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 1974-2009

Year of Service	Persons Served		Visits			Total Charges in Thousands	Visit Charges				Program Payments		
	Number in Thousands	Per 1,000 Enrollees[1]	Number in Thousands	Per Person Served	Per 1,000 Enrollees[1]		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
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
2007	3,099.5	87	114,654	37	3,231	15,156,114	14,912,303	130	4,811	420	15,565,441	5,046	439
2008	3,171.6	90	121,005	38	3,426	16,570,487	16,262,053	134	5,127	460	16,872,735	5,361	478
2009	3,281.1	93	130,099	40	3,679	18,489,770	18,137,949	139	5,528	513	18,733,108	5,747	530

[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 Standard Analytical Files; 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 2009

Demographic Characteristic	Persons Served		Visits			Total Charges in Thousands	Visit Charges				Program Payments		
	Number in Thousands	Per 1,000 Enrollees[1]	Number in Thousands	Per Person Served	Per 1,000 Enrollees[1]		Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Person Served[2]	Per Enrollee[1]
Total	3,281	93	130,099	40	3,679	$18,489,770	$18,137,946	$139	$5,528	$513	$18,733,108	$5,747	$530
Age													
Under 65 Years	418	65	18,332	44	2,849	2,630,880	2,544,432	139	6,086	395	2,496,383	6,049	388
65-74 Years	768	50	29,073	38	1,896	4,118,558	4,038,674	139	5,257	263	4,110,580	5,394	268
75-84 Years	1,139	122	44,514	39	4,768	6,315,709	6,214,026	140	5,457	666	6,475,332	5,715	694
85 Years or Over	956	225	38,180	40	8,974	5,424,623	5,340,813	140	5,586	1,255	5,650,814	5,936	1,328
Sex													
Male	1,204	75	45,431	38	2,845	6,532,280	6,379,364	140	5,297	400	6,539,310	5,468	410
Female	2,077	107	84,668	41	4,366	11,957,490	11,758,582	139	5,662	606	12,193,798	5,908	629
Type of Entitlement													
Aged	2,863	99	111,767	39	3,864	15,858,890	15,593,514	140	5,446	539	16,236,725	5,703	561
Disabled	418	65	18,332	44	2,849	2,630,880	2,544,432	139	6,086	395	2,496,383	6,049	388
Race													
White	2,642	90	94,374	36	3,201	13,639,551	13,363,292	142	5,057	453	14,071,717	5,358	477
Other[3]	639	109	35,724	56	6,076	4,850,219	4,774,654	134	7,475	812	4,661,390	7,356	793

[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 Standard Analytical Files; 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 2009

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]	3,281	93	130,099	40	3,679	$18,489,770
United States [4]	3,220	93	128,448	40	3,700	18,234,335
Northeast	608	93	18,206	30	2,774	2,615,678
Midwest	694	84	20,765	30	2,521	3,112,225
South	1,480	108	75,346	51	5,515	10,191,016
West	439	70	14,132	32	2,262	2,315,415
New England	205	105	6,299	31	3,226	818,241
Connecticut	49	105	1,697	35	3,665	184,839
Maine	20	84	462	24	1,996	66,827
Massachusetts	98	117	3,058	31	3,647	421,162
New Hampshire	18	91	497	27	2,464	68,295
Rhode Island	11	99	301	27	2,614	42,665
Vermont	9	91	285	31	2,760	34,452
Middle Atlantic	402	87	11,906	30	2,582	1,797,438
New Jersey	93	81	2,299	25	2,009	375,299
New York	174	84	6,279	36	3,016	916,316
Pennsylvania	135	98	3,329	25	2,404	505,822
East North Central	536	94	16,709	31	2,942	2,523,854
Illinois	178	110	5,756	32	3,541	872,739
Indiana	58	70	1,939	33	2,325	265,605
Michigan	148	123	4,409	30	3,655	737,622
Ohio	119	87	3,805	32	2,784	531,195
Wisconsin	33	51	800	24	1,238	116,693
West North Central	158	62	4,055	26	1,586	588,371
Iowa	23	51	575	25	1,293	69,878
Kansas	21	56	661	31	1,744	95,319
Minnesota	30	61	681	23	1,418	106,510
Missouri	63	80	1,625	26	2,067	243,505
Nebraska	14	56	339	25	1,395	48,902
North Dakota	4	43	84	20	850	12,080
South Dakota	4	34	90	21	721	12,176

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 2009

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served [2]
$18,137,946	$139	$5,528	$513	$18,733,108	$144	$5,747
17,891,056	139	5,556	515	18,472,543	144	5,773
2,559,311	141	4,211	390	2,707,259	149	4,481
3,054,123	147	4,400	371	3,481,837	168	5,055
10,004,887	133	6,761	732	9,938,914	132	6,753
2,272,736	161	5,181	364	2,344,533	166	5,393
802,411	127	3,906	411	964,553	153	4,726
180,679	107	3,721	390	233,265	137	4,847
64,877	140	3,327	280	73,313	159	3,780
415,196	136	4,221	495	492,061	161	5,030
66,616	134	3,642	330	78,859	159	4,336
41,620	138	3,664	362	47,953	159	4,244
33,423	117	3,569	323	39,103	137	4,225
1,756,900	148	4,366	381	1,742,706	146	4,356
363,123	158	3,912	317	398,178	173	4,314
898,028	143	5,152	431	812,039	129	4,686
495,748	149	3,665	358	532,489	160	3,960
2,478,591	148	4,626	436	2,860,396	171	5,376
855,532	149	4,806	526	1,071,909	186	6,056
259,535	134	4,468	311	292,746	151	5,065
728,100	165	4,925	603	816,862	185	5,582
521,835	137	4,396	382	552,352	145	4,680
113,589	142	3,423	176	126,527	158	3,848
575,532	142	3,636	225	621,441	153	3,965
68,745	119	3,037	154	75,641	132	3,368
93,634	142	4,406	247	94,630	143	4,474
105,044	154	3,567	219	110,762	163	3,851
236,704	146	3,759	301	262,606	162	4,195
47,591	140	3,516	196	52,825	156	3,936
11,893	141	2,817	120	10,717	128	2,575
11,920	133	2,806	96	14,259	158	3,409

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 2009

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	710	97	33,310	47	4,547	$4,349,271
Delaware	11	80	248	23	1,802	33,686
District of Columbia	6	85	157	27	2,294	24,452
Florida	317	136	22,654	71	9,692	2,829,363
Georgia	83	82	2,761	33	2,728	376,080
Maryland	52	73	1,099	21	1,559	167,749
North Carolina	95	80	2,397	25	2,013	341,807
South Carolina	48	75	1,292	27	2,035	188,326
Virginia	79	83	2,184	28	2,292	312,585
West Virginia	20	69	518	26	1,804	75,224
East South Central	254	101	10,098	40	4,025	1,412,800
Alabama	64	100	2,345	37	3,638	327,876
Kentucky	56	89	1,861	33	2,959	258,815
Mississippi	52	118	2,273	44	5,155	332,908
Tennessee	81	102	3,620	45	4,557	493,201
West South Central	517	135	31,937	62	8,345	4,428,945
Arkansas	33	74	1,332	40	2,974	181,276
Louisiana	75	145	4,096	55	7,913	565,546
Oklahoma	64	127	3,856	60	7,640	508,800
Texas	345	146	22,654	66	9,611	3,173,323
Mountain	134	67	4,526	34	2,272	652,712
Arizona	31	54	709	23	1,246	118,285
Colorado	29	71	826	29	2,061	114,837
Idaho	11	70	355	32	2,221	49,884
Montana	7	48	144	22	1,063	20,973
Nevada	21	87	744	36	3,131	116,895
New Mexico	16	68	548	36	2,397	77,836
Utah	18	94	1,107	63	5,921	142,631
Wyoming	3	43	92	29	1,253	11,371
Pacific	305	72	9,606	32	2,257	1,662,703
Alaska	2	37	52	23	841	11,265
California	242	81	8,312	34	2,758	1,405,944
Hawaii	3	26	51	17	426	10,709
Oregon	20	57	386	19	1,099	80,703
Washington	37	53	806	22	1,135	154,083
Outlying Areas [5]	61	94	1,651	27	2,544	255,436

[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 Standard Analytical Files; 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 2009

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served [2]
$4,269,122	$128	$6,016	$583	$4,266,414	$128	$6,047
32,839	132	2,996	238	41,741	168	3,836
23,902	152	4,088	348	27,954	178	4,820
2,800,368	124	8,827	1198	2,454,417	108	7,783
365,771	132	4,420	361	449,792	163	5,462
162,853	148	3,152	231	211,936	193	4,131
325,896	136	3,436	274	416,703	174	4,416
180,923	140	3,794	285	231,727	179	4,880
303,383	139	3,848	318	347,737	159	4,439
73,187	141	3,696	255	84,408	163	4,297
1,379,291	137	5,440	550	1,528,488	151	6,057
321,522	137	5,005	499	352,256	150	5,508
250,851	135	4,468	399	288,143	155	5,162
324,765	143	6,258	737	341,748	150	6,611
482,153	133	5,931	607	546,342	151	6,753
4,356,474	136	8,433	1138	4,144,012	130	8,062
177,259	133	5,336	396	166,067	125	5,030
555,162	136	7,415	1073	562,064	137	7,537
500,727	130	7,834	992	468,605	122	7,367
3,123,326	138	9,064	1325	2,947,276	130	8,598
639,707	141	4,788	321	671,049	148	5,065
115,112	162	3,757	202	128,068	181	4,208
113,097	137	3,961	282	131,391	159	4,648
48,554	137	4,366	304	51,689	146	4,687
20,344	141	3,124	150	23,658	164	3,659
114,547	154	5,552	482	124,243	167	6,075
76,154	139	4,927	333	78,867	144	5,138
140,820	127	8,035	753	119,667	108	6,892
11,078	120	3,500	151	13,466	146	4,292
1,633,029	170	5,354	384	1,673,483	174	5,537
10,683	206	4,650	173	10,810	208	4,721
1,383,453	166	5,706	459	1,400,206	168	5,834
10,528	205	3,393	87	11,546	226	3,746
78,240	203	3,925	223	81,792	212	4,133
150,126	186	4,029	212	169,129	210	4,568
246,889	150	4,067	380	260,565	158	4,319

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 2009

Type of Visit	Type of Agency: 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: Government
					Persons Served in Thousands				
Total[2]	3,281	479	7	315	577	2,034	1,253	2,006	142
Nursing Care	3,104	430	6	282	517	1,868	1,117	1,848	129
Home Health Aide	776	114	2	76	126	457	277	456	40
Physical Therapy	2,355	335	5	210	392	1,413	867	1,393	90
Speech Therapy	149	20	(4)	12	23	94	51	94	4
Occupational Therapy	938	135	1	78	151	573	346	562	29
Other[3]	462	79	1	37	79	266	188	261	12
					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	94.6	89.9	88.9	89.5	89.6	91.8	89.1	92.1	90.9
Home Health Aide	23.6	23.9	31.2	24.2	21.8	22.5	22.1	22.7	28.4
Physical Therapy	71.8	70.0	66.8	66.7	68.0	69.5	69.2	69.4	63.7
Speech Therapy	4.6	4.1	2.9	3.9	4.0	4.6	4.0	4.7	3.1
Occupational Therapy	28.6	28.2	12.0	24.8	26.2	28.1	27.6	28.0	20.7
Other[3]	14.1	16.4	13.0	11.8	13.8	13.1	15.0	13.0	8.5
					Visits in Thousands				
Total	130,099	12,846	246	12,501	13,272	91,234	30,379	95,709	4,011
Nursing Care	71,886	6,132	122	6,990	6,572	52,069	14,766	55,231	1,889
Home Health Aide	21,239	2,679	58	2,216	2,206	14,079	5,506	14,771	962
Physical Therapy	28,802	3,046	58	2,603	3,465	19,631	7,699	20,164	939
Speech Therapy	1,077	115	1	92	139	730	299	749	29
Occupational Therapy	6,239	722	5	529	757	4,226	1,772	4,298	169
Other[3]	855	153	2	70	132	498	336	497	22

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 2009

Type of Visit	Type of Agency: All Agencies	Visiting Nurse Association	Combined Government and Voluntary	Official Health Agency	Hospital-Based	Other[1]	Type of Control: Voluntary Non-Profit	Proprietary	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	55.3	47.7	49.6	55.9	49.5	57.1	48.6	57.7	47.1
Home Health Aide	16.3	20.9	23.6	17.7	16.6	15.4	18.1	15.4	24.0
Physical Therapy	22.1	23.7	23.4	20.8	26.1	21.5	25.3	21.1	23.4
Speech Therapy	0.8	0.9	0.5	0.7	1.0	0.8	1.0	0.8	0.7
Occupational Therapy	4.8	5.6	2.0	4.2	5.7	4.6	5.8	4.5	4.2
Other[3]	0.7	1.2	0.8	0.6	1.0	0.5	1.1	0.5	0.6
	Visit Charges in Millions								
Total	$18,138	$1,826	$28	$1,704	$2,121	$12,459	$4,593	$13,026	$519
Nursing Care	10,350	967	15	993	1,119	7,256	2,415	7,659	276
Home Health Aide	1,797	205	4	184	205	1,199	456	1,272	69
Physical Therapy	4,631	489	8	414	607	3,113	1,300	3,192	139
Speech Therapy	180	19	(5)	15	25	120	53	123	4
Occupational Therapy	1,012	115	1	85	135	676	299	687	26
Other[3]	169	30	(5)	13	31	95	70	94	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	57.1	53.0	53.4	58.3	52.7	58.2	52.6	58.8	53.2
Home Health Aide	9.9	11.2	13.9	10.8	9.7	9.6	9.9	9.8	13.3
Physical Therapy	25.5	26.8	28.2	24.3	28.6	25.0	28.3	24.5	26.7
Speech Therapy	1.0	1.1	0.7	0.9	1.2	1.0	1.1	0.9	0.8
Occupational Therapy	5.6	6.3	2.5	5.0	6.3	5.4	6.5	5.3	5.1
Other[3]	0.9	1.6	1.3	0.8	1.4	0.8	1.5	0.7	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 2009

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	Government
	Average Number of Visits per Person Served								
Total	40	27	36	40	23	45	24	48	28
Nursing Care	23	14	20	25	13	28	13	30	15
Home Health Aide	27	23	28	29	18	31	20	32	24
Physical Therapy	12	9	13	12	9	14	9	15	10
Speech Therapy	7	6	7	8	6	8	6	8	7
Occupational Therapy	7	5	6	7	5	7	5	8	6
Other[3]	2	2	2	2	2	2	2	2	2
	Average Visit Charge per Visit								
Total	$139	$142	$112	$136	$160	$137	$151	$136	$129
Nursing Care	144	158	120	142	170	139	164	139	146
Home Health Aide	85	76	66	83	93	85	83	86	72
Physical Therapy	161	161	135	159	175	159	169	158	148
Speech Therapy	167	168	142	165	183	164	176	164	150
Occupational Therapy	162	160	139	161	178	160	169	160	155
Other[3]	197	193	177	186	232	191	208	190	207
	Average Visit Charge per Person Served								
Total	$5,528	$3,815	$4,060	$5,408	$3,676	$6,125	$3,664	$6,495	$3,661
Nursing Care	3,335	2,248	2,438	3,520	2,164	3,884	2,163	4,145	2,143
Home Health Aide	2,317	1,789	1,811	2,415	1,632	2,623	1,645	2,787	1,720
Physical Therapy	1,966	1,461	1,716	1,968	1,547	2,203	1,499	2,292	1,535
Speech Therapy	1,204	979	952	1,230	1,102	1,273	1,039	1,303	1,004
Occupational Therapy	1,079	855	850	1,087	892	1,181	864	1,223	896
Other[3]	365	376	400	349	386	358	371	361	382

[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 $500,000.

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 Standard Analytical Files; 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 2000 and 2009

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
2000								
Total	2,461	100.0	90,566	100.0	$9,488,429	100.0	$7,215,958	100.0
1-9	767	31.2	3,903	4.3	464,863	4.9	424,383	5.9
10-19	577	23.4	8,050	8.9	936,155	9.9	790,594	11.0
20-29	318	12.9	7,644	8.4	866,230	9.1	686,760	9.5
30-39	194	7.9	6,608	7.3	733,211	7.7	562,678	7.8
40-49	129	5.2	5,715	6.3	625,562	6.6	471,194	6.5
50-99	273	11.1	18,817	20.8	1,997,487	21.1	1,477,357	20.5
100 or More	203	8.2	39,832	44.0	3,864,922	40.7	2,802,993	38.8
2009								
Total	3,281	100.0	130,099	100.0	$18,489,770	100.0	$18,733,108	100.0
1-9	809	24.7	4,770	3.7	796,449	4.3	1,266,883	6.8
10-19	858	26.2	12,606	9.7	2,053,096	11.1	2,615,920	14.0
20-29	490	14.9	12,294	9.4	1,936,484	10.5	2,270,326	12.1
30-39	296	9.0	10,503	8.1	1,612,885	8.7	1,860,890	9.9
40-49	199	6.1	9,153	7.0	1,378,869	7.5	1,573,059	8.4
50-99	403	12.3	28,132	21.6	4,110,600	22.2	4,400,251	23.5
100 or More	225	6.9	52,641	40.5	6,601,389	35.7	4,745,780	25.3

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 Standard Analytical Files; 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 2009

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served [2]		Visits		Total Charges in Thousands	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served		Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Total All Diagnoses[4]	---	3,281	100.0	130,099	40	$18,489,770	$18,137,946	$139	$5,528	$18,733,108	$144	$5,747
Total Leading Diagnoses[5]	---	1,929	58.8	70,288	36	9,586,779	9,421,536	134	4,884	8,891,990	127	4,640
Infectious and Parasitic Diseases (MDC 1)	001-139	22	0.7	423	19	61,798	60,743	144	2,789	62,615	148	2,896
Neoplasms (MDC 2)	140-239	111	3.4	2,273	21	338,316	327,739	144	2,958	355,565	156	3,231
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	23	0.7	420	18	63,517	61,731	147	2,686	68,310	163	2,990
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	377	11.5	30,844	82	3,970,470	3,936,232	128	10,430	3,057,229	99	8,165
Diabetes Mellitus	250	345	10.5	30,150	87	3,872,740	3,840,154	127	11,124	2,954,551	98	8,627
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	12	0.4	188	16	27,766	27,234	145	2,360	29,253	155	2,550
Diseases of the Blood and Blood Forming Organs (MDC 4)	280-289	64	1.9	1,760	28	220,246	217,522	124	3,414	240,503	137	3,792
Other Deficiency Anemias	281	33	1.0	1,069	32	125,295	123,742	116	3,719	138,820	130	4,188
Other and Unspecified Anemias	285	21	0.7	478	22	65,360	64,598	135	3,022	71,337	149	3,356
Coagulation Defects	286	2	0.1	45	23	6,097	6,013	133	3,072	5,893	130	3,042
Mental Disorders (MDC 5)	290-319	80	2.4	1,895	24	264,018	262,337	138	3,290	289,598	153	3,672
Schizophrenic Disorders	295	8	0.2	214	27	28,755	28,578	134	3,611	32,873	154	4,268
Affective Psychoses	296	11	0.3	251	23	36,196	36,035	144	3,320	39,910	159	3,737
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	159	4.8	5,048	32	697,491	687310	136	4,320	765,060	152	4,858
Parkinson's Disease	332	36	1.1	1,204	34	171,817	170573	142	4,785	200,301	166	5,647

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 2009

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 Circulatory System (MDC 7)	390-459	906	27.6	25,805	28	$3,700,984	$3,643,020	$141	$4,022	$3,924,780	$152	$4,358
Essential Hypertension	401	282	8.6	6,936	25	949,950	943,400	136	3,349	1,059,857	153	3,784
Hypertensive Heart Disease	402	30	0.9	793	27	105,788	104,943	132	3,523	117,580	148	4,004
Acute Myocardial Infarction	410	19	0.6	326	17	49,050	48,707	149	2,600	50,915	156	2,731
Other Acute and Subacute Forms of Ischemic Heart Disease	411	3	0.1	51	18	7,340	7,299	142	2,586	7,749	151	2,775
Angina Pectoris	413	5	0.1	86	18	11,513	11,440	134	2,425	12,197	142	2,605
Other Forms of Chronic Ischemic Heart Disease	414	67	2.0	1,358	20	191,525	190,031	140	2,845	206,051	152	3,101
Cardiac Dysrhythmias	427	81	2.5	1,688	21	242,168	239,626	142	2,964	251,419	149	3,124
Heart Failure	428	232	7.1	5,802	25	832,150	823,047	142	3,548	858,536	148	3,717
Transient Cerebral Ischemia	435	6	0.2	132	21	18,567	19,305	147	3,015	19,874	151	3,125
Acute but Ill-Defined Cerebrovascular Disease	436	3	0.1	110	34	14,829	14,690	133	4,472	15,721	143	4,882
Other Peripheral Vascular Disease	443	12	0.4	329	27	46,268	44,450	135	3,596	44,339	135	3,604
Diseases of the Respiratory System (MDC 8)	460-519	290	8.8	6,567	23	951,215	939,872	143	3,241	1,012,795	154	3,512
Pneumonia, Organism Unspecified	486	61	1.9	985	16	149,188	147,805	150	2,431	160,311	163	2,648
Chronic Airway Obstruction, not Elsewhere Classified	496	36	1.1	808	23	113,227	111,975	139	3,136	112,529	139	3,184
Diseases of the Digestive System (MDC 9)	520-579	80	2.4	1,463	18	214,715	209,532	143	2,611	226,890	155	2,845
Diseases of the Genitourinary System (MDC 10)	580-629	90	2.7	1,829	20	262,610	256,037	140	2,850	268,966	147	3,011
Other Disorders of Urethra and Urinary Tract	599	54	1.6	974	18	141,563	138,706	142	2,588	150,209	154	2,813
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	209	6.4	7,102	34	1,101,780	1,017,636	143	4,881	936,208	132	4,517
Other Cellulitis and Abscess	682	60	1.8	1,288	22	204,375	192,961	150	3,223	184,281	143	3,097
Chronic Ulcer of Skin	707	141	4.3	5,540	39	856,843	785,877	142	5,577	716,172	129	5,112

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 2009

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	402	12.2	11,128	28	$1,556,003	$1,544,790	$139	$3,844	$1,814,914	$163	$4,550
Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	714	17	0.5	571	33	75,638	74,946	131	4,297	82,946	145	4,788
Osteoarthrosis and Allied Disorders	715	113	3.5	2,764	24	382,728	380,440	138	3,360	476,316	172	4,243
Other and Unspecified Arthropathies	716	46	1.4	1,264	28	168,745	167,628	133	3,648	198,303	157	4,347
Other and Unspecified Disorders of Back	724	50	1.5	1,041	21	150,640	149,823	144	3,020	185,478	178	3,772
Other Disorders of Bone and Cartilage	733	17	0.5	1,034	62	126,839	126,362	122	7,617	91,476	88	5,564
Congenital Anomalies (MDC 14)	740-759	3	0.1	70	23	9,800	9,560	137	3,171	9,938	143	3,383
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	238	7.2	5,129	22	748,955	740,568	144	3,116	865,915	169	3,669
General Symptoms	780	57	1.7	1,120	20	163,047	162,059	145	2,825	180,068	161	3,163
Symptoms Involving Urinary System	788	15	0.5	362	23	49,482	46,881	130	3,040	48,761	135	3,189
Injury and Poisoning (MDC 17)	800-999	210	6.4	5,727	27	880,268	837,754	146	3,984	777,244	136	3,737
Fracture of Neck of Femur	820	3	0.1	78	26	11,043	10,945	141	3,612	12,603	162	4,187
Open Wound of Other and Unspecified Sites, Except Limbs	879	6	0.2	164	30	24,018	22,758	139	4,142	19,565	120	3,606
Open Wound of Knee, Leg (Except Thigh), and Ankle	891	24	0.7	666	28	102,713	96,776	145	4,068	87,486	131	3,714
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V89	1,123	34.2	23,035	21	3,510,648	3,446,873	150	3,068	4,124,491	179	3,695

[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 Standard Analytical Files; 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 2009

		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]	---	1845	51.9	7,042,517	42.1	3,817
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
Other Disorders of the Urethra and Urinary Track	599	78	2.2	247,528	1.5	3,177
Other Cellulitis and Abscess	682	59	1.7	177,454	1.1	3,034
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
General Symptoms	780	99	2.8	271,892	1.6	2,762
All Other Diagnoses	---	1,713	48.1	9,675,746	57.9	5,648

[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 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 beginning in 1997 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).

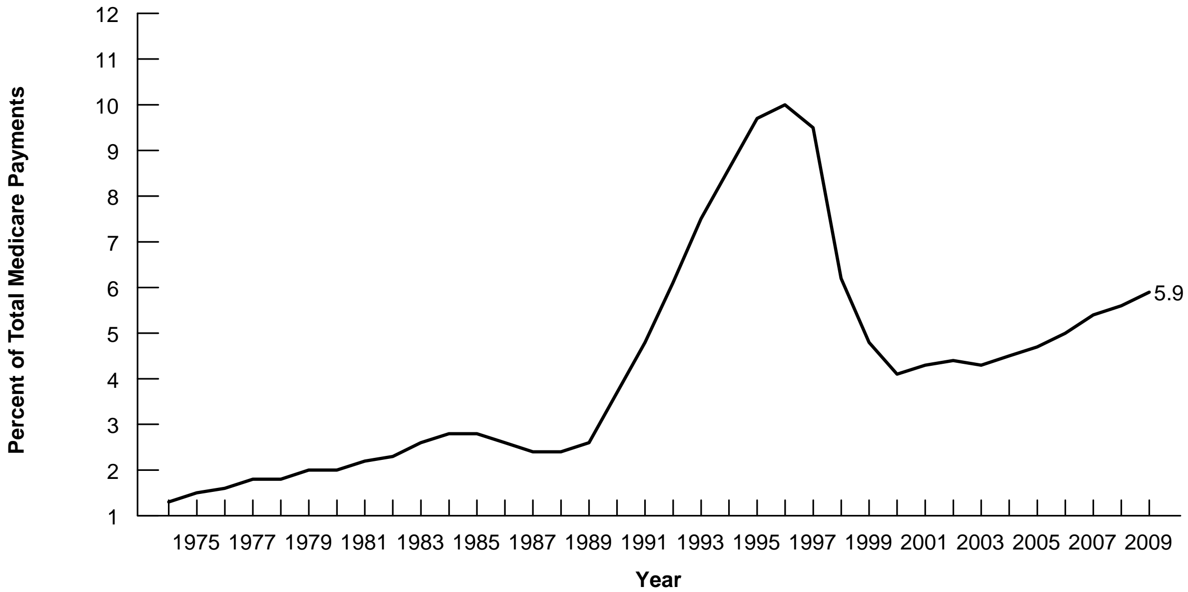
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Research, Development, and Information.

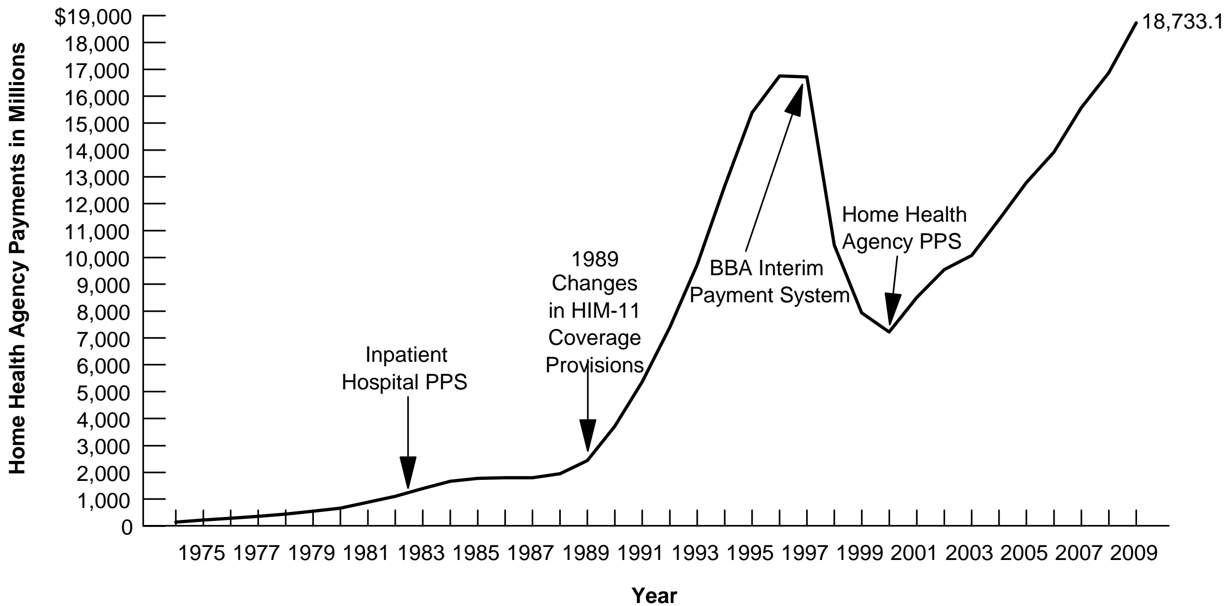
Table 7.7–Continued

Persons Served and Program Payments for Medicare Home Health Agency (HHA) Services, by Selected Diagnoses: Calendar Years 1997 and 2009

2009					Percent Change 1997-2009		
		Program Payments					
Persons in Thousands	Percent	Amount in Thousands	Percent	Per Person Served [2]	Persons	Program Payments	Average Program Payment
3,281	100.0	$18,733,108	100.0	$5,747	-8	12	22
1,492	45.5	7,197,771	38.4	4,823	-19	2	26
345	10.5	2,954,551	15.8	8,627	7	31	23
282	8.6	1,059,857	5.7	3,784	15	26	10
67	2.0	206,051	1.1	3,101	-46	-18	52
81	2.5	251,419	1.3	3,124	-30	-16	20
232	7.1	858,536	4.6	3,717	-32	-25	10
61	1.9	160,311	0.9	2,648	-44	-23	38
54	1.6	150,209	0.8	2,813	-31	-39	-11
60	1.8	184,281	1.0	3,097	2	4	2
141	4.3	716,172	3.8	5,112	-5	-22	-17
113	3.5	476,316	2.5	4,243	-45	10	101
57	1.7	180,068	1.0	3,163	-42	-34	15
1,789	54.5	11,535,337	61.6	6,449	4	19	14

Figure 7.1
Medicare Home Health Agency Program Payments: Calendar Years 1974-2009

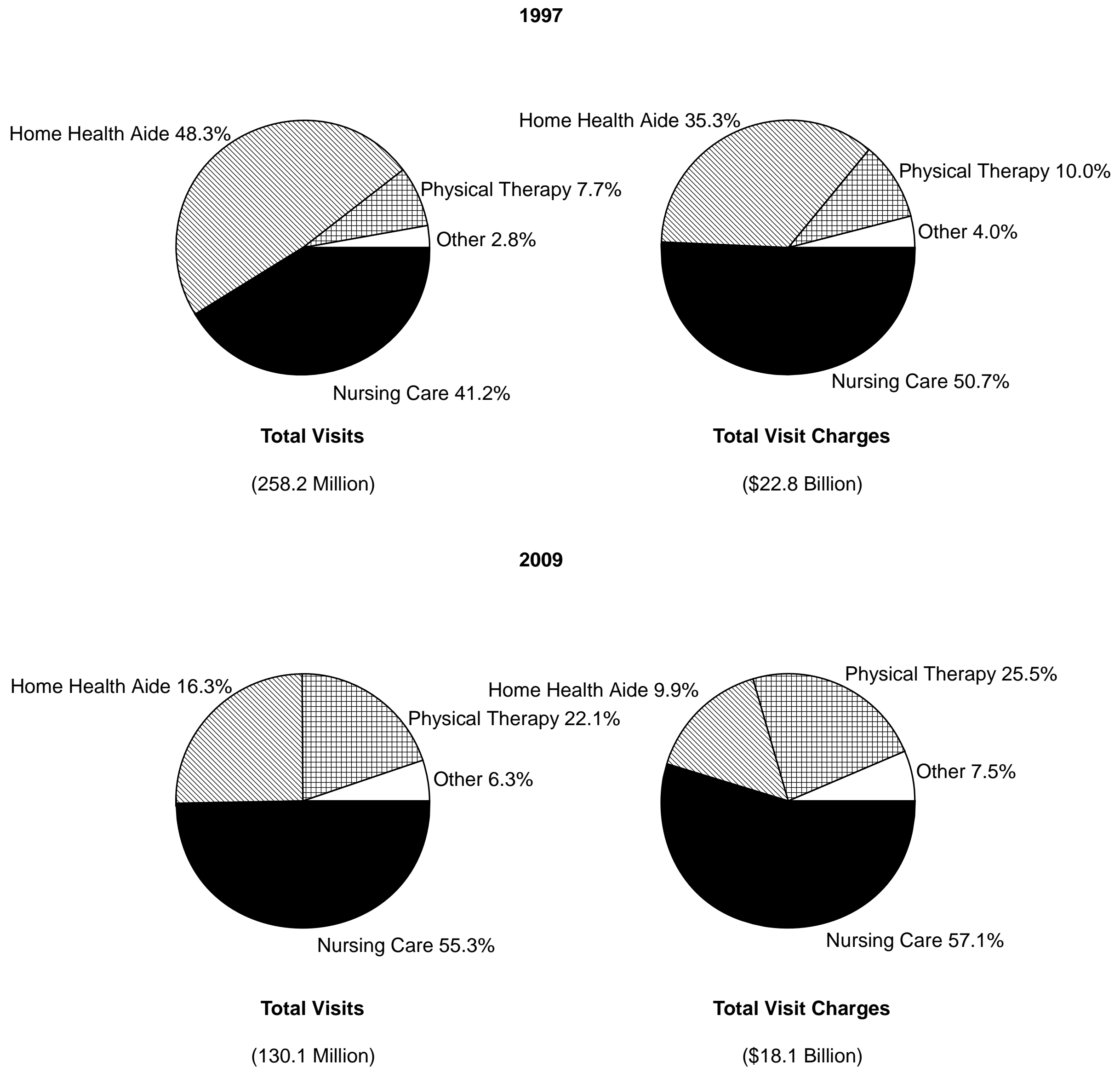




NOTES: The home health prospective payment system (PPS) was implemented beginning October 1, 2000. HIM-11 is Health Insurance Manual-11. BBA is Balanced Budget Act of 1997.

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

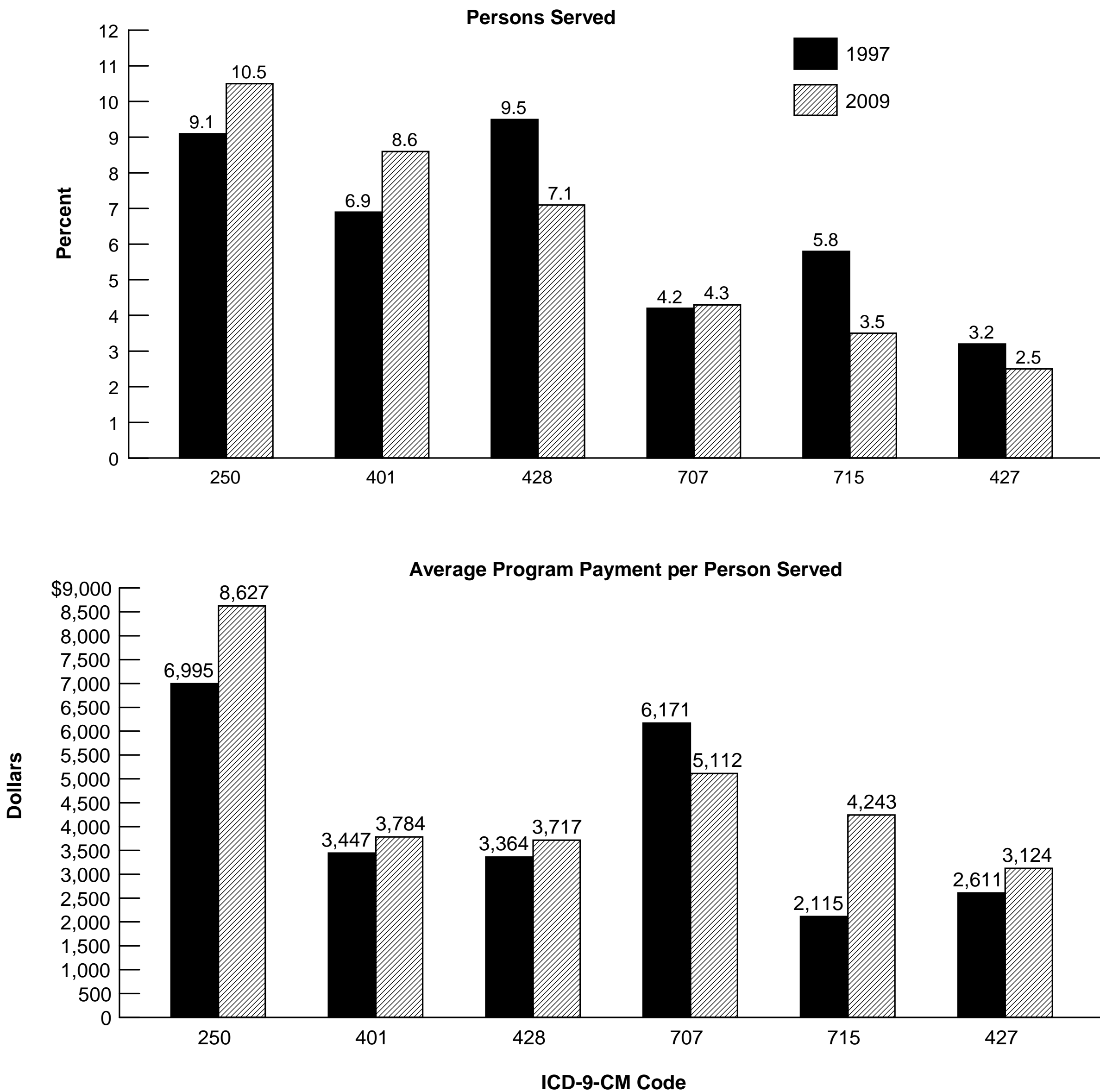
Figure 7.2
Percent Distribution of Medicare Home Health Visits and Charges, by Type of Visit: Calendar Years 1997 and 2009



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 Standard Analytical Files; 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 2009



NOTES: Diagnoses have the following codes from the *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1): diabetes mellitus, 250; essential hypertension, 401; heart failure 428; chronic ulcer of skin, 707; osteoarthrosis and allied disorders, 715; cardiac dysrhythmias, 427. 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 Standard Analytical Files; data development by the Office of Research, Development, and Information.