Table 7.1

Trends in Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Year of Service: Selected Calendar Years 1974-2005

Year of Service	Persons Served		Visits			Total Charges	Visit Charges				Program Payments		
	Number in Thousands	Per 1,000 Enrollees[1]	Number in Thousands	Per Person Served	Per 1,000 Enrollees[1]	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Person Served[2]	Per Enrollee[1]
1974	392.7	16	8,070	21	340	$147,499	$137,406	$17	$350	$6	$141,464	$360	$6
1976	588.7	23	13,335	23	520	312,325	292,697	22	497	11	289,851	492	11
1978	769.7	28	17,345	23	639	500,747	474,498	27	617	18	435,322	566	16
1980	957.4	34	22,428	23	788	770,703	734,718	33	767	26	662,133	692	23
1982	1,171.9	40	30,787	26	1,044	1,296,454	1,232,684	40	1,052	42	1,104,715	943	37
1984	1,515.9	50	40,337	27	1,324	1,982,033	1,843,706	46	1,216	61	1,666,253	1,099	55
1986	1,600.2	50	38,359	24	1,208	2,190,238	2,102,253	55	1,314	66	1,795,820	1,122	57
1987	1,564.5	48	36,088	23	1,113	2,210,670	2,104,753	58	1,345	65	1,791,589	1,145	55
1988	1,601.7	49	37,713	24	1,144	2,453,974	2,341,441	62	1,462	71	1,945,768	1,215	59
1990	1,967.1	57	70,268	36	2,054	5,031,248	4,856,147	69	2,469	142	3,713,652	1,892	109
1991	2,242.9	64	99,825	45	2,862	7,365,931	7,117,436	71	3,173	204	5,369,051	2,397	154
1992	2,506.2	70	132,220	53	3,714	10,229,130	9,900,157	75	3,950	278	7,396,822	2,955	208
1993	2,874.1	79	164,234	57	4,520	13,673,836	13,241,340	81	4,607	364	9,726,444	3,389	268
1994	3,179.2	86	208,621	66	5,646	17,761,662	17,234,388	83	5,421	466	12,660,526	3,987	343
1995	3,469.4	102	249,394	72	7,322	21,591,139	20,973,734	84	6,045	616	15,391,094	4,441	452
1996	3,599.7	107	264,798	74	7,857	23,327,834	22,655,440	86	6,294	672	16,756,767	4,660	497
1997	3,557.5	108	258,168	73	7,821	23,460,105	22,766,628	88	6,400	690	16,718,263	4,704	506
1998	3,061.6	95	155,407	51	4,804	14,846,358	14,399,716	93	4,703	445	10,456,908	3,420	323
1999	2,719.7	85	113,439	42	3,525	11,370,780	11,065,837	98	4,069	344	7,936,513	2,921	247
2000	2,461.2	75	90,566	37	2,766	9,488,429	9,245,053	102	3,756	282	7,215,958	2,936	193
2001	2,402.5	71	73,573	31	2,173	8,199,439	7,987,887	109	3,325	236	8,513,702	3,545	251
2002	2,544.4	73	78,192	31	2,236	9,088,756	8,654,757	113	3,484	253	9,550,683	3,765	273
2003	2,681.1	75	82,851	31	2,313	9,966,568	9,744,912	118	3,635	272	10,069,628	3,770	281
2004	2,835.6	78	89,130	31	2,452	11,054,455	10,814,509	121	3,814	298	11,402,560	4,039	314
2005	2,975.6	81	95,989	32	2,617	12,262,325	12,021,384	125	4,040	328	12,779,158	4,314	348
						Average Annual Rate of Change							
1974-1982	14.6	12.1	18.2	2.7	15.1	31.2	31.6	11.3	14.7	27.5	29.3	12.8	25.5
1982-1987	5.9	3.7	3.2	-2.4	1.3	11.3	11.3	7.7	5.0	9.1	10.2	4.0	8.3
1987-2005	3.6	2.9	5.6	1.9	4.9	10.0	10.2	4.4	6.3	9.4	11.5	7.6	10.8
1974-2005	6.8	5.4	8.3	1.4	6.8	15.3	15.5	6.6	8.2	13.8	15.6	8.3	14.0

[1]Beginning with 1994, Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates and average payments.

[2]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. The change in program payments and utilization for home health agency services between 1997 and 2004 is due in part to the Balanced Budget Act of 1997 (Public Law 105-33) which called for the gradual transfer of home health services unassociated with a hospital or skilled nursing facility stay from hospital insurance to supplementary medical insurance. The use of the benefit was also affected by the efforts to identify fraudulent activities in the use of services and by the introduction of interim per beneficiary cost limits at levels resulting in substantially lower aggregate payments. These cost limits were used until the prospective payment system was implemented in October 2000. Program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.1

Trends in Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Year of Service: Selected Calendar Years 1974-2006

	Persons Served		Visits			Total	Visit Charges				Program Payments		
Year of Service	Number in Thousands	Per 1,000 Enrollees[1]	Number in Thousands	Per Person Served	Per 1,000 Enrollees[1]	Charges in Thousands	Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Person Served[2]	Per Enrollee[1]
1974	392.7	16	8,070	21	340	$147,499	$137,406	$17	$350	$6	$141,464	$360	$6
1976	588.7	23	13,335	23	520	312,325	292,697	22	497	11	289,851	492	11
1978	769.7	28	17,345	23	639	500,747	474,498	27	617	18	435,322	566	16
1980	957.4	34	22,428	23	788	770,703	734,718	33	767	26	662,133	692	23
1982	1,171.9	40	30,787	26	1,044	1,296,454	1,232,684	40	1,052	42	1,104,715	943	37
1984	1,515.9	50	40,337	27	1,324	1,982,033	1,843,706	46	1,216	61	1,666,253	1,099	55
1986	1,600.2	50	38,359	24	1,208	2,190,238	2,102,253	55	1,314	66	1,795,820	1,122	57
1987	1,564.5	48	36,088	23	1,113	2,210,670	2,104,753	58	1,345	65	1,791,589	1,145	55
1988	1,601.7	49	37,713	24	1,144	2,453,974	2,341,441	62	1,462	71	1,945,768	1,215	59
1990	1,967.1	57	70,268	36	2,054	5,031,248	4,856,147	69	2,469	142	3,713,652	1,892	109
1991	2,242.9	64	99,825	45	2,862	7,365,931	7,117,436	71	3,173	204	5,369,051	2,397	154
1992	2,506.2	70	132,220	53	3,714	10,229,130	9,900,157	75	3,950	278	7,396,822	2,955	208
1993	2,874.1	79	164,234	57	4,520	13,673,836	13,241,340	81	4,607	364	9,726,444	3,389	268
1994	3,179.2	86	208,621	66	5,646	17,761,662	17,234,388	83	5,421	466	12,660,526	3,987	343
1995	3,469.4	102	249,394	72	7,322	21,591,139	20,973,734	84	6,045	616	15,391,094	4,441	452
1996	3,599.7	107	264,798	74	7,857	23,327,834	22,655,440	86	6,294	672	16,756,767	4,660	497
1997	3,557.5	108	258,168	73	7,821	23,460,105	22,766,628	88	6,400	690	16,718,263	4,704	506
1998	3,061.6	95	155,407	51	4,804	14,846,358	14,399,716	93	4,703	445	10,456,908	3,420	323
1999	2,719.7	85	113,439	42	3,525	11,370,780	11,065,837	98	4,069	344	7,936,513	2,921	247
2000	2,461.2	75	90,566	37	2,766	9,488,429	9,245,053	102	3,756	282	7,215,958	2,936	193
2001	2,402.5	71	73,573	31	2,173	8,199,439	7,987,887	109	3,325	236	8,513,702	3,545	251
2002	2,544.4	73	78,192	31	2,236	9,088,756	8,654,757	113	3,484	253	9,550,683	3,765	273
2003	2,681.1	75	82,851	31	2,313	9,966,568	9,744,912	118	3,635	272	10,069,628	3,770	281
2004	2,835.6	78	89,130	31	2,452	11,054,455	10,814,509	121	3,814	298	11,402,560	4,039	314
2005	2,975.6	81	95,989	32	2,617	12,262,325	12,021,384	125	4,040	328	12,779,158	4,314	348
2006	3,026.2	84	104,127	34	2,905	13,627,482	13,410,519	129	4,431	374	13,912,750	4,619	388

[1]Beginning with 1994, Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates and average payments.

[2]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. The change in program payments and utilization for home health agency services between 1997 and 2004 is due in part to the Balanced Budget Act of 1997 (Public Law 105-33) which called for the gradual transfer of home health services unassociated with a hospital or skilled nursing facility stay from hospital insurance to supplementary medical insurance. The use of the benefit was also affected by the efforts to identify fraudulent activities in the use of services and by the introduction of interim per beneficiary cost limits at levels resulting in substantially lower aggregate payments. These cost limits were used until the prospective payment system was implemented in October 2000. Program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.2

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Demographic Characteristics: Calendar Year 2005

Demographic Characteristic	Persons Served		Visits			Total Charges	Visit Charges				Program Payments		
	Number in Thousands	Per 1,000 Enrollees[1]	Number in Thousands	Per Person Served	Per 1,000 Enrollees[1]	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Person Served[2]	Per Enrollee[1]
Total	2,976	81	95,989	32	2,617	$12,262,325	$12,021,384	$125	$4,040	$328	$12,779,158	$4,314	$348
Age													
Under 65 Years	324	52	11,788	36	1,875	1,540,858	1,484,295	126	4,579	236	1,457,882	4,546	232
65-74 Years	699	45	20,782	30	1,333	2,688,030	2,633,662	127	3,767	169	2,768,587	3,983	178
75-84 Years	1,149	108	36,417	32	3,407	4,643,611	4,568,356	125	3,976	427	4,896,734	4,275	458
85 Years or Over	803	195	27,002	34	6,549	3,389,825	3,335,072	124	4,152	809	3,655,955	4,564	887
Sex													
Male	1,078	66	32,760	30	2,016	4,249,565	4,145,424	127	3,845	255	4,338,259	4,042	267
Female	1,898	93	63,229	33	3,094	8,012,760	7,875,960	125	4,151	385	8,440,899	4,468	413
Medicare Status													
Aged	2,652	87	84,201	32	2,770	10,721,466	10,537,089	125	3,974	347	11,321,276	4,286	372
Disabled	324	52	11,788	36	1,875	1,540,858	1,484,295	126	4,579	236	1,457,882	4,546	232
Race													
White	2,435	79	73,246	30	2,375	9,364,448	9,175,849	125	3,769	298	9,891,586	4,080	321
Other[3]	541	93	22,743	42	3,888	2,897,877	2,845,534	125	5,259	486	2,887,572	5,368	494

[1]Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates and average payments.

[2]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

[3]Includes unknown race.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.2

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Demographic Characteristics: Calendar Year 2006

Demographic Characteristic	Persons Served: Number in Thousands	Persons Served: Per 1,000 Enrollees[1]	Visits: Number in Thousands	Visits: Per Person Served	Visits: Per 1,000 Enrollees[1]	Total Charges in Thousands	Visit Charges: Amount in Thousands	Visit Charges: Per Visit	Visit Charges: Per Person Served	Visit Charges: Per Enrollee[1]	Program Payments: Amount in Thousands	Program Payments: Per Person Served[2]	Program Payments: Per Enrollee[1]
Total	3,026	84	104,127	34	2,905	$13,627,482	$13,410,519	$129	$4,431	$374	$13,912,750	$4,619	$388
Age													
Under 65 Years	339	54	13,137	39	2,110	1,754,364	1,702,283	130	5,023	273	1,644,648	4,908	264
65-74 Years	709	47	22,920	32	1,510	3,027,033	2,981,005	130	4,206	196	3,040,979	4,316	200
75-84 Years	1,141	111	38,502	34	3,739	5,028,134	4,959,827	129	4,347	482	5,194,744	4,568	504
85 Years or Over	838	202	29,569	35	7,133	3,817,951	3,767,403	127	4,498	909	4,032,379	4,828	973
Sex													
Male	1,100	69	35,713	33	2,238	4,741,412	4,645,825	130	4,222	291	4,748,864	4,337	298
Female	1,926	97	68,414	36	3,440	8,886,069	8,764,694	128	4,551	441	9,163,886	4,780	461
Type of Entitlement													
Aged	2,687	91	90,990	34	3,072	11,873,117	11,708,236	129	4,357	395	12,268,102	4,583	414
Disabled	339	54	13,137	39	2,110	1,754,364	1,702,283	130	5,023	273	1,644,648	4,908	264
Race													
White	2,468	82	78,267	32	2,598	10,271,691	10,086,374	129	4,087	335	10,656,082	4,337	354
Other[3]	559	98	25,861	46	4,519	3,355,790	3,324,145	129	5,951	581	3,256,668	5,867	569

[1]Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates and average payments.

[2]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

[3]Includes unknown race.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.3

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2005

Area of Residence	Persons Served: Number in Thousands	Persons Served: Per 1,000 Enrollees[1]	Visits: Number in Thousands	Visits: Per Person Served	Visits: Per 1,000 Enrollees[1]	Total Charges in Thousands
All Areas [3]	2,976	81	95,989	32	2,617	$12,262,325
United States [4]	2,904	81	94,182	32	2,627	12,014,835
Northeast	615	89	18,253	30	2,643	2,243,602
Midwest	631	71	16,081	26	1,804	2,115,827
South	1,257	90	48,286	38	3,466	5,947,745
West	400	66	11,561	29	1,895	1,707,661
New England	196	101	6,271	32	3,230	684,839
Connecticut	50	100	1,658	34	3,345	161,323
Maine	19	81	470	25	1,999	55,277
Massachusetts	91	112	3,045	34	3,757	348,259
New Hampshire	16	82	469	30	2,471	52,235
Rhode Island	11	98	274	24	2,389	34,885
Vermont	10	100	355	37	3,696	32,858
Middle Atlantic	420	85	11,983	29	2,414	1,558,763
New Jersey	87	77	2,155	25	1,914	292,038
New York	182	81	6,282	35	2,810	788,908
Pennsylvania	151	94	3,545	24	2,213	477,818
East North Central	476	77	12,454	26	2,004	1,662,741
Illinois	138	86	3,500	25	2,188	494,674
Indiana	50	57	1,497	30	1,698	181,006
Michigan	138	95	3,594	26	2,465	515,306
Ohio	115	75	3,007	26	1,974	369,474
Wisconsin	35	46	856	25	1,136	102,281
West North Central	155	57	3,627	23	1,343	453,086
Iowa	22	48	558	25	1,204	57,380
Kansas	20	51	496	25	1,283	63,114
Minnesota	28	49	606	22	1,049	81,321
Missouri	62	78	1,493	24	1,872	193,006
Nebraska	13	51	277	22	1,113	36,032
North Dakota	5	52	102	19	993	10,798
South Dakota	5	40	95	19	765	11,436

See footnotes at end of table.

Table 7.3—Continued

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2005

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served[2]
$12,021,384	$125	$4,040	$328	$12,779,158	$133	$4,314
11,785,985	125	4,059	329	12,541,371	133	4,339
2,202,661	121	3,581	319	2,371,558	130	3,870
2,075,800	129	3,290	233	2,325,786	145	3,704
5,824,610	121	4,633	418	6,096,332	126	4,870
1,682,914	146	4,203	276	1,747,694	151	4,392
673,676	107	3,446	347	798,826	127	4,102
158,672	96	3,206	320	202,842	122	4,112
53,729	114	2,810	229	62,361	133	3,278
343,677	113	3,797	424	393,961	129	4,367
51,328	110	3,307	271	62,481	133	4,041
34,068	125	3,034	297	39,867	146	3,564
32,202	91	3,348	335	37,314	105	3,917
1,528,985	128	3,644	308	1,572,733	131	3,761
287,432	133	3,314	255	319,966	148	3,702
772,378	123	4,248	346	750,617	119	4,144
469,175	132	3,105	293	502,150	142	3,335
1,633,595	131	3,432	263	1,839,543	148	3,882
485,568	139	3,519	304	578,169	165	4,208
177,112	118	3,511	201	187,115	125	3,727
507,737	141	3,675	348	565,145	157	4,109
362,924	121	3,165	238	397,906	132	3,482
100,254	117	2,887	133	111,209	130	3,224
442,205	122	2,855	164	486,243	134	3,157
56,303	101	2,552	122	62,924	113	2,870
61,670	124	3,104	160	66,233	134	3,355
80,120	132	2,862	139	84,902	140	3,057
187,262	125	3,016	235	207,864	139	3,362
35,032	126	2,769	141	38,301	138	3,042
10,618	104	2,009	104	12,093	119	2,310
11,200	118	2,256	90	13,926	147	2,821

Table 7.3—Continued

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2005

Area of Residence	Persons Served: Number in Thousands	Persons Served: Per 1,000 Enrollees[1]	Visits: Number in Thousands	Visits: Per Person Served	Visits: Per 1,000 Enrollees[1]	Total Charges in Thousands
South Atlantic	619	83	19,412	31	2,599	$2,422,699
Delaware	9	74	215	23	1,695	26,987
District of Columbia	5	80	127	23	1,870	16,508
Florida	263	107	10,501	40	4,278	1,297,324
Georgia	69	69	2,017	29	1,995	251,179
Maryland	46	70	945	20	1,423	127,494
North Carolina	91	76	2,155	24	1,798	265,192
South Carolina	43	67	1,031	24	1,608	132,262
Virginia	72	74	1,954	27	2,013	248,903
West Virginia	20	60	467	23	1,403	56,851
East South Central	222	85	8,023	36	3,050	963,937
Alabama	56	82	1,936	35	2,819	220,559
Kentucky	51	77	1,531	30	2,325	186,827
Mississippi	42	93	1,636	39	3,623	199,664
Tennessee	74	88	2,920	40	3,503	356,887
West South Central	416	108	20,852	50	5,440	2,561,110
Arkansas	30	64	1,079	36	2,297	127,102
Louisiana	69	128	3,829	55	7,065	449,805
Oklahoma	49	100	2,543	52	5,126	285,045
Texas	267	115	13,400	50	5,763	1,699,157
Mountain	125	62	3,695	30	1,840	466,145
Arizona	29	49	602	21	1,038	82,467
Colorado	28	73	759	27	1,990	97,572
Idaho	11	65	303	27	1,766	37,651
Montana	7	46	154	23	1,051	18,952
Nevada	16	74	474	30	2,240	70,758
New Mexico	14	61	397	29	1,777	52,003
Utah	18	82	914	50	4,078	96,222
Wyoming	3	48	93	28	1,333	10,520
Pacific	275	67	7,866	29	1,922	1,241,517
Alaska	2	41	44	21	849	8,296
California	208	73	6,571	32	2,296	1,028,545
Hawaii	3	27	60	18	489	10,199
Oregon	24	67	461	19	1,264	77,622
Washington	38	54	731	19	1,054	116,853
Outlying Areas[5]	72	87	1,808	25	2,178	247,489

[1]Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates and average payments.

[2]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

[3]Includes United States and outlying areas.

[4]Includes 50 States and District of Columbia.

[5]Includes Puerto Rico, Virgin Islands, Guam, residence unknown, and all other outlying areas.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.3—Continued

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2005

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served[2]
$2,366,603	$122	$3,822	$317	$2,534,709	$131	$4,111
26,517	123	2,823	209	31,024	144	3,319
16,206	128	2,979	239	20,799	164	3,843
1,281,619	122	4,874	522	1,207,588	115	4,613
242,323	120	3,491	240	291,286	144	4,210
123,948	131	2,670	187	153,256	162	3,314
251,480	117	2,774	210	323,622	150	3,585
126,632	123	2,954	198	167,041	162	3,912
243,428	125	3,384	251	270,211	138	3,774
54,450	117	2,709	163	69,881	150	3,488
934,319	116	4,200	355	1,025,974	128	4,633
214,744	111	3,835	313	248,048	128	4,449
178,556	117	3,515	271	197,699	129	3,903
191,763	117	4,564	425	205,429	126	4,912
349,256	120	4,744	419	374,798	128	5,117
2,523,689	121	6,072	658	2,535,649	122	6,127
123,523	114	4,100	263	115,333	107	3,852
442,937	116	6,404	817	442,879	116	6,429
280,731	110	5,690	566	271,388	107	5,522
1,676,498	125	6,278	721	1,706,049	127	6,416
457,759	124	3,658	228	495,007	134	3,979
80,578	134	2,823	139	93,756	156	3,301
96,359	127	3,471	253	105,362	139	3,819
36,464	121	3,298	213	41,519	137	3,788
18,416	120	2,740	126	21,437	139	3,200
69,562	147	4,443	329	74,605	157	4,783
50,802	128	3,716	228	54,737	138	4,021
95,173	104	5,183	425	92,245	101	5,064
10,405	112	3,104	149	11,346	122	3,415
1,225,154	156	4,451	299	1,252,687	159	4,580
8,161	186	3,845	158	8,452	192	4,006
1,018,812	155	4,903	356	1,019,956	155	4,941
9,977	167	3,039	82	11,202	187	3,434
74,724	162	3,079	205	79,958	173	3,312
113,480	155	3,005	164	133,119	182	3,542
235,398	130	3,267	284	237,787	132	3,314

Table 7.3

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2006

Area of Residence	Persons Served		Visits			Total Charges
	Number in Thousands	Per 1,000 Enrollees[1]	Number in Thousands	Per Person Served	Per 1,000 Enrollees[1]	in Thousands
All Areas[3]	3,026	84	104,127	34	2,905	$13,627,482
United States[4]	2,959	84	102,476	35	2,913	13,387,090
Northeast	604	89	18,012	30	2,664	2,305,475
Midwest	646	74	17,192	27	1,974	2,320,984
South	1,311	96	55,706	43	4,067	6,970,573
West	398	66	11,566	29	1,924	1,790,058
New England	199	102	6,360	32	3,254	724,643
Connecticut	50	101	1,675	34	3,409	166,753
Maine	20	82	482	25	2,026	59,672
Massachusetts	92	113	3,099	34	3,790	374,503
New Hampshire	17	85	487	30	2,500	55,774
Rhode Island	11	95	272	25	2,381	34,757
Vermont	10	96	345	36	3,501	33,183
Middle Atlantic	405	84	11,652	29	2,425	1,580,831
New Jersey	87	77	2,093	24	1,852	304,955
New York	178	82	6,186	35	2,827	806,767
Pennsylvania	140	94	3,373	24	2,268	469,110
East North Central	494	81	13,538	27	2,222	1,847,845
Illinois	145	91	3,929	27	2,462	561,594
Indiana	53	61	1,647	31	1,909	203,337
Michigan	145	102	3,838	27	2,693	567,087
Ohio	117	78	3,274	28	2,182	410,490
Wisconsin	34	49	851	25	1,201	105,336
West North Central	152	58	3,654	24	1,397	473,140
Iowa	22	48	548	25	1,225	59,043
Kansas	20	53	527	26	1,382	68,009
Minnesota	27	50	587	22	1,110	82,554
Missouri	61	77	1,532	25	1,932	203,828
Nebraska	13	52	276	22	1,133	37,272
North Dakota	5	49	92	19	928	10,699
South Dakota	5	37	93	20	753	11,736

See footnotes at end of table.

Table 7.3—Continued

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2006

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served[2]
$13,410,519	$129	$4,431	$374	$13,912,750	$134	$4,619
13,179,610	129	4,454	375	13,680,152	133	4,645
2,259,066	125	3,741	334	2,376,178	132	3,952
2,279,799	133	3,529	262	2,545,924	148	3,961
6,848,094	123	5,223	500	6,955,768	125	5,329
1,792,652	155	4,501	298	1,802,282	156	4,554
713,297	112	3,593	365	832,055	131	4,209
164,110	98	3,305	334	208,310	124	4,213
57,901	120	2,959	243	66,592	138	3,422
369,983	119	4,002	452	411,782	133	4,470
54,938	113	3,327	282	66,457	136	4,042
33,992	125	3,136	298	39,382	145	3,647
32,374	94	3,415	328	39,532	115	4,209
1,545,768	133	3,814	322	1,544,123	133	3,825
295,045	141	3,402	261	322,291	154	3,730
789,591	128	4,428	361	739,952	120	4,167
461,132	137	3,288	310	481,880	143	3,450
1,817,948	134	3,681	298	2,046,011	151	4,162
552,329	141	3,798	346	666,903	170	4,606
198,683	121	3,756	230	212,722	129	4,039
560,075	146	3,873	393	621,247	162	4,318
403,676	123	3,465	269	428,453	131	3,692
103,184	121	2,996	146	116,686	137	3,408
461,851	126	3,036	177	499,913	137	3,307
58,074	106	2,691	130	63,731	116	2,972
66,432	126	3,267	174	70,956	135	3,509
81,230	138	3,047	154	86,280	147	3,263
197,844	129	3,224	250	213,918	140	3,503
36,234	131	2,846	149	39,738	144	3,143
10,547	115	2,172	107	11,419	124	2,370
11,490	123	2,516	93	13,872	149	3,050

Table 7.3—Continued

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2006

Area of Residence	Persons Served: Number in Thousands	Persons Served: Per 1,000 Enrollees[1]	Visits: Number in Thousands	Visits: Per Person Served	Visits: Per 1,000 Enrollees[1]	Total Charges in Thousands
South Atlantic	637	87	23,168	36	3,163	$2,901,110
Delaware	9	72	215	23	1,661	27,686
District of Columbia	5	79	120	22	1,760	16,217
Florida	277	117	13,938	50	5,870	1,706,313
Georgia	73	73	2,178	30	2,177	276,770
Maryland	47	69	957	21	1,425	134,307
North Carolina	90	77	2,198	24	1,873	277,745
South Carolina	44	70	1,126	26	1,783	147,255
Virginia	73	77	1,974	27	2,089	257,781
West Virginia	19	59	462	24	1,401	57,036
East South Central	226	88	8,426	37	3,270	1,043,356
Alabama	58	86	2,073	36	3,068	242,440
Kentucky	51	79	1,584	31	2,451	200,401
Mississippi	44	98	1,745	40	3,928	225,731
Tennessee	74	91	3,025	41	3,733	374,783
West South Central	448	118	24,111	54	6,351	3,026,107
Arkansas	31	67	1,159	38	2,527	142,311
Louisiana	68	127	3,876	57	7,251	467,219
Oklahoma	53	107	2,921	55	5,895	344,843
Texas	296	128	16,155	55	7,000	2,071,734
Mountain	123	64	3,691	30	1,918	484,480
Arizona	26	48	539	21	1,014	80,338
Colorado	27	72	715	26	1,885	94,612
Idaho	11	66	320	29	1,930	40,368
Montana	7	49	149	22	1,068	18,754
Nevada	17	77	503	30	2,325	75,422
New Mexico	14	66	461	32	2,104	61,584
Utah	18	86	913	52	4,491	103,022
Wyoming	3	46	91	28	1,308	10,379
Pacific	276	68	7,876	29	1,927	1,305,578
Alaska	2	42	50	22	931	9,828
California	211	73	6,640	32	2,316	1,093,406
Hawaii	3	27	58	18	486	10,370
Oregon	22	62	390	18	1,123	67,607
Washington	38	55	738	19	1,054	124,367
Outlying Areas[5]	67	100	1,651	25	2,460	240,392

[1]Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates and average payments.

[2]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

[3]Includes United States and outlying areas.

[4]Includes 50 States and District of Columbia.

[5]Includes Puerto Rico, Virgin Islands, Guam, residence unknown, and all other outlying areas.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.3—Continued

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 2006

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served[2]
$2,842,470	$123	$4,460	$388	$2,860,637	$123	$4,508
27,127	126	2,910	209	31,619	147	3,404
15,861	133	2,948	233	19,747	165	3,705
1,690,353	121	6,110	712	1,473,243	106	5,349
266,660	122	3,646	267	316,556	145	4,344
130,285	136	2,805	194	156,476	164	3,381
264,388	120	2,930	225	335,515	153	3,733
140,801	125	3,190	223	182,105	162	4,144
252,080	128	3,466	267	277,964	141	3,844
54,914	119	2,843	167	67,412	146	3,505
1,010,775	120	4,471	392	1,116,827	133	4,961
236,095	114	4,078	349	269,949	130	4,682
192,229	121	3,778	297	211,060	133	4,163
217,161	124	4,995	489	230,235	132	5,316
365,291	121	4,946	451	405,583	134	5,521
2,994,849	124	6,691	789	2,978,304	124	6,683
138,967	120	4,519	303	125,909	109	4,118
461,146	119	6,783	863	458,621	118	6,769
343,054	117	6,485	692	319,110	109	6,059
2,051,682	127	6,932	889	2,074,663	128	7,041
476,248	129	3,887	248	498,565	135	4,097
78,728	146	3,066	148	85,697	159	3,358
93,420	131	3,417	246	101,314	142	3,728
39,421	123	3,584	238	42,398	132	3,875
18,239	122	2,690	131	21,771	146	3,230
74,151	147	4,487	343	81,938	163	4,989
60,184	131	4,168	275	62,072	135	4,326
101,846	112	5,807	501	92,336	101	5,320
10,258	113	3,183	148	11,040	121	3,472
1,316,404	167	4,774	322	1,303,716	166	4,756
9,615	191	4,264	178	9,566	191	4,256
1,110,000	167	5,272	387	1,073,216	162	5,131
10,110	175	3,147	85	11,470	198	3,604
65,626	168	3,047	189	69,867	179	3,255
121,053	164	3,170	173	139,597	189	3,670
230,909	140	3,443	344	232,598	141	3,486

Table 7.4

Persons Using Medicare Home Health Agency Services, Visits, and Charges, by Type of Visit, Type of Agency, and Type of Control: Calendar Year 2005

Type of Visit	Type of Agency						Type of Control		
	All Agencies	Visiting Nurse Association	Combined Government and Voluntary	Official Health Agency	Hospital-based	Other[1]	Voluntary Non-Profit	Proprietary	Govern-ment
	Persons Served in Thousands								
Total[2]	2,976	455	6	265	759	1,602	1,457	1,455	175
Nursing Care	2,746	403	6	234	666	1,437	1,275	1,310	159
Home Health Aide	770	108	2	72	180	407	342	373	55
Physical Therapy	1,990	297	4	166	483	1,040	948	939	103
Speech Therapy	101	15	(4)	8	27	51	51	46	5
Occupational Therapy	702	116	1	53	175	358	357	317	29
Other[3]	433	68	1	34	110	220	221	196	16
	Percent of Persons Served								
Total[2]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Care	92.3	88.4	95.0	88.5	87.8	89.7	87.6	90.0	90.5
Home Health Aide	25.9	23.8	35.0	27.3	23.8	25.4	23.5	25.6	31.4
Physical Therapy	66.9	65.3	56.9	62.7	63.6	64.9	65.1	64.6	58.7
Speech Therapy	3.4	3.4	1.4	3.1	3.5	3.2	3.5	3.2	2.7
Occupational Therapy	23.6	25.5	9.5	19.9	23.1	22.3	24.5	21.8	16.6
Other[3]	14.5	14.9	12.4	12.8	14.4	13.8	15.2	13.5	8.9
	Visits in Thousands								
Total	95,989	11,626	231	8,781	17,417	57,933	35,075	55,936	4,979
Nursing Care	49,442	5,549	128	4,513	8,508	30,743	16,731	30,397	2,314
Home Health Aide	19,703	2,544	56	1,877	3,311	11,915	7,072	11,293	1,337
Physical Therapy	21,343	2,707	40	1,938	4,354	12,303	8,697	11,558	1,088
Speech Therapy	663	88	(5)	58	165	350	305	322	36
Occupational Therapy	4,041	602	5	326	889	2,219	1,860	2,008	173
Other[3]	798	136	2	68	190	402	410	357	30

See footnotes at end of table.

Table 7.4—Continued

Persons Using Medicare Home Health Agency Services, Visits, and Charges, by Type of Visit, Type of Agency, and Type of Control: Calendar Year 2005

Type of Visit	All Agencies	Visiting Nurse Association	Combined Government and Voluntary	Official Health Agency	Hospital-Based	Other[1]	Voluntary Non-Profit	Proprietary	Govern-ment
	Type of Agency						Type of Control		
	Percent Distribution of Visits								
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Care	51.5	47.7	55.2	51.4	48.9	53.1	47.7	54.3	46.5
Home Health Aide	20.5	21.9	24.2	21.4	19.0	20.6	20.2	20.2	26.9
Physical Therapy	22.2	23.3	17.5	22.1	25.0	21.2	24.8	20.7	21.9
Speech Therapy	0.7	0.8	0.2	0.7	0.9	0.6	0.9	0.6	0.7
Occupational Therapy	4.2	5.2	2.1	3.7	5.1	3.8	5.3	3.6	3.5
Other[3]	0.8	1.2	0.8	0.8	1.1	0.7	1.2	0.6	0.6
	Visit Charges in Millions								
Total	$12,021	$1,404	$23	$1,082	$2,338	$7,175	$4,508	$6,957	$557
Nursing Care	6,613	744	14	605	1,224	4,026	2,337	3,984	292
Home Health Aide	1,533	168	4	141	271	948	528	911	94
Physical Therapy	3,054	373	5	269	647	1,761	1,254	1,662	139
Speech Therapy	98	13	(6)	9	25	51	46	48	5
Occupational Therapy	583	83	1	47	133	320	269	292	23
Other[3]	140	23	(6)	11	37	68	74	61	5
	Percent Distribution of Visit Charges								
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Care	55.0	53.0	60.2	55.9	52.4	56.1	51.9	57.3	52.4
Home Health Aide	12.7	12.0	16.0	13.1	11.6	13.2	11.7	13.1	16.9
Physical Therapy	25.4	26.5	19.9	24.9	27.6	24.5	27.8	23.9	24.9
Speech Therapy	0.8	0.9	0.3	0.8	1.1	0.7	1.0	0.7	0.8
Occupational Therapy	4.9	5.9	2.6	4.3	5.7	4.5	6.0	4.2	4.0
Other[3]	1.2	1.6	1.1	1.0	1.6	1.0	1.6	0.9	0.9

See footnotes at end of table.

Table 7.4—Continued
Persons Using Medicare Home Health Agency Services, Visits, and Charges, by Type of Visit, Type of Agency, and Type of Control: Calendar Year 2005

Type of Visit	Type of Agency						Type of Control		
	All Agencies	Visiting Nurse Association	Combined Government and Voluntary	Official Health Agency	Hospital-Based	Other[1]	Voluntary Non-Profit	Proprietary	Govern-ment
	Average Number of Visits per Person Served								
Total	32	26	37	33	23	36	24	38	28
Nursing Care	18	14	22	19	13	21	13	23	15
Home Health Aide	26	24	26	26	18	29	21	30	24
Physical Therapy	11	9	11	12	9	12	9	12	11
Speech Therapy	7	6	5	7	6	7	6	7	7
Occupational Therapy	6	5	8	6	5	6	5	6	6
Other[3]	2	2	2	2	2	2	2	2	2
	Average Visit Charge per Visit								
Total	$125	$121	$100	$129	$134	$124	$129	$124	$112
Nursing Care	134	134	109	134	144	131	140	131	126
Home Health Aide	78	66	66	75	82	80	75	81	70
Physical Therapy	143	138	114	139	148	143	144	144	127
Speech Therapy	148	145	142	145	153	146	149	148	131
Occupational Therapy	144	138	123	143	150	144	145	145	130
Other[3]	176	169	136	165	198	170	181	171	167
	Average Visit Charge per Person Served								
Total	$4,040	$3,083	$3,690	$4,085	$3,080	$4,477	$3,095	$4,781	$3,179
Nursing Care	2,409	1,848	2,338	2,582	1,837	2,803	1,833	3,042	1,841
Home Health Aide	1,990	1,555	1,688	1,957	1,504	2,327	1,543	2,442	1,708
Physical Therapy	1,534	1,254	1,290	1,620	1,339	1,693	1,322	1,769	1,348
Speech Therapy	966	836	692	1,031	951	1,004	901	1,038	975
Occupational Therapy	831	718	991	886	760	894	755	920	776
Other[3]	324	339	314	331	342	310	335	312	325

[1]Represents skilled nursing facility-based, freestanding non-visiting nurse association agencies, community home health agencies, rehabilitation-based agencies, and unknown agencies.

[2]Numbers do not add to total since persons may receive more than 1 type of service.

[3]Includes medical social services and other health disciplines.

[4]Fewer than 500 persons served.

[5]Less than $500.

[6]Less than $500,000.

NOTE: Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. Numbers may not add to total because of rounding

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 7.4

Persons Using Medicare Home Health Agency Services, Visits, and Charges, by Type of Visit, Type of Agency, and Type of Control: Calendar Year 2006

Type of Visit	All Agencies	Type of Agency: Visiting Nurse Association	Type of Agency: Combined Government and Voluntary	Type of Agency: Official Health Agency	Type of Agency: Hospital-Based	Type of Agency: Other[1]	Type of Control: Voluntary Non-Profit	Type of Control: Proprietary	Type of Control: Govern-ment
				Persons Served in Thousands					
Total[2]	3,026	486	6	264	714	1,672	1,392	1,583	164
Nursing Care	2,809	433	5	236	629	1,506	1,223	1,435	148
Home Health Aide	774	121	2	73	167	411	325	398	51
Physical Therapy	2,063	324	3	169	464	1,103	923	1,041	98
Speech Therapy	106	17	(4)	8	26	56	50	52	5
Occupational Therapy	737	126	(4)	52	171	387	354	354	29
Other[3]	429	75	1	31	101	222	208	207	14
				Percent of Persons Served					
Total[2]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Care	92.8	89.0	96.1	89.5	88.1	90.1	87.9	90.6	90.2
Home Health Aide	25.6	24.8	33.6	27.5	23.4	24.6	23.3	25.1	30.9
Physical Therapy	68.2	66.7	57.0	63.9	65.0	66.0	66.4	65.8	60.1
Speech Therapy	3.5	3.5	1.1	3.0	3.6	3.3	3.6	3.3	2.8
Occupational Therapy	24.4	26.0	6.4	19.9	23.9	23.2	25.5	22.4	17.7
Other[3]	14.2	15.4	12.0	11.8	14.1	13.3	15.0	13.1	8.3
				Visits in Thousands					
Total	104,127	13,288	172	9,856	16,420	64,392	34,120	65,389	4,619
Nursing Care	54,373	6,220	87	5,122	8,030	34,914	16,287	35,986	2,101
Home Health Aide	21,267	3,129	46	2,247	3,039	12,806	6,906	13,111	1,251
Physical Therapy	22,637	3,009	35	2,022	4,151	13,420	8,394	13,208	1,036
Speech Therapy	721	99	(5)	60	160	402	302	385	34
Occupational Therapy	4,342	680	2	344	867	2,449	1,850	2,320	172
Other[3]	788	151	1	61	173	400	382	380	26

See footnotes at end of table.

Table 7.4—Continued

Persons Using Medicare Home Health Agency Services, Visits, and Charges, by Type of Visit, Type of Agency, and Type of Control: Calendar Year 2006

Type of Visit	All Agencies	Type of Agency: Visiting Nurse Association	Type of Agency: Combined Government and Voluntary	Type of Agency: Official Health Agency	Type of Agency: Hospital-Based	Type of Agency: Other[1]	Type of Control: Voluntary Non-Profit	Type of Control: Proprietary	Type of Control: Govern-ment
				Percent Distribution of Visits					
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Care	52.2	46.8	50.8	52.0	48.9	54.2	47.7	55.0	45.5
Home Health Aide	20.4	23.6	26.5	22.8	18.5	19.9	20.2	20.1	27.1
Physical Therapy	21.7	22.6	20.6	20.5	25.3	20.8	24.6	20.2	22.4
Speech Therapy	0.7	0.7	0.2	0.6	1.0	0.6	0.9	0.6	0.7
Occupational Therapy	4.2	5.1	1.0	3.5	5.3	3.8	5.4	3.5	3.7
Other[3]	0.8	1.1	0.8	0.6	1.1	0.6	1.1	0.6	0.6
				Visit Charges in Millions					
Total	$13,411	$1,638	$18	$1,246	$2,296	$8,213	$4,523	$8,352	$535
Nursing Care	7,461	864	10	704	1,202	4,681	2,349	4,834	278
Home Health Aide	1,718	211	3	182	259	1,064	528	1,100	90
Physical Therapy	3,336	426	4	292	640	1,975	1,252	1,949	135
Speech Therapy	109	15	(6)	9	26	60	47	58	5
Occupational Therapy	643	96	(6)	50	135	362	276	344	23
Other[3]	142	26	(6)	11	35	70	71	67	5
				Percent Distribution of Visit Charges					
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Care	55.6	52.8	57.8	56.5	52.4	57.0	51.9	57.9	51.9
Home Health Aide	12.8	12.9	15.9	14.6	11.3	12.9	11.7	13.2	16.8
Physical Therapy	24.9	26.0	23.7	23.4	27.9	24.1	27.7	23.3	25.3
Speech Therapy	0.8	0.9	0.3	0.7	1.1	0.7	1.0	0.7	0.8
Occupational Therapy	4.8	5.9	1.2	4.0	5.9	4.4	6.1	4.1	4.4
Other[3]	1.1	1.6	1.2	0.9	1.5	0.9	1.6	0.8	0.8

See footnotes at end of table.

Table 7.4—Continued
Persons Using Medicare Home Health Agency Services, Visits, and Charges, by Type of Visit, Type of Agency, and Type of Control: Calendar Year 2006

Type of Visit	All Agencies	Type of Agency: Visiting Nurse Association	Combined Government and Voluntary	Official Health Agency	Hospital-Based	Other[1]	Type of Control: Voluntary Non-Profi	Proprietary	Govern-ment
				Average Number of Visits per Person Servec					
Total	34	27	30	37	23	39	25	41	28
Nursing Care	19	14	16	22	13	23	13	25	14
Home Health Aide	28	26	24	31	18	31	21	33	25
Physical Therapy	11	9	11	12	9	12	9	13	11
Speech Therapy	7	6	6	8	6	7	6	7	8
Occupational Therapy	6	5	5	7	5	6	5	7	6
Other[3]	2	2	2	2	2	2	2	2	2
				Average Visit Charge per Visi					
Total	$129	$123	$102	$126	$140	$128	$133	$128	$116
Nursing Care	137	139	116	137	150	134	144	134	132
Home Health Aide	81	67	61	81	85	83	77	84	72
Physical Therapy	147	141	117	144	154	147	149	148	131
Speech Therapy	152	148	131	145	160	150	154	151	132
Occupational Therapy	148	142	118	144	155	148	149	148	136
Other[3]	181	170	150	175	205	176	186	176	176
				Average Visit Charge per Person Servec					
Total	$4,431	$3,368	$3,066	$4,727	$3,216	$4,913	$3,250	$5,275	$3,268
Nursing Care	2,656	1,996	1,843	2,981	1,910	3,109	1,921	3,369	1,879
Home Health Aide	2,220	1,748	1,448	2,510	1,546	2,585	1,627	2,766	1,774
Physical Therapy	1,617	1,312	1,271	1,730	1,379	1,791	1,356	1,872	1,375
Speech Therapy	1,031	858	778	1,105	998	1,088	935	1,128	981
Occupational Therapy	872	762	575	947	789	935	778	971	805
Other[3]	331	343	313	343	352	317	341	322	334

[1]Represents skilled nursing facility-based, freestanding non-visiting nurse association agencies, community home health agencies, rehabilitation-based agencies, and unknown agencies.

[2]Numbers do not add to total since persons may receive more than 1 type of service.

[3]Includes medical social services and other health disciplines.

[4]Fewer than 500 persons served.

[5]Less than 500.

[6]Less than $500,000.

NOTE: Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. Numbers may not add to total because of rounding

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 7.5

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, and Program Payments, by Number of Visits: Calendar Years 1997 and 2005

Number of Visits	Persons Served		Visits		Total Charges		Program Payments	
	Number in Thousands	Percent	Number in Thousands	Percent	Amount in Thousands	Percent	Amount in Thousands	Percent
1997								
Total	3,558	100.0	258,168	100.0	$23,460,105	100.0	$16,718,263	100.0
1-9	820	23.0	4,096	1.6	453,521	1.9	326,454	2.0
10-19	647	18.2	9,094	3.5	978,214	4.2	676,581	4.0
20-29	395	11.1	9,532	3.7	1,002,319	4.3	694,720	4.2
30-39	265	7.4	9,085	3.5	936,294	4.0	653,835	3.9
40-49	193	5.4	8,563	3.3	869,803	3.7	610,492	3.7
50-99	506	14.2	35,469	13.7	3,486,321	14.9	2,466,810	14.8
More than 100	732	20.6	182,330	70.6	15,733,632	67.1	11,289,371	67.5
2005								
Total	2,976	100.0	95,989	100.0	$12,262,325	100.0	$12,779,158	100.0
1-9	863	29.0	4,925	5.1	708,753	5.8	1,178,004	9.2
10-19	835	28.1	12,129	12.6	1,714,115	14.0	2,469,735	19.3
20-29	439	14.8	10,926	11.4	1,499,113	12.2	1,801,794	14.1
30-39	244	8.2	8,639	9.0	1,156,546	9.4	1,280,637	10.0
40-49	152	5.1	6,940	7.2	916,665	7.5	981,974	7.7
50-99	284	9.5	19,837	20.7	2,537,457	20.7	2,506,459	19.6
More than 100	160	5.4	32,593	34.0	3,729,676	30.4	2,560,554	20.0

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.5

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, and Program Payments, by Number of Visits: Calendar Years 1997 and 2006

Number of Visits	Persons Served		Visits		Total Charges		Program Payments	
	Number in Thousands	Percent	Number in Thousands	Percent	Amount in Thousands	Percent	Amount in Thousands	Percent
1997								
Total	3,558	100.0	258,168	100.0	$23,460,105	100.0	$16,718,263	100.0
1-9	820	23.0	4,096	1.6	453,521	1.9	326,454	2.0
10-19	647	18.2	9,094	3.5	978,214	4.2	676,581	4.0
20-29	395	11.1	9,532	3.7	1,002,319	4.3	694,720	4.2
30-39	265	7.4	9,085	3.5	936,294	4.0	653,835	3.9
40-49	193	5.4	8,563	3.3	869,803	3.7	610,492	3.7
50-99	506	14.2	35,469	13.7	3,486,321	14.9	2,466,810	14.8
100 or More	732	20.6	182,330	70.6	15,733,632	67.1	11,289,371	67.5
2006								
Total	3,026	100.0	104,127	100.0	$13,627,482	100.0	$13,912,750	100.0
1-9	833	27.5	4,794	4.6	715,150	5.2	1,170,554	8.4
10-19	842	27.8	12,274	11.8	1,797,036	13.2	2,538,364	18.2
20-29	454	15.0	11,321	10.9	1,609,324	11.8	1,911,030	13.7
30-39	253	8.4	8,958	8.6	1,240,706	9.1	1,368,051	9.8
40-49	161	5.3	7,353	7.1	1,002,696	7.4	1,082,017	7.8
50-99	307	10.1	21,458	20.6	2,829,790	20.8	2,826,991	20.3
100 or More	176	5.8	37,969	36.5	4,432,780	32.5	3,015,744	21.7

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.6

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2005

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Total All Diagnoses[4]	---	2,976	100.0	95,989	32	$12,262,325	$12,021,384	$125	$4,040	$12,779,158	$133	$4,314
Total Leading Diagnoses[5]	---	1,433	48.1	42,140	29	5,245,685	5,137,481	122	3,586	4,938,579	117	3,465
Infectious and Parasitic Diseases (MDC 1)	001-139	17	0.6	309	18	39,307	38,454	124	2,287	36,858	119	2,209
Neoplasms (MDC 2)	140-239	90	3.0	1,643	18	210,616	205,276	125	2,287	201,814	123	2,262
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	18	0.6	288	16	37,439	36,895	128	2,042	36,453	126	2,027
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	291	9.8	14,781	51	1,826,443	1,813,170	123	6,232	1,538,803	104	5,329
Diabetes Mellitus	250	261	8.8	14,188	54	1,753,933	1,741,853	123	6,684	1,462,254	103	5,652
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	14	0.5	216	15	27,069	26,590	123	1,848	28,640	132	2,001
Diseases of the Blood and Blood Forming Organs (MDC 4)	280-289	53	1.8	1,465	28	157,777	155,815	106	2,935	160,519	110	3,036
Other Deficiency Anemias	281	25	0.9	844	33	83,502	82,369	98	3,255	86,157	102	3,414
Other and Unspecified Anemias	285	18	0.6	405	23	48,295	47,795	118	2,698	48,725	120	2,760
Coagulation Defects	286	4	0.1	78	19	9,388	9,244	119	2,281	9,192	118	2,288
Mental Disorders (MDC 5)	290-319	48	1.6	1,007	21	123,872	123,262	122	2,549	126,982	126	2,647
Schizophrenic Disorders	295	5	0.2	124	23	15,379	15,335	124	2,844	15,483	125	2,926
Affective Psychoses	296	9	0.3	175	19	22,858	22,776	130	2,523	23,109	132	2,570
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	90	3.0	2,850	32	340,296	335,248	118	3,743	392,072	138	4,432
Parkinson's Disease	332	22	0.7	668	31	80,974	80,376	120	3,707	98,787	148	4,590

See footnotes at end of table.

Table 7.6—Continued

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2005

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Number of Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Diseases of the Circulatory System (MDC 7)	390-459	596	20.0	13,934	23	$1,751,445	$1,721,552	$124	$2,887	$1,767,487	$127	$2,977
Essential Hypertension	401	116	3.9	2,323	20	278,572	277,416	119	2,395	297,456	128	2,582
Hypertensive Heart Disease	402	15	0.5	345	24	40,116	39,897	116	2,719	42,863	124	2,948
Acute Myocardial Infarction	410	17	0.6	256	15	33,037	32,887	129	1,931	33,251	130	1,959
Other Acute and Subacute Forms of Ischemic Heart Disease	411	4	0.1	60	16	7,520	7,492	125	2,013	7,471	125	2,015
Angina Pectoris	413	6	0.2	101	18	11,645	11,600	115	2,021	12,148	120	2,122
Other Forms of Chronic Ischemic Heart Disease	414	45	1.5	748	17	93,358	92,803	124	2,052	96,467	129	2,140
Cardiac Dysrhythmias	427	52	1.8	875	17	109,267	108,560	124	2,074	111,511	127	2,135
Heart Failure	428	170	5.7	3,573	21	443,217	439,286	123	2,581	433,864	121	2,558
Transient Cerebral Ischemia	435	16	0.5	300	19	37,682	37,512	125	2,411	47,911	160	3,085
Acute but Ill-Defined Cerebrovascular Disease	436	26	0.9	704	28	90,174	89,595	127	3,502	104,296	148	4,107
Other Peripheral Vascular Disease	443	11	0.4	306	28	37,436	36,042	118	3,306	33,328	109	3,076
Diseases of the Respiratory System (MDC 8)	460-519	218	7.3	4,074	19	509,584	505,056	124	2,321	516,926	127	2,386
Pneumonia, Organism Unspecified	486	56	1.9	807	14	105,199	104,278	129	1,857	110,514	137	1,973
Chronic Airway Obstruction, not Elsewhere Classified	496	73	2.4	1,481	20	179,196	178,026	120	2,451	179,368	121	2,482
Diseases of the Digestive System (MDC 9)	520-579	60	2.0	1,022	17	129,385	126,596	124	2,102	127,229	124	2,121
Diseases of the Genitourinary System (MDC 10)	580-629	64	2.1	1,255	20	151,080	146,729	117	2,305	151,924	121	2,397
Other Disorders of Urethra and Urinary Tract	599	33	1.1	556	17	68,510	66,889	120	2,032	72,121	130	2,198
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	188	6.3	6,707	36	904,742	835,239	125	4,438	775,021	116	4,136
Other Cellulitis and Abscess	682	43	1.4	939	22	128,697	121,756	130	2,844	100,103	107	2,351
Chronic Ulcer of Skin	707	138	4.6	5,520	40	744,441	683,496	124	4,955	648,529	117	4,719

See footnotes at end of table.

Table 7.6—Continued

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2005

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Number of Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	223	7.5	6,091	27	$742,420	$737,205	$121	$3,313	$832,950	$137	$3,767
Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	714	10	0.3	371	36	41,624	41,314	111	4,011	46,561	125	4,558
Osteoarthrosis and Allied Disorders	715	43	1.4	1,102	26	130,070	129,639	118	3,030	138,813	126	3,277
Other and Unspecified Arthropathies	716	47	1.6	1,390	30	162,075	161,358	116	3,470	201,065	145	4,349
Other and Unspecified Disorders of Back	724	27	0.9	549	20	68,440	68,116	124	2,503	84,342	154	3,115
Other Disorders of Bone and Cartilage	733	12	0.4	537	44	65,821	65,471	122	5,350	46,399	86	3,812
Congenital Anomalies (MDC 14)	740-759	3	0.1	54	21	6,596	6,460	120	2,526	6,679	124	2,648
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	217	7.3	4,492	21	567,731	560,048	125	2,583	661,339	147	3,065
General Symptoms	780	44	1.5	791	18	98,120	97,541	123	2,201	107,528	136	2,438
Symptoms Involving Urinary System	788	19	0.6	512	27	58,810	55,104	108	2,916	55,251	108	2,942
Injury and Poisoning (MDC 17)	800-999	177	5.9	4,741	27	633,919	607,078	128	3,440	544,607	115	3,116
Fracture of Neck of Femur	820	6	0.2	128	23	16,086	15,952	125	2,915	19,696	154	3,617
Open Wound of Other and Unspecified Sites, Except Limbs	879	9	0.3	262	30	34,939	33,307	127	3,871	28,544	109	3,366
Open Wound of Knee, Leg (Except Thigh), and Ankle	891	21	0.7	617	30	82,798	78,912	128	3,801	70,379	114	3,414
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	1,398	47.0	31,562	23	4,166,762	4,103,867	130	2,935	4,937,666	156	3,546

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1). Only the first listed or principal diagnosis has been used.

[2]Numbers do not add to total since persons may have more that one principal diagnosis reported for covered HHA services.

[3]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

[4]Includes invalid codes not listed separately.

[5]Specific leading diagnostic categories were selected for presentation because of frequency of occurrences or because of special interest.

NOTES: MDCs 11 and 15 were not shown separately (but included in the total), because they were for the most part, not applicable to Medicare beneficiaries. Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Changes, as of October 2003, in the medical coding of the ICD-9-CM diagnosis field has resulted in the significant increase in the use of V-codes (Supplementary Classification of Factors Influencing Health Status and Contact with Health Services). That is, V-codes are now being used more frequently in the principal diagnostic field to reflect the fact that the HHA episode is oriented to providing some type of aftercare or rehabilitation service in a post-acute care setting. This is in direct contrast to the acute care setting when the coding of the principal diagnosis is directly related to the underlying condition. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.6

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2006

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Total All Diagnoses[4]	---	3,026	100.0	104,127	34	$13,627,482	$13,410,519	$129	$4,431	$13,912,750	$134	$4,619
Total Leading Diagnoses[5]	---	1,549	51.2	48,855	32	6,245,273	6,151,749	126	3,971	5,788,949	118	3,757
Infectious and Parasitic Diseases (MDC 1)	001-139	17	0.6	322	19	42,022	41,255	128	2,400	39,655	123	2,320
Neoplasms (MDC 2)	140-239	93	3.1	1,700	18	225,104	220,034	129	2,380	216,362	127	2,355
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	19	0.6	309	16	41,168	40,441	131	2,145	40,232	130	2,146
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	326	10.8	18,836	58	2,366,238	2,368,112	126	7,266	1,948,706	103	6,022
Diabetes Mellitus	250	295	9.7	18,191	62	2,284,877	2,287,962	126	7,769	1,863,008	102	6,372
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	13	0.4	210	16	27,804	27,174	129	2,025	28,135	134	2,107
Diseases of the Blood and Blood Forming Organs (MDC 4)	280-289	55	1.8	1,528	28	170,359	168,367	110	3,082	172,081	113	3,163
Other Deficiency Anemias	281	26	0.9	867	33	88,815	87,683	101	3,356	90,557	104	3,477
Other and Unspecified Anemias	285	19	0.6	435	23	53,605	53,085	122	2,861	54,250	125	2,934
Coagulation Defects	286	4	0.1	80	21	9,885	9,758	122	2,566	9,743	122	2,584
Mental Disorders (MDC 5)	290-319	52	1.7	1,109	21	138,818	138,105	125	2,673	142,212	128	2,777
Schizophrenic Disorders	295	6	0.2	136	25	17,091	17,039	125	3,098	17,320	127	3,222
Affective Psychoses	296	9	0.3	182	21	24,110	24,031	132	2,717	24,245	133	2,757
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	110	3.6	3,560	32	437,248	432,080	121	3,931	505,182	142	4,648
Parkinson's Disease	332	28	0.9	870	32	110,672	109,959	126	3,984	132,683	152	4,843

See footnotes at end of table.

Table 7.6—Continued

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2006

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Diseases of the Circulatory System (MDC 7)	390-459	646	21.4	15,874	25	$2,067,825	$2,035,330	$128	$3,149	$2,059,933	$130	$3,200
Essential Hypertension	401	138	4.6	2,878	21	358,451	357,163	124	2,594	377,492	131	2,755
Hypertensive Heart Disease	402	16	0.5	381	23	47,113	46,704	123	2,879	49,815	131	3,086
Acute Myocardial Infarction	410	16	0.5	260	16	34,981	34,778	134	2,133	33,987	131	2,093
Other Acute and Subacute Forms of Ischemic Heart Disease	411	4	0.1	58	17	7,475	7,449	129	2,150	7,369	127	2,128
Angina Pectoris	413	5	0.2	96	18	11,745	11,691	121	2,199	11,734	122	2,209
Other Forms of Chronic Ischemic Heart Disease	414	46	1.5	815	18	104,663	103,991	128	2,258	105,694	130	2,303
Cardiac Dysrhythmias	427	57	1.9	1,033	18	133,541	132,495	128	2,310	133,792	129	2,341
Heart Failure	428	181	6.0	4,014	22	515,913	511,402	127	2,828	497,035	124	2,757
Transient Cerebral Ischemia	435	18	0.6	352	20	46,197	45,764	130	2,605	57,091	162	3,261
Acute but Ill-Defined Cerebrovascular Disease	436	18	0.6	511	28	68,055	67,770	133	3,745	76,949	151	4,292
Other Peripheral Vascular Disease	443	11	0.4	311	28	39,234	37,837	122	3,372	35,145	113	3,144
Diseases of the Respiratory System (MDC 8)	460-519	217	7.2	4,280	20	556,851	551,973	129	2,546	553,929	129	2,567
Pneumonia, Organism Unspecified	486	54	1.8	818	15	110,532	109,687	134	2,018	113,076	138	2,086
Chronic Airway Obstruction, not Elsewhere Classified	496	71	2.4	1,534	21	194,496	193,176	126	2,705	190,957	124	2,689
Diseases of the Digestive System (MDC 9)	520-579	62	2.1	1,085	17	141,605	138,468	128	2,230	138,928	128	2,248
Diseases of the Genitourinary System (MDC 10)	580-629	69	2.3	1,381	20	174,178	169,604	123	2,453	172,833	125	2,510
Other Disorders of Urethra and Urinary Tract	599	37	1.2	645	18	82,631	81,116	126	2,221	85,644	133	2,352
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	187	6.2	6,612	35	923,351	854,475	129	4,559	783,205	118	4,199
Other Cellulitis and Abscess	682	45	1.5	964	21	138,468	131,022	136	2,913	106,582	111	2,383
Chronic Ulcer of Skin	707	135	4.4	5,375	40	749,399	689,382	128	5,124	646,823	120	4,830

See footnotes at end of table.

Table 7.6—Continued

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2006

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2] Number in Thousands	Persons Served[2] Percent	Visits Number in Thousands	Visits Per Person Served	Total Charges in Thousands	Visit Charges Amount in Thousands	Visit Charges Per Visit	Visit Charges Per Person Served	Program Payments Amount in Thousands	Program Payments Per Visit	Program Payments Per Person Served[3]
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	317	10.5	8,905	28	$1,131,300	$1,124,103	$126	$3,544	$1,270,831	$143	$4,031
Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	714	13	0.4	447	35	52,380	52,031	116	4,124	59,649	133	4,754
Osteoarthrosis and Allied Disorders	715	49	1.6	1,313	27	159,857	159,376	121	3,234	168,047	128	3,443
Other and Unspecified Arthropathies	716	63	2.1	1,893	30	231,088	230,311	122	3,683	284,719	150	4,577
Other and Unspecified Disorders of Back	724	38	1.3	795	21	102,739	102,376	129	2,704	126,364	159	3,360
Other Disorders of Bone and Cartilage	733	14	0.5	661	48	81,739	81,471	123	5,955	56,685	86	4,165
Congenital Anomalies (MDC 14)	740-759	3	0.1	57	21	7,202	7,095	125	2,635	7,390	131	2,786
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	264	8.7	5,653	21	743,248	735,917	130	2,788	860,259	152	3,274
General Symptoms	780	52	1.7	939	18	121,165	120,411	128	2,338	130,753	139	2,551
Symptoms Involving Urinary System	788	18	0.6	456	26	55,038	51,935	114	2,939	52,146	114	2,970
Injury and Poisoning (MDC 17)	800-999	186	6.1	5,087	27	702,015	674,059	133	3,634	597,236	117	3,251
Fracture of Neck of Femur	820	5	0.2	135	26	17,037	16,932	125	3,210	19,663	146	3,753
Open Wound of Other and Unspecified Sites, Except Limbs	879	8	0.3	255	31	35,190	34,076	134	4,106	28,367	111	3,482
Open Wound of Knee, Leg (Except Thigh), and Ankle	891	21	0.7	634	30	88,118	84,720	133	3,975	73,198	116	3,478
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	1,258	41.6	28,138	22	3,799,814	3,751,244	133	2,981	4,443,788	158	3,548

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1). Only the first listed or principal diagnosis has been used.

[2]Numbers do not add to total since persons may have more that one principal diagnosis reported for covered HHA services.

[3]Does not reflect beneficiaries who received covered services but for whom no program payments were reported during the reporting year.

[4]Includes invalid codes not listed separately.

[5]Specific leading diagnostic categories were selected for presentation because of frequency of occurrences or because of special interest.

NOTES: MDCs 11 and 15 were not shown separately (but included in the total), because they were for the most part, not applicable to Medicare beneficiaries. Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges. Changes, as of October 2003, in the medical coding of the ICD-9-CM diagnosis field has resulted in the significant increase in the use of V-codes (Supplementary Classification of Factors Influencing Health Status and Contact with Health Services). That is, V-codes are now being used more frequently in the principal diagnostic field to reflect the fact that the HHA episode is oriented to providing some type of aftercare or rehabilitation service in a post-acute care setting. This is in direct contrast to the acute care setting when the coding of the principal diagnosis is directly related to the underlying condition. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.7

Persons Served and Program Payments for Medicare Home Health Agency (HHA) Services, by Selected Diagnoses: Calendar Years 1997 and 2005

		1997				
				Program Payments		
Principal ICD-9-CM Diagnosis[1]	ICD-9-CM Codes	Persons in Thousands	Percent	Amount in Thousands	Percent	Per Person Served[2]
Total All Diagnoses	---	3,558	100.0	$16,718,263	100.0	$4,702
Total Selected Diagnoses[3]	---	1894	53.2	7,185,024	43.0	3,794
Diabetes Mellitus	250	324	9.1	2,260,343	13.5	6,995
Essential Hypertension	401	244	6.9	839,278	5.0	3,447
Other Forms of Chronic Ischemic Heart Disease	414	124	3.5	252,328	1.5	2,037
Cardiac Dysrhythmias	427	115	3.2	298,792	1.8	2,611
Heart Failure	428	339	9.5	1,139,447	6.8	3,364
Pneumonia, Organism Unspecified	486	108	3.0	208,135	1.2	1925
Chronic Airway Obstruction, Not Elsewhere Classified	496	145	4.1	453,561	2.7	3,131
Chronic Ulcer of Skin	707	149	4.2	913,679	5.5	6,171
Osteoarthrosis and Allied Disorders	715	206	5.8	433,641	2.6	2,115
Other and Unspecified Arthropathies	716	41	1.2	113,928	0.7	2,801
General Symptoms	780	99	2.8	271,892	1.6	2,762
All Other Diagnoses	---	1,664	46.8	9,533,239	57.0	5,729

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1). Only the first listed or principal diagnosis has been used.

[2]Does not reflect persons who received covered services but for whom no program payments were reported during the reporting year.

[3]Specific leading diagnoses were selected for presentation because of frequency of occurrences or because of special interest.

NOTE: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. The change in program payments and utilization for home health between 1997 and 2005 is due in part to the Balanced Budget Act of 1997 (Public Law 105-33) which called for the gradual transfer of home health services unassociated with a hospital or skilled nursing facility stay from hospital insurance to supplementary medical insurance. The use of benefit was also affected by the efforts to identify fraudulent activities in the use of services. The impact was first noted in 1998 (not shown).

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.7—Continued

Persons Served and Program Payments for Medicare Home Health Agency (HHA) Services, by Selected Diagnoses: Calendar Years 1997 and 2005

2005					Percent Change 1997-2005		
		Program Payments					
Persons in Thousands	Percent	Amount in Thousands	Percent	Per Person Served[2]	Persons	Program Payments	Average Program Payment
2,976	100.0	$12,779,158	100.0	$4,314	-16	-24	-8
1,045	35.1	3,787,369	29.6	3,626	-45	-47	-4
261	8.8	1,462,254	11.4	5,652	-20	-35	-19
116	3.9	297,456	2.3	2,582	-53	-65	-25
45	1.5	96,467	0.8	2,140	-64	-62	5
52	1.8	111,511	0.9	2,135	-54	-63	-18
170	5.7	433,864	3.4	2,558	-50	-62	-24
56	1.9	110,514	0.9	1,973	-48	-47	2
73	2.4	179,368	1.4	2,482	-50	-60	-21
138	4.6	648,529	5.1	4,719	-7	-29	-24
43	1.4	138,813	1.1	3,277	-79	-68	55
47	1.6	201,065	1.6	4,349	13	76	55
44	1.5	107,528	0.8	2,438	-55	-60	-12
1,931	64.9	8,991,789	70.4	4,656	16	-6	-19

Table 7.7

Persons Served and Program Payments for Medicare Home Health Agency (HHA) Services, by Selected Diagnoses: Calendar Years 1997 and 2006

Principal ICD-9-CM Diagnosis[1]	ICD-9-CM Codes	1997 Persons in Thousands	1997 Percent	1997 Program Payments Amount in Thousands	1997 Program Payments Percent	1997 Program Payments Per Person Served[2]
Total All Diagnoses	---	3,558	100.0	$16,718,263	100.0	$4,702
Total Selected Diagnoses[3]	---	1894	53.2	7,185,024	43.0	3,794
Diabetes Mellitus	250	324	9.1	2,260,343	13.5	6,995
Essential Hypertension	401	244	6.9	839,278	5.0	3,447
Other Forms of Chronic Ischemic Heart Disease	414	124	3.5	252,328	1.5	2,037
Cardiac Dysrhythmias	427	115	3.2	298,792	1.8	2,611
Heart Failure	428	339	9.5	1,139,447	6.8	3,364
Pneumonia, Organism Unspecified	486	108	3.0	208,135	1.2	1925
Chronic Airway Obstruction, Not Elsewhere Classified	496	145	4.1	453,561	2.7	3,131
Chronic Ulcer of Skin	707	149	4.2	913,679	5.5	6,171
Osteoarthrosis and Allied Disorders	715	206	5.8	433,641	2.6	2,115
Other and Unspecified Arthropathies	716	41	1.2	113,928	0.7	2,801
General Symptoms	780	99	2.8	271,892	1.6	2,762
All Other Diagnoses	---	1,664	46.8	9,533,239	57.0	5,729

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1). Only the first listed or principal diagnosis has been used.

[2]Does not reflect persons who received covered services but for whom no program payments were reported during the reporting year.

[3]Specific leading diagnoses were selected for presentation because of frequency of occurrences or because of special interest.

NOTE: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. The change in program payments and utilization for home health between 1997 and 2006 is due in part to the Balanced Budget Act of 1997 (Public Law 105-33) which called for the gradual transfer of home health services unassociated with a hospital or skilled nursing facility stay from hospital insurance to supplementary medical insurance. The use of benefit was also affected by the efforts to identify fraudulent activities in the use of services. The impact was first noted in 1998 (not shown).

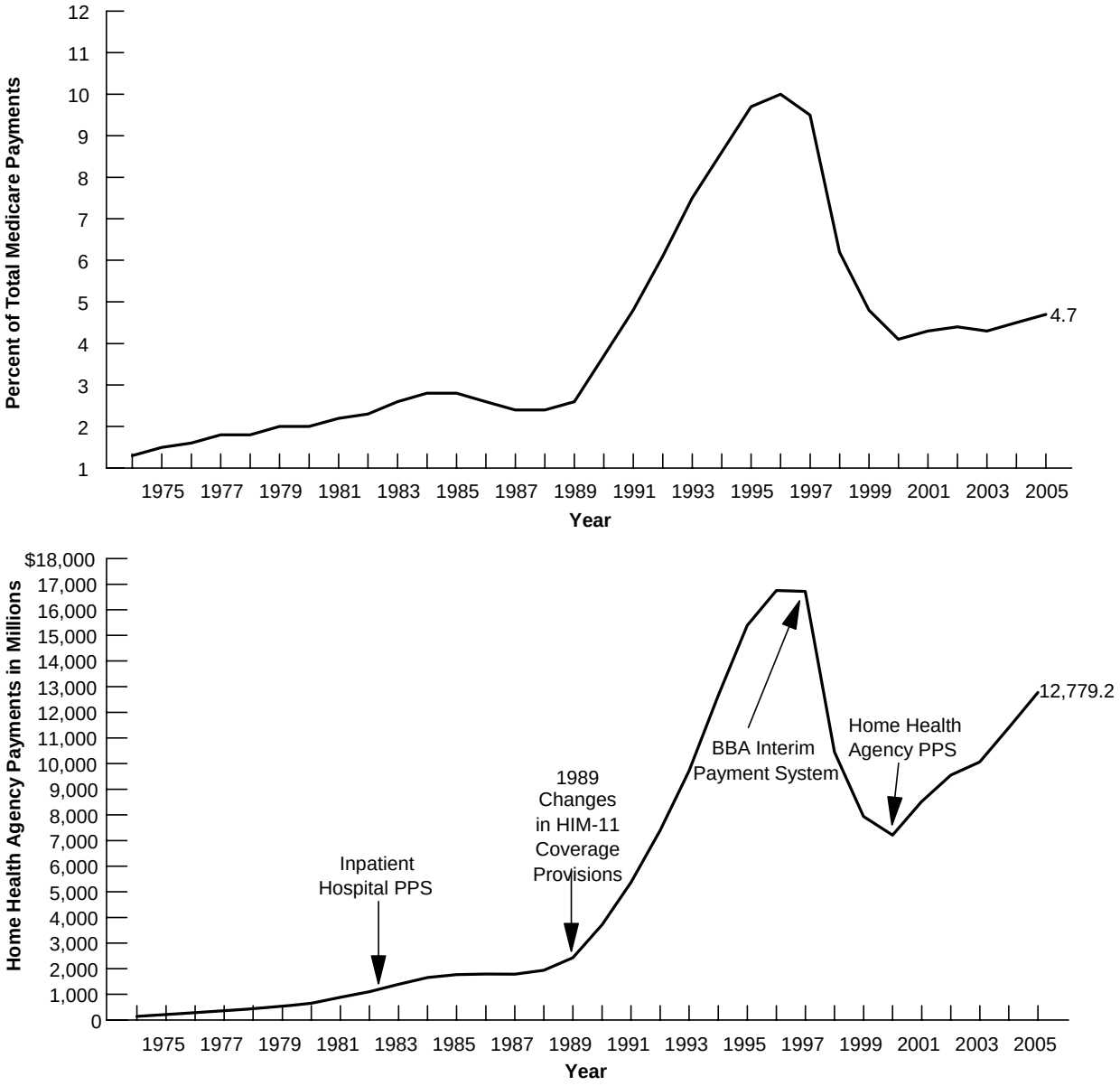
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 7.7—Continued

Persons Served and Program Payments for Medicare Home Health Agency (HHA) Services, by Selected Diagnoses: Calendar Years 1997 and 2006

2006					Percent Change 1997-2006		
		Program Payments					
Persons in Thousands	Percent	Amount in Thousands	Percent	Per Person Served[2]	Persons	Program Payments	Average Program Payment
3,026	100.0	$13,912,750	100.0	$4,619	-15	-17	-2
1,140	37.7	4,511,396	32.4	3,957	-40	-37	4
295	9.7	1,863,008	13.4	6,372	-9	-18	-9
138	4.5	377,492	2.7	2,755	-44	-55	-20
46	1.5	105,694	0.8	2,303	-63	-58	13
57	1.9	133,792	1.0	2,341	-50	-55	-10
181	6.0	497,035	3.6	2,757	-47	-56	-18
54	1.8	113,076	0.8	2,086	-50	-46	8
71	2.4	190,957	1.4	2,689	-51	-58	-14
135	4.4	646,823	4.6	4,830	-10	-29	-22
49	1.6	168,047	1.2	3,443	-76	-61	63
63	2.1	284,719	2.0	4,577	52	150	63
52	1.7	130,753	0.9	2,551	-48	-52	-8
1,886	62.3	9,401,354	67.6	4,985	13	-1	-13

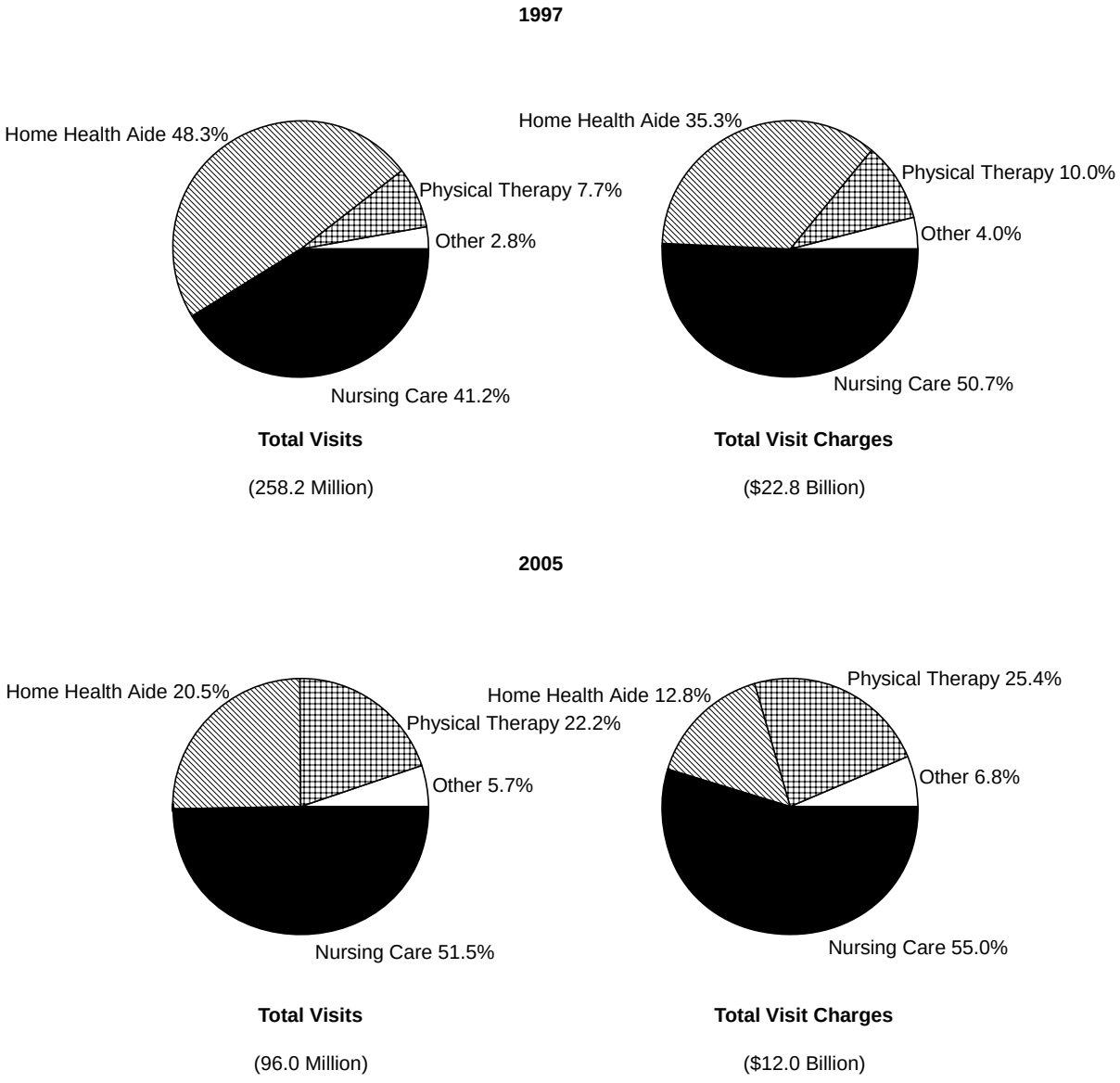
Figure 7.1
Medicare Home Health Agency Program Payments: Calendar Years 1974-2005



NOTES: The home health prospective payment system (PPS) was implemented beginning October 1, 2000. HIM-11 is Health Insurance Manual-11. BBA is Balanced Budget Act of 1997.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

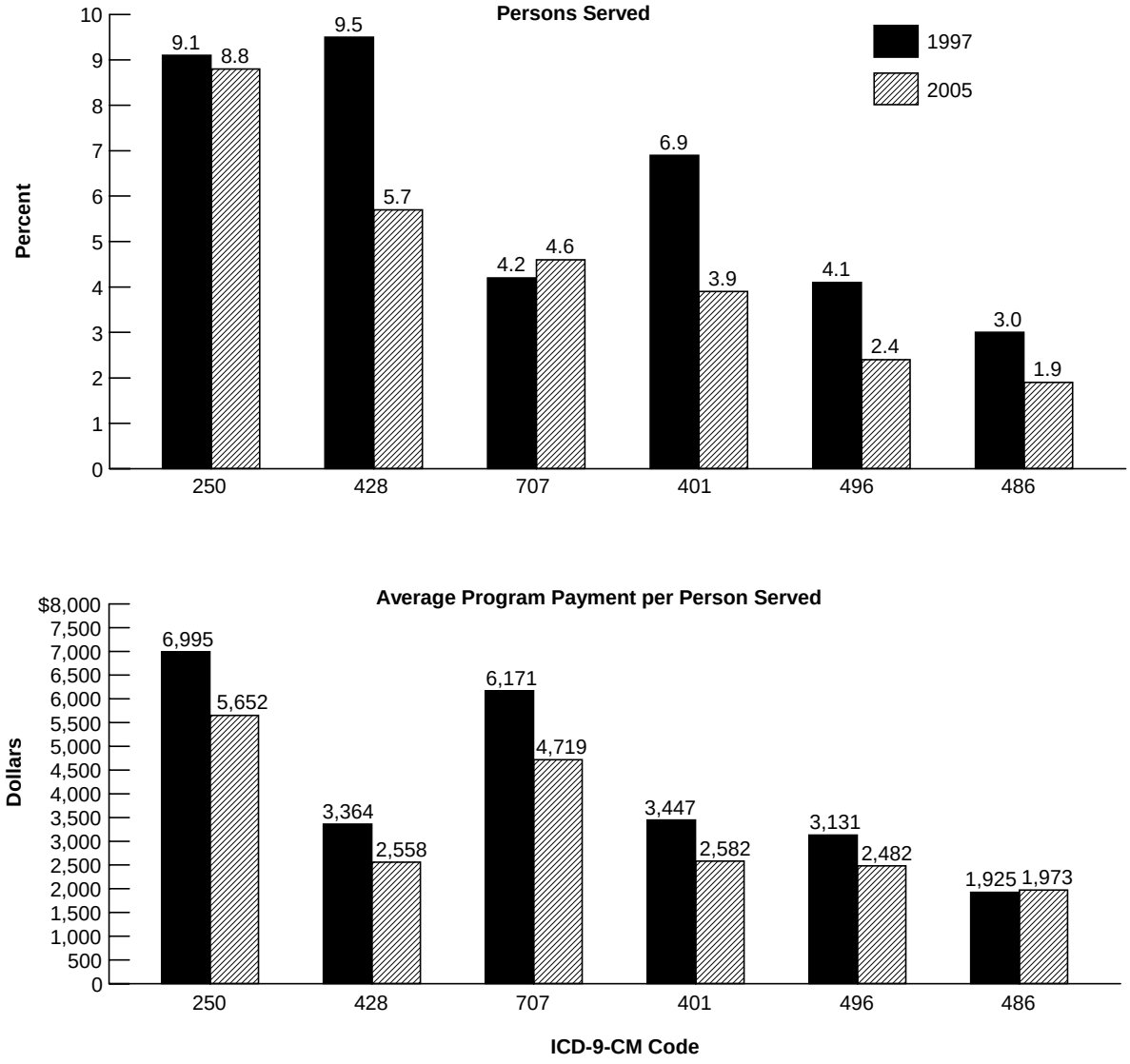
Figure 7.2
Percent Distribution of Medicare Home Health Visits and Charges, by Type of Visit: Calendar Years 1997 and 2005



NOTES: Other includes speech therapy, occupational therapy, medical social services, and other health disciplines. The home health prospective payment system was implemented beginning October 1, 2000. Distribution may not add to 100 percent because of rounding.

SOURCE: Centers for Medicare and Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 7.3
Trends in the Six Most Frequent Medicare Home Health Agency Diagnoses: Calendar Years 1997 and 2005



NOTES: Diagnoses have the following codes from the *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1): diabetes mellitus, 250; heart failure, 428; chronic ulcer of skin, 707; essential hypertension, 401; chronic airway obstruction, not elsewhere classified, 496; pneumonia, organism unspecified, 486. The home health prospective payment system was implemented beginning October 1, 2000.

SOURCE: Centers for Medicare & Medicaid Services, Office of information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.