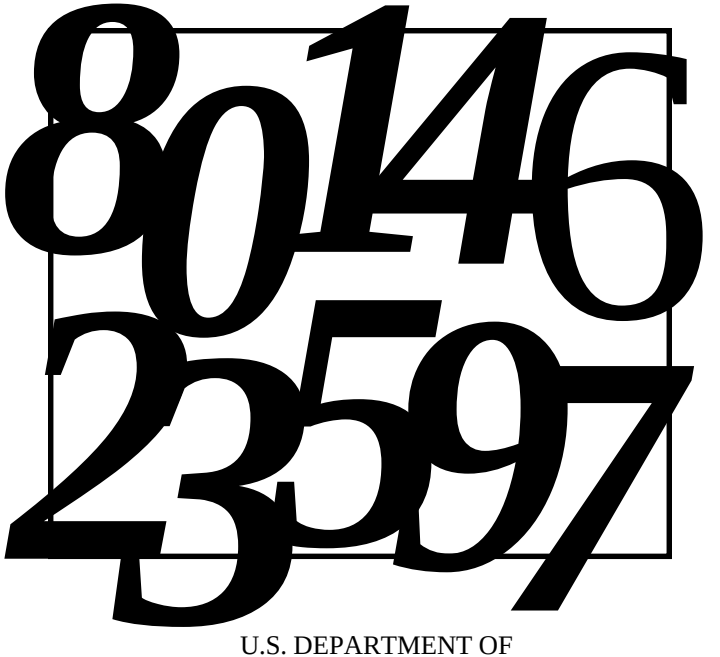
2004 CMS Statistics



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Preface

This reference booklet provides significant summary information about health expenditures and Centers for Medicare & Medicaid Services (CMS) programs. The information presented was the most current available at the time of publication. Significant time lags may occur between the end of a data year and aggregation of data for that year.

The data are organized as follows:

Glossary of Acronyms for Data Source Attribution

CBC	Center for Beneficiary Choices
CMM	Center for Medicare Management
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
DHHS	Department of Health and Human Services
HCFA	Health Care Financing Administration
HCIS	Health Care Information System
HRSA	Health Resources and Services Administration
OACT	Office of the Actuary
OCSQ	Office of Clinical Standards and Quality
OFM	Office of Financial Management
OIS	Office of Information Services
ORDI	Office of Research, Development, and Information
SSA	Social Security Administration

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Highlights

Growth in CMS programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 41.0 million in 2003, a 115 percent increase.
- On average, the number of Medicaid enrollees in 2003 is estimated to be about 41.9 million, the largest group being children (19.3 million or 46 percent).
- In 2001, 12.5 percent of the population was enrolled in the Medicaid program.
- Medicare enrollees with end-stage renal disease increased from 66.7 thousand in 1980 to 350.1 thousand in 2003, an increase of 425 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to nearly 6.0 million beneficiaries in 2002, an increase of about 111 percent.

- The average number of dually entitled persons (that is, persons covered by both Medicare and Medicaid) during 2001 amounted to about 6.5 million persons.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,770 in December 1975 to 6,057 in December 2003. Total inpatient hospital beds have dropped from 46.5 beds per 1,000 enrolled in 1975 to 23.4 in 2003, a decrease of nearly 50 percent.

- The total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaked at 1,025,000 in 1984-86. Since that time, the number has dropped to 827,000. (NOTE: A portion of this decline is due to the reclassification of some short-stay hospitals as critical access hospitals.)

- The number of psychiatric hospitals grew to about 400 by 1976, where it remained until the start of the prospective payment system (PPS) in 1983. After PPS, the number increased to over 700 in the early 1990's and has since dropped to 478.

- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, generally increased thereafter to over 15,000 in the late 1990's and again decreased, reaching 14,838 in 2002.

- The number of participating home health agencies has fluctuated considerably over the years, most recently

almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed. The number decreased sharply but has since stablized, reaching 6,928 in 2002.

Expenditures

- National health expenditures were $1,553.0 billion in 2002, 14.9 percent of the gross domestic product.

- In 2003, total net Federal outlays for CMS programs were $414.4 billion, 19.2 percent of the Federal budget.

- Medicare skilled nursing facility benefit payments increased from $14.5 billion in 2003 to $15.7 billion in 2004.

- Medicare home health agency benefit payments increased slightly between 2003 and 2004 from $10.1 billion to $10.5 billion.

- National health expenditures per person were $205 in 1965 and grew steadily to reach $5,440 by 2002.

Utilization of Medicare and Medicaid services

- Between 1990 and 2002, the number of short-stay hospital discharges increased from 10.5 million to 12.5 million, an increase of 19 percent.

- The short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.9 days in 2002, a decrease of 34 percent. Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 11.7 days in 2002, a decrease of 40 percent.

- About 31 million persons received a reimbursed service under Medicare fee-for-service during 2001. Comparably, almost 47 million persons used Medicaid services or had a premium paid on their behalf in 2001.
- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 918 per 1,000 enrolled in 2001.
- 7.2 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2001.
- 29.9 million persons received reimbursable fee-for-service physician services under Medicare during 2001. 20.1 million persons received reimbursable physician services under Medicaid during 2001.
- 22.1 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2001. During 2001, 13.8 million persons received Medicaid reimbursable outpatient hospital services.
- Over 1.5 million persons received care in SNFs covered by Medicare during 2001. 1.7 million persons received care in nursing facilities, which include SNFs and all other intermediate care facilities other than mentally retarded, covered by Medicaid during 2001.
- 22.0 million persons received prescribed drugs under Medicaid during 2001.

Populations

Information about persons covered by Medicare, Medicaid, or SCHIP

For Medicare, statistics are based on persons enrolled for coverage. Historically, for Medicaid, recipient (beneficiary) counts were used as a surrogate of persons eligible for coverage, as well as for persons utilizing services. Current data systems now allow the reporting of total eligibles for Medicaid and for SCHIP. Statistics are available by major program categories, by demographic and geographic variables, and as proportions of the U.S. population. Utilization data organized by persons served may be found in the Utilization section.

Table 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
July		In millions	
1966	19.1	19.1	--
1970	20.5	20.5	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
1997	38.4	33.6	4.8
1998	38.8	33.8	5.0
Average monthly			
1999	39.2	33.9	5.2
2000	39.7	34.3	5.4
2001	40.1	34.5	5.6
2002	40.5	34.7	5.8
2003[1]	41.0	35.0	6.0
2004[1]	41.8	35.4	6.5

[1]Projected.

NOTES: Data for 1966-1998 are as of July. Data for 1999-2004 represent average monthly enrollment. Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of Information Services and Office of the Actuary.

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
			In millions			
All persons	41.0	40.6	38.5	38.1	2.5	0.4
Aged persons	35.0	34.6	33.1	32.7	1.8	0.4
Disabled persons	6.0	6.0	5.3	5.3	0.7	([1])

[1]Number less than 500.

NOTE: Average monthly enrollment during calendar year 2003.

SOURCE: CMS, Office of the Actuary.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	40,489	17,612	22,877
Aged	34,668	14,412	20,256
65-74 years	17,758	8,140	9,618
75-84 years	12,465	4,971	7,494
85 years and over	4,445	1,301	3,144
Disabled	5,821	3,200	2,621
Under 45 years	1,679	959	721
45-54 years	1,798	994	805
55-64 years	2,343	1,248	1,096
White	34,275	14,894	19,382
Black	3,878	1,643	2,234
All Other	2,245	1,043	1,201
Native American	142	64	78
Asian/Pacific	601	261	340
Hispanic	935	442	493
Other	567	276	291
Unknown Race	92	32	60

NOTES: Data as of July 1, 2002. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development, and Information.

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
		In thousands	
Year			
1980	66.7	66.3	64.9
1990	172.0	170.6	163.7
1995	257.0	255.0	245.1
1999[1]	270.4	270.4	254.7
2000[1]	291.8	291.3	273.1
2001[1]	315.7	315.4	295.4
2002[1]	336.5	336.2	315.1
2003[1]	350.1	347.3	332.3

[1]Denominator File; estimated person years.

NOTE: Data as of July 1.

SOURCE: CMS, Office of Research, Development, and Information.

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	379.4
Age	
Under 35 years	29.1
35-44 years	40.5
45-64 years	142.6
65 years and over	167.2
Sex	
Male	207.2
Female	172.2
Race	
White	212.2
Other	166.2
Unknown	1.0

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2002.

SOURCE: CMS, Office of Research, Development, and Information.

Table 6
Medicare managed care

	Number of Plans	Enrollees (in thousands)
Total prepaid	270	5,304
Medicare + Choice Programs	150	4,622
TEFRA Cost	30	335
Demos and/or PPOs	54	218
HCPPs Part B	15	102
PFFS	4	24
PACE	17	3
Percent of total Medicare beneficiaries		12.9

[1]Health care prepayment plans/group practice prepayment plans.

NOTES: Data as of August 1, 2003. Percent of total Medicare beneficiaries based on average monthly enrollment during calendar year 2003. Numbers may not add to totals because of rounding.

SOURCE: CMS, Center for Beneficiary Choices.

Table 7
Medicare enrollment/CMS region

	Resident[1] population	Medicare[2] enrollees	Enrollees as percent of population
	In thousands		
All regions	288,369	39,582	13.7
Boston	14,145	2,139	15.1
New York	27,748	3,940	14.2
Philadelphia	28,267	4,224	14.9
Atlanta	54,949	8,254	15.0
Chicago	50,692	7,101	14.0
Dallas	34,322	4,159	12.1
Kansas City	13,055	2,000	15.3
Denver	9,626	1,130	11.7
San Francisco	43,990	5,148	11.7
Seattle	11,576	1,485	12.8

[1]Estimated July 1, 2002 resident population.
[2]Medicare denominator enrollment file data are as of July 1, 2002.

NOTES: Resident population is a provisional estimate. The 2002 resident population data for Outlying Areas, Puerto Rico, and the Virgin Islands are not available.

SOURCES: CMS, Office of Research, Development, and Information; U.S. Bureau of the Census, Population Division, Population Estimates Branch.

Table 8
Aged population/projected

	1999	2000	2025	2050	2075	2080
	In millions					
65 years and over	35.2	35.4	62.3	80.6	93.7	96.0
75 years and over	16.6	16.9	25.7	42.6	51.6	53.2
85 years and over	4.3	4.4	6.0	15.0	18.6	19.9

SOURCE: CMS, Office of the Actuary.

Table 9
Life expectancy at age 65/trends

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1985	14.4	18.6
1990	15.0	19.0
1995	15.3	19.0
2000[1]	15.8	18.9
2010[2]	16.4	19.3
2020[2]	17.0	19.9
2030[2]	17.7	20.5
2040[2]	18.3	21.1
2050[2]	18.8	21.7
2060[2]	19.4	22.2
2070[2]	19.9	22.7

[1]Preliminary. [2]Projected.

SOURCE: Social Security Administration, Office of the Actuary.

Table 10
Life expectancy at birth and at age 65 by race/trends

Calendar Year	All Races	White	Black
		At Birth	
1950	68.2	69.1	60.7
1980	73.7	74.4	68.1
1985	74.7	75.3	69.3
1990	75.4	76.1	69.1
1995	75.8	76.5	69.6
2001[1]	77.2	77.7	72.2
		At Age 65	
1950	13.9	NA	13.9
1980	16.4	16.5	15.1
1985	16.7	16.8	15.2
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2001[1]	18.1	18.2	16.4

[1]Preliminary.
SOURCE: Public Health Service, Health United States, 2003.

Table 11
Medicaid and SCHIP enrollment

	Fiscal year					
	1990	1995	2000	2002	2003	2004
	Person Years in millions					
Total	22.9	33.4	34.8	39.9	41.9	42.9
Age 65 years and over	3.1	3.7	3.9	4.2	4.3	4.4
Blind/Disabled	3.8	5.8	6.8	7.5	7.8	8.0
Children	10.7	16.5	16.3	18.4	19.3	19.7
Adults	4.9	6.7	7.8	9.8	10.5	10.8
Other Title XIX	0.5	0.6	NA	NA	NA	NA
SCHIP	NA	NA	2.1	3.5	3.9	4.1
	Eligibles in millions					
Total	NA	42.5	44.3	51.0	53.6	54.9
Age 65 years and over	NA	4.4	4.5	4.9	5.0	5.1
Blind/Disabled	NA	6.5	7.6	8.4	8.7	8.9
Children	NA	21.3	21.2	23.9	25.0	25.7
Adults	NA	9.4	11.0	13.9	14.9	15.3
Other Title XIX	NA	0.9	NA	NA	NA	NA
SCHIP	NA	NA	3.4	5.4	5.8	6.1

NOTES: Totals may not add due to rounding. Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty level recipients who are not disabled. Medicaid enrollment projections for fiscal years 2002-2004 and SCHIP projections for 2004 were prepared by the Office of the Actuary for the President's 2005 budget.

In 1997 (not shown), the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories. SCHIP includes both Medicaid expansion groups and separate State programs. Medicaid children totals exclude Medicaid expansion groups under SCHIP.

SOURCES: CMS, Office of Information Services, Office of the Actuary, and the Center for Medicaid and State Operations.

Table 12
Medicaid eligibles/demographics

	Fiscal year 2001 Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	46.8	100.0
Age	46.8	100.0
Under 21	25.4	54.4
21-64 years	16.1	34.4
65 years and over	5.1	10.9
Unknown	0.1	0.2
Sex	46.8	100.0
Male	18.6	39.7
Female	28.1	60.1
Unknown	0.1	0.3
Race	46.8	100.0
White, not Hispanic	20.5	43.8
Black, not Hispanic	11.7	25.0
Am. Indian/Alaskan Native	0.6	1.3
Asian	1.0	2.2
Hawaiian/Pacific Islander	0.5	1.1
Hispanic	9.5	20.4
Other	0.1	0.2
Unknown	2.9	6.1

NOTES: The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of rounded components. Eligible is defined as any one eligible and enrolled in the Medicaid program at some point during the fiscal year, regardless of duration of enrollment, receipt of a paid medical service, or whether or not a capitated premium for managed care or private health insurance coverage had been made.

SOURCES: CMS, Center for Medicaid and State Operations, Office of Information Services, and the Office of Research, Development, and Information.

Table 13
Medicaid enrollment/CMS region

	Resident[1] population	Medicaid[2] enrollment	Enrollment as percent of population
	In thousands		
All regions	285,318	35,698	12.5
Boston	14,052	1,678	11.9
New York	27,595	3,562	12.9
Philadelphia	28,058	2,868	10.2
Atlanta	54,194	7,580	14.0
Chicago	50,434	5,274	10.5
Dallas	33,837	3,870	11.4
Kansas City	12,991	1,438	11.1
Denver	9,504	673	7.1
San Francisco	43,232	7,354	17.0
Seattle	11,421	1,401	12.3

[1]Estimated July 1, 2001 population. [2]Medicaid person years for fiscal year 2001.

NOTES: Numbers may not add to totals because of rounding. Resident population is a provisional estimate. Excludes data for Puerto Rico, Virgin Islands and Outlying Areas.

SOURCES: CMS, Office of the Actuary; U.S. Department of Commerce, Bureau of the Census.

Table 14
Medicaid beneficiaries/State buy-ins for Medicare

	1975[1]	1980[1]	2001[2]	2002[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,744	5,991
Aged	2,483	2,449	3,714	3,832
Disabled	363	504	2,031	2,159
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	15.2	15.1
Aged	11.4	10.0	11.3	11.3
Disabled	18.7	18.9	41.2	40.4

[1]Beneficiaries for whom the State paid the SMI premium during the year.
[2]Beneficiaries in person years.

NOTES: Numbers may not add to totals because of rounding. Percent calculated using July enrollment.

SOURCE: CMS, Office of Research, Development, and Information.

Providers/Suppliers

Information about institutions, agencies, or professionals who provide health care services and individuals or organizations who furnish health care equipment or supplies

These data are distributed by major provider/supplier categories, by geographic region, and by type of program participation. Utilization data organized by type of provider/supplier may be found in the Utilization section.

Table 15
Inpatient hospitals/trends

	1990	1995	2000	2003
Total hospitals	6,522	6,376	6,031	6,057
Beds in thousands	1,105	1,056	983	952
Beds per 1,000 enrollees[1]	32.8	28.4	25.1	23.4
Short-stay	5,549	5,252	4,704	4,101
Beds in thousands	970	926	863	827
Beds per 1,000 enrollees[1]	28.8	24.9	22.0	20.3
Psychiatric	674	682	519	478
Beds in thousands	99	86	69	57
Beds per 1,000 enrollees[1]	2.9	2.3	1.8	1.4
Other non-short-stay	299	442	808	1,478
Beds in thousands	35	45	51	67
Beds per 1,000 enrollees[1]	1.0	1.2	1.3	1.6

[1] Based on number of total HI enrollees as of July 1.

NOTES: Facility data are as of December 31 and represent essentially those facilities eligible to participate the start of the calendar year. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: CMS, ORDI, and OIS; SSA, Social Security Bulletin, Annual Statistical Supplement.

Table 16
Medicare assigned claims/CMS region

	Net assignment rates		
	2001	2002	2003
All regions	98.1	98.4	98.5
Boston	99.8	99.8	99.9
New York	98.2	98.4	98.7
Philadelphia	98.5	98.6	98.8
Atlanta	98.4	98.8	98.8
Chicago	98.1	98.1	98.1
Dallas	98.2	98.4	98.6
Kansas City	97.5	97.8	98.0
Denver	97.2	97.5	97.7
San Francisco	99.1	99.2	99.2
Seattle	91.0	92.1	99.4

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

Table 17
Medicare hospital and unit status

Total hospitals	6,051
Hospitals under any Prospective Payment System (PPS)[1]	4,537
Short-term hospitals under Inpatient PPS (IPPS)	4,108
Receiving special consideration under IPPS	995
Regional referral centers	195
Sole community hospitals	512
Sole community/regional referral center	85
Medicare dependent hospitals	162
Indian Health Service hospitals	41
Not receiving special consideration	3,113
Long-term hospital under Long-Term Hospital PPS (LTCH PPS)	213
Rehabilitation hospitals under Inpatient Rehabilitation Facility PPS (IRF PPS)	216
Hospitals currently exempt or not yet transitioned to PPS (as of 6/30/03)	1,514
Psychiatric	480
Religious non-medical	15
Childrens	81
Long-term facility (not transitioned into LTCH PPS)	86
Critical access	788
Short-term hospitals in MD, VI, AS, GU, and NMI (Exempt from IPPS)	53
Cancer hospitals (Short-Term Non-PPS Hospitals)	11
Total hospital units (PPS and Non-PPS)	2,394
Psychiatric	1,410
Rehabilitation	984

[1]Total number of hospitals subject to PPS regardless of actual submitted inpatient hospital claims during the fiscal year.

NOTES: The table is designed to give a "snapshot" as of the end of June 2003 of hospitals participating in the program by type of provider (short term, long term, rehab., etc.) and by their payment status as active and participating in Medicare on the June 2003 Provider of Service (POS) File. PPS and Special Consideration Status under PPS determined using provider lists from CMM and the Provider Specific File which may reflect cumulative history as opposed to current status. Numbers may differ from other reports and program memoranda.

SOURCES: CMS, CMM, CMSO, and ORDI.

Table 18
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	14,838	1,678	6,749
Boston	1,056	40	170
New York	1,031	2	759
Philadelphia	1,388	95	462
Atlanta	2,599	132	705
Chicago	3,243	418	1,637
Dallas	1,743	419	1,521
Kansas City	1,231	377	189
Denver	587	64	88
San Francisco	1,479	94	1,137
Seattle	472	37	81

[1]Skilled nursing facilities.
[2]Institutions for mentally retarded.
[3]All regions' totals include U.S. Possessions and Territories.

NOTE: Data as of December 2002.

SOURCE: CMS, Office of Research, Development, and Information.

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	2002	2003
Home health agencies	2,242	2,924	6,813	6,928
Clinical Lab Improvement Act Facilities	NA	NA	173,807	176,947
End stage renal disease facilities	NA	999	4,113	4,309
Outpatient physical therapy	117	419	2,836	2,961
Portable X-ray	132	216	644	641
Rural health clinics	NA	391	3,283	3,306
Comprehensive outpatient rehabilitation facilities	NA	NA	524	587
Ambulatory surgical centers	NA	NA	3,371	3,597
Hospices	NA	NA	2,275	2,323

NOTES: Facility data for selected years 1975-1980 are as of July 1. Facility data for 2002 and 2003 are as of December 2001 and December 2002, respectively.

SOURCE: CMS, Office of Research, Development, and Information.

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	4,231	14,838	6,928
		Percent of total	
Non-profit	60.6	28.2	34.2
Proprietary	15.6	66.7	51.2
Government	23.8	5.1	14.6

NOTES: Data as of December 31, 2002. Facilities certified for Medicare are deemed to meet Medicaid standards. Percent distribution may not add to 100 percent due to rounding.

SOURCE: CMS, Office of Research, Development, and Information.

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	2001	2002	2003
Hospitals					
Number of PIP	2,276	3,242	754	687	657
Percent of total participating	33.8	48.3	12.5	11.4	10.9
Skilled nursing facilities					
Number of PIP	203	224	1,161	862	1,001
Percent of total participating	3.9	3.4	7.9	5.8	6.7
Home health agencies					
Number of PIP	481	931	42	40	44
Percent of total participating	16.0	16.0	0.1	0.1	0.1

NOTES: Data from 1985 to date are as of September; 1980 data are as of December. These are facilities receiving periodic interim payments (PIP) under Medicare. Effective for claims received on or after July 1, 1987, the Omnibus Budget Reconciliation Act of 1986 eliminates PIP for many PPS hospitals when the servicing intermediary meets specified processing time standards.

SOURCE: CMS, Office of Financial Management.

Table 22
Part B practitioners active in patient care/selected years

	February 2004	
	Number	Percent
All Part B Practitioners	906,422	100.0
Physician Specialties	586,411	64.7
Primary Care	213,468	23.6
Medical Specialties	93,685	10.3
Surgical Specialties	99,509	11.0
Emergency Medicine	30,171	3.3
Anesthesiology	33,960	3.7
Radiology	33,463	3.7
Pathology	12,471	1.4
Ostetrics/Gynecology	34,884	3.8
Psychiatry	34,618	3.8
Other and Unknown	182	0.0
Limited Licensed Practitioners	108,964	12.0
Non-physician Practitioners	211,047	23.3

NOTES: Specialty code is self-reported and may not correspond to actual board certification. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Office of Research, Development, and Information.

Table 23
Part B practitioners/CMS region

	Practitioners active in patient care	Practitioners per 100,000 population
All regions	[1]907,273	312
Boston	66,040	465
New York	106,232	382
Philadelphia	97,497	343
Atlanta	159,941	288
Chicago	157,543	310
Dallas	90,421	260
Kansas City	44,782	342
Denver	31,987	329
San Francisco	113,846	256
Seattle	38,984	333

[1]Non-Federal physicians only. Includes physicians, limited licensed and non-physician practitioners. Total excludes Puerto Rico and outlying areas.

NOTES: Physicians as of April 2003. Civilian population as of July 1, 2003.

SOURCES: CMS, ORDI, and the Bureau of the Census.

Table 24
Inpatient hospitals/CMS region

	Short-stay hospitals	Beds per 1,000 enrollees	Non Short-stay facilities	Beds per 1,000 enrollees
All regions	4,101	20.4	1,956	3.1
Boston	171	15.0	90	5.0
New York	337	23.2	83	3.1
Philadelphia	356	18.6	154	3.6
Atlanta	842	20.6	279	2.4
Chicago	704	22.5	343	2.7
Dallas	657	22.7	365	4.3
Kansas City	256	22.5	246	4.2
Denver	173	19.2	143	5.1
San Francisco	470	18.5	128	1.7
Seattle	135	14.9	98	2.8

NOTES: Data as of December 31, 2003. Rates based on number of hospital insurance enrollees as of July 1, 2003.

SOURCE: CMS, Office of Research, Development, and Information.

Expenditures

Information about spending for health care services by Medicare, Medicaid, SCHIP, and for the Nation as a whole

Health care spending at the aggregate levels is distributed by source of funds, types of service, geographic area, and broad beneficiary or eligibility categories. Direct out-of-pocket, other private, and non-CMS-related expenditures are also covered in this section. Expenditures on a per-unit-of-service level are covered in the Utilization section.

Table 25
CMS and total Federal outlays

	Fiscal year 2002	Fiscal year 2003
	$ in billions	
Gross domestic product (current dollars)	$10,373.4	$10,828.3
Total Federal outlays[1]	2,011.0	2,157.6
Percent of gross domestic product	19.4	19.9
Dept. of Health and Human Services[1]	465.8	505.3
Percent of Federal Budget	23.2	23.4
CMS Budget (Federal Outlays)		
Medicare benefit payments	252.2	272.6
SMI transfer to Medicaid[2]	0.1	0.1
Medicaid benefit payments	140.4	152.8
Medicaid State and local admin.	7.3	8.0
Medicaid offsets[3]	-0.1	-0.1
State Children's Health Ins. Prog.	3.7	4.4
CMS program management	2.3	2.4
Other Medicare admin. expenses[4]	1.2	1.3
Quality improvement organizations[5]	0.4	0.4
Health Care Fraud and Abuse Control	1.0	1.0
State Grants and Demonstrations[6]	*	*
Total CMS outlays (unadjusted)	408.4	442.9
Offsetting receipts[7]	-26.0	-28.4
Total net CMS outlays	382.4	414.4
Percent of Federal budget	19.0	19.2

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($112.1 million in FY 2002 and $112.1 million in FY 2003).
[3]SMI transfers for premium assistance and additionally, in FY 2002, an SCHIP transfer of $25.8 to reimburse Medicaid for the cost of SCHIP-related expansions before FY 2001.
[4]Medicare administrative expenses of the Social Security Administration and other Federal agencies.
[5]Formerly peer review organizations (PROs).
[6]Grants and demonstrations under the Ticket to Work and Work incentives Improvement Act (P.L. 106-170) and qualified high risk pools under the Trade Act of 2002 (P.L. 107-210). These programs had outlays of $10.3 million in FY 2002 and $15 million in FY 2003. These amounts are included in total CMS outlays.
[7]Almost entirely Medicare premiums. Also includes certain receipts from the sale of strategic materials ($31 million in FY 2002 and $8 million in FY 2003) transferred by the Department of Defense in accordance with P.L. 105-261.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table 26
Program expenditures/trends

	Total	Medicare[1]	Medicaid[2]	SCHIP[3]
		in billions		
Fiscal year				
1980	$60.8	$35.0	$25.8	--
1990	182.2	109.7	72.5	--
2000	428.7	219.0	208.0	$1.7
2002	522.0	257.2	259.5	5.3
2003	560.0	277.8	276.0	6.2

[1]Medicare amounts reflect gross outlays (i.e., not net of offsetting receipts). These amounts include outlays for benefits, administration, the Health Care Fraud and Abuse Control (HCFAC) activity, Quality Improvement Organizations (QIOs) and the SMI transfer to Medicaid for Medicare Part B premium assistance for low income Medicare beneficiaries. [2]The Medicaid amounts include total computable outlays (Federal and State shares) for benefits and administration, the Federal and State shares of the cost of Medicaid survey/certification and State Medicaid fraud control units and outlays for the Vaccines for Children program. These amounts do not include the SMI transfer to Medicaid for Medicare Part B premium assistance for low-income Medicare beneficiaries. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays. Please note that SCHIP-related Medicaid began to be financed under Title XXI in FY 2001.

SOURCE: CMS, Office of Financial Management.

Table 27
Benefit outlays by program

	1967	1968	2002	2003
Annually	Amounts in billions			
CMS program outlays	$5.1	$8.4	$504	$540
Federal outlays	NA	6.7	396	430
Medicare[1]	3.2	5.1	252	273
HI	2.5	3.7	144	151
SMI	0.7	1.4	108	122
Medicaid[2]	1.9	3.3	247	261
Federal share	NA	1.6	140	153
SCHIP[3]	NA	NA	5	6
Federal share	NA	NA	4	4

[1]The Medicare benefit amounts reflect gross outlays (i.e., not net of offsetting premiums). These amounts exclude outlays for the SMI transfer to Medicaid for premium assistance and the Quality Improvement Organizations (QIOs). [2]The Medicaid amounts include total computable outlays (Federal and State shares) for benefits and outlays for the Vaccines for Children program. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays as reported by the States on line 4 of the CMS-21. Please note that SCHIP-related Medicaid expansions began to be financed under SCHIP (Title XXI) in FY 2001.

NOTES: Fiscal year data. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table 28
Program benefit payments/CMS region

	Fiscal year 2002 benefit payments	
	Medicaid	
	Total payments computable for Federal funding	Net expenditures reported Federal share[1]
	In millions	
All regions	$246,284	$140,042
Boston	15,985	8,381
New York	44,593	22,338
Philadelphia	22,797	12,657
Atlanta	41,650	26,424
Chicago	39,085	21,824
Dallas	24,684	16,153
Kansas City	11,112	6,808
Denver	5,165	3,150
San Francisco	32,014	17,159
Seattle	9,199	5,148

[1]Excludes CMS adjustments.

NOTES: Data from Form CMS-64 -- Line 11, Net Expenditures Reported. Medical assistance only. Territories are at capped levels. Excludes the State Childrens' Health Insurance Program (SCHIP). Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS, OFM, OACT, and CMSO.

Table 29
Medicare benefit outlays

	Fiscal year		
	2002	2003	2004
	In billions		
HI benefit payments	$144.1	$153.1	$166.2
Aged	125.3	132.6	143.1
Disabled	18.9	20.6	23.1
SMI benefit payments	108.1	119.5	127.8
Aged	91.7	100.5	107.1
Disabled	16.4	19.0	20.7

NOTES: Based on FY 2005 President's Budget. Benefit estimates do not reflect proposed legislation. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Office of the Actuary.

Table 30
Medicare/type of benefit

	Fiscal year 2004 benefit payments in millions	Percent distribution
Total HI	$166,182	100.0
Inpatient hospital	118,552	71.3
Skilled nursing facility	15,732	9.5
Home health agency	5,189	3.1
Hospice	6,466	3.9
Managed care	20,242	12.2
Total SMI	127,786	100.0
Physician/other suppliers	51,125	40.0
Durable Medical Equipment	7,783	6.1
Other Carrier[1]	13,834	10.8
Outpatient hospital	15,866	12.4
Home health agency	5,317	4.2
Other intermediary[2]	9,962	7.8
Laboratory	5,681	4.4
Managed care	18,218	14.3

[1]Includes drugs administered by a physician, free-standing ambulatory surgical center facility costs, ambulance and supplies. [2]Includes ESRD free-standing and hospital-based dialysis facility payments and payments for rural health clinics, outpatient rehabilitation facilities, and federally qualified health centers.

NOTES: Based on FY 2005 President's Budget. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, OACT.

Table 31
National health care/trends

	Calendar year			
	1965	1980	2001	2002
National total in billions	$41.0	$245.8	$1,420.7	$1,553.0
Percent of GDP	5.7	8.8	14.1	14.9
Per capita amount	$205	$1,067	$5,021	$5,440
Source of funds		Percent of total		
Private	75.1	57.3	54.1	54.1
Public	24.9	42.7	45.9	45.9
Federal	11.4	29.0	32.4	32.5
State/local	13.5	13.6	13.5	13.4

NOTE: Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of the Actuary; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

Table 32
Medicaid/type of service

	Fiscal year		
	2000	2001	2002
	In billions		
Total medical assistance payments[1]	$195.5	$216.2	$246.3
	Percent of total		
Inpatient services	14.1	13.6	13.9
General hospitals	12.7	12.5	12.6
Mental hospitals	1.3	1.2	1.3
Nursing facility services	20.2	19.8	18.8
Intermediate care facility (MR) services	5.1	4.8	4.4
Community-based long term care svs.[2]	9.4	9.6	9.7
Prescribed drugs[3]	8.5	9.1	9.5
Physician services	3.5	3.6	3.6
Dental services	0.9	1.0	1.1
Outpatient hospital services	3.7	3.7	4.0
Clinic services[4]	2.9	2.8	2.9
Laboratory and radiological services	0.3	0.3	0.3
Early and periodic screening	0.4	0.4	0.4
Targeted case management services	0.9	0.9	1.0
Capitation payments (non-Medicare)	15.2	15.4	16.0
Medicare premiums	2.1	2.1	2.1
Disproportionate share hosp. payments	7.4	7.2	6.2
Other services	4.9	5.0	5.1
Adjustments[5]	0.4	0.6	0.9

[1]Excludes payments under SCHIP. [2]Comprised of home health, home and community-based waivers, personal care and home and community-based services for functionally disabled elderly. [3]Net of prescription drug rebates. [4]Federally qualified health clinics, rural health clinics, and other clinics.[5]Includes increasing and decreasing payment adjustments from prior quarters, collections, and other unallocated expenditures.

SOURCES: CMS, CMSO, and OACT.

Table 33
Medicare savings attributable to secondary payor provisions/type of provision

	Workers Comp.	Working Aged	ESRD	Auto	Disability	Total
2001	$95.9	$1,626.2	$172.1	$251.5	$1,278.2	$3,644.3
2002	106.2	1,942.7	199.5	296.5	1,508.5	4,278.5
2003	122.2	2,146.7	206.1	273.9	1,604.1	4,593.3

NOTES: Fiscal year data. In millions of dollars. FYs 2001 through 2003 totals include liability amounts of $220.3, $225.0, and $240.3 million, respectively.

SOURCE: CMS, OFM.

Table 34
Medicaid/payments by eligibility status

	Fiscal year 2002 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$246.3	100.0
Age 65 years and over	63.8	25.9
Blind/disabled	97.0	39.4
Dependent children under 21 years of age	39.2	15.9
Adults in families with dependent children	28.0	11.4
DSH and other unallocated	18.2	7.4

[1]Excludes payments under State Children's Health Insurance Program (SCHIP).

SOURCE: CMS, Office of the Actuary.

Table 35
Medicare/durable medical equipment[1]

Category	Allowed Charges[2]	
	2001	2002
	In thousands	
Total	$7,760,316	$9,124,460
Surgical dressings	37,741	47,825
Supplies/accessories	325,952	380,733
Capped rental	1,537,864	1,962,314
Customized items	49	0
Oxygen	1,959,620	2,201,542
Prosthetics/orthotics	933,217	1,045,510
Inexpensive/routine	1,066,079	1,293,805
Items with frequent maintenance	133,180	125,663
Other	188,883	280,238
Parenteral/enteral	719,725	731,196
DME to admin. drugs	858,006	1,055,635

[1]Data are for calendar year.
[2]The allowed charge is the Medicare approved payment reported on a line item on the physician/supplier claim.

SOURCE: CMS, Office of Research, Development, and Information.

Table 36
National health care/type of expenditure

	National total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$1,553.0	$5,440	33.2	17.2	16.0
Health serv/suppl.	1,496.3	5,241	34.5	17.9	16.6
Personal health care	1,340.2	4,695	36.7	19.3	17.3
Hospital care	486.5	1,704	47.8	30.7	17.1
Prof. services	501.5	1,757	27.3	15.0	12.3
Phys./clinical	339.5	1,189	27.5	20.3	7.2
Nursing/home hlth.	139.3	488	60.1	17.5	42.6
Retail outlet sales	212.9	746	18.1	4.8	13.3
Admn. and pub. hlth.	156.1	547	15.8	5.1	10.6
Investment	56.7	199	--	--	--

NOTES: Data are as of calendar year 2002.

SOURCE: CMS, Office of the Actuary.

Table 37
Personal health care/payment source

	Calendar year			
	1970	1980	2001	2002
	In billions			
Total	$63.2	$214.6	$1,231.4	$1,340.2
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	64.8	59.7	56.2	55.8
Private health insurance	22.3	28.3	35.5	35.8
Out-of-pocket	39.7	27.1	16.3	15.9
Other private	2.8	4.3	4.4	4.2
Public funds	35.2	40.3	43.8	44.2
Federal	22.9	29.3	33.5	33.6
State and local	12.3	11.1	10.4	10.6

NOTE: Excludes administrative expenses, research, construction, and other types of spending that are not directed at patient care.

SOURCE: CMS, Office of the Actuary.

Utilization

Information about the use of health care services

Utilization information is organized by persons receiving services and alternately by services rendered. Measures of health care usage include: persons served, units of service (e.g., discharges, days of care, etc.), and dimensions of the services rendered (e.g., average length of stay, charge per person or per unit of service). These utilization measures are aggregated by program coverage categories, provider characteristics, type of service, and demographic and geographic variables.

Table 38
Medicare/short-stay hospital utilization

	1985	1990	2001	2002
Discharges				
Total in millions	10.5	10.5	12.2	12.5
Rate per 1,000 enrollees[1]	347	313	310	314
Days of care				
Total in millions	92	94	73	74
Rate per 1,000 enrollees[1]	3,016	2,805	1,846	1,860
Average length of stay				
All short-stay	8.7	9.0	6.0	5.9
Excluded units[2]	18.8	19.5	12.0	11.7
Total charges per day	$597	$1,060	$3,027	$3,506

[1]The population base is HI enrollment excluding HI enrollees residing in foreign countries and should be treated as preliminary. [2]Includes alcohol/drug, psychiatric, and rehabilitation units through 1990, and psychiatric and rehabilitation units for 2001 and 2002.

NOTES: Data may reflect under reporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; and no-pay Medicare secondary payer bills. Average length of stay data are shown in days. The data for 1990 through 2002 are based on 100 percent MEDPAR. Data may differ from other sources or from the same source with different update cycle.

SOURCE: CMS, Office of Information Services.

Table 39
Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
1985	315	10	1,576	51
1990	638	19	1,978	58
1995	1,240	33	3,457	93
1999	1,390	[1]47	2,720	[1]85
2000	1,468	[1]45	2,461	[1]75
2001	1,545	[1]46	2,403	[1]71

[1]Managed care enrollees excluded in determining rate.

SOURCE: CMS, Office of Research, Development, and Information.

Table 40
Medicare average length of stay/trends

	Fiscal year					
	1984	1990	1995	2000	2001	2002
All short-stay hospitals	9.1	9.0	7.1	6.0	6.0	5.9
PPS hospitals	8.0	8.9	7.1	6.0	6.0	5.9
Excluded units	18.0	19.5	14.8	12.3	12.0	11.7

NOTES: Fiscal year data. Average length of stay is shown in days. For all short-stay and PPS hospitals, 1984 data are based on a 20-percent sample of Medicare HI enrollees. Data for 1990 through 2002 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Information Services.

Table 41
Medicare persons served/trends

	Calendar year				
	1975	1980	1985	2000	2001
Aged persons served per 1,000 enrollees					
HI and/or SMI	528	638	722	916	918
HI	221	240	219	232	233
SMI	536	652	739	965	968
Disabled persons served per 1,000 enrollees					
HI and/or SMI	450	594	669	835	843
HI	219	246	228	196	199
SMI	471	634	715	943	952

NOTES: Prior to 1998, data were obtained from the Annual Person Summary Record were not yet modified to exclude persons enrolled in managed care. Beginning in 1998, utilization counts are based on a five-percent sample of fee-for-service beneficiaries and the rates are adjusted to exclude managed care enrollees.

SOURCES: CMS, Office of Information Services, and the Office of Research, Development, and Information.

Table 42
Medicare fee-for-service (FFS) persons served

	Calendar year				
	1997	1998	1999	2000	2001
	Numbers in millions				
HI					
Aged					
FFS Enrollees	28.1	27.3	27.0	27.4	28.3
Persons served	7.1	6.7	6.3	6.4	6.6
Rate per 1,000	254	243	232	232	233
Disabled					
FFS Enrollees	4.5	4.6	4.7	4.9	5.2
Persons served	1.0	1.0	0.9	1.0	1.0
Rate per 1,000	218	206	198	196	199
SMI					
Aged					
FFS Enrollees	27.0	26.2	25.9	26.2	27.0
Persons served	25.9	25.3	25.0	25.3	26.1
Rate per 1,000	959	964	966	965	968
Disabled					
FFS Enrollees	4.0	4.1	4.2	4.3	4.5
Persons served	3.7	3.8	3.9	4.1	4.3
Rate per 1,000	925	925	936	943	952

NOTES: Enrollment represents persons enrolled in Medicare fee-for-service as of July. Persons served represents estimates of beneficiaries receiving reimbursed services under fee-for-service during the calendar year.

SOURCE: CMS, Office of Research, Development, and Information.

Table 43
Medicare persons served/CMS region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	26,326	918	4,358	843
Boston	1,363	910	229	828
New York[2]	2,578	914	393	823
Philadelphia	2,843	921	436	843
Atlanta	5,638	942	1,111	882
Chicago	5,218	945	746	855
Dallas	2,837	920	483	868
Kansas City	1,482	953	214	874
Denver	777	946	110	834
San Francisco[3]	2,370	889	398	785
Seattle	896	947	143	832

[1]Includes utilization for residents of outlying territories, possessions and foreign countries.
[2]Excludes residents of Puerto Rico and Virgin Islands.
[3]Excludes residents of American Samoa, Guam, and Northern Mariana Islands.

NOTES: Data as of calendar year 2001 for persons served under HI and/or SMI. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development, and Information.

Table 44
Medicare/end stage renal disease (ESRD)

	Calendar year		
	2001	2002	2003
Total enrollees[1]	317,460	336,545	350,085
Dialysis patients[2]	285,982	297,928	310,095
Outpatient	258,195	269,741	281,460
Home	27,787	28,187	28,635
Transplants performed[3]	14,628	14,714	15,589
Living donor	4,236	4,044	4,217
Cadaveric donor	8,824	9,026	9,402
Living unrelated	1,568	1,644	1,970
Average dialysis payment rate	$129	$129	$129
Hospital-based facilities	$131	$131	$131
Freestanding facilities	$127	$127	$127

[1]Medicare ESRD enrollees as of July 1.
[2]Includes Medicare and non-Medicare patients receiving dialysis as of December 31.
[3]Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: CMS, Office of Clinical Standards and Quality, and the Office of Research, Development, and Information.

Table 45
Medicaid/type of service

	Fiscal year 2001 Medicaid beneficiaries
	In thousands
Total eligibles	46,757
Number using service:	
Total beneficiaries, any service	45,562
Inpatient services	
General hospitals	4,895
Mental hospitals	91
Nursing facility services[1]	1,697
Intermediate care facility (MR) services[2]	117
Physician services	20,142
Dental services	6,985
Other practitioner services	5,071
Outpatient hospital services	13,796
Clinic services	8,444
Laboratory and radiological services	12,337
Home health services	1,011
Prescribed drugs	22,004
Personal care support services	4,970
Sterilization services	145
PCCM services	6,223
Capitated payment services	23,108
Other care	9,696
Unknown	143

[1]Nursing facilities include: SNFs and all categories of ICF, other than "MR".
[2]"MR" indicates mentally retarded.

NOTE: Beginning in 1998, beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations.

SOURCE: CMS, Center for Medicaid and State Operations.

Table 46
Medicaid/units of service

	Fiscal year 2001 units of service
	In thousands
Inpatient hospital	
Total discharges	9,023
Beneficiaries discharged	4,874
Total days of care	32,169
Nursing facility	
Total days of care	442,210
Intermediate care facility/mentally retarded	
Total days of care	46,899

NOTES: Data are derived from the MSIS 2001 State Summary Mart. For New York, the hard copy HCFA-2082 data were used. Excludes territories.

SOURCE: CMS, Center for Medicaid and State Operations.

Administrative/Operating

Information on activities and services related to oversight of the day-to-day operations of CMS programs

Included are data on Medicare contractors, contractor activities and performance, CMS and State agency administrative costs, quality control, and summaries of the operation of the Medicare trust funds.

Table 47
Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1967	$89	3.5
1970	149	3.1
1975	259	2.5
1980	497	2.1
1985	813	1.7
1990	774	1.2
1995	1,300	1.1
2000	[1]2,350	1.8
2002	[1]2,464	1.7
2003	[1]2,542	1.7
SMI Trust Fund		
1967	[2]135	20.3
1970	217	11.0
1975	405	10.8
1980	593	5.8
1985	922	4.2
1990	1,524	3.7
1995	1,722	2.7
2000	1,780	2.0
2002	1,830	1.7
2003	2,356	1.9

[1]Includes non-expenditure transfers for Health Care Fraud and Abuse Control.
[2]Includes expenses paid in fiscal years 1966 and 1967.

NOTE: Fiscal year data.

SOURCE: CMS, Office of the Actuary.

Table 48
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	26	15
Other	2	5

NOTE: Data as of May 2003.

SOURCE: CMS, Office of Financial Management.

Table 49
Medicare appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	20,130	3,623,510
Percent with increased payments[1]	28.2	67.7

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 2003.

SOURCE: CMS, Office of Financial Management.

Table 50
Medicare claims processing bottom line unit costs

	Unit cost per claim				
	1975	1980	1999	2000	2001
Intermediaries[1]	$3.84	$2.96	$0.76[3]	$0.86[3]	$0.86[3]
Carriers[2]	2.90	2.33	0.60	0.63	0.61

[1]Includes direct costs and overhead costs for bill payment, reconsiderations, and hearings lines. [2]Includes direct costs and overhead costs for the claims payment, reviews and hearings, and beneficiary/physician inquiries lines. [3]Beginning in FY 1998, inquiries and PET activities are separated from other bill payment cost for intermediaries.

NOTE: Fiscal year data.

SOURCE: CMS, Office of Financial Management.

Table 51
Medicare claims processing

	Intermediaries	Carriers
Claims processed in millions	158.6	772.0
Total PM costs in millions	$330.4	$940.8
Total MIP costs in millions	$396.7	$280.7
Claims processing costs in millions	$188.1	$615.5
Claims processing unit costs	$0.86	$0.61
Range		
High	$1.57	$1.22
Low	$0.70	$0.57

NOTES: Data for fiscal year 2001. PM= Program Management. MIP= Medicare Integrity Program.

SOURCE: CMS, Office of Financial Management.

Table 52
Medicare claims received

	Claims received
Intermediary claims received in thousands	172,303
	Percent of total
Inpatient hospital	8.8
Outpatient hospital	47.7
Home health agency	6.4
Skilled nursing facility	2.6
Other	34.5
Carrier claims received in thousands	860,746
	Percent of total
Assigned	98.5
Unassigned	1.5

NOTE: Data for calendar year 2003.

SOURCE: CMS, Office of Financial Management.

Table 53
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	757.0	11.1
Percent reduced	90.1	81.7
Total covered charges		
Amount in millions	$189,902	$1,066
Percent reduced	51.8	15.8
Amount reduced per claim	$127.33	$15.03

NOTES: Data for calendar year 2003. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Office of Financial Management.

Table 54
Medicaid administration

	Fiscal year	
	2001	2002
	In thousands	
Total payments computable for Federal funding[1]	$11,880,615	$11,931,761
Federal share[1]		
Family planning	$23,198	$24,246
Design, development or installation of MMIS[2]	141,923	248,448
Skilled professional medical personnel	327,814	370,312
Operation of an approved MMIS[2]	962,534	1,006,146
Other financial participation	5,017,419	4,875,267
Mechanized systems not approved under MMIS[2]	82,503	76,930
Total administration	$6,555,391	$6,601,349
Net adjusted Federal share[3]	$6,357,267	$6,976,026

[1]Source: Form CMS-64. (Net Expenditures Reported--Administration).
[2]Medicaid Management Information System.
[3]Includes CMS adjustments.

Sources: CMS, Center for Medicaid and State Operations, and the Office of Financial Management.

Table 54
Quality control/Medicaid

Fiscal year	Eligibility national average error rate[1] in percent of dollars
1985	2.7
1986	2.5
1987	2.3
1988	2.2
1989	2.0
1990	1.9
1991	1.9
1992	1.9
1993	2.0
1994[2]	2.0

[1]Excludes Supplemental Security Income determinations.

[2]Preliminary.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Program Performance

Program financing

Medicare/source of income

Hospital Insurance trust fund:
1. Payroll taxes*
2. Income from taxation of social security benefits
3. Transfers from railroad retirement account
4. General revenue for
   a. uninsured persons
   b. military wage credits
5. Premiums from voluntary enrollees
6. Interest on investments

*Contribution rate	2002	2003	2004
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2004) None[1]

Voluntary HI Premium[2]

Monthly Premium (CY 2004): $343

Supplementary Medical Insurance trust fund:
1. Premiums paid by or on behalf of enrollees
2. General revenue
3. Interest on investments

Part B Premium

Monthly Basic Premium (CY 2004): $66.60

Medicaid/financing

1. Federal contributions (ranging from 50 to 77.08 percent for fiscal year 2004)
2. State contributions (ranging from 22.92 to 50 percent for fiscal year 2004)

[1]The Omnibus Reconciliation Act of 1993 eliminated the Annual Maximum Taxable Earnings amounts for 1994 and later. For these years, the contribution rate is applied to all earnings in covered employment.
[2]Premium paid for voluntary participation of individuals aged 65 and over not otherwise entitled to hospital insurance and certain disabled individuals who have exhausted other entitlement. A reduced premium of $189 is available to individuals aged 65 and over who are not otherwise entitled to hospital insurance but who have, or whose spouse has or had, at least 30 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

Medicare deductible and coinsurance amounts

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/04)	$876/benefit period
Regular coinsurance days (1/1/04)	$219/day for 61st thru 90th day
Lifetime reserve days (1/1/04)	$438/day (60 nonrenewable days)
SNF coinsurance days (1/1/04)	$109.50/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/04)	$343/month $189/month if have at least 30 quarters of coverage
Limitations:	
Inpatient psychiatric hospital days	190 nonrenewable days
Part B (effective date)	**Amount**
Deductible (1/1/91)[1]	$100 in reasonable charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Premium (1/1/04)	$66.60/month
Limitations:	
Outpatient treatment for mental illness	No limitations

[1]The Part B deductible and coinsurance applies to most services. Items and/or services not subject to either the deductible or coinsurance are clinical diagnostic lab tests subject to a fee schedule, home health services, items and services furnished in connection to obtaining a second or third opinion, and some preventive services. In addition, federally qualified health center services and some preventive services are not subject to the deductible but are subject to the coinsurance.

SOURCE: CMS, Office of the Actuary.

Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2004

I.	Boston	FMAP
	Connecticut	50
	Maine	66
	Massachusetts	50
	New Hampshire	50
	Rhode Island	56
	Vermont	61

II.	New York	FMAP
	New Jersey	50
	New York	50
	Puerto Rico	50
	Virgin Islands	50
	Canada	--

III.	Philadelphia	
	Delaware	50
	Dist. of Columbia	70
	Maryland	50
	Pennsylvania	55
	Virginia	50
	West Virginia	75

IV.	Atlanta	
	Alabama	71
	Florida	59
	Georgia	60
	Kentucky	70
	Mississippi	77
	North Carolina	63
	South Carolina	70
	Tennessee	64

V.	Chicago	
	Illinois	50
	Indiana	62
	Michigan	56
	Minnesota	50
	Ohio	59
	Wisconsin	58

VI.	Dallas	
	Arkansas	75
	Louisiana	72
	New Mexico	75
	Oklahoma	70
	Texas	60

VII.	Kansas City	
	Iowa	64
	Kansas	61
	Missouri	61
	Nebraska	60

VIII.	Denver	
	Colorado	50
	Montana	73
	North Dakota	68
	South Dakota	66
	Utah	72
	Wyoming	60

IX.	San Francisco	
	Arizona	67
	California	50
	Hawaii	59
	Nevada	55
	American Samoa	50
	Guam	50
	N. Mariana Islands	50

X.	Seattle	
	Alaska	58
	Idaho	70
	Oregon	61
	Washington	50

SOURCE: CMS, Center for Medicaid and State Operations.