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 1974-2012

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
2011	3,463.9	95	123,249	36	3,380	18,894,146	18,473,688	150	5,333	507	18,362,264	5,357	504
2012	3,459.6	92	117,669	34	3,161	18,498,219	18,095,404	154	5,231	486	18,025,554	5,256	484

[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 Information Products & Data Analytics.