HOME HEALTH · 2026 EDITION

# The 2026 National Home Health Study

Built on 2024 federal data and current 2026 policy. **The headline numbers are hiding the industry.**

| AGENCIES OUTSIDE CA | FFS VS ALL-PAYER MARGIN | VISITS PER 30-DAY PERIOD | MEDIAN DIRECT-CARE WAGE |
|---|---|---|---|
| 9,320 | 21.2 / 5.0 | 8.4 | $34,900 |
| down from 9,823 in 2019 | percent, freestanding, 2024 | down from 10.2 in 2019 | 765,800 openings a year |

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MedPAC · CMS · KFF · BLS · peer-reviewed research

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THE THESIS

# Where the headline numbers break

This is the Astrelis State of the Industry series: federal data, read straight, with the distortions named. This edition covers home health. Every figure in it comes from federal data, independent research organizations, and peer-reviewed studies: the MedPAC March 2026 report on 2024 data, the CMS CY2026 Home Health PPS final rule, CMS public quality and value-based purchasing files, KFF, BLS, and published studies in JAMA Health Forum and elsewhere. The full source list is in Appendix B.

The thesis of this edition is simple. The numbers everyone quotes about home health, the agency count, the Medicare margin, the star ratings, are all technically true. And each one, taken at face value, will lead an operator, a board, or a policymaker to the wrong conclusion. Here is where they break.

IN THIS STUDY

FINDING 1 · THE AGENCY COUNT

1

# The growth that isn't

## America outside California has fewer home health agencies than it did in 2019.

The national count looks healthy: 12,234 Medicare-participating home health agencies in 2024, up from 11,356 in 2019, a gain of almost 8 percent. Pull one state out and the story reverses. California went from 1,533 agencies to 2,914 over those five years, nearly doubling. Everywhere else combined fell from 9,823 to 9,320. That is a net loss of about 1 percent per year across 49 states and the territories, hidden inside a national growth headline.

MedPAC flags Los Angeles County specifically for potentially aberrant utilization and program integrity concerns, and CMS acted on the pattern: a nationwide six-month enrollment moratorium on new home health agencies took effect May 13, 2026. So the fastest-growing slice of the national denominator is the slice federal regulators trust least, and the front door to the industry is now closed while they sort it out.

The churn beneath the count matters as much as the count. Freestanding agencies are 93 percent for-profit. A 2025 JAMA Health Forum study identified 749 private equity home health acquisitions from 2006 through 2024, accelerating sharply after 2017, with nearly half in the South. A separate study of 294 agencies that changed ownership found star ratings and Medicare per-capita payments rose after the transaction while claims-based quality did not, and staffing fell hard: registered nurse FTEs down 17 percent, aide FTEs down 26 percent, with shorter visit minutes. The sign on the door changes more often than the care behind it improves.

> WHAT IT MEANS
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> any agency-weighted national average or benchmark carries a heavy California thumb on the scale and a churn signal underneath. Read national figures with the geography and the weighting disclosed. Net supply is the real number. Gross count is a press release.

FINDING 2 · THE TWO MARGINS

# The margin that sets your rates is not the margin you live

## Freestanding agencies earned a 21.2 percent margin on fee-for-service Medicare in 2024. Their all-payer margin was 5.0 percent.

The 21.2 percent number is the one that drives policy. MedPAC cited it in recommending another 7 percent base rate reduction for 2027, on top of the aggregate 1.3 percent cut CMS finalized for 2026. The 5.0 percent number is the one a board actually lives with, because almost no agency runs on fee-for-service Medicare alone.

And the payer generating the 21.2 percent is the shrinking one. Fee-for-service home health users fell from 3.3 million in 2019 to 2.7 million in 2024, and the share of fee-for-service beneficiaries using home health slid from 8.5 percent to 7.9 percent. Rate policy is being calibrated to the most profitable slice of a contracting book of business, while the growing slice pays less and demands more paperwork (see Finding 4).

One number worth keeping for the rural conversation: majority-rural agencies posted a 20.5 percent fee-for-service margin against 21.3 percent for urban agencies. Rural home health is not uniformly unprofitable on the Medicare lens. It is squeezed everywhere else, on travel, labor, and payer mix, which that lens does not see.

> WHAT IT MEANS
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> when someone quotes a home health margin at you, ask which one. The distance between 21.2 and 5.0 is the entire policy argument of 2026, and almost nobody puts both numbers in the same sentence.

FINDING 3 · VISIT INTENSITY

3

# The vanishing visit

## Home health delivered 65.4 million in-person visits in 2024. In 2019 it delivered 99.7 million.

Visits per full 30-day period fell from 10.2 in 2019 to 8.4 in 2024, an 18 percent decline. The turn came with PDGM in 2020, which removed therapy volume as a payment driver, and the drop has never reversed. Cost per period stayed nearly flat in 2024 for exactly this reason: agencies paid more per visit and simply made fewer of them.

Is that efficiency or erosion? MedPAC's own analysis of PDGM found fewer visits per stay, especially therapy, with little measurable effect on quality or profitability in the aggregate. Which means the honest reading is uncomfortable for both camps: the visit cuts did not obviously hurt patients on the measured outcomes, and the aggregate data cannot say whether the visits that disappeared were fat or muscle. Under PDGM, high visit intensity is neither a virtue nor a sin. It is a cost with an outcome attached, and the only question that matters is whether your visits are buying outcomes your peers get with fewer.

> WHAT IT MEANS
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> benchmarking visit intensity against 2019 habits, or against a national average polluted by Finding 1, tells you nothing. The comparison that matters is intensity against outcomes among agencies built like yours.

FINDING 4 · MEDICARE ADVANTAGE

# The Medicare Advantage gap

## Medicare Advantage now covers 55 percent of eligible beneficiaries, and it buys less home health per patient than traditional Medicare does.

The scale first: 35.2 million people are in MA in 2026, per KFF, including 42 percent of beneficiaries in the most rural counties. Then the friction: 90 percent of MA enrollees in 2024 were in plans requiring prior authorization for home health, and 99 percent are in plans requiring prior authorization for something in 2026.

Then the gap itself. MedPAC found MA home health users received 18.2 visits per year against 20.4 in fee-for-service, about 11 percent fewer. Roughly a quarter of MA enrollees sat in plans with home health cost sharing, and those plans showed lower use still. A JAMA Health Forum study across 285,297 home health patients found MA patients had shorter stays, fewer visits in every discipline (nursing, PT, OT, speech, aide), and 3 to 4 percent lower odds of improving in mobility and self-care, even after adjustment.

The one place MA uses more home health is after a hospital stay, 41.7 percent versus 40.4 percent, because plans deploy it as a cheaper substitute for institutional post-acute care. So the MA pattern in one line: more referrals, less care per referral, slower authorization, and payment terms the public data cannot see.

> WHAT IT MEANS
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> the referral is not the revenue. An agency that cannot see its MA economics separately from its Medicare economics is flying on the 21.2 percent gauge from Finding 2 while the fuel mix changes underneath it.

FINDING 5 · THE REFERRAL PIPELINE

5

# The discharge that never lands

## Home health is the most common formal post-acute destination in traditional Medicare, and the handoff to it fails four times out of ten.

In 2024, 18.0 percent of traditional Medicare hospital discharges went first to home health, more than to skilled nursing at 17.3 percent, and above the 15.8 percent pre-pandemic share. Home health won the discharge. It is losing the follow-through. Commonwealth Fund analysis shows home health referral fulfillment after hospitalization fell from 66 percent in 2016 to 59 percent in 2022, and earlier research found about 29 percent of hospitalizations with a home health discharge plan never produced home health within seven days.

Timing is not a paperwork detail. Patients whose care started 3 to 7 days after discharge had 28 percent higher odds of rehospitalization than those started within two days. At 8 to 14 days, the odds were roughly four times higher. Start-of-care lag is a clinical outcome wearing an operations costume.

> WHAT IT MEANS
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> hospitals count contracted agencies and believe they have a network. Patients experience whether a nurse showed up by day two. The gap between those two things, call it the phantom network, is where readmissions, length-of-stay pressure, and rural discharge failures actually live.

FINDING 6 · RURAL ACCESS

# The windshield tax

6

## One in ten rural ZIP areas has no home health agency at all. In the most remote areas, it is one in three.

Only 14 percent of freestanding agencies are majority rural, and they carry 13 percent of national volume. Rural utilization runs 21.7 thirty-day periods per 100 beneficiaries against 24.8 urban, and frontier counties sit at 11.7. Rural health research puts the access floor in plain terms: 10.3 percent of rural ZIP areas have zero home health service (versus 2.2 percent urban), 18.3 percent have exactly one agency, and 33.1 percent of the most remote frontier areas have none. Meanwhile 22 percent of urban agencies serve patient populations that are at least 10 percent rural, which means rural access often depends on an urban agency's continued willingness to drive.

The economics of the drive are the whole problem. Medicare pays per 30-day period; travel costs accrue per visit. Rural field research found nearly every administrator interviewed named windshield time as a defining barrier, one agency reported losing money on any visit more than 30 miles from the office, and more than half relied on contracted therapists. Telehealth is not yet the answer: only 2.2 percent of periods included a telehealth or remote monitoring touch in 2024. And the human cost of the gap is measurable: only 58.7 percent of rural beneficiaries with a planned home health discharge actually received the care.

> WHAT IT MEANS
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> geography is a per-visit tax that the payment system does not itemize. Route density, territory discipline, and honest math about which ZIP codes an agency can afford to serve are strategy, not scheduling.

FINDING 7 · WORKFORCE

7

# The workforce math does not close

## The labor pool must fill roughly 765,800 aide openings a year, most of them replacements, at a median wage of $34,900.

BLS projects 17 percent employment growth for home health and personal care aides from 2024 to 2034, among the largest of any occupation, with roughly 765,800 openings every year, most created by workers leaving the occupation rather than by expansion. The median pay for those workers in 2024 was $34,900. The retention data say what you would expect: home health agencies average more than 21 percent staff turnover, and PHI puts direct-care home care turnover near 75 percent in 2024.

The therapy side has the opposite problem, price instead of supply. Physical therapists earned a median of $101,020, and $108,110 in home health specifically, which is why low-volume rural branches lean on contract therapists they cannot fully afford (Finding 6). Every visit in Finding 3, every start-of-care clock in Finding 5, and every rural route in Finding 6 runs through this labor pool.

> WHAT IT MEANS
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> staffing is not a department. It is the binding constraint on every other number in this study, and any plan that projects volume growth without a wage, retention, and route-density answer is projecting someone else's workforce.

THE NEXT CYCLE

# The 2027 setup

Four forces are already in motion for the next cycle. Rates: CMS finalized an aggregate 1.3 percent cut for 2026, and MedPAC's recommended 7 percent reduction for 2027 is on the table. Value-based payment: the expanded HHVBP model now swings real money, plus or minus 5 percent of Medicare payment, with a revised HHCAHPS survey beginning with the April 2026 sample and a CY2026 measure set that adds bathing and dressing measures and Medicare Spending per Beneficiary. Data: OASIS became all-payer on July 1, 2025, so the visibility floor under every agency is rising. Structure: the enrollment moratorium slows new entry and complicates deal-making, which favors incumbents with clean compliance and punishes everyone who planned to grow through new Medicare enrollment or ownership deals.

The agencies that come through 2027 well will be the ones that can prove, with their own numbers, which side of each of these seven findings they are on.

THE LIMIT OF A NATIONAL STUDY

# Where you actually stand

This study is national by design, and that is exactly its limit. Finding 1 shows why the national benchmark is contaminated. Finding 2 shows why the average margin is a fiction for any specific agency. Finding 6 shows why geography reshuffles the whole deck. A state average or a national median cannot tell you whether your cost per visit, your LUPA rate, your visit intensity, or your margin per period is a problem, because it is comparing you to agencies that are nothing like you.

The Astrelis Home Health Benchmark Report answers that for a single agency: your filed cost report, benchmarked against structurally matched peers on size, ownership, rurality, and payer mix, with every gap priced in annual dollars and every claim traceable to the source line.

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APPENDIX A

# The Quick Read

The seven numbers from this study worth carrying into your next board meeting:

| | |
|---|---|
| 9,320 | Medicare home health agencies outside California in 2024, down from 9,823 in 2019. National growth is a California story, and CMS froze new enrollment nationwide in May 2026. |
| 21.2 vs 5.0 | The 2024 fee-for-service Medicare margin versus the all-payer margin for freestanding agencies. Policy prices the first number. You live the second. |
| 8.4 | In-person visits per 30-day period in 2024, down from 10.2 in 2019. Total visits fell from 99.7 million to 65.4 million. |
| 11 percent | How many fewer visits Medicare Advantage patients receive than fee-for-service patients, while MA covers 55 percent of eligible beneficiaries and 90 percent face prior authorization for home health. |
| 59 percent | The share of hospital referrals to home health that are actually fulfilled, down from 66 percent in 2016. Care starting 8 to 14 days late carries roughly four times the rehospitalization odds. |
| 10.3 percent | The share of rural ZIP areas with no home health agency at all. In the most remote frontier areas, 33.1 percent. |
| $34,900 | Median pay for the workforce that must fill 765,800 openings a year through 2034, most of them replacements, with turnover running from 21 percent to near 75 percent depending on the segment. |

APPENDIX B

# Sources and methods

This edition is built on published federal data, independent research organizations, and peer-reviewed studies. Figures are attributed in the text to their originating source, and where sources measure different years or populations, the year and population are stated. The web edition links each figure to its source document.


1. MedPAC, Report to the Congress: Medicare Payment Policy, March 2026, home health chapter (2024 data year). medpac.gov
2. MedPAC, Report to the Congress, June 2025, Medicare Advantage home health analysis. medpac.gov
3. CMS, CY2026 Home Health Prospective Payment System final rule. cms.gov
4. CMS public files: Provider of Services, Care Compare, HHCAHPS, Home Health QRP, and HHVBP provider and cohort files. data.cms.gov
5. CMS, nationwide Medicare home health enrollment moratorium, effective May 13, 2026. cms.gov
6. KFF, Medicare Advantage enrollment and prior authorization analyses, 2026. kff.org
7. BLS, Occupational Outlook Handbook, Home Health and Personal Care Aides, and wage data, 2024. bls.gov
8. JAMA Health Forum: Medicare Advantage home health service intensity (2024); home health agency ownership change (2024); private equity acquisitions in home health, 2006 to 2024 (2025). jamanetwork.com
9. Commonwealth Fund, home health referral fulfillment after hospitalization. commonwealthfund.org
10. Peer-reviewed research on start-of-care timing and rehospitalization and on incomplete home health referrals; full citations in the web edition.
11. WWAMI Rural Health Research Center, Rural Health Information Hub, and University of North Dakota rural home health field research. ruralhealthinfo.org
12. PHI and UCSF health workforce research on direct-care turnover, 2024. phinational.org


One methods note in the spirit of this series: national medians in home health carry the California composition effect documented in Finding 1. Wherever this study cites an agency-weighted national figure, that effect applies, which is a reason to treat it as context rather than a target.

The next edition, releasing after the FY2025 cost report wave lands this fall, adds Astrelis-computed findings from the full national cost report file: peer-group verdict reversals, state-by-state benchmark tables, the fee-for-service versus all-payer margin distribution agency by agency, and the dollar value of an HHVBP point. Same series, deeper cut.


ABOUT THE AUTHOR

Matt Borchardt is the founder of Astrelis. He has spent roughly twenty years in healthcare finance, about half of it inside critical access hospitals, working directly with Medicare cost reports and reimbursement. Astrelis builds national benchmarking and data products for rural and post-acute providers. Corrections and inquiries: astrelis.co/about



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