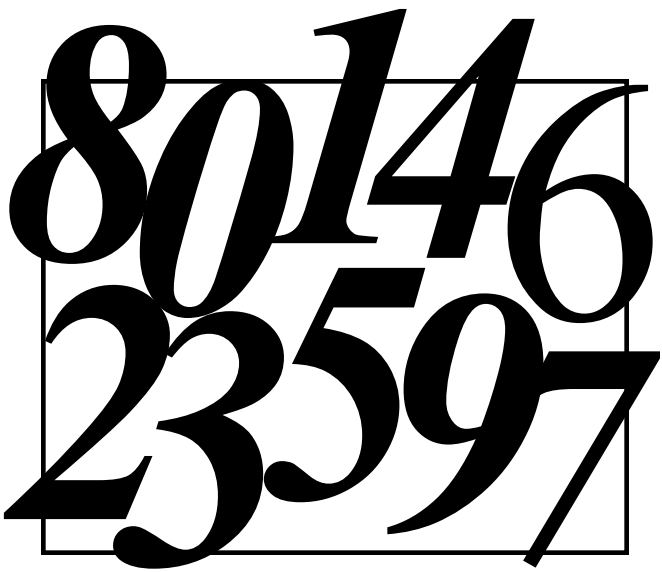
2016 CMS Statistics



U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services

Office of Enterprise Data and Analytics

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Preface

This reference booklet provides 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 and may not always reflect changes due to recent legislation. Similar reported statistics may differ because of differences in sources and/or methodology.

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Glossary of Acronyms

AFDC	**Aid to Families with Dependent Children**
BETOS	**Berenson-Eggers Type of Service**
CAHs	**Critical Access Hospitals**
CBC	**Community-Based Care**
CCPs	**Coordinated Care Plans**
CCW	**Chronic Conditions Data Warehouse**
CHIP	**Children's Health Insurance Program**
CM	**Center for Medicare**
CMCS	**Center for Medicaid and CHIP Services**
CMS	**Centers for Medicare & Medicaid Services**
DHHS	**Department of Health & Human Services**
DME	**Durable Medical Equipment**
DME MACs	**DME Medicare Administrative Contractors**
DMEPOS	**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies**
ESRD	**End Stage Renal Disease**
FFS	**Fee-For-Service**

GDP	**Gross Domestic Product**
HCPP	**Health Care Prepayment Plan**
HI	**Hospital Insurance (Part A)**
HIT	**Health Information Technology**
HMO	**Health Maintenance Organization**
ICF/IID	**Intermediate Care Facility for Individuals with Intellectual Disabilities**
ICF-MR	**Intermediate Care Facility for Mentally Retarded**
IPAB	**Independent Payment Advisory Board**
MA	**Medicare Advantage**
MACs	**Medicare Administrative Contractors**
MA-PD	**Medicare Advantage Prescription Drug Plan**
MIF	**Medicare Improvement Fund**
MSA	**Medical Savings Account**
MSIS	**Medicaid Statistical Information System**
NF	**Nursing Facility**
NHE	**National Health Expenditures**
OACT	**Office of the Actuary**

Glossary of Acronyms (continued)

PACE	**Program of All-Inclusive Care for the Elderly**
PCCM	**Primary Care Case Management**
PDP	**Prescription Drug Plan**
PFFS	**Private Fee for Service Plan**
PHP	**Prepaid Health Plan**
PPS	**Prospective Payment System**
QIO	**Quality Improvement Organization**
RDS	**Retiree Drug Subsidy**
RPPOs	**Regional Preferred Provider Organizations**
SMI	**Supplementary Medical Insurance (Part B)**
SNF	**Skilled Nursing Facility**
SSA	**Social Security Administration**
TANF	**Temporary Assistance for Needy Families**
VA	**Veteran's Affairs**

Populations

Information about persons covered by Medicare, Medicaid, or CHIP

For Medicare, statistics are based on persons enrolled for coverage. Original Medicare enrollees are also referred to as fee-for-service enrollees. Historically, for Medicaid, recipient (beneficiary) counts were used as a surrogate for 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 Children's Health Insurance Program (CHIP). 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 I.1
Medicare Enrollment/Trends

	Total Persons	Aged Persons	Disabled Persons
July		In millions	
1966	19.1	19.1	--
1970	20.4	20.4	--
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
Average monthly			
2000	39.7	34.3	5.4
2005	42.6	35.8	6.8
2010	47.7	39.6	8.1
2013	52.5	43.6	8.9
2014	54.1	45.1	9.0
2015	55.3	46.3	9.0
2016	57.1	48.1	9.0

NOTES: Represents those enrolled in HI (Part A) and/or SMI (Part B and Part D) of Medicare. Data for 1966-1995 are as of July. Data for calendar years 2000-2016 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on 2016 Trustees Report.

SOURCE: CMS, Office of the Actuary.

Table I.2
Medicare Enrollment/Coverage

	HI and/or SMI	HI	SMI		HI and SMI	HI Only	SMI Only
			Part B	Part D			
			In millions				
All persons	56.6	56.3	51.7	42.9	51.4	4.9	0.3
Aged persons	47.6	47.3	43.5	--	43.2	4.1	0.3
Disabled persons	9.0	9.0	8.2	--	8.2	0.8	0.0

NOTES: Projected average monthly enrollment during fiscal year 2016. Aged/disabled split of Part D enrollment not available. Based on 2016 Trustees Report. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of the Actuary.

Table I.3
Medicare Enrollment/Demographics

	Total	Male	Female
		In thousands	
All persons	55,584	25,276	30,308
Aged	46,728	20,716	26,012
65-74 years	26,209	12,338	13,871
75-84 years	13,975	6,117	7,858
85 years and over	6,543	2,261	4,283
Disabled	8,856	4,560	4,297
Under 45 years	1,902	1,024	878
45-54 years	2,420	1,233	1,187
55-64 years	4,534	2,303	2,231
Non-Hispanic White	41,726	18,932	22,794
Black (or African-American)	5,759	2,484	3,274
All Other	7,458	3,441	4,017
Am. Indian/Alaska Native	250	112	139
Asian/Pacific Islander	1,720	770	950
Hispanic	5,017	2,329	2,688
Other	471	230	240
Unknown Race	642	419	223

NOTES: Person-year enrollee counts for 2015. Numbers may not add to totals because of rounding. Race information is based on Research Triangle Institute (RTI) race codes.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.4
Medicare Part D Enrollment/Demographics

	Total	Male	Female
		In thousands	
All persons	39,509	16,773	22,736
Aged			
65-74 years	17,657	7,646	10,011
75-84 years	10,405	4,305	6,100
85 years and over	4,689	1,475	3,214
Disabled			
Under 45 years	1,551	813	738
45-54 years	1,865	931	934
55-64 years	3,343	1,603	1,740

NOTES: Person-year enrollee counts for 2015 as reported in the CMS Chronic Conditions Data Warehouse. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.5
Medicare ESRD Enrollment/Trends

	HI and/or SMI	HI	SMI
		In thousands	
Year			
1985	110.0	109.1	106.5
1990	172.1	170.6	163.7
1995	255.7	253.6	243.8
2000	290.9	290.4	272.8
2005	369.9	369.8	351.6
2010	427.5	427.3	405.6
2015	507.6	504.1	483.3

NOTES: Data as of July 1 for years 1985-2010. Enrollee counts for 2015 are determined using a person-year methodology.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.6
Medicare ESRD Enrollment/Demographics

	Number of Enrollees (in thousands)
All persons	557.5
Age	
Under 35 years	23.7
35-44 years	40.2
45-64 years	213.5
65 years and over	280.1
Sex	
Male	318.5
Female	239.0
Race	
Non-Hispanic White	232.4
Black (or African-American)	187.9
Other	132.5
Unknown	4.7

NOTES: CMS Chronic Conditions Data Warehouse. Represents persons with ESRD ever enrolled during calendar year 2015.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.7
Medicare Advantage, Cost, PACE, Demo, & Prescription Drug

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	694	2,034	16,571	18,604
Local CCPs	464	1,430	14,510	15,940
PFFS	7	79	149	228
1876 Cost	16	340	280	619
1833 Cost (HCPP)	9	60	--	60
PACE	122	--	37	37
Other plans[2]	76	124	1,595	1,719
Total PDPs[1]	72	--	24,988	24,988
Total	766	2,034	41,559	43,592

[1]Totals include beneficiaries enrolled in employer/union-only group plans (contracts with "800 series" plan IDs). Where a beneficiary is enrolled in both an 1876 cost or PFFS plan and a PDP plan, both enrollments are reflected in these counts. [2]Includes MSA, Medicare-Medicaid Plans, and RPPOs.

NOTE: Data as of November 2016.

SOURCE: CMS, Center for Medicare.

Table I.8
Medicare Enrollment/CMS Region

	Resident U.S. Population[1]	Medicare Enrollees[2]	Enrollees as Percent of Population
	In thousands		
All regions	321,419	54,348	16.9
Boston	14,728	2,760	18.7
New York	28,754	4,844	16.8
Philadelphia	30,654	5,506	18.0
Atlanta	64,302	11,896	18.5
Chicago	52,277	9,240	17.7
Dallas	41,114	6,081	14.8
Kansas City	14,015	2,512	17.9
Denver	11,687	1,704	14.6
San Francisco	50,295	7,491	14.9
Seattle	13,593	2,314	17.0

[1]Preliminary annual estimate July 1, 2015 resident population.
[2]Medicare enrollment data for 2015 are determined using a person-year methodology. Excludes beneficiaries living in territories, possessions, foreign countries or with residence unknown.

NOTES: Resident population is a provisional estimate based on 50 States and the District of Columbia. Numbers may not add to totals because of rounding. For regional breakouts, see Reference section.
SOURCES: CMS, Office of Enterprise Data and Analytics; U.S. Bureau of the Census, Population Estimates Branch.

Table I.9
Medicare Enrollment by Health Delivery/CMS Region

	Total Enrollees	Original Medicare Enrollees	MA and Other Health Plan Enrollees
		In thousands	
All regions	55,584	37,786	17,799
Boston	2,760	2,163	596
New York	5,621	3,577	2,044
Philadelphia	5,506	4,007	1,499
Atlanta	11,896	8,051	3,845
Chicago	9,240	6,065	3,176
Dallas	6,081	4,308	1,773
Kansas City	2,512	1,991	520
Denver	1,704	1,204	500
San Francisco	7,512	4,458	3,054
Seattle	2,314	1,528	786

NOTES: Person-year enrollee counts for 2015. Numbers may not add because of rounding. Foreign residents and unknowns are not included in the regions, but included in the total figure.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.9a
Medicare Enrollment by Health Delivery/Demographics

	Total	Original Medicare	MA and Other Health Plans
		In thousands	
All persons	55,584	37,786	17,799
Aged	46,728	31,324	15,404
65-74 years	26,209	17,720	8,489
75-84 years	13,975	9,040	4,935
85 years and over	6,543	4,564	1,980
Disabled	8,856	6,462	2,395
Under 45 years	1,902	1,542	359
45-54 years	2,420	1,808	613
55-64 years	4,534	3,111	1,423
Male	25,276	17,557	7,719
Female	30,308	20,229	10,079
Non-Hispanic White	41,726	29,359	12,367
Black (or African-American)	5,759	3,708	2,051
All Other	7,458	4,228	3,229
Am. Indian/Alaska Native	250	215	36
Asian/Pacific Islander	1,720	1,082	638
Hispanic	5,017	2,616	2,400
Other	471	315	156
Unknown Race	642	490	151

NOTES: Person-year enrollee counts for 2015. Numbers may not add to totals because of rounding. Race information based on Research Triangle Institute race codes.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.10
Medicare Part D Enrollment by CMS Region

	Total Medicare Enrollees	Total Part D Enrollees	% of Total Enrollees
		In thousands	
All regions[1]	55,584	39,509	71.1
Boston	2,760	1,920	69.6
New York	5,621	4,187	74.5
Philadelphia	5,506	3,738	67.9
Atlanta	11,896	8,601	72.3
Chicago	9,240	6,780	73.4
Dallas	6,081	4,173	68.6
Kansas City	2,512	1,821	72.5
Denver	1,704	1,162	68.2
San Francisco	7,512	5,605	74.6
Seattle	2,314	1,509	65.2

[1]Foreign residents and unknowns are not included in the regions but are included in the total figure.

NOTE: Data for calendar year 2015 as reported in the CMS Chronic Conditions Data Warehouse.
SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.11
Medicare Part D Enrollment by Plan Type/CMS Region

	Total Part D Enrollees	Total PDP Enrollees	Total MA-PD Enrollees
		In thousands	
All regions[1]	39,509	24,101	15,408
Boston	1,920	1,371	549
New York	4,187	2,294	1,893
Philadelphia	3,738	2,494	1,244
Atlanta	8,601	5,033	3,568
Chicago	6,780	4,602	2,178
Dallas	4,173	2,692	1,480
Kansas City	1,821	1,357	464
Denver	1,162	726	436
San Francisco	5,605	2,703	2,902
Seattle	1,509	819	691

[1]Foreign residents and unknowns are not included in the regions but are included in the total figure.

NOTE: Data for calendar year 2015 as reported in the CMS Chronic Conditions Data Warehouse.
SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.12
Medicare Part D and RDS Enrollment/CMS Region

	Total Part D and RDS Enrollees	Total Part D Enrollees	Total RDS Enrollees
		In thousands	
All regions[1]	41,764	39,509	2,255
Boston	2,102	1,920	182
New York	4,452	4,187	265
Philadelphia	3,963	3,738	225
Atlanta	8,996	8,601	396
Chicago	7,206	6,780	426
Dallas	4,416	4,173	243
Kansas City	1,884	1,821	63
Denver	1,207	1,162	45
San Francisco	5,862	5,605	256
Seattle	1,660	1,509	150

[1] Foreign residents and unknowns are not included in the regions but are included in the total figure.

NOTES: Data for calendar year 2015 as reported in the CMS Chronic Conditions Data Warehouse. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.13
Projected Population[1]

	2010	2020	2040	2060	2080	2100
			In millions			
Total	315	342	396	437	481	526
Under 20	86	87	99	107	115	125
20-64	188	199	215	236	257	277
65 years and over	41	56	82	94	108	124

[1] As of July 1.

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

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2016 Trustees Report Intermediate Alternative.

Table I.14
Period Life Expectancy at Age 65,
Historical and Projected

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1990	15.1	19.1
2000	15.9	19.0
2010	17.6	20.2
2020[1]	18.6	21.0
2030[1]	19.3	21.6
2040[1]	19.9	22.2
2050[1]	20.5	22.7
2060[1]	21.1	23.2
2070[1]	21.6	23.7
2080[1]	22.1	24.1
2090[1]	22.6	24.6
2100[1]	23.0	25.0

[1] Projected.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2016 Trustees Report Intermediate Alternative.

Table I.15
Life Expectancy at Birth and at Age 65 by Race/Trends

Calendar Year	All Races	White	Black
		At Birth	
1960	69.7	70.6	63.6
1980	73.7	74.4	68.1
1990	75.4	76.1	69.1
2000	76.8	77.3	71.8
2005	77.6	78.0	73.0
2010	78.7	78.9	75.1
2012	78.8	79.1	75.5
2013	78.8	79.1	75.5
2014	78.8	79.0	75.6
		At Age 65	
1960	14.3	14.4	13.9
1980	16.4	16.5	15.1
1990	17.2	17.3	15.4
2000	17.6	17.7	16.1
2005	18.4	18.5	16.9
2010	19.1	19.2	17.8
2012	19.3	19.3	18.1
2013	19.3	19.3	18.1
2014	19.3	19.3	18.2

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

Table I.16
Medicaid and CHIP Enrollment

	Fiscal Year					
	1995	2000	2005	2010	2015	2016
	Average monthly enrollment in millions					
Total	34.2	34.5	46.5	53.5	68.5	70.9
Age 65 years and over	3.7	3.7	4.6	4.8	5.5	5.7
Blind/Disabled	5.8	6.7	8.1	9.3	10.5	10.6
Children	16.5	16.2	22.3	26.4	28.0	28.0
Adults	6.7	6.9	10.6	13.1	15.4	15.5
Expansion Adults	NA	NA	NA	NA	9.1	11.2
Other Title XIX[1]	0.6	NA	NA	NA	NA	NA
Territories	0.8	0.9	1.0	1.0	1.5	1.4
CHIP	NA	2.0	5.9	5.4	5.9	6.5

[1]In 1997, the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories.

NOTES: 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-related recipients who are not disabled. Medicaid enrollment excludes Medicaid expansion and CHIP programs. CHIP numbers include adults covered under waivers. Medicaid and CHIP figures for FY 2015-2016 are estimates from the Midsession Review of the President's FY 2017 budget. Enrollment for Territories for FY 2000 and later is estimated. Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of the Actuary, and the Center for Medicaid and CHIP Services.

Table I.17
Medicaid Eligibles/Demographics

	Medicaid Eligibles	Percent Distribution
	In millions	
Total eligibles	72.2	100.0
Age	72.2	100.0
Under 21	37.2	51.5
21-64 years	28.1	38.9
65 years and over	6.9	9.5
Unknown	0.1	0.1
Sex	72.2	100.0
Male	30.3	41.9
Female	41.9	57.9
Unknown	0.1	0.1
Race	72.2	100.0
Non-Hispanic White	29.1	40.3
Black, (or African-American)	15.7	21.7
Am. Indian/Alaskan Native	0.9	1.2
Asian	2.5	3.4
Hawaiian/Pacific Islander	0.6	0.9
Hispanic	17.7	24.5
Other	0.4	0.6
Unknown	5.4	7.5

NOTES: Fiscal Year 2013 data derived from MSIS Granular Database. The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of rounded components. Eligible is defined as anyone 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 has been made. Age groups are determined using the eligible's age at the end of the fiscal year. Excludes beneficiaries ever enrolled in separate Title XXI Children's Health Insurance Program (CHIP). Excludes data for Colorado, Idaho, and Rhode Island, and includes partial data for Kansas and North Carolina.

SOURCE: CMS, Center for Medicaid and CHIP Services.

Table I.18
Medicaid Eligibles/CMS Region

	Resident U.S. Population[1]	Medicaid Enrollment[2]	Enrollment as Percent of Population
	In thousands		
All regions	316,205	72,228	22.8
Boston	14,635	3,212	21.9
New York	28,573	7,671	26.8
Philadelphia	30,403	5,948	19.6
Atlanta	62,892	13,776	21.9
Chicago	52,079	11,995	23.0
Dallas	39,996	9,195	23.0
Kansas City	13,896	2,532	18.2
Denver	11,336	838	7.4
San Francisco	49,153	14,807	30.1
Seattle	13,243	2,252	17.0

[1]Estimated July 1, 2013 population.

[2]Persons ever enrolled in Medicaid during fiscal year 2013.

NOTES: Numbers may not add to totals because of rounding. Excludes data for Colorado, Idaho, and Rhode Island, and includes partial data for Kansas and North Carolina. Excludes enrollees ever enrolled in separate Title XXI Children's Health Insurance Program (CHIP).

SOURCES: CMS, Center for Medicaid and CHIP Services; U.S. Department of Commerce, Bureau of the Census.

Table I.19
Medicaid Beneficiaries/Part B State Buy-Ins for Medicare

	1975	1980	2000 [1]	2015 [1]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	9,518
Aged	2,483	2,449	3,632	5,513
Disabled	363	504	1,917	4,005
		Percent of Part B enrollees		
All buy-ins	12.0	10.9	14.9	18.4
Aged	11.4	10.0	11.1	12.7
Disabled	18.7	18.9	40.2	48.4

[1]Beneficiaries in person years.

NOTES: Represent beneficiaries for whom the State paid the Medicare Part B premium during the year. Numbers may not add to totals because of rounding. Includes outlying areas, foreign countries, and unknown.

SOURCE: CMS, Office of Enterprise Data and Analytics.

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 II.1
Inpatient Hospitals/Trends

	1990	2000	2010	2015
Total hospitals	6,522	5,985	6,169	6,140
Beds in thousands	1,105	991	928	932
Beds per 1,000 enrollees[1]	32.8	25.3	19.6	16.9
Short-stay	5,549	4,900	3,566	3,436
Beds in thousands	970	873	785	784
Beds per 1,000 enrollees[1]	28.8	22.3	16.6	14.2
Critical access hospitals	NA	NA	1,325	1,336
Beds in thousands	---	---	30	31
Beds per 1,000 enrollees[1]	---	---	0.6	0.6
Other non-short-stay	973	1,085	1,278	1,368
Beds in thousands	135	118	113	117
Beds per 1,000 enrollees[1]	4.0	3.0	2.4	2.1

[1]Based on number of total HI enrollees as of July 1 for years 1990, 2000, and 2010. Based on person-year HI enrollee count for 2015.

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

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.2
Inpatient Hospitals/CMS Region

	Short-stay and CAH hospitals	Beds per 1,000 enrollees	Non Short-stay hospitals	Beds per 1,000 enrollees
All regions	4,772	14.7	1,368	2.1
Boston	175	11.5	65	3.5
New York	302	15.8	73	2.0
Philadelphia	358	13.0	133	2.4
Atlanta	878	15.1	251	1.7
Chicago	847	16.0	211	1.8
Dallas	758	17.4	362	3.8
Kansas City	453	18.4	64	1.8
Denver	314	15.6	50	2.5
San Francisco	477	12.9	132	1.5
Seattle	210	10.4	27	1.3

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2015. Rates based on person-year hospital insurance enrollee count for 2015.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.3
Medicare Hospital and SNF/NF/ICF Facility Counts

Total participating hospitals	6,140
Short-term hospitals	3,436
Psychiatric units	1,118
Rehabilitation units	908
Swing bed units	488
Psychiatric	560
Long-term	426
Rehabilitation	266
Children's	100
Religious non-medical	16
Critical Access	1,336
Non-participating hospitals	782
Emergency	432
Federal	350
All SNFs/SNF-NFs/NFs only	15,640
All SNFs/SNF-NFs	15,236
Title 18-only SNF	750
Hospital-based	179
Free-standing	571
Title 18/19 SNF/NF	14,486
Hospital-based	564
Free-standing	13,922
Title 19-only NFs	404
Hospital-based	98
Free-standing	306
All ICF/IID facilities	6,202

NOTES: Data as of December 31, 2015. Numbers may differ from other reports and program memoranda.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.4
Long-Term Facilities/CMS Region

	Title XVIII and XVIII/XIX SNFs	Nursing Facilities	ICF/IIDs
All regions [1]	15,236	404	6,202
Boston	933	8	117
New York	995	2	508
Philadelphia	1,365	38	381
Atlanta	2,651	43	699
Chicago	3,391	68	1,375
Dallas	2,059	44	1,546
Kansas City	1,409	102	195
Denver	589	35	113
San Francisco	1,407	48	1,189
Seattle	437	16	79

[1] Includes outlying areas.

NOTE: Data as of December 2015.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.5
Other Medicare Providers and Suppliers/Trends

	1980	1990	2010	2015
Home health agencies	2,924	5,661	10,914	12,149
Independent and Clinical Lab Improvement Act Facilities	NA	4,828	224,679	252,044
End stage renal disease facilities	999	1,987	5,631	6,558
Outpatient physical therapy and/or speech pathology	419	1,144	2,536	2,130
Portable X-ray	216	435	561	499
Rural health clinics	391	517	3,845	4,104
Comprehensive outpatient rehabilitation facilities	NA	184	354	207
Ambulatory surgical centers	NA	1,165	5,316	5,470
Hospices	NA	772	3,509	4,302

NOTES: Facility data for 1980 are as of July 1. Facility data for 1990, 2010, and 2015 are as of December 31.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.6
Selected Facilities/Type of Control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,436	15,236	12,149
		Percent of total	
Non-profit	59.8	23.6	15.3
Proprietary	21.4	69.9	80.0
Government	18.8	6.5	4.7

NOTES: Data as of December 31, 2015. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.7
Periodic Interim Payment (PIP) Facilities/Trends

	1980	1990	2000	2010	2015
Hospitals					
Number of PIP	2,276	1,352	869	547	474
Percent of total participating	33.8	20.6	14.4	8.9	7.7
Skilled nursing facilities					
Number of PIP	203	774	1,236	381	320
Percent of total participating	3.9	7.3	8.3	2.5	2.0
Home health agencies					
Number of PIP	481	1,211	1,038	114	163
Percent of total participating	16.0	21.0	14.4	1.0	1.3

NOTES: 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 Part A MAC meets specified processing time standards.

SOURCE: CMS, Center for Medicare.

Table II.8
Medicare Non-Institutional Providers by Specialty[1]

	Count
Total Providers	1,209,667
Primary Care	224,187
Surgical Specialties	108,784
Medical Specialties	144,942
Anesthesiology	40,993
Obstetrics/Gynecology	34,640
Radiology	37,038
Emergency Medicine	45,595
Non-Physician Practitioners	360,558
Limited Licensed Practitioners	104,681
All Other Providers	130,768

[1] Providers utilized by Original Medicare beneficiaries for all Part B non-institutional provider services. Providers may be counted in more than one specialty classification, but are reported as a single provider in the "Total Providers" count.

NOTE: Data for calendar year 2015, as reported on the Original Medicare claims.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.9
Medicare DMEPOS Providers by Specialty[1]

	Count
Total DMEPOS Providers	86,313
Pharmacy	50,124
Medical Supply Company	10,613
Optometry	5,871
Podiatry	5,380
Individual Certified Prosthetist/Orthotist	2,514
Optician	2,161
All Other DMEPOS Providers	9,951

[1] Providers utilized by Original Medicare beneficiaries for all Part B non-institutional DMEPOS services. Providers may be counted in more than one specialty classification, but are reported as a single provider in the "Total DMEPOS Providers" count.

NOTE: Data for calendar year 2015, as reported on the Original Medicare claims.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Expenditures

Information about spending for health care services by Medicare, Medicaid, CHIP, 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 III.1
CMS and Total Federal Outlays

	Fiscal year 2014	Fiscal year 2015
	$ in billions	
Gross domestic product (current dollars)	$17,244.0	$17,803.4
Total Federal outlays[1]	3,506.1	3,688.3
Percent of gross domestic product	20.3%	20.7%
Dept. of Health and Human Services[1]	936.0	1,027.5
Percent of Federal Budget	26.7%	27.9%
CMS Budget (Federal Outlays)		
Medicare benefit payments	591.3	615.6
SMI transfer to Medicaid[2]	0.7	0.7
Medicaid benefit payments	301.5	332.9
Medicaid State and local admin.	15.2	17.6
Medicaid offsets[3]	-0.7	-0.7
Children's Health Ins. Prog.	9.0	9.1
CMS program management	3.6	4.3
Other Medicare admin. expenses[4]	2.0	2.1
State Eligibility Determinations, for Part D	0.0	0.0
Quality Improvement Organizations[5]	0.5	0.6
Health Care Fraud and Abuse Control	1.4	1.6
State Grants and Demonstrations[6]	0.5	0.6
User Fees and Reimbursables	0.5	1.6
Total CMS outlays (unadjusted)	910.3	968.4
Offsetting receipts[7]	-94.5	-94.2
Total net CMS outlays	815.8	874.2
Percent of Federal budget	23.3%	23.7%

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($688 million in FY 2014 and $749 million in FY 2015).
[3]SMI transfers for low-income premium assistance.
[4]Medicare administrative expenses of the Social Security Administration and other Federal agencies.
[5]Formerly peer review organizations (PROs).
[6]Includes grants and demonstrations for various free-standing programs, such as the Ticket to Work and Work Incentives Improvement Act (P.L. 106-170), emergency health services for undocumented aliens (P.L.108-173), and Medicaid's Money Follows the Person Rebalancing Demonstration (P.L. 109-171).
[7]Almost entirely Medicare premiums. Also includes offsetting collections for user fee and reimbursable activities, as well as refunds to the trust funds.

SOURCE: CMS, Office of Financial Management.

Table III.2
Program Expenditures/Trends

	Total	Medicare[1]	Medicaid[2]	CHIP[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
2010	940.9	525.6	403.9	11.4
2015	1,198.9	632.9	552.3	13.7

[1]Medicare amounts reflect gross outlays (i.e., not net of offsetting receipts). These amounts include: outlays for benefits, administration, Health Care Fraud and Abuse Control (HCFAC) activities, Quality Improvement Organizations (QIOs), the SMI transfer to Medicaid for Medicare Part B premium assistance for low-income Medicare beneficiaries and, since FY 2004, the administrative and benefit costs of the Transitional Assistance and Part D Drug benefits under the Medicare Modernization Act of 2003.

[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 beneficiaries, nor do they include the Medicare Part D compensation to States for low-income eligibility determinations in the Part D Drug program.

[3]The CHIP amounts reflect both Federal and State shares of Title XXI outlays. Please note that CHIP-related Medicaid began to be financed under Title XXI in 2001.

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

SOURCE: CMS, Office of Financial Management.

Table III.3
Annual Benefit Outlays by Program

	1967	1980	2010	2015
	Amounts in billions			
CMS program outlays	$5.1	$57.8	$915	$1,181
Federal outlays	NA	47.2	793	973
Medicare[1]	3.2	33.9	518	615
HI	2.5	23.8	250	275
SMI	0.7	10.1	209	265
Prescription (Part D)	NA	NA	59	75
Medicaid[2]	1.9	23.9	386	552
Federal share	NA	13.2	266	348
CHIP[3]	NA	NA	11	14
Federal share	NA	NA	8	10

[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 Medicaid benefits and outlays for the Vaccines for Children program.

[3]The CHIP 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 CHIP-related Medicaid expansions began to be financed under CHIP (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 III.4
Program Benefit Payments/CMS Region

	Fiscal Year 2014 Net Expenditures Reported[1]	
	Medicaid	
	Total Payments Computable for Federal funding	Federal Share
	In millions	
All regions	$470,269	$284,104
Boston	28,720	15,659
New York	66,189	35,900
Philadelphia	47,610	26,981
Atlanta	74,088	49,396
Chicago	75,970	47,353
Dallas	52,117	32,992
Kansas City	17,251	10,547
Denver	11,287	6,774
San Francisco	77,021	45,155
Seattle	20,016	13,347

[1]Data from Form CMS-64--Net Expenditures Reported by the States. Medical assistance payments only; excludes administrative expenses and Children's Health Insurance Program (CHIP). Unadjusted by CMS.

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

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table III.5
Medicare Benefit Outlays

	Fiscal Year		
	2014	2015	2016
	In billions		
Part A benefit payments	$261.8	$272.4	$284.7
Aged	216.8	225.9	237.2
Disabled	45.0	46.6	47.5
Part B benefit payments	256.6	271.5	294.4
Aged	207.9	220.6	240.3
Disabled	48.7	50.9	54.1
Part D	72.2	83.8	104.8

NOTES: Based on 2016 Trustees Report. Part A benefits include additional payments for HIT, CBC, IPAB, and Sequester. Part B benefits include additional payments for HIT, IPAB, and Sequester. Part D benefits include additional payments for IPAB. Aged/disabled split of Part D benefit outlays not available. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Office of the Actuary.

Table III.6
Medicare/Type of Benefit

	Fiscal Year 2016 Benefit Payments[1] in millions	Percent Distribution
Total Part A[2,3]	$284,748	100.0
Inpatient hospital	139,140	48.9
Skilled nursing facility	31,332	11.0
Home health agency[4]	6,787	2.4
Hospice	16,717	5.9
Managed care	90,772	31.9
Total Part B[3,5]	294,371	100.0
Physician/other suppliers[6]	70,516	24.0
DME	6,701	2.3
Other carrier	21,903	7.4
Outpatient hospital	45,446	15.4
Home health agency[4]	11,222	3.8
Other intermediary	20,305	6.9
Laboratory	9,054	3.1
Managed care	109,224	37.1
Total Part D[7]	104,786	100.0

[1]Includes the effects of regulatory items and recent legislation but not proposed law. [2]Includes HIT, CBC, IPAB, and Sequester expenditures. [3]Excludes QIO expenditures. [4]Distribution of home health benefits between the trust funds estimated based on outlays reported to date by the Treasury. [5]Includes HIT, IPAB, and Sequester expenditures. [6]Includes payments made for HIT. [7]Includes payments made for IPAB and Sequester.

NOTES: Based on 2016 Trustees Report. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Office of the Actuary.

Table III.7
National Health Care/Trends

	Calendar Year		
	1990	2000	2014
National total in billions	$721.4	$1,369.7	$3,031.3
Percent of GDP	12.1	13.3	17.5
Per capita amount	$2,843	$4,857	$9,523
Sponsor		Percent of total	
Private Business	23.6	24.5	20.0
Household	36.2	32.4	27.8
Other Private Revenues	7.8	7.6	7.3
Governments	32.3	35.5	44.8
Federal government	17.2	19.0	27.8
State and local government	15.1	16.5	17.0

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 III.8
Medicaid/Type of Service

	Fiscal Year		
	2012	2013	2014
	In billions		
Total medical assistance payments[1]	$408.8	$433.1	$470.3
	Percent of Total		
Inpatient services	14.5	14.5	12.1
General hospitals	13.7	13.7	11.6
Mental hospitals	0.8	0.8	0.5
Nursing facility services	12.3	11.7	10.6
ICF/IID services	3.3	2.8	2.2
Community-based long term care svs.[2]	13.5	13.0	11.9
Prescribed drugs[3]	2.1	1.5	1.7
Physician and other practitioner services	3.6	3.3	3.6
Dental services	1.1	0.9	0.8
Outpatient hospital services	3.8	3.9	3.4
Clinic services[4]	2.6	2.4	2.2
Laboratory and radiological services	0.4	0.4	0.4
Early and periodic screening	0.3	0.3	0.2
Case management services	0.7	0.7	0.6
Capitation payments (non-Medicare)	29.1	31.9	37.8
Medicare premiums	3.3	3.2	3.0
Disproportionate share hosp. payments	4.2	3.8	3.8
Other services	7.1	7.3	7.3
Collections[5]	-2.0	-1.6	-1.7

[1]Excludes payments under CHIP.

[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 third party liability, probate, fraud and abuse, overpayments, and other collections.

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

SOURCES: CMS, CMCS, and OACT.

Table III.9
Medicare Savings Attributable to Secondary Payer Provisions by Type of Provision

	Fiscal Year		
	2013	2014	2015
		In millions	
Total	$8,925.8	$8,199.9	$8,490.8
Workers' Compensation[1]	1,888.5	1,711.7	2,148.2
Working Aged	3,838.4	3,545.8	3,426.8
ESRD	303.1	270.9	254.4
Auto	190.1	172.9	170.1
Disability	2,119.6	1,996.8	1,884.8
Liability	566.3	488.5	600.7
VA/Other	19.8	13.3	5.8

[1]Includes Workers' Compensation set-asides.

NOTES: Includes Liability savings of the global settlements recovered by CMS. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table III.10
Medicaid/Payments by Eligibility Status

	Fiscal Year 2014 Medical Assistance Payments[1]	Percent Distribution
	In billions	
Total[2]	$470.0	100.0
Age 65 years and over	81.7	17.4
Blind/disabled	192.1	40.9
Dependent children under 21 years of age	86.5	18.4
Adults	73.6	15.7
Expansion Adults	23.9	5.1
Disproportionate share hospital and other unallocated payments[3]	12.2	2.6

[1]Medicaid Total Computable Expenditures.

[2]Excludes payments under Children's Health Insurance Program (CHIP).

[3]Includes collections, prior period adjustments, and payments to territories.

SOURCE: CMS, Office of the Actuary.

Table III.11
Medicare/DME/POS[1]

BETOS Category	Allowed Charges[2]	
	2014	2015
	In thousands	
Total	$8,686,710	$9,222,185
Medical/surgical supplies	204,469	226,900
Hospital beds	119,600	110,304
Oxygen and supplies	1,429,545	1,427,220
Wheelchairs	617,261	616,072
Prosthetic/orthotic devices	2,363,720	2,495,475
Drugs admin. through DME[3]	827,574	874,702
Parenteral and enteral nutrition	512,214	499,397
Other DME	2,612,327	2,972,114

[1]Data are for calendar year. DME=durable medical equipment. POS=Prosthetic, orthotic, and supplies.

[2]The allowed charge is the Medicare approved payment reported on a line item on the physician/ supplier claim.

[3]Includes inhalation drugs administered through nebulizers only and does not include drugs administered through other DME such as infusion pumps.

NOTES: Over time, the composition of BETOS categories has changed with the reassignment of selected procedures, services, and supplies. Data for 2014 and 2015 as reported in the CMS Chronic Conditions Data Warehouse.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table III.12
National Health Care/Type of Expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$3,031.3	$9,523	36.8	20.4	16.4
Health Consumption Expenditures	2,877.4	9,040	38.7	21.5	17.2
Personal health care	2,563.6	8,054	40.1	22.7	17.4
Hospital care	971.8	3,053	43.1	25.8	17.3
Prof. services	801.6	2,518	29.8	19.8	10.0
Phys./clinical	603.7	1,896	33.5	22.9	10.6
Other Professional	84.4	265	30.6	23.2	7.4
Dental	113.5	357	9.3	0.4	8.9
Other Health Residential & Personal Care	150.4	472	59.2	3.4	55.8
Nursing Care Facilities & Continuing Care Retirement Communities	155.6	489	54.8	22.9	31.9
Home Health	83.2	261	77.3	41.7	35.6
Retail outlet sales	401.0	1,260	32.3	24.0	8.3
Admn., Net Cost, and public health	313.8	986	28.3	12.1	16.2
Investment	153.9	483	--	--	--

NOTE: Data are as of calendar year 2014.

SOURCE: CMS, Office of the Actuary.

Table III.13
Personal Health Care/Payment Source

	Calendar Year			
	1980	1990	2000	2014
	In billions			
Total	$217.0	$615.3	$1,162.0	$2,563.6
	Percent			
Total	100.0	100.0	100.0	100.0
Out of pocket	26.8	22.4	17.1	12.9
Health Insurance	60.9	65.5	72.6	78.0
Private Health Insurance	28.4	33.3	34.9	33.9
Medicare	16.7	17.4	18.6	22.7
Medicaid (Title XIX)	11.4	11.3	16.1	17.4
Total CHIP (Title XIX and Title XXI)	--	--	0.2	0.4
Department of Defense	1.8	1.7	1.1	1.5
Department of Veterans Affairs	2.6	1.8	1.6	2.2
Other Third Party Payers and Programs	12.3	12.1	10.2	9.1

NOTES: Excludes administrative expenses, the net cost of insurance, non-commercial medical research, investment in structures and equipment, and public health expenditures. Numbers may not add to totals because of rounding.

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 IV.1
Medicare/Short-Stay Hospital Utilization

	2012	2013	2014	2015
Discharges				
Total in millions	10.5	10.1	9.8	9.8
Rate per 1,000 enrollees[1]	284	270	261	260
Days of care				
Total in millions	51	49	48	48
Rate per 1,000 enrollees[1]	1,382	1,323	1,284	1,275
Total payments per day	$2,152	$2,235	$2,280	$2,314

[1]The population base for the denominator is Part A Original Medicare enrollment. The enrollee counts are based on a person-year methodology.

NOTES: Data may reflect underreporting 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. Data are based on 100-percent Original Medicare claims data from the Chronic Conditions Data Warehouse (CCW). Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.2
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				
2010	1,844	52	3,424	95
2011	1,870	52	3,442	94
2012	1,847	50	3,440	93
2013	1,846	50	3,469	92
2014	1,832	49	3,415	91
2015	1,845	49	3,453	91

NOTE: Managed care enrollees excluded in determining rates.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.3
Medicare Average Length of Stay/Trends

	Calendar Year				
	2011	2012	2013	2014	2015
Total All Hospitals	6.0	6.0	6.1	6.1	6.0
Short-Stay	5.1	5.1	5.1	5.1	5.1
Critical Access	3.6	3.5	3.5	3.4	3.4
Long Term	30.1	30.1	30.5	30.5	31.4
Psychiatric	15.1	15.1	15.1	15.0	15.3
Rehabilitation	13.0	12.9	12.8	12.8	12.7
Religious Nonmedical	20.0	19.8	21.9	23.7	22.6
Childrens'	7.5	7.5	7.4	7.4	6.9
Other	6.4	6.7	6.8	6.9	6.9

NOTES: Calendar year data. Average length of stay is shown in days. Data are based on 100-percent Original Medicare claims data from the Chronic Conditions Data Warehouse. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.4
Medicare Persons Served/Trends

	Calendar Year				
	2011	2012	2013	2014	2015
Aged persons served per 1,000 enrollees					
HI and/or SMI	925	918	916	916	915
HI	223	216	210	204	205
SMI	1,004	1,003	1,004	1,006	1,007
Disabled persons served per 1,000 enrollees					
HI and/or SMI	869	872	877	885	891
HI	210	207	202	201	201
SMI	958	958	959	962	967

NOTES: Managed care enrollees excluded in determining rates. Persons served represent estimates of beneficiaries receiving services under Original Medicare during the calendar year. Data are based on 100-percent Original Medicare claims data from the Chronic Conditions Data Warehouse. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.5
Original Medicare Persons Served

	Year				
	2011	2012	2013	2014	2015
HI					
Aged					
Original Medicare Enrollees	29.5	30.1	30.5	30.7	31.0
Persons served	6.6	6.5	6.4	6.3	6.4
Rate per 1,000	223	216	210	204	205
Disabled					
Original Medicare Enrollees	6.7	6.7	6.7	6.6	6.5
Persons served	1.4	1.4	1.4	1.3	1.3
Rate per 1,000	210	207	202	201	201
SMI					
Aged					
Original Medicare Enrollees	27.0	27.4	27.6	27.8	28.0
Persons served	27.1	27.5	27.7	27.9	28.2
Rate per 1,000	1,004	1,003	1,004	1,006	1,007
Disabled					
Original Medicare Enrollees	6.0	6.1	6.1	6.0	5.9
Persons served	5.7	5.8	5.8	5.8	5.7
Rate per 1,000	958	958	959	962	967

NOTES: Medicare enrollment is based on a person-year methodology. Persons served represents counts of beneficiaries receiving reimbursed services under Original Medicare during the calendar year. Rate is the ratio of persons served during the calendar year to the number of Original Medicare enrollees. Counts are based on 100-percent Original Medicare claims data from the Chronic Conditions Data Warehouse (CCW). Data may differ from other sources or from the same source with a different update cycle.

Original Medicare enrollees and persons served counts are in millions.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.6
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]	28,653	915	5,775	891
Boston	1,585	896	354	898
New York	2,592	867	481	818
Philadelphia	3,062	915	588	891
Atlanta	6,217	947	1,367	918
Chicago	4,914	998	1,065	932
Dallas	3,254	921	691	893
Kansas City	1,561	944	301	895
Denver	981	952	152	876
San Francisco	2,776	727	472	740
Seattle	1,127	881	213	856

[1]Includes utilization for residents of outlying territories, possessions, foreign countries, and unknown.

NOTES: Data are based on counts of beneficiaries receiving HI and/or SMI reimbursed services under Original Medicare during calendar year 2015. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.6a
Original Medicare Persons Served by Type of Service

	Total Persons Served in thousands	Aged Persons Served in thousands	Disabled Persons Served in thousands
Parts A and/or B	34,408	28,653	5,755
Part A	7,655	6,360	1,295
Inpatient hospital	6,630	5,394	1,235
Skilled nursing facility	1,845	1,676	169
Hospice	1,395	1,320	75
Home health agency	1,669	1,464	204
Part B	33,834	28,152	5,682
Physician/supplier	33,320	27,748	5,572
Outpatient	25,289	20,829	4,460
Home health agency	1,958	1,711	248

NOTES: Data are as of calendar year 2015. Persons served represents counts of beneficiaries receiving services under Original Medicare during the calendar year.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.7
Medicare End Stage Renal Disease (ESRD) by Treatment Modalities

	Medicare Entitled		
Year	Total	Dialysis Patients	Transplant Patients
1991	179,726	140,899	38,827
1999	317,965	247,446	70,519
2000	334,485	260,179	74,306
2004	394,465	303,848	90,617
2005	409,499	314,057	95,442
2006	426,249	325,777	100,472
2007	442,203	337,212	104,991
2008	459,037	349,622	109,415
2009	477,223	363,491	113,732
2010	495,294	377,117	118,177
2011	511,802	388,877	122,925
2012	528,661	401,776	126,885
2013	549,108	414,921	134,187
2014	568,255	426,574	141,681

SOURCES: United States Renal Data System. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases.

Table IV.8
Medicare End Stage Renal Disease (ESRD)
by Treatment Modalities and Demographics, 2013

	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
Total--all patients	549,108	414,921	134,187
Age			
0-19 years	3,072	1,240	1,832
20-64 years	298,722	212,386	86,336
65-74 years	143,898	107,743	36,155
75 years and over	103,416	93,552	9,857
Sex			
Male	315,124	234,521	80,603
Female	233,984	180,400	53,574
Race			
White	335,879	241,045	94,834
Black	176,620	146,764	29,856
Native American	5,991	4,803	1,188
Asian/Pacific	27,952	21,077	6,875
Other/Unknown	2,666	1,232	1,434

SOURCES: United States Renal Data System. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases.

Table IV.9
Medicaid/Type of Service

	Fiscal year 2013 Medicaid Beneficiaries
	In thousands
Total eligibles	72,228
Number using service:	
Total beneficiaries, any service[1]	64,529
Inpatient services	
General hospitals	8,203
Mental hospitals	43
Nursing facility services[2]	1,446
ICF/IID services[3]	93
Physician services	45,213
Dental services	19,345
Other practitioner services	10,026
Outpatient hospital services	28,009
Clinic services	16,608
Laboratory and radiological services	29,644
Home health services	1,733
Prescribed drugs	39,933
Personal care support services	1,171
Sterilization services	280
PCCM capitation	7,882
HMO capitation	41,351
PHP capitation	19,838
Targeted case management	2,650
Other services, unspecified	16,058
Additional service categories[4]	14,239
Unknown	741

[1]Excludes summary records with unknown basis of eligibility, most of which are lump-sum payments not attributable to any one person. Counts are duplicated across types of services because a beneficiary may receive more than one type of service (e.g. physician and prescription drugs). [2]All nursing facility services. Unlike Medicare there is no distinction for SNFs. [3]Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) services were previously known as Intermediate Care Facility for the Mentally Retarded (ICF-MR) services. [4]Additional services not shown separately sum to 7.6 million beneficiaries, not unduplicated.

NOTES: Data were derived from the MSIS State Summary Datamart. Beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations. Excludes data for Colorado, Idaho, and Rhode Island and includes partial data for Kansas and North Carolina. Excludes CHIP.

SOURCE: CMS, Center for Medicaid and CHIP Services.

Table IV.10
Medicaid/Units of Service

	Fiscal Year 2013 Units of Service
	In thousands
Inpatient hospital	
Total discharges	7,799
Beneficiaries discharged	7,056
Total days of care	43,765
Nursing facility[1]	
Total days of care	286,312
ICF/IID[2]	
Total days of care	25,612

[1]All nursing facility services. Unlike Medicare, there is no distinction for skilled nursing facilities.

[2]ICF-IID indicates Intermediate Care Facility for Individuals with Intellectual Disabilities. This category is the same as what was previously labeled "Intermediate Care Facility for the Mentally Retarded."

NOTES: Data are derived from the MSIS Granular Database. Service counts produced using inpatient and long term care original fee-for-service and Medicaid managed care claims. Excludes enrollees ever enrolled in separate Title XXI CHIP program and beneficiaries that had claims but no matching Medicaid enrollment in 2013. Excludes data for Colorado, Idaho, and Rhode Island, and includes partial data for Kansas and North Carolina.

SOURCE: CMS, Center for Medicaid and CHIP Services.

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 V.1
Medicare Administrative Expenses/Trends

	Administrative Expenses	
Fiscal Year	Amount in millions	As a Percent of Benefit Payments
HI Trust Fund		
1967	$89	3.5
1970	149	3.1
1980	497	2.1
1990	774	1.2
1995	1,300	1.1
2000 [1]	2,350	1.8
2005 [1]	2,850	1.6
2010	3,328	1.4
2013	4,135	1.6
2014	4,332	1.7
2015	5,488	2.0
SMI Trust Fund[2]		
1967	135[3]	20.3
1970	217	11.0
1980	593	5.8
1990	1,524	3.7
1995	1,722	2.7
2000	1,780	2.0
2005	2,348	1.6
2010	3,513	1.3
2013	3,756	1.2
2014	4,297	1.3
2015	3,606	1.0

[1]Includes non-expenditure transfers for Health Care Fraud and Abuse Control.

[2]Starting in FY 2004, includes the transactions of the Part D account.

[3]Includes expenses paid in fiscal years 1966 and 1967.

SOURCE: CMS, Office of Actuary.

Table V.2
Medicare Administrative Contractors

	Number
A/B MACs	12
DME MACs	4

NOTE: Data as of January 2016.

SOURCE: CMS, Center for Medicare.

Table V.3
Medicare Redeterminations

	A/B MAC Redeterminations (Part A Cases Involved)	A/B MAC Redeterminations (Part B Cases Involved)	A/B MAC and DME MAC Redeterminations (Part B Cases Involved)
Number Processed	122,834	199,319	2,484,598
Percent Reversed (Includes Fully & Partially Reversed Cases)	20.1	47.4	38.5

NOTES: Data for fiscal year 2015. Data presented in cases.

SOURCE: CMS, Center for Medicare.

Table V.4
Medicare Physician/Supplier Claims Assignment Rates

	2005	2010	2012	2013	2014	2015
			In millions			
Claims total	951.6	972.7	1,003.2	994.6	990.4	997.7
Claims assigned	940.7	965.7	997.4	989.2	985.4	993.1
Claims unassigned	10.9	7.0	5.8	5.4	5.0	4.7
Percent assigned	98.9	99.3	99.4	99.5	99.5	99.5

NOTE: Calendar year data (Railroad Board, A/B MACs (B), DME MACs).

SOURCE: CMS, Center for Medicare.

Table V.5
Medicare Claims Processing

	Fiscal Year 2015
Part A claims processed in millions	213.3
Part B claims processed in millions[1]	1,009.2

[1]Includes replicate claims.

SOURCE: CMS, Center for Medicare.

Table V.6
Medicare Claims Received

	Claims received
A/B MAC (A) claims received in millions	214.1
	Percent of total
Inpatient hospital	7.0
Outpatient hospital	59.7
Home health agency	7.1
Skilled nursing facility	2.7
Other	23.5
A/B MAC (B) claims received in millions	997.7
	Percent of total
Assigned	99.5
Unassigned	0.5

NOTE: Data for calendar year 2015.

SOURCE: CMS, Center for Medicare.

Table V.7
Medicare Charge Reductions

	Assigned	Unassigned
Claims approved		
Number in millions	904.8	4.0
Percent reduced	96.4	83.5
Total covered charges		
Amount in millions	$371,731	$506
Percent reduced	64.2	23.0
Amount reduced per claim	$263.57	$29.05

NOTES: Data for calendar year 2015. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Center for Medicare.

Table V.8
Medicaid Administration

	Fiscal Year	
	2014	2015
	In millions	
Total payments computable for Federal funding[1]	$24,418	$25,603
Federal share[1]		
Family Planning	30	28
Design, development or installation of MMIS[2]	663	806
Skilled professional medical personnel	487	462
Operation of an approved MMIS[2]	1,569	1,783
All other	12,359	13,139
Mechanized systems not approved under MMIS[2]	85	153
Total Federal Share	$15,193	$16,371
Net adjusted Federal share[3]	$14,675	$15,954

[1]Source: Form CMS-64. (Net Expenditures Reported—Administration).

[2]Medicaid Management Information System.

[3]Includes CMS adjustments.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Reference

Selected reference material including program financing, cost-sharing features of the Medicare program, and Medicaid Federal medical assistance percentages

Program Financing, Cost Sharing and Limitations

Medicare/Source of Income

Medicare Part A

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 uninsured persons and military wage credits
5. Premiums from voluntary enrollees
6. Interest on investments

*Contribution rate	2015	2016	2017
	Percent		
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2017) None[1]

Voluntary HI monthly premium[2] $413.00

Part A (effective date)	Amount
Inpatient hospital deductible (1/1/17)	$1,316/benefit period
Regular coinsurance days (1/1/17)	$329/day for 61st through 90th day
Lifetime reserve days (1/1/17)	$658/day (60 non-renewable days)
SNF coinsurance days (1/1/17)	$164.50/day for 21st through 100th day
Blood deductible	first 3 pints/calendar year
Voluntary hospital insurance premium (1/1/17)[2]	$413/month; $227/mo. with 30-39 quarters of coverage
Limitations:	
Inpatient psychiatric hospitals	190 nonrenewable days

[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 $227 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, 30-39 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

Program Financing, Cost Sharing and Limitations

Medicare Part B

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

Part B (effective date)	**Amount**
Deductible (1/1/17)	$183 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/17)	$134/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.

SOURCE: CMS, Office of the Actuary.

Medicare Part B (continued)

Listed below are the 2017 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	Less than or equal to $170,000	$0.00	$134.00
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$53.50	$187.50
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$133.90	$267.90
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$214.30	$348.30
Greater than $214,000	Greater than $428,000	$294.60	$428.60

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse are listed below:

Married beneficiaries who lived with their spouse and filed a separate tax return:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	$0.00	$134.00
Greater than $85,000 and less than or equal to $129,000	$214.30	$348.30
Greater than $129,000	$294.60	$428.60

SOURCE: CMS, Office of the Actuary.

Medicare Part D Standard Benefits

Deductible (1/1/2017)	$400 in charges/year
Initial coverage limit (1/1/2017)	$3,700 in charges/year
Out-of-pocket threshold (1/1/2017)	$4,950 in charges/year
Base beneficiary premium (1/1/2017)[1]	$35.63/month

Medicaid Financing

1. Federal contributions (ranging from 50 to 75 percent for fiscal year 2017)
2. State contributions (ranging from 25 to 50 percent for fiscal year 2017)

[1]The base beneficiary premium was calculated based on a national average plan bid. The actual premium that a beneficiary pays varies according to the plan in which the beneficiary is enrolled.

NOTES: The beneficiaries who qualify for the low-income subsidy under Part D pay a reduced or zero premium. In addition, low-income beneficiaries are subject to only minimal copayment amounts in most instances.

SOURCE: CMS, Office of the Actuary.

Geographical Jurisdictions of CMS Regional Offices and Federal Medical Assistance Percentages (FMAP) Fiscal Year 2017

I. Boston	FMAP
Connecticut	50.00
Maine	64.38
Massachusetts	50.00
New Hampshire	50.00
Rhode Island	51.02
Vermont	54.46

III. Philadelphia	
Delaware	54.20
Dist. of Columbia	70.00
Maryland	50.00
Pennsylvania	51.78
Virginia	50.00
West Virginia	71.80

V. Chicago	
Illinois	51.30
Indiana	66.74
Michigan	65.15
Minnesota	50.00
Ohio	62.32
Wisconsin	58.51

VII. Kansas City	
Iowa	56.74
Kansas	56.21
Missouri	63.21
Nebraska	51.85

IX. San Francisco	
Arizona	69.24
California	50.00
Hawaii	54.93
Nevada	64.67
American Samoa	55.00
Guam	55.00
N. Mariana Islds	55.00

II. New York	FMAP
New Jersey	50.00
New York	50.00
Puerto Rico	55.00
Virgin Islands	55.00

IV. Atlanta	
Alabama	70.16
Florida	61.10
Georgia	67.89
Kentucky	70.46
Mississippi	74.63
North Carolina	66.88
South Carolina	71.30
Tennessee	64.96

VI. Dallas	
Arkansas	69.69
Louisiana	62.28
New Mexico	71.13
Oklahoma	59.94
Texas	56.18

VIII. Denver	
Colorado	50.02
Montana	65.56
North Dakota	50.00
South Dakota	54.94
Utah	69.90
Wyoming	50.00

X. Seattle	
Alaska	50.00
Idaho	71.51
Oregon	64.47
Washington	50.00

NOTE: FMAPs are used in determining the amount of Federal matching funds for State expenditures for assistance payments.

SOURCE: DHHS, Office of the Assistant Secretary for Planning and Evaluation.

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Office of Enterprise Data and Analytics
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