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 1974-2010

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
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	92	130,099	40	3,679	18,489,770	18,137,946	139	5,528	513	18,733,108	5,747	530
2010	3,434.4	95	126,063	37	3,510	18,615,688	18,262,337	145	5,318	509	19,407,218	5,688	540

[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 Center for Strategic Planning.

Table 7.2

Persons Served, Visits, Total Charges, Visit Charges, and Program Payments for Medicare Home Health Agency Services, by Demographic Characteristics: Calendar Year 2010

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	3,434	96	126,063	37	3,511	$18,615,688	$18,262,337	$145	$5,318	$509	$19,407,218	$5,688	$540
Age													
Under 65 Years	458	69	18,054	39	2,727	2,694,423	2,605,264	144	5,688	394	2,624,102	5,814	396
65-74 Years	810	52	26,703	33	1,706	3,981,129	3,899,254	146	4,812	249	4,179,425	5,199	267
75-84 Years	1,159	125	42,345	37	4,558	6,230,269	6,131,490	145	5,290	660	6,555,514	5,681	706
85 Years or Over	1,007	231	38,962	39	8,952	5,709,866	5,626,329	144	5,587	1,293	6,048,177	6,030	1,390
Sex													
Male	1,270	78	44,122	35	2,710	6,604,099	6,446,397	146	5,078	396	6,807,884	5,400	418
Female	2,165	110	81,941	38	4,174	12,011,589	11,815,940	144	5,458	602	12,599,334	5,857	642
Type of Entitlement													
Aged	2,976	102	108,010	36	3,687	15,921,265	15,657,072	145	5,260	535	16,783,116	5,669	573
Disabled	458	69	18,054	39	2,727	2,694,423	2,605,264	144	5,688	394	2,624,102	5,814	396
Race													
White	2,745	92	94,012	34	3,155	14,057,736	13,780,221	147	5,020	462	14,728,010	5,398	494
Other[3]	689	113	32,051	47	5,246	4,557,952	4,482,116	140	6,504	734	4,679,208	6,843	766

[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 Center for Strategic Planning.

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 2010

Area of Residence	Persons Served		Visits			Total Charges in Thousands
	Number in Thousands	Per 1,000 Enrollees[1]	Number in Thousands	Per Person Served	Per 1,000 Enrollees[1]	
All Areas [3]	3,434	96	126,063	37	3,511	$18,615,688
United States [4]	3,380	96	124,602	37	3,533	18,383,876
Northeast	626	94	19,312	31	2,907	2,831,078
Midwest	732	88	22,253	30	2,662	3,420,536
South	1,557	112	69,893	45	5,041	9,899,347
West	464	72	13,143	28	2,052	2,232,914
New England	215	108	7,198	33	3,627	955,782
Connecticut	51	110	1,900	37	4,100	210,511
Maine	19	84	453	23	1,960	67,985
Massachusetts	105	122	3,701	35	4,315	518,540
New Hampshire	19	92	521	28	2,533	72,849
Rhode Island	12	99	325	27	2,714	47,858
Vermont	10	90	297	31	2,784	38,039
Middle Atlantic	411	88	12,114	29	2,600	1,875,296
New Jersey	95	82	2,251	24	1,941	380,688
New York	175	84	6,339	36	3,040	934,413
Pennsylvania	141	99	3,524	25	2,491	560,195
East North Central	567	98	18,053	32	3,112	2,786,087
Illinois	192	115	6,483	34	3,902	1,004,601
Indiana	60	72	2,147	36	2,549	302,068
Michigan	166	120	4,772	29	3,453	815,571
Ohio	115	91	3,846	33	3,025	541,803
Wisconsin	33	52	805	24	1,249	122,044
West North Central	165	65	4,201	25	1,643	634,449
Iowa	24	52	602	26	1,340	76,176
Kansas	22	58	691	31	1,793	102,373
Minnesota	31	67	673	22	1,468	108,721
Missouri	66	83	1,693	26	2,134	264,877
Nebraska	14	58	359	25	1,462	55,032
North Dakota	4	42	87	21	873	13,140
South Dakota	4	35	97	22	770	14,129

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 2010

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served[2]
$18,262,337	$145	$5,318	$509	$19,407,218	$154	$5,688
18,037,216	145	5,337	511	19,168,082	154	5,709
2,780,227	144	4,440	418	2,843,642	147	4,591
3,354,936	151	4,581	401	3,833,386	172	5,263
9,713,133	139	6,237	701	10,117,247	145	6,530
2,188,918	167	4,721	342	2,373,807	181	5,154
940,168	131	4,369	474	1,027,785	143	4,878
206,065	108	4,049	445	251,504	132	5,048
66,121	146	3,412	286	75,876	167	3,950
513,460	139	4,910	599	520,842	141	5,111
71,041	136	3,767	345	84,875	163	4,562
46,968	144	3,944	392	54,699	168	4,648
36,512	123	3,815	343	39,989	135	4,270
1,840,060	152	4,477	395	1,815,857	150	4,442
375,214	167	3,947	324	405,510	180	4,285
916,353	145	5,223	440	829,649	131	4,759
548,493	156	3,903	388	580,697	165	4,153
2,734,815	151	4,825	471	3,158,933	175	5,601
985,596	152	5,138	593	1,248,999	193	6,546
295,193	138	4,886	351	330,697	154	5,500
803,947	168	4,837	582	886,909	186	5,362
531,749	138	4,620	418	561,021	146	4,899
118,331	147	3,552	184	131,307	163	3,963
620,121	148	3,747	243	674,453	161	4,104
74,794	124	3,176	166	83,367	138	3,567
100,365	145	4,469	261	101,393	147	4,535
107,122	159	3,501	234	117,078	174	3,878
257,555	152	3,906	325	285,034	168	4,343
53,579	149	3,757	218	59,337	165	4,182
12,874	147	3,038	129	12,226	140	2,913
13,832	143	3,110	110	16,019	166	3,624

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 2010

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
South Atlantic	751	101	27,755	37	3,745	$3,873,680
Delaware	12	80	265	23	1,845	38,887
District of Columbia	6	84	156	26	2,207	25,541
Florida	340	144	16,660	49	7,064	2,232,643
Georgia	83	85	2,734	33	2,809	386,928
Maryland	55	76	1,192	22	1,653	191,647
North Carolina	101	83	2,550	25	2,081	371,699
South Carolina	50	77	1,338	27	2,059	196,146
Virginia	83	86	2,322	28	2,383	347,584
West Virginia	21	70	539	26	1,828	82,605
East South Central	265	104	10,618	40	4,165	1,553,650
Alabama	68	102	2,486	37	3,743	367,043
Kentucky	59	92	2,005	34	3,148	291,414
Mississippi	55	123	2,425	44	5,393	372,448
Tennessee	83	104	3,702	44	4,637	522,744
West South Central	541	139	31,520	58	8,075	4,472,017
Arkansas	35	77	1,356	39	2,978	193,000
Louisiana	78	148	4,238	55	8,094	604,917
Oklahoma	67	131	4,100	61	8,004	550,512
Texas	361	150	21,825	60	9,049	3,123,588
Mountain	143	69	4,600	32	2,236	689,480
Arizona	34	57	792	23	1,332	135,354
Colorado	31	75	963	31	2,319	141,013
Idaho	11	68	331	30	2,033	48,014
Montana	7	48	147	22	1,057	22,046
Nevada	23	91	755	33	3,039	122,231
New Mexico	16	68	568	35	2,419	83,589
Utah	18	95	951	54	5,070	125,314
Wyoming	3	45	93	28	1,241	11,919
Pacific	321	74	8,543	27	1,964	1,543,435
Alaska	2	34	54	24	829	11,662
California	256	83	7,168	28	2,333	1,259,160
Hawaii	3	24	46	16	381	9,834
Oregon	21	57	413	20	1,139	90,490
Washington	40	54	862	22	1,184	172,289
Outlying Areas [5]	55	86	1,461	27	2,292	231,812

[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 Center for Strategic Planning.

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 2010

Visit Charges				Program Payments		
Amount in Thousands	Per Visit	Per Person Served	Per Enrollee[1]	Amount in Thousands	Per Visit	Per Person Served[2]
$3,793,119	$137	$5,050	$512	$4,147,843	$149	$5,554
37,969	143	3,301	264	45,588	172	3,981
25,054	161	4,243	356	28,775	185	4,906
2,204,443	132	6,476	935	2,207,943	133	6,531
377,258	138	4,533	388	453,869	166	5,477
186,597	157	3,416	259	237,129	199	4,361
355,235	139	3,504	290	453,949	178	4,499
188,061	141	3,761	289	243,074	182	4,884
338,004	146	4,055	347	386,851	167	4,667
80,498	149	3,874	273	90,665	168	4,394
1,517,016	143	5,720	595	1,654,875	156	6,267
359,909	145	5,308	542	380,656	153	5,634
282,016	141	4,796	443	314,962	157	5,384
363,992	150	6,587	810	377,257	156	6,853
511,100	138	6,133	640	581,999	157	7,016
4,402,999	140	8,139	1128	4,314,530	137	8,013
188,888	139	5,419	415	172,566	127	4,976
593,527	140	7,654	1134	606,968	143	7,856
543,447	133	8,082	1061	522,018	127	7,792
3,077,136	141	8,516	1276	3,012,978	138	8,380
676,658	147	4,743	329	726,129	158	5,131
132,164	167	3,904	222	148,499	188	4,417
139,320	145	4,459	335	152,620	158	4,934
46,767	141	4,245	287	50,791	153	4,650
21,367	145	3,211	154	24,962	170	3,769
119,785	159	5,268	482	135,272	179	5,995
81,674	144	5,086	348	87,315	154	5,473
123,970	130	6,977	661	112,815	119	6,410
11,611	125	3,495	156	13,857	150	4,193
1,512,260	177	4,711	348	1,647,677	193	5,165
11,082	205	4,981	170	11,688	217	5,277
1,235,607	172	4,835	402	1,350,065	188	5,316
9,635	210	3,322	80	11,042	240	3,824
87,670	212	4,234	242	89,148	216	4,333
168,266	195	4,250	231	185,733	215	4,712
225,121	154	4,105	353	239,136	164	4,395

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 2010

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]	3,434	501	7	328	549	2,193	1,256	2,171	134
Nursing Care	3,275	455	7	295	496	2,022	1,129	2,008	123
Home Health Aide	779	118	2	75	116	468	272	468	37
Physical Therapy	2,509	355	5	225	377	1,547	878	1,536	87
Speech Therapy	176	23	(4)	14	23	114	54	117	4
Occupational Therapy	1,055	149	1	90	150	665	361	663	30
Other[3]	498	83	1	41	77	296	191	294	13
					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	95.4	90.8	91.3	90.1	90.4	92.2	89.9	92.5	91.4
Home Health Aide	22.7	23.5	30.1	23.0	21.1	21.3	21.6	21.6	27.7
Physical Therapy	73.1	70.8	70.5	68.8	68.7	70.5	69.9	70.8	65.0
Speech Therapy	5.1	4.6	2.1	4.4	4.3	5.2	4.3	5.4	3.3
Occupational Therapy	30.7	29.8	18.8	27.4	27.2	30.3	28.7	30.5	22.3
Other[3]	14.5	16.6	14.5	12.4	14.1	13.5	15.2	13.5	9.3
					Visits in Thousands				
Total	126,063	13,720	260	11,976	12,603	87,504	30,195	92,152	3,716
Nursing Care	65,771	6,727	123	6,204	6,292	46,426	14,644	49,392	1,736
Home Health Aide	19,982	2,697	60	2,139	1,999	13,088	5,335	13,772	875
Physical Therapy	30,918	3,202	66	2,829	3,292	21,529	7,720	22,318	880
Speech Therapy	1,272	130	1	103	139	899	316	927	30
Occupational Therapy	7,198	807	8	627	753	5,003	1,840	5,186	172
Other[3]	921	157	2	74	128	559	341	557	23

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 2010

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
	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	49.0	47.2	51.8	49.9	53.1	48.5	53.6	46.7
Home Health Aide	15.9	19.7	22.9	17.9	15.9	15.0	17.7	14.9	23.6
Physical Therapy	24.5	23.3	25.3	23.6	26.1	24.6	25.6	24.2	23.7
Speech Therapy	1.0	0.9	0.5	0.9	1.1	1.0	1.0	1.0	0.8
Occupational Therapy	5.7	5.9	3.2	5.2	6.0	5.7	6.1	5.6	4.6
Other[3]	0.7	1.1	0.9	0.6	1.0	0.6	1.1	0.6	0.6
	Visit Charges in Millions								
Total	$18,262	$2,020	$31	$1,676	$2,097	$12,439	$4,717	$13,046	$499
Nursing Care	9,908	1,086	16	907	1,113	6,787	2,475	7,168	265
Home Health Aide	1,702	217	4	180	190	1,111	456	1,183	64
Physical Therapy	5,065	529	9	455	599	3,473	1,338	3,593	134
Speech Therapy	215	23	(5)	17	27	148	57	153	5
Occupational Therapy	1,187	133	1	102	138	812	318	842	27
Other[3]	184	31	(5)	14	31	107	73	107	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	54.3	53.8	51.8	54.1	53.1	54.6	52.5	54.9	53.1
Home Health Aide	9.3	10.8	12.5	10.8	9.0	8.9	9.7	9.1	12.8
Physical Therapy	27.7	26.2	29.7	27.2	28.6	27.9	28.4	27.5	26.7
Speech Therapy	1.2	1.1	0.7	1.0	1.3	1.2	1.2	1.2	1.0
Occupational Therapy	6.5	6.6	4.1	6.1	6.6	6.5	6.7	6.5	5.4
Other[3]	1.0	1.5	1.3	0.8	1.5	0.9	1.5	0.8	1.0

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 2010

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
				Average Number of Visits per Person Served					
Total	37	27	36	37	23	40	24	42	28
Nursing Care	20	15	18	21	13	23	13	25	14
Home Health Aide	26	23	27	28	17	28	20	29	23
Physical Therapy	12	9	13	13	9	14	9	15	10
Speech Therapy	7	6	9	7	6	8	6	8	7
Occupational Therapy	7	5	6	7	5	8	5	8	6
Other[3]	2	2	2	2	2	2	2	2	2
				Average Visit Charge per Visit					
Total	$145	$147	$120	$140	$166	$142	$156	$142	$134
Nursing Care	151	161	132	146	177	146	169	145	153
Home Health Aide	85	81	66	84	95	85	85	86	73
Physical Therapy	164	165	141	161	182	161	173	161	152
Speech Therapy	169	174	149	167	192	165	182	165	161
Occupational Therapy	165	165	151	163	183	162	173	162	157
Other[3]	200	199	176	192	241	192	213	192	212
				Average Visit Charge per Person Served					
Total	$5,318	$4,032	$4,291	$5,115	$3,816	$5,672	$3,755	$6,009	$3,717
Nursing Care	3,025	2,386	2,434	3,071	2,241	3,357	2,193	3,569	2,161
Home Health Aide	2,185	1,849	1,780	2,390	1,638	2,374	1,677	2,525	1,719
Physical Therapy	2,018	1,492	1,807	2,019	1,587	2,245	1,525	2,339	1,530
Speech Therapy	1,225	977	1,337	1,192	1,139	1,296	1,065	1,306	1,077
Occupational Therapy	1,125	894	926	1,138	921	1,222	882	1,271	899
Other[3]	370	375	390	352	401	363	380	363	383

[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 Center for Strategic Planning.

Table 7.5

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, and Program Payments, by Number of Visits: Calendar Years 2000 and 2010

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
2010								
Total	3,434	100.0	126,063	100.0	$18,615,688	100.0	$19,407,218	100.0
1-9	824	24.0	4,904	3.9	841,023	4.5	1,336,640	6.9
10-19	900	26.2	13,278	10.5	2,209,517	11.9	2,824,072	14.6
20-29	520	15.2	13,094	10.4	2,109,040	11.3	2,487,493	12.8
30-39	316	9.2	11,239	8.9	1,759,351	9.5	2,060,542	10.6
40-49	215	6.3	9,873	7.8	1,522,587	8.2	1,761,012	9.1
50-99	435	12.7	30,350	24.1	4,536,776	24.4	4,912,696	25.3
100 or More	224	6.5	43,325	34.4	5,637,395	30.3	4,024,763	20.7

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 Standard Analytical Files; data development by the Center for Strategic Planning.

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 2010

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]	---	3,434	100.0	126,063	37	$18,615,688	$18,262,337	$145	$5,318	$19,407,218	$154	$5,688
Total Leading Diagnoses[5]	---	2,057	59.9	63,400	31	9,043,047	8,878,337	140	4,317	8,629,564	136	4,230
Infectious and Parasitic Diseases (MDC 1)	001-139	23	0.7	428	19	64,631	63,395	148	2,744	66,185	155	2,889
Neoplasms (MDC 2)	140-239	111	3.2	2,261	20	345,845	335,166	148	3,015	362,727	160	3,285
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	23	0.7	411	18	64,273	62,204	151	2,703	68,673	167	3,003
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	387	11.3	21,464	56	2,919,175	2,892,210	135	7,482	2,231,295	104	5,834
Diabetes Mellitus	250	352	10.2	20,705	59	2,809,698	2,784,125	134	7,909	2,114,603	102	6,073
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	12	0.3	192	16	29,019	28,571	149	2,425	31,257	163	2,661
Diseases of the Blood and Blood Forming Organs (MDC 4)	280-289	64	1.8	1,739	27	225,134	222,470	128	3,503	249,357	143	3,943
Other Deficiency Anemias	281	34	1.0	1,080	32	130,751	129,266	120	3,803	148,207	137	4,375
Other and Unspecified Anemias	285	21	0.6	452	22	64,481	63,690	141	3,079	70,221	155	3,408
Coagulation Defects	286	2	0.1	42	26	5,873	5,804	138	3,582	5,511	131	3,434
Mental Disorders (MDC 5)	290-319	90	2.6	2,377	26	333,696	332,313	140	3,699	322,512	136	3,727
Schizophrenic Disorders	295	10	0.3	410	40	55,928	55,684	136	5,437	37,517	91	4,311
Affective Psychoses	296	13	0.4	349	28	49,882	49,928	143	3,964	43,783	126	3,721
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	163	4.7	5,036	31	718,212	708,273	141	4,350	778,700	155	4,835
Parkinson's Disease	332	36	1.1	1,224	34	178,509	177,122	145	4,892	205,566	168	5,713

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 2010

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	981	28.6	28,019	29	$4,120,280	$4,059,828	$145	$4,139	$4,375,059	$156	$4,489
Essential Hypertension	401	319	9.3	7,799	24	1,089,315	1,082,205	139	3,397	1,223,433	157	3,868
Hypertensive Heart Disease	402	33	1.0	854	26	116,897	116,077	136	3,537	131,836	154	4,044
Acute Myocardial Infarction	410	19	0.6	334	17	51,524	51,208	153	2,678	53,395	160	2,803
Other Acute and Subacute Forms of Ischemic Heart Disease	411	3	0.1	49	18	7,160	7,135	144	2,546	7,585	153	2,733
Angina Pectoris	413	5	0.1	82	18	11,406	11,359	138	2,439	12,298	150	2,666
Other Forms of Chronic Ischemic Heart Disease	414	70	2.0	1,431	20	206,756	205,317	143	2,923	222,058	155	3,182
Cardiac Dysrhythmias	427	90	2.6	1,903	21	281,809	278,814	147	3,105	292,606	154	3,275
Heart Failure	428	253	7.4	6,363	25	941,943	932,243	147	3,691	965,435	152	3,839
Transient Cerebral Ischemia	435	5	0.2	112	21	16,280	16,788	150	3,083	17,366	155	3,214
Acute but Ill-Defined Cerebrovascular Disease	436	3	0.1	101	32	13,918	13,797	137	4,433	14,710	146	4,827
Other Peripheral Vascular Disease	443	13	0.4	331	26	48,050	46,287	140	3,584	46,206	140	3,603
Diseases of the Respiratory System (MDC 8)	460-519	306	8.9	7,002	23	1,041,072	1,030,113	147	3,368	1,108,066	158	3,645
Pneumonia, Organism Unspecified	486	63	1.8	1,049	17	164,540	163,174	156	2,577	175,313	167	2,781
Chronic Airway Obstruction, not Elsewhere Classified	496	37	1.1	846	23	120,823	119,831	142	3,226	120,898	143	3,292
Diseases of the Digestive System (MDC 9)	520-579	86	2.5	1,591	18	241,141	235,981	148	2,738	256,057	161	2,988
Diseases of the Genitourinary System (MDC 10)	580-629	99	2.9	1,966	20	290,722	284,388	145	2,870	302,050	154	3,065
Other Disorders of Urethra and Urinary Tract	599	62	1.8	1,134	18	169,407	166,491	147	2,665	180,792	159	2,906
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	223	6.5	7,476	34	1,184,633	1,095,517	147	4,920	1,027,097	137	4,638
Other Cellulitis and Abscess	682	65	1.9	1,418	22	230,754	217,710	154	3,339	210,517	148	3,245
Chronic Ulcer of Skin	707	149	4.3	5,758	39	908,437	834,479	145	5,598	775,787	135	5,232

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 2010

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	434	12.6	11,591	27	$1,660,657	$1,649,045	$142	$3,800	$1,998,654	$172	$4,638
Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	714	18	0.5	564	31	77,239	76,651	136	4,260	84,828	150	4,754
Osteoarthrosis and Allied Disorders	715	128	3.7	3,072	24	434,181	431,739	141	3,377	544,214	177	4,291
Other and Unspecified Arthropathies	716	43	1.2	1,144	27	155,566	154,632	135	3,610	183,970	161	4,322
Other and Unspecified Disorders of Back	724	54	1.6	1,134	21	163,220	162,476	143	2,988	211,417	186	3,917
Other Disorders of Bone and Cartilage	733	14	0.4	623	43	79,386	78,826	126	5,488	64,475	103	4,527
Congenital Anomalies (MDC 14)	740-759	3	0.1	76	27	10,944	10,536	139	3,750	9,906	130	3,649
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	241	7.0	5,240	22	783,049	774,783	148	3,209	895,829	171	3,735
General Symptoms	780	59	1.7	1,158	20	172,799	171,778	148	2,929	187,743	162	3,224
Symptoms Involving Urinary System	788	15	0.4	356	23	49,942	47,534	134	3,127	48,346	136	3,212
Injury and Poisoning (MDC 17)	800-999	215	6.3	5,708	27	899,037	855,796	150	3,980	814,079	143	3,822
Fracture of Neck of Femur	820	2	0.1	59	25	8,642	8,545	144	3,624	9,767	165	4,201
Open Wound of Other and Unspecified Sites, Except Limbs	879	6	0.2	165	29	24,455	23,015	140	4,104	20,808	126	3,773
Open Wound of Knee, Leg (Except Thigh), and Ankle	891	26	0.8	697	27	110,186	103,834	149	4,014	98,425	141	3,825
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V89	1,209	35.2	24,087	20	3,777,018	3,712,097	154	3,070	4,609,310	191	3,834

[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 Center for Strategic Planning.

Table 7.7

Persons Served and Program Payments for Medicare Home Health Agency (HHA) Services, by Selected Diagnoses: Calendar Years 1997 and 2010

Principal ICD-9-CM Diagnosis [1]	ICD-9-CM Codes	1997 Persons in Thousands	1997 Program Payments Amount in Thousands	1997 Program Payments Percent	1997 Program Payments Per Person Served [2]	2010 Persons in Thousands	2010 Program Payments Amount in Thousands	2010 Program Payments Percent	2010 Program Payments Per Person Served [2]	Percent Change 1997-2010 Persons	Percent Change 1997-2010 Program Payments	Percent Change 1997-2010 Average Program Payment
Total All Diagnoses	---	3,558	16,718,263	100.0	4,702	3,434	19,407,218	100.0	5,688	-3	16	21
Diabetes Mellitus	250	324	2,260,343	13.5	6,995	352	2,114,603	10.9	6,073	9	-6	-13
Essential Hypertension	401	244	839,278	5.0	3,447	319	1,223,433	6.3	3,868	31	46	12
Other Forms of Chronic Ischemic Heart Disease	414	124	252,328	1.5	2,037	70	222,058	1.1	3,182	-44	-12	56
Cardiac Dysrhythmias	427	115	298,792	1.8	2,611	90	292,606	1.5	3,275	-22	-2	25
Heart Failure	428	339	1,139,447	6.8	3,364	253	965,435	5.0	3,839	-25	-15	14
Pneumonia, Organism Unspecified	486	108	208,135	1.2	1925	63	175,313	0.9	2,781	-42	-16	45
Other Disorders of the Urethra and Urinary Track	599	78	247,528	1.5	3,177	62	180,792	0.9	2,906	-21	-27	-9
Other Cellulitis and Abscess	682	59	177,454	1.1	3,034	65	210,517	1.1	3,245	10	19	7
Chronic Ulcer of Skin	707	149	913,679	5.5	6,171	149	775,787	4.0	5,232	0	-15	-15
Osteoarthrosis and Allied Disorder	715	206	433,641	2.6	2,115	128	544,214	2.8	4,291	-38	25	103
General Symptoms	780	99	271,892	1.6	2,762	59	187,743	1.0	3,224	-40	-31	17

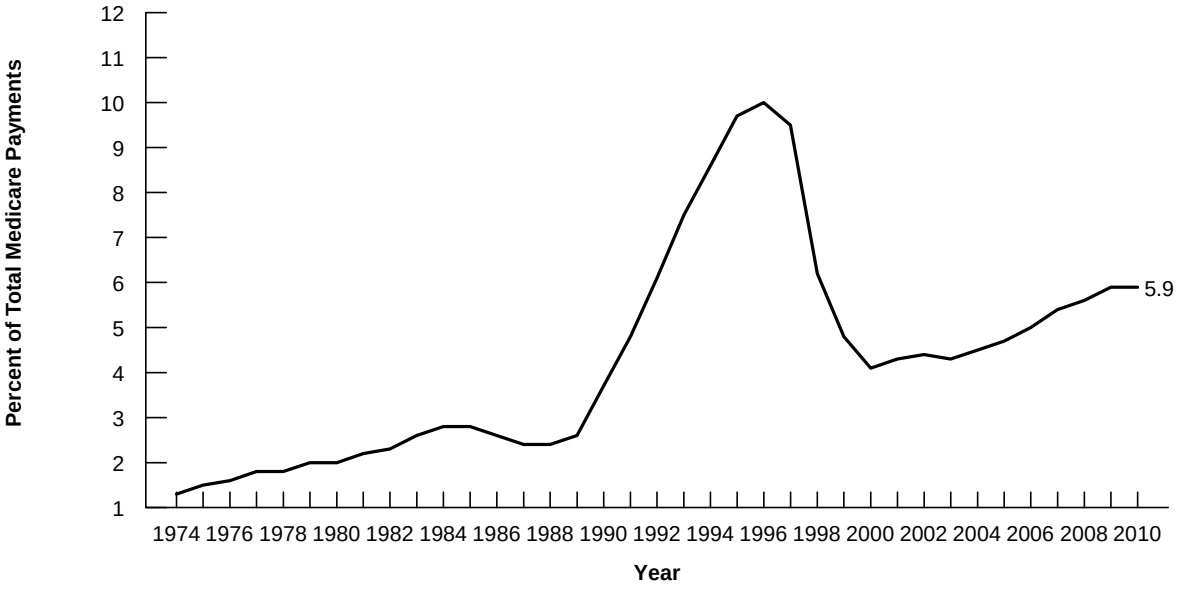
[1] ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1). Only the first listed or principal diagnosis has been used.

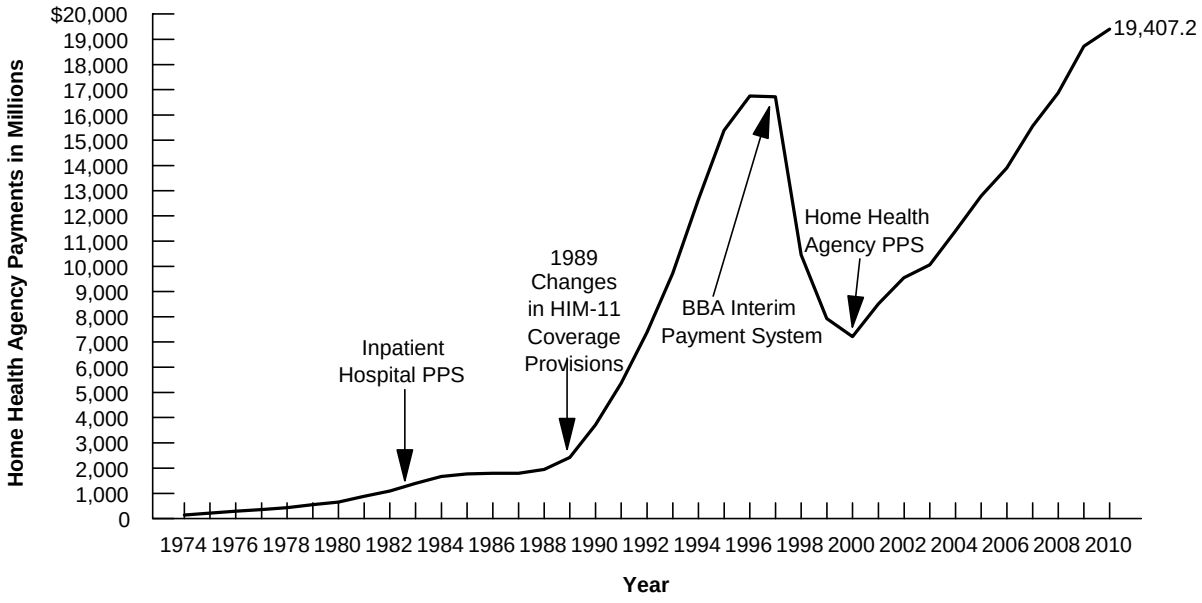
[2] Does not reflect persons who received covered services, but for whom no program payments were reported during the reporting year.

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 Center for Strategic Planning.

Figure 7.1
Medicare Home Health Agency Program Payments: Calendar Years 1974-2010

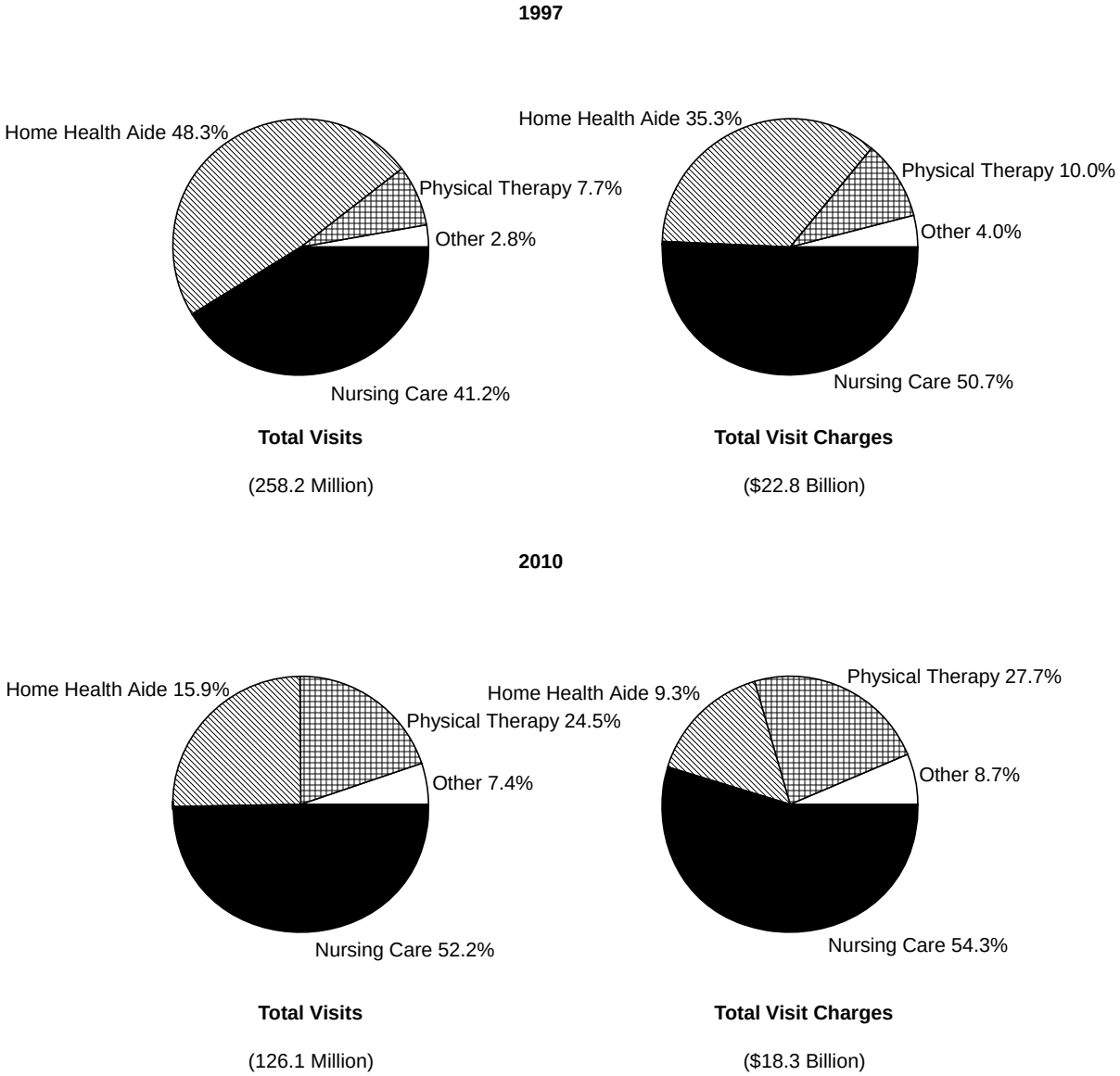




NOTES: The home health prospective payment system (PPS) was implemented beginning October 1, 2000. HIM-11 is Health Insurance Manual-11. BBA is Balanced Budget Act of 1997.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Center for Strategic Planning. See Table 7.1.

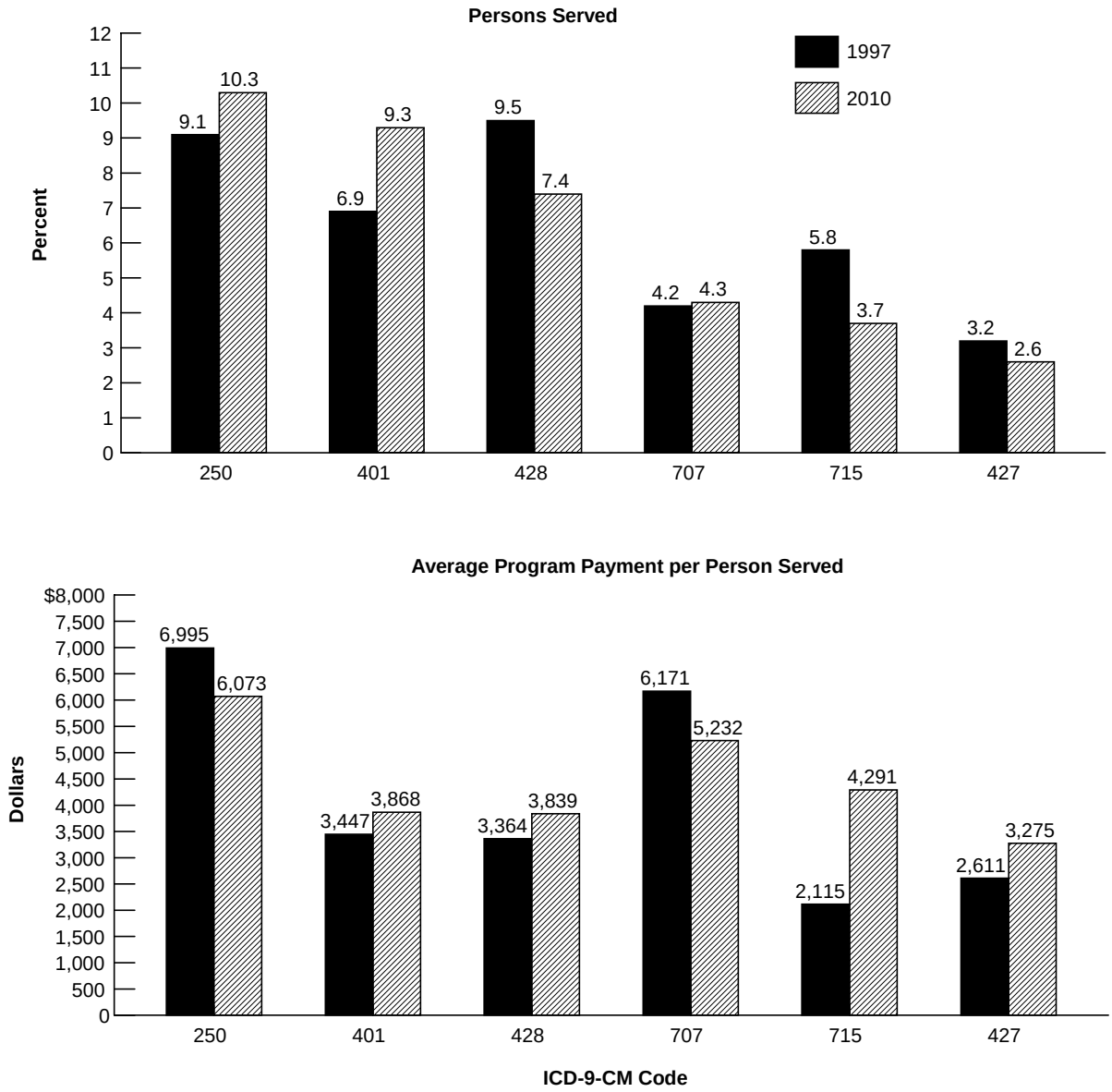
Figure 7.2
Percent Distribution of Medicare Home Health Visits and Charges, by Type of Visit: Calendar Years 1997 and 2010



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 Center for Strategic Planning. See Table 7.4.

Figure 7.3
Trends in the Six Most Frequent Medicare Home Health Agency Diagnoses: Calendar Years 1997 and 2010



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 Center for Strategic Planning. See Table 7.7.