. In 2021, almost half (49.8 percent) of home health stays were community-based, accounting for 1.8 million of the 3.8 million total episodes initiated that year (MedPAC 2025a, table 7-7).

As summarized in figure 1, community-based stays are more consistent with a population receiving ongoing supportive care than a population recovering from an acute medical event. The beneficiaries tend to be older (mean age 78.8, compared

1. Low Utilization Payment Adjustment pays a per-visit fee instead of the full episode payment (Christman 2021).

FIGURE 1

Differences between community-based and post-discharge home health patients



Source: MedPAC 2025a.

Note: Figure displays patient and use characteristics for community-based home health patients and post-discharge (from a hospital or SNF stay) home health patients. ADRD = Alzheimer's disease and related dementias.

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with 76.8 for post-hospital beneficiaries), substantially more likely to be dually eligible for Medicare and Medicaid (32.7 percent vs. 23.3 percent), and have markedly higher rates of Alzheimer's disease and related dementias (39.3 percent vs. 29.1 percent) (MedPAC 2025a, table 7-8). The service mix also differs in revealing ways: Post-hospital stays have a ratio of skilled-nursing to therapy visits of roughly 0.91 to 1 (9.0 vs. 9.8 visits per episode), consistent with a rehabilitative, post-acute function. Community-based stays, by contrast, have a ratio of therapy to skilled nursing visits of roughly 1.67 to 1 (14.9 vs. 9.6 visits per episode). The dominance of therapy visits relative to skilled nursing visits in community-based episodes is suggestive of more ongoing clinical monitoring and management rather than rehabilitation and recovery. Relatedly, community-based home health episodes tend to be longer, on average, than post-hospital ones (93.9 days vs. 57.9 days) and to involve more visits per episode (26.6 vs. 19.9; MedPAC 2025a).

Because community-based patients, by definition, lack a preceding hospital or SNF stay, they do not qualify for Medicare SNF coverage under Medicare's three-day prior hospitalization requirement. This means that nearly half of all home health stays

occur outside the conditions under which direct post-acute substitution could plausibly operate, although it is of course possible that, absent that home care, the patient might have ended up with a SNF-qualifying hospital stay. The academic literature reinforces the sense that the current Medicare home health program does little to substitute for Medicare-covered SNF usage: Studies examining whether reductions in home health use lead to increased SNF use have failed to find consistent evidence of such substitution (Einav et al. 2025; Kemper 1988; McKnight 2006).

2.3. A brief history of Medicare home health

The current structure of Medicare home health reflects a series of policy expansions and retrenchments without an obviously consistent guiding objective. This history of litigation and policy reforms may reflect a lack of agreement as to what the Medicare home health program's objectives are and/or what they should be. We return in sections 3 and 4 to outlining several possible objectives and their implications for policy design.

When Medicare was enacted in 1965, the home health benefit was conceived as a post-acute service tied to hospitalization, closely paralleling SNF coverage. As with eligibility for Medicare coverage of SNF use, home health eligibility required a prior inpatient stay, and coverage was limited in duration, reflecting an intent to provide a lower-intensity, lower-cost, home-based alternative to institutional post-acute care rather than an open-ended long-term care benefit (Social Security Amendments of 1965). In an effort to encourage patients to use Medicare home health as a less costly, and presumably preferable, substitute for institutional care, the 1972 Social Security Amendments and the 1980 Omnibus Budget Reconciliation Act (OBRA) removed the coinsurance and deductible, respectively, from Medicare home health. Home health thus became distinctive among Medicare-covered services in requiring zero cost sharing for all patients (Senate Committee on Finance 1972; Talaga 2013).

Along with removing deductibles, the 1980 OBRA also eliminated the prior hospital stay requirement for Medicare coverage of home health, and removed statutory limits on the number of covered home health visits (Center for Medicare Advocacy 2024; Fishman et al. 2003). These changes broadened access to home health services and expanded eligibility beyond the traditional post-acute care setting.

Since then, use of Medicare home health has fluctuated substantially, with major changes in use closely tracking changes in Medicare payment policy and program oversight (see figure 2). Utilization rose sharply following a 1988 class action lawsuit (Duggan v. Bowen) that substantially expanded the effective scope of the home health benefit by clarifying that patients were allowed to receive home health services for stable needs even if their condition was not improving (Liu et al. 1999).

Rising use ultimately prompted Congress to reform the home health payment system in the Balanced Budget Act of 1997. The act replaced the previous cost-based (fee-for-service) reimbursement system with a two-stage transition. The first stage was the Interim Payment System (IPS) from 1997 to 2000, and the second was the Home Health Prospective Payment System (PPS) beginning in 2000. The IPS lowered per-visit caps and introduced HHA-level annual per-patient limits, leading to a sharp decline in the number of home health visits and total payments (Liu et al. 2003; McCall et al. 2001; McGinnis et al. 2013; McKnight 2006). Utilization rebounded following the introduction of PPS in 2000, which created prospective, case-mix-adjusted episode payments. These payment episodes were originally 60 days but were refined under the Bipartisan Budget Act of 2018, which required the Centers for Medicare & Medicaid Services (CMS) to shorten the unit of payment from 60-day episodes to 30-day periods and to eliminate therapy thresholds from the case-mix adjustment. These changes were implemented beginning in 2020 under the Patient-Driven Groupings Model (CMS 2024).

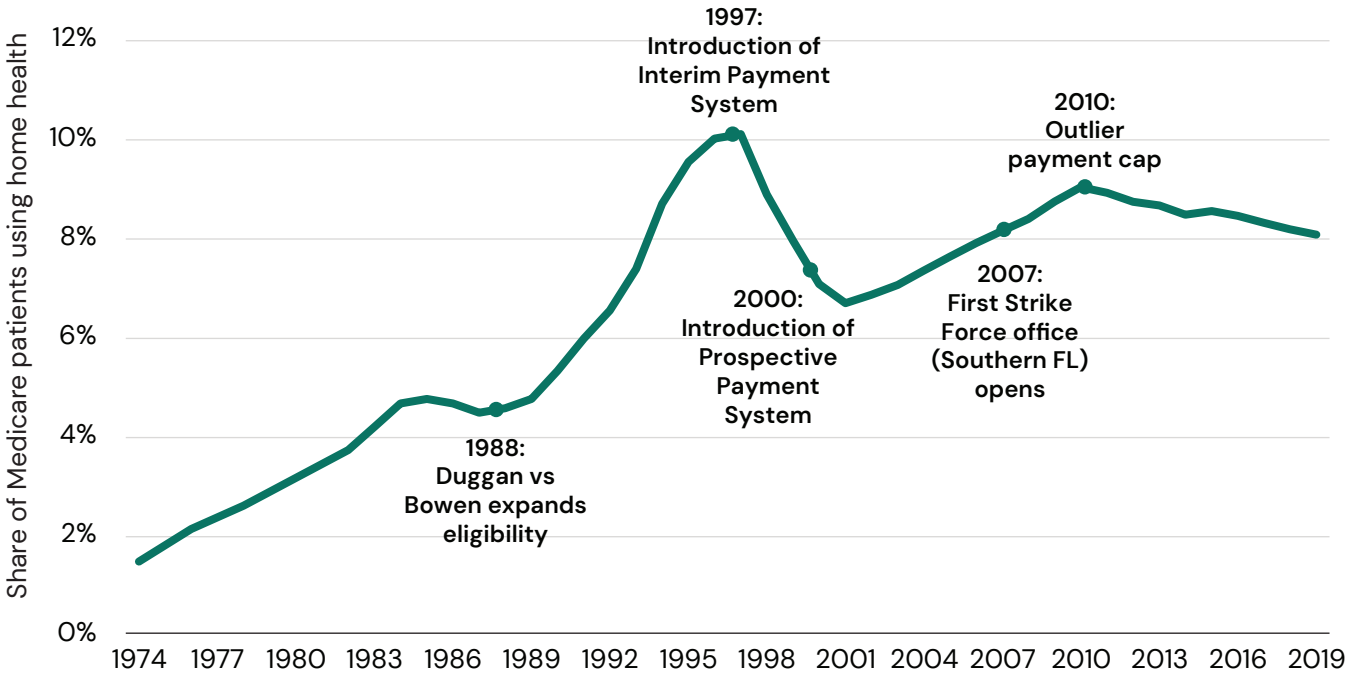
2.4. Concerns about fraud

Several features of Medicare-financed home health may make it particularly susceptible to both unnecessary care and actual fraud (GAO 2017).[2] First, it is difficult to independently verify the physician assessment-based eligibility determination. Second, services are delivered in private settings with limited potential for or actual third-party oversight. Third, unlike most medical interventions, home health carries low clinical risk and can provide direct utility to otherwise healthy individuals. Finally, unlike most other Medicare services, patients face no cost sharing for home health. While cost sharing does not provide a direct check on provider fraud (e.g., a provider who fraudulently overbills Medicare could

2. Medicare-financed home health covers a large gray area of activities that could plausibly be classified as fraud or as waste or abuse. A challenging issue is distinguishing outright fraud (such as billing for care not delivered, or billing for providing services to a patient who is neither actually home bound nor in need of services) from what the GAO (2017) calls waste (i.e., overuse of low-value care) or abuse (e.g., up-coding or aggressive billing practices).

FIGURE 2

Propensity to use Medicare home health over time, 1974–2019



Source: Centers for Medicare & Medicaid Services (CMS) 2001 Statistical Supplement n.d.; Medicare claims data n.d.

Notes: Figure displays trends in the share of Medicare enrollees receiving Medicare-financed home health care each year between 1974 and 2019. Data for 1974 through 1998 are from the CMS 2001 Statistical Supplement, while data for 1999 and beyond are from the 20 percent sample of Medicare claims data.

avoid patient scrutiny by simply not billing patients), it does reduce the revenue from such behavior and could provide additional opportunities for monitoring and detection.

Following the introduction of the Home Health Prospective Payment System in 2000, home health use and spending grew rapidly (figure 2). This growth was concentrated in certain regions, most notably a four-fold increase in Miami-Dade County, Florida, which raises first-order concerns about fraud and program integrity (O'Malley et al. 2023). In response, the U.S. Department of Health and Human Services and the U.S. Department of Justice launched joint Medicare Fraud Strike Force (Strike Force) initiatives between 2009 and 2018, targeting home health fraud in 12 judicial districts. By 2019, these efforts had resulted in more than 2,800 cases and approximately $3.5 billion in alleged losses (Office of the Inspector General 2020). Complementing these enforcement actions, CMS imposed moratoria on the enrollment of new HHAs, beginning in high-growth areas such as Miami, Fort Lauderdale, Dallas, Houston, Chicago, and Detroit in 2013 and 2014, and later expanding to all of Illinois, Texas, Florida, and Michigan in 2016.

Einav et al. (2025) find that the Strike Force actions and moratoria on entry of new HHAs reduced per-capita Medicare home health spending by 9 percent and 22 percent, respectively, in targeted counties, far larger than the amount of successfully prosecuted fraud. Yet, moratoria also restrict entry by legitimate agencies, illustrating a broader tension: When enforcement tools address symptoms rather than the structural features that make fraud attractive, they may reduce fraudulent, low-value, and high-value services. We return to those features in section 4.

Einav et al. (2026) use the Strike Forces to size the extent of fraud in the Medicare home health system. They define fraud based on what Strike Forces successfully prosecuted by 2019 in the nine districts in which a home health Strike Force was launched between 2009 and 2013. Using characteristics of the 2008 HHAs in those districts that were and were not subsequently prosecuted for fraud, Einav et al. train a machine learning algorithm to predict, out of sample, the probability that each HHA in existence in 2008 in the remaining 85 districts would have been prosecuted had a Strike Force entered between 2009 and 2013. They estimate that, in 2008, approximately 3.4 percent of

national Medicare home health spending, or about $520 million, was billed by fraudulent HHAs. Almost two-thirds of the spending by fraudulent HHAs was in the nine districts that subsequently received a Strike Force, although those districts accounted for only about two-fifths of Medicare home health spending. Einav et al. also find that the characteristics of HHAs follow a largely intuitive pattern. For example, fraudulent HHAs are more likely to rely on extremely high-volume referring physicians, to serve healthier-than-average patients, and to exhibit unusually uniform patterns of care provision.

3. Three possible objectives for Medicare home health

The history of frequent policy reforms and corresponding shifts in the use of Medicare home health, as seen in figure 2, suggests that home health use is highly responsive to policy design. At the same time, the pattern of episodic expansion and retrenchment may reflect a lack of clarity or agreement about the objective of the Medicare home health benefit.

In this section, we discuss three possible, distinct—albeit interrelated and not mutually exclusive—objectives for Medicare home health. In describing these separate objectives, we make no claims about the appropriate interpretation of the Medicare statute; rather, these are conceptual objectives that our reading of the program's history suggests may have been an objective or could be an objective of a (possibly re-designed) Medicare home health benefit.

3.1. Cost mitigation

The original motivation for the establishment of Medicare home health coverage was, as discussed in section 2, to reduce Medicare costs by encouraging patient substitution away from more-expensive institutionalized care, typically at a SNF, to the less-expensive home health setting. The idea was that, by substituting from more-expensive (to Medicare) and presumably less-desirable (to the patient) institutional care, Medicare home health could save taxpayer money without harming, and perhaps even improving, patient well-being. Under this conception, Medicare home health is valuable insofar as it reduces hospital length of stay, avoids SNF admissions, and/or shortens SNF stays, thereby lowering total Medicare spending.

This objective aligns most closely with the pre-1980 design of the benefit, which required a preceding hospital stay and limited coverage duration, closely paralleling SNF coverage. The 1980 elimination of the prior hospitalization requirement opened the door to the community-based use documented above, which now accounts for half of all episodes. Beyond this, as noted above, evidence on Medicare home health as a substitute for SNF care is not encouraging; studies have failed to find consistent evidence that reductions in home health use led to increased SNF utilization (Einav et al. 2025; Kemper 1988; McKnight 2006).

3.2. Coverage of medical services delivered in the home

The second objective of Medicare home health is to provide the same sorts of benefits that the Medicare program provides for all other types of care (including physician visits, inpatient admissions, emergency room visits, prescription drugs, and skilled nursing care): coverage of health-related services for treatment and recovery from acute illness that would normally be covered by Medicare but that, for certain patients, make more sense to be delivered at the patient's home.

This purpose in turn nests two distinct categories of services. The first category covers traditional outpatient medical services , such as wound care for surgical wounds, catheter changes, or injections, that are normally provided at the clinic, but would be more appropriately delivered at the patient's home for Medicare beneficiaries who are less mobile and find it difficult or impossible to visit the provider's clinic. Under this category, eligibility hinges on a physician's certification of need for skilled nursing or therapy and of the patient's being homebound (Legal Information Institute 2024).

The second category covers help with activities of daily living (ADLs) that, for noninstitutionalized patients, can be provided only at the patient's home, such as personal assistance with bathing, dressing, and eating for patients who have difficulties performing these functions themselves. If these functional limitations are connected to an acute health event, such as recovery from hip replacement or stroke, covering them at home is part of a similar rehabilitative goal as covering them in an institutional setting.

In practice, however, one challenge with the current structure of the Medicare home health benefit is that eligibility criteria (as certified by a physician) often focus on the functional limitations, which may or may not be projected to improve. Thus, coverage for people needing help with ADLs can include patients with chronic conditions and long-term ADL needs. Indeed, as mentioned earlier, half of all Medicare home health stays are community-based, serving a population that is older, more cognitively impaired, and more likely to be dually eligible for Medicaid than post-hospital beneficiaries, suggesting the program plays a non-negligible role in providing ongoing supportive care rather than a standard acute medical benefit. This set of patients also figures prominently in the third potential objective of Medicare home health that we now discuss.

3.3. Coverage of long-term services and support

A third potential objective would be to consider Medicare home health as a vehicle for covering LTSS in the home, such as assistance with ADLs. Of course, as noted above, help with ADLs may also be covered under the objective of providing coverage of medical services at home; however, in that case, the assistance with ADLs is offered only in conjunction with the provision of medical services designed to help with treatment of and recovery from an acute illness. By contrast, coverage of LTSS could be provided even in the absence of any needed medical services in the home, or without any expectation of improvement, and need not be time limited in duration.

The purpose of insurance of any kind is to make the resources that are available to an individual more equal across uncertain situations. That is, insurance transfers resources from situations in which the individual has more resources (e.g., the individual is in good health) to ones in which they have fewer resources (e.g., the individual is sick) and therefore values the additional resources more. In this case, an elderly patient needing assistance living at home is likely to have larger expenses and demands on their resources than an elderly individual who does not need such assistance. Viewed from this perspective, another natural alternative would be to provide cash transfers. Lieber and Lockwood (2019) describe the trade-offs involved in providing social insurance through in-kind transfers, such as home health care benefits rather than cash. On the one hand, they note that in-kind transfers may be a more effective way of targeting taxpayer resources to those who need them the most. On the other hand, relative to cash, a home health benefit has the downside of potential moral hazard, and could end by spending money on something that individuals may value at less than its cost because they are not required to pay for it.

Interestingly, Lieber and Lockwood (2019)'s argument, while broadly applicable, is developed in the specific context of analyzing Medi*caid* home health benefits. While the same social insurance perspective can be used to justify providing long-term care coverage through Medicare home health services, it also raises important and challenging questions about how to coordinate this type of Medicare social insurance function with Medicaid, which provides the same function to a partial and varying extent (Centers for Medicare & Medicaid Services, n.d.).

Formally, Medicare home health and Medicaid LTSS serve distinct purposes and partially distinct populations. Medicare is supposed to cover short-term, skilled, medically certified care, without income or asset tests, while Medicaid is supposed to provide long-term assistance with ADLs, such as eating and bathing, for low-income patients with incomes and assets below state-level thresholds. As a result, Medicare home health is structured as a medical benefit, while Medicaid LTSS functions as the primary public insurance program for long-term care (MedPAC 2024; Mohamed et al. 2025).

The programs also have notable differences in their fiscal models and the nature of federal control. Medicare is a federal program, financed by federal payroll taxes and general revenue (as well as beneficiary premiums), while Medicaid is jointly financed by the federal government and the states, with states retaining considerable flexibility over eligibility thresholds and benefit design. This means that a policymaker weighing whether to expand LTSS via Medicare or Medicaid must consider not only traditional program objectives, but also trade-offs involving federal versus state fiscal responsibilities and control.

In practice, however, there is substantial overlap in the populations served by these programs. Many Medicare beneficiaries have meaningful functional limitations but do not qualify for Medicaid. Others qualify only after spending down assets. For beneficiaries who spent down their assets, Medicare home health often functions as a partial substitute for Medicaid LTSS. Empirically, as discussed in section 2, a meaningful share of Medicare home health episodes is community-initiated and more closely resemble ongoing supportive care (Kim et al. 2025).

Historically, focusing on short-term rehabilitative care has been central to Medicare's stated mission. For example, Medicare coverage of SNF care is capped at 100 days and is predicated on the expectation that the patient is on a path to recovery

and return to the community (CMS 2019). Long-term patients who require continuous care are expected to obtain private long-term care insurance or rely on Medicaid. Medicare home health may, in practice, already deviate from this stated principle since it covers many community-based patients. Having Medicare home health care coverage more formally and expansively deviates from this general principle could be a justifiable objective. However, it would need to be accompanied by reforms to Medicaid to avoid the cost and care inefficiencies that naturally stem from programs with duplicative design and function.

4. Levers to consider for redesigning Medicare home health

We highlight three key policy levers worth considering as part of a redesign of the Medicare home health benefit. The first two are already features of Medicare home health, as well as Medicare coverage of other services: consumer cost sharing and eligibility requirements. The third lever, which is not currently part of Medicare home health (or other Medicare services) but has been adopted in many other OECD countries, is providing optional cash payments for those in need of home care rather than providing a care-based, in-kind benefit.

Several key points emerge from this discussion. First, the attractiveness of different uses of cost sharing, targeted eligibility, and cash transfers depends critically on the perceived goal (or goals) of the Medicare home health benefits. Second, and relatedly, there is no single right answer for the optimal use of each possible tool; the decision depends on how different goals are weighed in the design.

4.1. Consumer cost sharing

Most health insurance coverage that is not designed for a low-income population includes some cost sharing with consumers. The key, long-standing idea behind such consumer cost sharing is to give patients some financial "skin in the game" so that they exercise some restraint before seeking care; a large body of empirical evidence makes clear that consumer cost sharing reduces the amount of medical care that consumer receives (Einav and Finkelstein 2018).

Most other Medicare-covered services have some consumer cost sharing, even if in practice many recipients are shielded from this cost sharing through, for example, Medicaid, Medigap, or retiree supplemental coverage. If Medicare home health is conceived of as primarily a way of covering medical services that need to be delivered to the patient in the home, it seems a particularly odd category of care to exclude from this cost sharing. Home health is a service where one would expect moral hazard to be particularly large; many people try to avoid medical services if they can, but home health covers services that people might want to consume, such as physical therapy or assistance with ADLs. Indeed, as noted in section 2, the combination of no cost sharing and a service that patients may want to consume for purposes other than health restoration may make Medicare home health particularly susceptible to issues of both unnecessary care and fraud since it represents a potential win-win situation for the home health providers and the patients, although at additional cost to Medicare. MedPAC, Congress's nonpartisan advisory body on Medicare reforms, has proposed introducing copays for home health (MedPAC 2011); President Barack Obama included a version of this proposal in several budgets, but the change was never adopted (e.g., Office of Management and Budget [OMB] 2014).

Viewed from the perspective of a way of covering medical services delivered in the home, therefore, the cost sharing in Medicare home health should be similar or even higher than cost sharing in other components of Medicare coverage. Likewise, as discussed in section 3.3, if the goal of Medicare is to provide coverage of LTSS, this would also suggest the importance of some cost sharing to minimize the moral hazard costs of in-kind transfers.

The strongest argument for having low or zero cost sharing in Medicare home health originated from a cost-minimizing objective. If the primary goal of Medicare home health is to encourage substitution out of SNFs, cost sharing could either be aligned with the SNF schedule on the grounds that the two are substitutes, or set below it, giving beneficiaries a financial incentive to choose the less-expensive option. In this case, however, it seems natural to make Medicare home health—or at least the portion of Medicare home health that has zero cost sharing—limited to patients who would otherwise be eligible for SNF care, who are the ones most likely to be candidates for potential substitution of home care for SNF care.

4.2. Eligibility requirements

Currently Medicare home health eligibility certification is focused on medical need and functional limitations, without much attempt to capture the distinction between short-term and long-term patients. However, eligibility policies could more clearly distinguish between post-acute patients and community-based patients. For example, if Medicare home health is primarily aimed at covering medical services delivered in the home and/or for cost containment, it seems natural to have a cap on the duration of home health episodes (unless a new triggering event occurs). An example might be to have no more than three 30-day episodes to parallel the 100-day cap on SNF coverage.

On the other hand, if the goal is coverage of LTSS, such caps could be counterproductive, and a broader redesign of the Medicare benefit may be warranted.

Glied et al. (2024) offer one concrete proposal along these lines. Their design would restrict eligibility to beneficiaries who are unable to perform two ADLs, as determined by independent clinical reviewers; eligibility would include means-tested cost sharing based on both income and assets.

4.3. Optional cash payments

In many OECD countries, publicly funded, long-term home-based support is accessed through needs-based assessments and delivered under personal budget arrangements, which give beneficiaries flexibility to choose providers and services based on functional needs. These systems explicitly accommodate ongoing home-based support that is not limited to medical needs (Colombo et al. 2011). In some countries, benefits are delivered as unrestricted cash, which recipients can use to meet their needs as they see fit.

Over the past several decades, a number of European countries have introduced cash-for-care options into their long-term care programs (Da Roit and Le Bihan 2010). Under these programs, individuals who are eligible for publicly-financed home care services may choose instead to receive cash payments. There are a number of rationales offered for such systems, including greater autonomy and control for recipients and their families, the ability to compensate relatives who are providing unpaid, informal care, and potential budgetary savings, such as in cases where the cash option is less than the expected cost of home health services. In some countries, including France, the Netherlands, and Sweden, the cash benefit is supposed to be used to finance home health services, while in other countries, including Germany, Italy and Austria, there are no restrictions placed on what recipients do with the cash benefits.

The U.S. Department of Veterans Affairs (VA) also offers personal budget arrangements for veterans who have been clinically assessed as needing personal care assistance (GAO 2020; Harrison 2023; Van Houtven et al. 2019). Eligibility for these options varies across the programs and may depend on factors such as the veteran's clinical assessment, disability rating, and military service history. These options do not provide unrestricted cash. Rather, they give eligible veterans the option of either paying a family or household member a monthly stipend or receiving a monthly budget that they can use to hire aides to provide personal care, in lieu of having VA arrange and pay for a contracted home health aide. Likewise, some state Medicaid programs give participants varying degrees of autonomy in directing their care, including hiring family members, although no programs provide unrestricted cash (Burns et al. 2026).

Either personal budget arrangements or actual cash benefits are a natural policy tool to consider in the context of coverage for LTSS such as ADL coverage, which is, as already noted, particularly vulnerable to moral hazard. This is because there is a lot of gray area as to the degree to which someone needs help with certain ADLs, as well as a lot of heterogeneity across patients as to how much help they can get from friends and family. Rather than offering coverage for only specific services, Medicare home health for community-based patients needing help with ADLs could be based on an assessment of each beneficiary and offer a reward for eligible individuals who opt out. These individuals could then choose how best to allocate their resources for their care and comfort among options available on the private market. Underlying these design questions is a trade-off between targeting and allocative efficiency. As the benefit gets closer to pure cash, any distortion in home health consumption is reduced, but at the expense of a larger incentive to gain eligibility and more pressure on that determination

5. Final thoughts

The current Medicare home health benefit reflects an unresolved compromise among competing goals. It attempts to function simultaneously as a potential cost-containment tool for post-acute rehabilitative care that would otherwise be delivered in an institution, as coverage of medical services for acute illness that are provided in the home, and as ongoing LTSS for chronically ill and functionally limited beneficiaries that overlaps with the domain of Medicaid LTSS. Yet it is not explicitly designed for any one of these roles.

Our hope is that the preceding discussion can provide some guidance for policymakers who are interested in reforming the Medicare home health program. In this concluding section, we summarize how a policymaker with a given objective might modify the program to better achieve whichever of these ends they desire, while recognizing that the design principles for different ends may be in conflict. Table 1 provides a rough schematic illustration of how different tools fit into different objectives for a Medicare home health benefit.

Consider first a policymaker who places the most weight on the cost mitigation objective. In pursuit of this goal, the policymaker may want to narrow eligibility, relative to the current policy, to patients who are eligible for SNFs and to limit the time frame of eligibility to something similar to the SNF 100-day limit. Cost sharing is desirable to the extent it discourages home health utilization by patients who would otherwise not use institutional post-acute care. However, lower—or even zero—cost sharing could be warranted for patients eligible for SNFs if it were successful at shifting them out of SNFs and into the less costly services provided by home health care. The MedPAC (2011) proposal to introduce co-pays for episodes not preceded by hospitalization or post-acute care use is broadly in this spirit.

Next, consider a policymaker who wants the home health program to cover medical services delivered in the home that are otherwise within the realm of conventional medical services. On the cost-sharing front, it would be natural to harmonize out-of-pocket payments with other parts of the Medicare system so that the decisions could be site-neutral from a patient's financial perspective. On the eligibility side, it would be appropriate to restrict coverage to services aimed at restoration, such as therapy, and that are needed during the time that restoration has not yet been achieved (e.g., temporary help with ADLs). In addition, the policymaker may want to make eligibility time limited, in much the same way that the duration of Medicare SNF coverage for a given medical episode is capped.

Finally, consider a policymaker who is focused on having Medicare home health provide LTSS to frail elderly individuals who do not expect to have functionality restored. Under such an objective, eligibility should be expanded to those in need of assistance with ADLs even if they are not recovering from a medical event or are not expected to regain functionality. Here it seems natural to consider providing a cash-based option instead of a traditional in-kind benefit only.

As we have endeavored to emphasize throughout, these options are not mutually exclusive. Indeed, it is natural to consider different program designs for different populations. For the purpose of cost containment, it could make sense to offer a time-limited Medicare home health benefit for which eligibility is limited to those who meet the eligibility requirements for Medicare-covered SNF care (including a recent prior hospital stay), and to continue to make Medicare home health available with zero cost sharing. For the purpose of long-term social services, the eligibility criteria would be the exact opposite: patients who are expected to need long-term support for ADLs, without requiring that they had suffered a precipitating medical event; for this type of benefit, a personal care budget or cash could offer an important complement to the traditional service-based Medicare coverage. For the purpose of insurance for medical services delivered in the home, the eligibility criteria might be broadened beyond those for cost-containment goals while some cost sharing on par with other Medicare services and a duration cap to benefits seem warranted.

TABLE 1

Summary of tools and goals

		Goals		
	Current policy	**Cost mitigation**	**Coverage of medical services delivered in the home**	**Coverage of LTSS**
Cost sharing	None	Similar to current policy: none or low	Similar to other Medicare cost sharing (desire for site neutrality)	Cost sharing with a possible cash-out option
Patient eligibility	Certification (by a physician) that the patient needs intermittent skilled care and is unable to leave their home without considerable effort	Narrow eligibility criteria to those required for SNF or other substitute care (e.g., care following an acute hospitalization for patients expected to recover)	Narrower than current policy (eligibility should be for treatment and recovery) but broader than cost mitigation eligibility (accommodate other short-term medical shocks that do not require SNF)	Complement of eligibility when covering medical services delivered in the home: Cover long-term chronic impairment (also known as "ADL insurance")
Covered services	Therapy and skilled nursing Home health aides can be covered if patient also needs skilled care	Similar to current	Similar to current	Primarily home health aides (assistance with ADLs), without requirement that patient also needs skilled care
Benefit duration	30-day periods, then required recertification	Time limited (similar to SNF)	Time limited (focused on health recovery)	Unlimited

Source: Authors' analysis.

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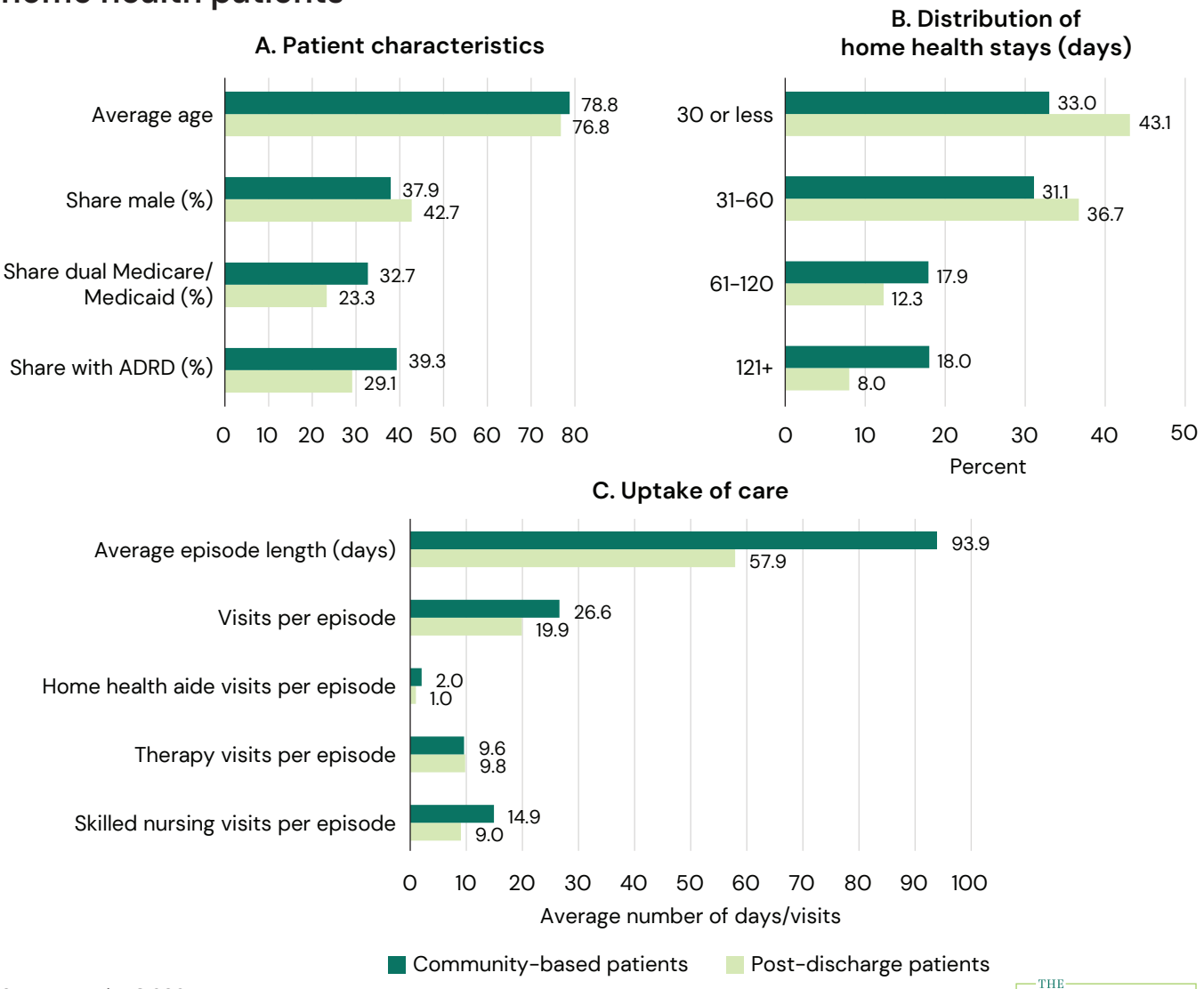
Home health care is an important component of the Medicare system, yet Medicare home health lacks a clear, agreed-upon objective. The program appears to try to serve multiple purposes—substituting for institutional post-acute care, covering the costs of treatment and recovery from acute health events for home-bound patients, and providing in-kind, long-term services and supports (LTSS) to frail older adults. Current program design reflects an unresolved compromise among these objectives. In this essay, we clarify the objectives that Medicare home health might potentially serve, assess how well current program design aligns with those objectives, and discuss reforms that might help the program better meet each of these objectives.

Differences between community-based and post-discharge home health patients



Source: MedPAC 2025a.

Note: Figure displays patient and use characteristics for community-based home health patients and post-discharge (from a hospital or SNF stay) home health patients. ADRD = Alzheimer's disease and related dementias.

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