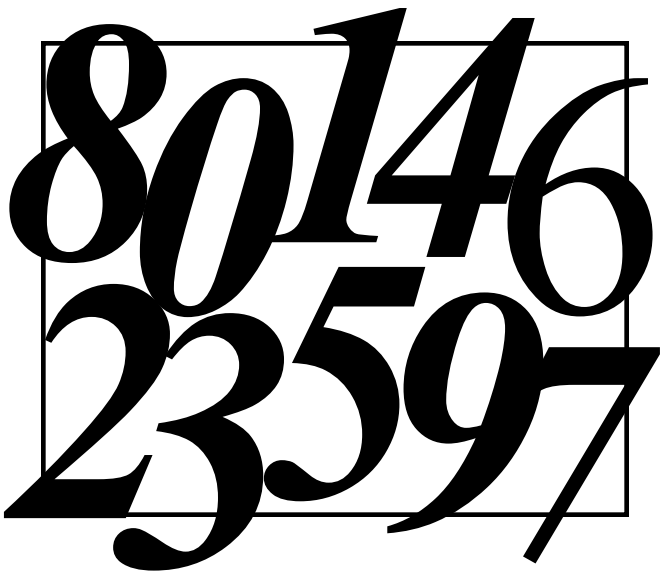
2010 CMS Statistics



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. Department of
Health and Human Services
Kathleen Sebelius, Secretary

Centers for Medicare & Medicaid Services
Marilyn Tavenner, Acting Administrator, Principal
Deputy Administrator and Chief Operating Officer

Michelle Snyder, Deputy Chief Operating Officer

Center for Strategic Planning
Anthony D. Rodgers, Deputy Administrator and Director

Office of Research, Development, and Information
Thomas W. Reilly, Acting Director

Information and Methods Group
Thomas M. Kickham, Director

John R. Garner, Deputy Director

Publication Coordinators
Maria Diacogiannis

Cheryl Sharpless

Press inquiries should be directed to the
CMS Media Relations Group, (202) 690-6145.

National health expenditure inquiries:
dnhs@cms.hhs.gov

Data availability: www.cms.hhs.gov/home/rsds.asp

Questions on this publication:
StatComments@cms.hhs.gov

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. Similar reported statistics may differ because of differences in sources and/or methodology.

The data are organized as follows:

Glossary of Acronyms for Data Source Attribution

CM	**Center for Medicare**
CMCS	**Center for Medicaid, CHIP and Survey & Certification**
CMS	**Centers for Medicare & Medicaid Services**
OACT	**Office of the Actuary**
ORDI	**Office of Research, Development, and Information**
SSA	**Social Security Administration**

Highlights

Growth in CMS programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 47.2 million in 2010, a 147 percent increase.
- On average, the number of Medicaid monthly enrollees in 2010 is estimated to be about 54.6 million, the largest group being children (27.0 million or 49.5 percent).
- In 2007, about 19.7 percent of the population was at some point enrolled in the Medicaid program.
- Medicare enrollees with end-stage renal disease increased from 66.7 thousand in 1980 to 424.7 thousand in 2009, an increase of 537 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 7.7 million beneficiaries in 2009, an increase of about 175 percent.

- By 2010, nearly 27.5 million Medicare enrollees had Part D drug coverage, 58.3 percent of all enrollees, and an additional 6.2 million had RDS.
- About 8.1 million persons were dually eligible for both Medicare and Medicaid as of July 1, 2008.
- As of March 2010, the proportion of female Medicare Part D enrollees aged 85 years and over was 14.5 percent, nearly double that of the 7.8 percent proportion of male Medicare Part D enrollees aged 85 years and over.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,770 in December 1975 to 6,172 in December 2009. Total inpatient hospital beds have dropped from 46.5 beds per 1,000 enrolled in 1975 to 20.1 in 2009, a decrease of 57 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 about 785,000 in 2009. (NOTE: This includes a reclassification of some short-stay hospitals as critical access hospitals. There were about 30,000 critical access hospital beds in 2009.)
- 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 1990s, and remains currently at this level.

- The number of participating home health agencies has fluctuated considerably over the years, 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 stabilized, reaching 10,184 in 2009.

Expenditures

- National health expenditures (NHE) were $2,338.7 billion in 2008, comprising 16.2 percent of the gross domestic product (GDP). Comparably, NHE amounted to $2,112.5 billion, or 15.8 percent of the GDP in 2006.
- In 2009, total net Federal outlays for CMS programs were $689.0 billion, 19.6 percent of the Federal budget.
- Medicare skilled nursing facility benefit payments increased from $25.5 billion in 2009 to about $26.3 billion in 2010.
- Medicare home health agency benefit payments increased slightly between 2009 and 2010 from $17.3 billion to $19.2 billion.
- National health expenditures per person were $211 in 1965 and grew steadily to reach $7,681 by 2008.

Utilization of Medicare and Medicaid services

- Between 1990 and 2008, the number of short-stay hospital discharges increased from 10.5 million to 11.9 million, an increase of 13 percent.
- The PPS short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.3 days in 2008, a decrease of 41 percent.

Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 12.0 days in 2008, a decrease of 38 percent.

- About 32.1 million persons received a reimbursed service under Medicare fee-for-service during 2008. Comparably, almost 56.8 million persons used Medicaid services or had a premium paid on their behalf in 2007.
- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 915 per 1,000 enrolled in 2008.
- 7.1 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2008.
- 31.1 million persons received reimbursable fee-for-services physician services under Medicare during 2008. 22.0 million persons received reimbursable physician services under Medicaid during 2007.
- 23.3 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2008. During 2007, 14.9 million persons received Medicaid reimbursable outpatient hospital services.
- Over 1.8 million persons received care in SNFs covered by Medicare during 2008. 1.6 million persons received care in nursing facilities, which include SNFs and all other nursing facilities other than mentally retarded, covered by Medicaid during 2007.
- Over 23 million persons received prescribed drugs under Medicaid during 2007.

Populations

Information about persons covered by Medicare, Medicaid, or CHIP

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 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
		In millions	
July			
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
2006	43.4	36.3	7.1
2007	44.3	37.0	7.3
2008	45.2	37.8	7.4
2009	45.9	38.3	7.6
2010	47.2	39.1	8.1

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 2000-2010 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on FY 2011 President's Budget.

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	47.0	46.7	43.3	34.2	42.9	3.8	0.3
Aged persons	39.0	38.7	36.2	--	35.8	2.9	0.3
Disabled persons	8.0	8.0	7.1	--	7.1	0.9	0.0

NOTES: Projected average monthly enrollment during fiscal year 2010. Aged/disabled split of Part D enrollment not available. Based on FY 2011 President's Budget. 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	46,521	20,778	25,743
Aged	38,765	16,715	22,050
65-74 years	20,606	9,636	10,970
75-84 years	12,714	5,327	7,387
85 years and over	5,445	1,752	3,693
Disabled	7,755	4,063	3,692
Under 45 years	1,837	987	849
45-54 years	2,417	1,264	1,153
55-64 years	3,501	1,811	1,690
White	38,589	17,248	21,341
Black	4,727	2,026	2,702
All Other	3,123	1,470	1,653
Native American	202	90	112
Asian/Pacific	899	390	509
Hispanic	1,169	547	621
Other	853	442	411
Unknown Race	81	34	47

NOTES: Data as of July 1, 2009. Numbers may not add to totals because of rounding.

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

Table I.4
Medicare Part D enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	27,485	11,234	16,247
Aged			
65-74 years	11,429	4,897	6,529
75-84 years	7,429	2,784	4,645
85 years and over	3,223	872	2,351
Disabled			
Under 45 years	1,439	764	675
45-54 years	1,718	882	836
55-64 years	2,245	1,035	1,210

NOTES: Data as of March 2010, as recorded in PEAR. Totals may not add due to rounding.

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

Table I.5
Medicare enrollment/end stage renal disease trends

Year	HI and/or SMI	HI	SMI
	In thousands		
1980	66.7	66.3	64.9
1990	172.0	170.6	163.7
1995	257.0	255.0	245.1
2000[1]	291.8	291.3	273.1
2005[1]	371.2	371.1	351.9
2007[1]	395.8	395.7	374.9
2008[1]	410.6	410.5	388.9
2009[1]	424.7	424.6	402.9

[1]Denominator File; estimated person years.

NOTES: Data prior to 2000 are as of July 1; estimated person years 2000-2009.

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

Table I.6
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	473.3
Age	
Under 35 years	26.9
35-44 years	42.5
45-64 years	189.8
65 years and over	214.2
Sex	
Male	267.9
Female	205.4
Race	
White	254.1
Other	216.5
Unknown	2.8

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2009.

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

Table I.7
Medicare advantage, cost, PACE, demo & prescription drug

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	699	1,551	10,012	11,563
Local CCPs	511	578	8,082	8,660
PFFS	47	514	1,155	1,669
Demos	15	1	5	6
1876 Cost	22	124	201	325
1833 Cost (HCPP)	12	64	--	64
PACE	73	--	18	18
Other plans[2]	19	269	551	821
Total PDPs[1]	93	--	17,584	17,584
Total	792	1,551	27,596	29,147

[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, EPFFS, Pilot, and RPPOs.
NOTE: Data as of April 2010.
SOURCE: CMS, Center for Medicare.

Table I.8
Medicare enrollment/CMS region

	Resident population[1]	Medicare enrollees[2]	Enrollees as percent of population
	In thousands		
All regions	307,007	45,467	14.8
Boston	14,430	2,362	16.4
New York	28,249	4,241	15.0
Philadelphia	29,491	4,725	16.0
Atlanta	60,580	9,770	16.1
Chicago	51,767	7,934	15.3
Dallas	37,861	4,987	13.2
Kansas City	13,611	2,198	16.1
Denver	10,788	1,361	12.6
San Francisco	47,496	6,062	12.8
Seattle	12,734	1,825	14.3

[1]Estimated July 1, 2009 resident population.
[2]Medicare enrollment file data are as of July 1, 2009. 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.

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

Table I.9
Medicare enrollment by health delivery system

	Total Enrollees	Fee-for-Service Enrollees	Managed Care Enrollees
		In thousands	
All regions	46,521	35,360	11,161
Boston	2,362	1,953	409
New York	4,910	3,494	1,416
Philadelphia	4,725	3,536	1,189
Atlanta	9,770	7,684	2,086
Chicago	7,935	6,159	1,776
Dallas	4,987	4,056	931
Kansas City	2,198	1,853	345
Denver	1,361	1,020	341
San Francisco	6,079	3,957	2,122
Seattle	1,825	1,282	543

NOTES: Data as of July 1, 2009. Totals may not add due to rounding. Foreign residents and unknowns are not included in the regions, but included in the total figure.

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

Table I.10
Medicare Part D enrollment by CMS region

	Total Medicare Enrollees	Total Part D Enrollees	Percent of Total Enrollees
	In thousands		
All regions[1]	47,174	27,485	58.3
Boston	2,379	1,356	57.0
New York	4,949	2,886	58.3
Philadelphia	4,767	2,667	55.9
Atlanta	9,864	5,802	58.8
Chicago	8,011	4,354	54.4
Dallas	5,059	2,931	58.0
Kansas City	2,214	1,397	63.1
Denver	1,377	801	58.2
San Francisco	6,106	4,052	66.4
Seattle	1,849	1,049	56.7

[1]Includes beneficiaries with pending State/region designation.

NOTE: Data as of March 2010, as recorded in PEAR.

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

Table I.11
Medicare Part D enrollment by plan type

	Total Part D Enrollees	Total PDP Enrollees	Total MA-PD Enrollees
		In thousands	
All regions[1]	27,485	17,505	9,979
Boston	1,356	977	379
New York	2,886	1,545	1,341
Philadelphia	2,667	1,744	923
Atlanta	5,802	3,822	1,979
Chicago	4,354	3,083	1,271
Dallas	2,931	2,064	868
Kansas City	1,397	1,091	306
Denver	801	505	296
San Francisco	4,052	2,002	2,049
Seattle	1,049	623	426

[1]Includes beneficiaries with pending State/region designation.

NOTE: Data as of March 2010, as recorded in PEAR.

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

Table I.12
Medicare Part D and RDS enrollment

	Total Part D and RDS Enrollees	Total Part D Enrollees	Total RDS Enrollees
		In thousands	
All regions[1]	33,647	27,485	6,162
Boston	1,730	1,356	375
New York	3,684	2,886	798
Philadelphia	3,277	2,667	610
Atlanta	6,997	5,802	1,195
Chicago	5,851	4,354	1,497
Dallas	3,532	2,931	601
Kansas City	1,600	1,397	203
Denver	937	801	136
San Francisco	4,602	4,052	551
Seattle	1,245	1,049	196

[1]Includes beneficiaries with pending State/region designation.

NOTE: Data as of March 2010, as recorded in PEAR.

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

Table I.13
Social security area projected population[1]

	2010	2020	2040	2060	2080	2100
	In millions					
Total	317	345	392	431	473	515
Under 20	86	90	99	107	115	122
20-64	190	200	216	236	256	274
65 years and over	41	54	78	88	103	118

[1]As of July 1.

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

SOURCE: SSA, Office of the Actuary, based on the 2009 Trustees Report Intermediate Alternative.

Table I.14
Period life expectancy at age 65, historical and projected intermediate alternative

	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[1]	17.0	19.4
2020[1]	17.8	19.9
2030[1]	18.4	20.5
2040[1]	19.0	21.1
2050[1]	19.6	21.7
2060[1]	20.2	22.3
2070[1]	20.7	22.8
2080[1]	21.2	23.3
2090[1]	21.7	23.8
2100[1]	22.2	24.2

[1]Projected.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2009 Trustees Report.

Table I.15
Life expectancy at birth and at age 65 by race/trends

Calendar Year	All Races	White	Black
		At Birth	
1950	68.2	69.1	60.8
1980	73.7	74.4	68.1
1990	75.4	76.1	69.1
1995	75.8	76.5	69.6
2000	76.8	77.3	71.8
2005	77.4	77.9	72.8
2006	77.7	78.2	73.2
		At Age 65	
1950	13.9	--	13.9
1980	16.4	16.5	15.1
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2000	17.6	17.7	16.1
2005	18.2	18.3	16.8
2006	18.5	18.6	17.1

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Health United States, 2009.

Table I.16
Medicaid and CHIP enrollment

	Fiscal year					
	1990	1995	2000	2005	2009	2010
	Average monthly enrollment in millions					
Total	22.9	34.2	34.5	46.5	51.7	54.6
Age 65 years and over	3.1	3.7	3.7	4.6	4.7	4.9
Blind/Disabled	3.8	5.8	6.7	8.1	9.0	9.3
Children	10.7	16.5	16.2	22.3	25.4	27.0
Adults	4.9	6.7	6.9	10.6	11.5	12.4
Other Title XIX[1]	0.5	0.6	NA	NA	NA	NA
Territories	NA	0.8	0.9	1.0	1.0	1.0
CHIP	NA	NA	2.0	4.4	5.3	5.8
	Unduplicated annual enrollment in millions					
Total	NA	43.3	44.3	58.4	65.4	69.2
Age 65 years and over	NA	4.4	4.3	5.3	5.6	5.8
Blind/Disabled	NA	6.5	7.5	8.9	10.0	10.3
Children	NA	21.3	21.1	28.1	31.9	33.9
Adults	NA	9.4	10.5	15.1	16.9	18.2
Other Title XIX[1]	NA	0.9	NA	NA	NA	NA
Territories	NA	0.8	0.9	1.0	1.0	1.0
CHIP	NA	NA	3.4	6.8	8.3	9.0

[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 CHIP programs. CHIP numbers include adults covered under waivers. Medicaid and CHIP figures for FY 2008-2009 are estimates from the President's FY 2011 Budget. Enrollment for Territories for FY 2000 and later is estimated. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of the Actuary.

Table I.17
Medicaid eligibles/demographics

	Fiscal year 2007 Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	59.4	100.0
Age	59.4	100.0
Under 21	32.2	54.1
21-64 years	21.2	35.7
65 years and over	5.9	10.0
Unknown	0.1	0.2
Sex	59.4	100.0
Male	24.1	40.6
Female	35.2	59.2
Unknown	0.1	0.2
Race	59.4	100.0
White, not Hispanic	24.6	41.3
Black, not Hispanic	13.5	22.6
Am. Indian/Alaskan Native	0.8	1.3
Asian	1.7	2.8
Hawaiian/Pacific Islander	0.6	1.0
Hispanic	14.4	24.2
Other	0.1	0.2
Unknown	3.8	6.4

NOTES: The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of the 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 had been made.

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

Table I.18
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	301,290	59,415	19.7
Boston	14,259	2,855	20.0
New York	28,082	6,021	21.4
Philadelphia	28,997	4,583	15.8
Atlanta	59,102	11,146	18.9
Chicago	51,470	9,402	18.3
Dallas	36,620	7,417	20.3
Kansas City	13,409	2,152	16.0
Denver	10,425	1,247	12.0
San Francisco	46,563	12,564	27.0
Seattle	12,362	2,028	16.4

[1]Estimated July 1, 2007 population.
[2]Persons ever enrolled in Medicaid during fiscal year 2007.

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 Research, Development, and Information; U.S. Department of Commerce, Bureau of the Census.

Table I.19
Medicaid beneficiaries/State buy-ins for Medicare

	1975[1]	1980[1]	2000[2]	2009[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	7,667
Aged	2,483	2,449	3,632	4,533
Disabled	363	504	1,917	3,134
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	17.9
Aged	11.4	10.0	11.1	12.5
Disabled	18.7	18.9	40.2	46.6

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

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

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 II.1
Inpatient hospitals/trends

	1990	2000	2008	2009
Total hospitals	6,522	5,985	6,171	6,172
Beds in thousands	1,105	991	930	926
Beds per 1,000 enrollees[1]	32.8	25.3	20.6	20.1
Short-stay	5,549	4,900	3,658	3,606
Beds in thousands	970	873	792	785
Beds per 1,000 enrollees[1]	28.8	22.3	17.6	17.0
Critical access hospitals	NA	NA	1,302	1,311
Beds in thousands	---	---	30	30
Beds per 1,000 enrollees[1]	---	---	0.7	0.7
Other non-short-stay	973	1,085	1,211	1,255
Beds in thousands	135	118	108	111
Beds per 1,000 enrollees[1]	4.0	3.0	2.4	2.4

[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 next calendar year. Facilities certified for Medicare are deemed to meet Medicaid standards.

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

Table II.2
Medicare assigned claims/CMS region

	Net assignment rates		
	2007	2008	2009
All regions	99.1	99.2	99.2
Boston	([1])	([1])	([1])
New York	99.0	99.1	99.8
Philadelphia	99.7	99.7	([1])
Atlanta	99.3	99.3	99.5
Chicago	98.9	99.0	99.1
Dallas	99.2	99.5	99.6
Kansas City	99.0	99.1	([1])
Denver	99.0	99.2	99.2
San Francisco	99.4	99.5	99.8
Seattle	96.2	96.6	97.1

[1]No carriers in the Boston, Philadelphia, or Kansas City regions.

NOTE: Calendar year data. Data do not include A/B MACs, DMACs.

SOURCE: CMS, Office of Financial Management.

Table II.3
Medicare hospital and SNF/NF/ICF facility counts

Total participating hospitals	6,169
Short-term hospitals	3,591
Psychiatric units	1,202
Rehabilitation units	956
Swing bed units	535
Psychiatric	508
Long-term	432
Rehabilitation	229
Childrens	78
Religious non-medical	17
Critical access	1,314
Non-participating Hospitals	758
Emergency	408
Federal	350
All SNFs/SNF-NFs/NFs only	15,706
All SNFs/SNF-NFs	15,066
Title 18 Only SNF	790
Hospital-based	282
Free-standing	508
Title 18/19 SNF/NF	14,276
Hospital-based	685
Free-standing	13,591
Title 19 only NFs	640
Hospital-based	124
Free-standing	516
All ICF-MR facilities	6,434

NOTES: The table is designed to give a "snapshot" as of May 2010 of institutional providers participating in the program by type of provider (short term, long term, rehab., etc.). Numbers may differ from other reports and program memoranda.

SOURCES: CMS, CM, and CMCS.

Table II.4
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	15,071	648	6,437
Boston	971	12	144
New York	1,005	2	576
Philadelphia	1,370	48	397
Atlanta	2,618	60	649
Chicago	3,323	141	1,518
Dallas	1,968	100	1,582
Kansas City	1,374	152	192
Denver	585	42	88
San Francisco	1,416	68	1,210
Seattle	441	23	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 2009.

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

Table II.5
Other Medicare providers and suppliers/trends

	1975	1980	2008	2009
Home health agencies	2,242	2,924	9,407	10,184
Independent and Clinical Lab Improvement Act Facilities	NA	NA	210,872	218,139
End stage renal disease facilities	NA	999	5,317	5,476
Outpatient physical therapy and/or speech pathology	117	419	2,781	2,640
Portable X-ray	132	216	547	546
Rural health clinics	NA	391	3,757	3,752
Comprehensive outpatient rehabilitation facilities	NA	NA	476	406
Ambulatory surgical centers	NA	NA	5,174	5,260
Hospices	NA	NA	3,346	3,405

NOTES: Facility data for selected years 1975 and 1980 are as of July 1. Facility data for 2008 and 2009 are as of December 31.

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

Table II.6
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,606	15,071	10,184
		Percent of total	
Non-profit	60.1	26.4	19.6
Proprietary	20.4	67.9	72.5
Government	19.5	5.7	7.8

NOTES: Data as of December 31, 2009. Facilities certified for Medicare are deemed to meet Medicaid standards.

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

Table II.7
Periodic interim payment (PIP) facilities/trends

	1980	1990	2000	2008	2009
Hospitals					
Number of PIP	2,276	1,352	869	620	574
Percent of total participating	33.8	20.6	14.4	10.0	9.3
Skilled nursing facilities					
Number of PIP	203	774	1,236	747	460
Percent of total participating	3.9	7.3	8.3	5.0	3.1
Home health agencies					
Number of PIP	481	1,211	1,038	86	86
Percent of total participating	16.0	21.0	14.4	0.9	0.8

NOTES: Data from 1990 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 II.8
Medicare participating & non-participating physicians & practitioners

	Calendar Year 2010
All Part B Practitioners	973,299
Physician Specialties	616,749
Internal Medicine[1]	103,840
Family Practice	82,242
Emergency Medicine	40,066
Anesthesiology	38,300
Radiology[2]	36,034
Obstetrics/Gynecology	32,367
Psychiatry[3]	28,739
Cardiology	24,590
Orthopedic Surgery	22,765
Other and Unknown	207,806
Limited License Practitioners	96,004
Non-physician Practitioners	260,546

[1]Includes the Internal Medicine, Endocrinology, and Medical Oncology.
[2]Includes Radiology, Nuclear Medicine, and Interventional Radiology.
[3]Includes Psychiatry and Neuropsychiatry.

NOTE: Top 9 specialties presented, in terms of total counts.

SOURCE: CMS, Office of Financial Management.

Table II.9
Part B practitioners/CMS region

	Active practitioners[1]
All regions	712,753
Boston	46,081
New York	82,897
Philadelphia	78,317
Atlanta	123,138
Chicago	130,457
Dallas	72,559
Kansas City	32,292
Denver	24,557
San Francisco	91,126
Seattle	31,329

[1]Includes MDs, DOs, and LLPs.

NOTE: Participating and Non-Participating physicians as of March 2010.

SOURCE: CMS, Office of Financial Management.

Table II.10
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	4,917	17.6	1,255	2.4
Boston	189	13.9	68	4.5
New York	319	18.5	74	2.6
Philadelphia	366	15.5	134	2.8
Atlanta	910	18.2	227	2.2
Chicago	878	19.1	187	1.9
Dallas	778	20.2	321	3.8
Kansas City	467	21.9	58	2.0
Denver	310	18.8	44	2.7
San Francisco	490	15.9	114	1.7
Seattle	210	13.1	27	1.4

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2009. Rates based on number of hospital insurance enrollees as of July 1, 2009, residing in U.S. and its territories.

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

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 2008	Fiscal year 2009
	$ in billions	
Gross domestic product (current dollars)	$14,441.4	$14,251.9
Total Federal outlays[1]	2,982.9	3,517.7
Percent of gross domestic product	20.7%	24.7%
Dept. of Health and Human Services[1]	700.5	796.3
Percent of Federal Budget	23.5%	22.6%
CMS Budget (Federal Outlays)		
Medicare benefit payments	454.3	497.4
SMI transfer to Medicaid[2]	0.4	0.4
Medicaid benefit payments	191.5	240.6
Medicaid State and local admin.	9.9	10.3
Medicaid offsets[3]	-0.4	-0.4
Children's Health Ins. Prog.	6.9	7.5
CMS program management	3.1	3.0
Other Medicare admin. expenses[4]	2.1	2.1
State Eligibility Determinations, for Part D	0.0	0.0
Quality improvement organizations[5]	0.4	0.4
Health Care Fraud and Abuse Control	1.1	1.1
State Grants and Demonstrations[6]	0.4	0.5
User Fees and Reimbursables	0.3	0.3
Total CMS outlays (unadjusted)	670.0	763.2
Offsetting receipts[7]	-70.5	-74.2
Total net CMS outlays	599.5	689.0
Percent of Federal budget	20.1%	19.6%

[1]Net of offsetting receipts.

[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($396.6 million in FY 2008 and $449.4 million in FY 2009).

[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
2005	664.0	339.4	317.2	7.4
2009	895.9	503.9	381.3	10.6

[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) 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 new 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
Benefit outlays by program

	1967	1968	2005	2009
Annually	Amounts in billions			
CMS program outlays	$5.1	$8.4	$642	$871
Federal outlays	NA	6.7	512	745
Medicare[1]	3.2	5.1	333	497
HI	2.5	3.7	183	240
SMI	0.7	1.4	150	204
Transitional Assistance[2]	NA	NA	1	0
Prescription (Part D)	NA	NA	NA	53
Medicaid[3]	1.9	3.3	302	363
Federal share	NA	1.6	173	241
CHIP[4]	NA	NA	7	11
Federal share	NA	NA	5	8

[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 transitional Prescription Drug Card program, begun in the third quarter of FY 2004 under the Medicare Modernization Act of 2003 (P.L. 108-173), was terminated in FY 2006 as it was replaced by Medicare Part D. Final benefit outlays for payment adjustments in FY 2008 totaled $42 thousand.

[3]The Medicaid amounts include total computable outlays (Federal and State shares) for Medicaid benefits and outlays for the Vaccines for Children program.

[4]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 2008 Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$334,205	$190,560
Boston	21,440	11,194
New York	56,680	28,428
Philadelphia	31,945	17,531
Atlanta	55,386	35,563
Chicago	51,374	29,055
Dallas	36,605	23,910
Kansas City	13,542	8,324
Denver	7,077	4,178
San Francisco	48,659	25,801
Seattle	11,497	6,575

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

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

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

Table III.5
Medicare benefit outlays

	Fiscal Year		
	2008	2009	2010
	In billions		
Part A benefit payments	$217.8	$234.3	$243.5
Aged	183.9	197.5	204.4
Disabled	33.9	36.8	39.2
Part B benefit payments	183.3	200.2	209.2
Aged	151.4	164.3	170.3
Disabled	31.9	35.9	39.0
Part D	46.7	56.7	63.1

NOTES: Based on FY 2011 President's Budget. 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 2010 benefit payments[1] in millions	Percent distribution
Total Part A[2]	$243,512	100.0
Inpatient hospital	136,787	56.2
Skilled nursing facility	26,268	10.8
Home health agency[3]	7,484	3.1
Hospice	12,580	5.2
Managed care	60,393	24.8
Total Part B[2]	209,229	100.0
Physician/other suppliers	58,295	27.9
DME	8,295	4.0
Other carrier	17,614	8.4
Outpatient hospital	34,968	16.7
Home health agency[3]	11,721	5.6
Other intermediary	15,023	7.2
Laboratory	8,429	4.0
Managed care	54,885	26.2
Total Part D	63,106	100.0

[1]Includes the effects of regulatory items and recent legislation but not proposed law.
[2]Excludes QIO expenditures.
[3]Distribution of home health benefits between the trust funds estimated based on outlays reported to date by the Treasury.

NOTES: Based on FY 2011 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, Office of the Actuary.

Table III.7
National health care/trends

	Calendar Year			
	1965	1980	2000	2008
National total in billions	$42.2	$253.4	$1,352.9	$2,338.7
Percent of GDP	5.9	9.1	13.6	16.2
Per capita amount	$211	$1,100	$4,789	$7,681
Source of funds	Percent of Total			
Private	75.2	58.0	55.9	52.7
Public	24.8	42.0	44.1	47.3
Federal	11.4	28.2	30.9	34.9
State/local	13.5	13.7	13.2	12.4

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 III.8
Medicaid/type of service

	Fiscal year		
	2006	2007	2008
	In billions		
Total medical assistance payments[1]	$299.0	$315.8	$334.2
	Percent of total		
Inpatient services	15.3	16.3	15.2
General hospitals	14.3	15.1	14.2
Mental hospitals	1.1	1.2	1.1
Nursing facility services	16.0	15.0	14.6
Intermediate care facility (MR) services	4.3	3.9	3.7
Community-based long term care svs.[2]	13.4	13.6	14.0
Prescribed drugs[3]	5.6	4.7	4.6
Physician services	4.2	3.9	4.1
Dental services	1.1	1.1	1.2
Outpatient hospital services	3.9	4.2	3.8
Clinic services[4]	3.1	3.0	3.0
Laboratory and radiological services	0.4	0.4	0.4
Early and periodic screening	0.4	0.3	0.3
Targeted case management services	1.0	0.9	0.9
Capitation payments (non-Medicare)	18.6	19.7	21.5
Medicare premiums	3.1	3.3	3.3
Disproportionate share hosp. payments	5.7	5.1	5.1
Other services	5.6	6.3	5.9
Collections[5]	-1.8	-1.7	-1.6

[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		
	2007	2008	2009
	In millions		
Total	$6,505.0	$6,787.5	$8,022.8
Workers Compensation[1]	877.2	1,053.3	1,232.5
Working Aged	2,919.0	3,033.3	3,583.3
ESRD	278.1	315.6	375.5
Auto	233.2	293.3	248.2
Disability	1,938.9	1,982.8	2,231.5
Liability	232.2	82.0	323.8
VA/Other	26.3	27.2	28.2

[1]Beginning in FY 2007, includes Workers' Compensation set-asides.

NOTE: 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 2008 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$334.2	100.0
Age 65 years and over	72.4	21.7
Blind/disabled	136.4	40.8
Dependent children under 21 years of age	62.1	18.6
Adults in families with dependent children	41.9	12.5
DSH and other unallocated	21.4	6.4

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

SOURCE: CMS, Office of the Actuary.

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

BETOS Category	Allowed Charges[2]	
	2008	2009[3]
	In thousands	
Total	$11,483,315	$10,625,561
Medical/surgical supplies	176,116	199,663
Hospital beds	275,952	240,945
Oxygen and supplies	2,844,561	2,051,527
Wheelchairs	1,453,779	1,372,176
Prosthetic/orthotic devices	2,004,981	2,173,285
Drugs admin. through DME[4]	656,381	586,025
Parenteral and enteral nutrition	730,321	673,712
Other DME	3,341,224	3,328,228

[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]Data for 2009 are preliminary through March 2010.
[4]Includes inhalation drugs administered through nebulizers only and does not include drugs administered through other DME such as infusion pumps.

NOTE: Over time, the composition of BETOS categories has changed with the re-assignment of selected procedures, services, and supplies.

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

Table III.12
National health care/type of expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$2,338.7	$7,681	34.8	20.1	14.7
Health serv/suppl.	2,181.3	7,164	37.3	21.5	15.8
Personal health care	1,952.3	6,411	39.0	22.8	16.2
Hospital care	718.4	2,359	46.5	29.4	17.1
Prof. services	731.2	2,401	29.3	16.2	13.1
Phys./clinical	496.2	1,629	28.0	20.7	7.3
Nursing/home hlth.	203.1	667	64.5	25.8	38.7
Retail outlet sales	299.6	984	27.3	20.8	6.5
Admn. and pub. hlth.	229.0	752	22.9	10.9	12.1
Investment	157.5	517	--	--	--

NOTE: Data are as of calendar year 2008.

SOURCE: CMS, Office of the Actuary.

Table III.13
Personal health care/payment source

	Calendar Year			
	1980	1990	2000	2008
	In billions			
Total	$214.8	$607.6	$1,139.2	$1,952.3
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	59.9	61.1	57.3	53.5
Private health insurance	28.5	33.7	35.4	35.4
Out-of-pocket	27.1	22.4	16.9	14.2
Other private	4.3	5.0	5.0	3.9
Public funds	40.1	38.9	42.7	46.5
Federal	29.0	28.4	32.5	36.8
State and local	11.1	10.4	10.3	9.7

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

	1985	1990	2005	2008
Discharges				
Total in millions	10.5	10.5	13.0	11.9
Rate per 1,000 enrollees[1]	347	320	361	340
Days of care				
Total in millions	92	94	75	67
Rate per 1,000 enrollees[1]	3,016	2,866	2,073	1,923
Average length of stay				
All short-stay	8.7	9.0	5.7	5.6
Excluded units	18.8	19.5	11.5	12.0
Total charges per day	$597	$1,060	$4,882	$6,181

[1]Beginning in 1990, the population base for the denominator is the July 1HI fee-for-service enrollment excluding HI fee-for-service enrollees residing in foreign countries.

NOTES: Data may reflect underreporting due to a variety of reasons, including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; no-pay Medicare secondary payer bills; and for certain years, discharges where the beneficiary received services out of State. The data for 1990 through 2008 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with a different update cycle.

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

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				
1985	315	10	1,576	51
1990	638	19	1,978	58
1995	1,233	37	3,468	103
2000	1,468	45 [1]	2,461	75 [1]
2005	1,847	51 [1]	2,976	81 [1]
2007	1,828	52 [1]	3,100	87 [1]
2008	1,841	53 [1]	3,172	90 [1]

[1]Managed care enrollees excluded in determining rate.

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

Table IV.3
Medicare average length of stay/trends

	Fiscal Year				
	1990	1995	2000	2007	2008
All short-stay and excluded units					
Short-stay PPS units	9.0	7.1	6.0	5.3	5.3
Short-stay hospital non-PPS units	8.9	7.1	6.0	5.2	5.3
Excluded units	19.5	14.8	12.3	11.8	12.0

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2008 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different update cycle.

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

Table IV.4
Medicare persons served/trends

	Calendar Year					
	1975	1985	1995	2000	2005	2008
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	916	923	915
HI	221	219	218	232	234	229
SMI	536	739	858	965	979	990
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	835	865	874
HI	219	228	212	196	205	202
SMI	471	715	837	943	977	1,001

NOTES: Prior to 2000, data were obtained from the Annual Person Summary Record and were not yet modified to exclude persons enrolled in managed care. Beginning in 2000, 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 IV.5
Medicare fee-for-service (FFS) persons served

	Calendar Year				
	2004	2005	2006	2007	2008
	Numbers in millions				
HI					
Aged					
FFS Enrollees	30.0	30.0	29.3	28.8	28.6
Persons served	6.9	7.0	6.8	6.7	6.6
Rate per 1,000	231	234	234	231	229
Disabled					
FFS Enrollees	6.0	6.3	6.2	6.3	6.4
Persons served	1.2	1.3	1.3	1.3	1.3
Rate per 1,000	203	205	205	204	202
SMI					
Aged					
FFS Enrollees	28.4	28.4	27.5	26.9	26.4
Persons served	27.6	27.8	27.3	26.6	26.2
Rate per 1,000	972	979	994	989	990
Disabled					
FFS Enrollees	5.3	5.5	5.4	5.5	5.5
Persons served	5.1	5.4	5.4	5.5	5.5
Rate per 1,000	965	977	998	999	1,001

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. Rate is the ratio of persons served during the calendar year to the number of fee-for-service enrollees as of July 1 (the average monthly enrollment).

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

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]	26,500	915	5,560	874
Boston	1,434	904	318	862
New York[2]	2,443	900	464	856
Philadelphia	2,748	940	539	882
Atlanta	5,831	947	1,388	914
Chicago	4,877	954	974	882
Dallas	3,021	925	679	897
Kansas City	1,458	947	288	914
Denver	807	944	138	878
San Francisco[3]	2,804	876	548	817
Seattle	939	896	189	835

[1]Includes utilization for residents of outlying territories, possessions, foreign countries, and unknown.
[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 2008 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 IV.7
Medicare end stage renal disease (ESRD) by treatment modalities

Year	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
1991	182,193	142,565	39,628
1996	265,634	206,905	58,729
1997	282,644	219,910	62,734
1998	300,382	233,322	67,060
1999	317,481	245,759	71,722
2000	334,082	258,397	75,685
2001	350,241	270,495	79,746
2002	365,915	281,589	84,326
2003	378,362	291,769	86,593
2004	393,746	301,470	92,276
2005	408,363	311,099	97,264
2006	424,095	321,718	102,377
2007	437,439	330,681	106,758

SOURCE: United States Renal Data System.

Table IV.8
Medicare end stage renal disease (ESRD)
by treatment modalities and demographics, 2006

	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
Total -- all patients	424,095	321,718	102,377
Age			
0-19 years	3,579	1,488	2,091
20-64 years	246,580	169,246	77,334
65-74 years	96,077	76,978	19,099
75 years and over	77,859	74,006	3,853
Sex			
Male	238,342	176,879	61,463
Female	185,753	144,839	40,914
Race			
White	256,688	182,064	74,624
Black	140,332	118,882	21,450
Native American	5,693	4,631	1,062
Asian/Pacific	18,324	13,758	4,566
Other/Unknown	3,058	2,383	675

SOURCE: United States Renal Data System.

Table IV.9
Medicaid/type of service

	Fiscal year 2007 Medicaid beneficiaries
	In thousands
Total eligibles	59,415
Number using service:	
Total beneficiaries, any service[1]	56,821
Inpatient services	
General hospitals	5,134
Mental hospitals	112
Nursing facility services[2]	1,645
Intermediate care facility (MR) services[3]	104
Physician services	22,047
Dental services	9,533
Other practitioner services	5,426
Outpatient hospital services	14,896
Clinic services	11,698
Laboratory and radiological services	15,788
Home health services	1,190
Prescribed drugs	23,923
Personal care support services	938
Sterilization services	147
PCCM capitation	7,090
HMO capitation	27,202
PHP capitation	21,369
Targeted case management	2,542
Other services, unspecified	9,896
Additional service categories[4]	7,674
Unknown	91

[1]Excludes summary records with unknown basis of eligibility, most of which are lump-sum payments not attributable to any one person.
[2]Nursing facilities include: SNFs and other facilities formerly classified as ICF, other than "MR".
[3]"MR" indicates mentally retarded.
[4]Additional services not shown separately sum to 7.7 million beneficiaries, not unduplicated.

NOTE: Beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations.

SOURCE: CMS, CMCS.

Table IV.10
Medicaid/units of service

	Fiscal year 2007 units of service
	In thousands
Inpatient hospital	
Total discharges	7,789
Beneficiaries discharged	5,134
Total days of care	35,064
Nursing facility	
Total days of care	412,858
Intermediate care facility/mentally retarded	
Total days of care	36,732

NOTES: Data are derived from the MSIS 2007 State Summary Mart and are based on reported States. Excludes territories.

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

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

Fiscal Year	Administrative expenses: Amount in millions	Administrative expenses: 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
2007[1]	2,636	1.3
2008[1]	3,231	1.4[2]
2009[1]	3,343	1.4
SMI Trust Fund[3]		
1967	135[4]	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
2007	3,398	1.5
2008	3,419	1.6[2]
2009	3,317	1.3

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

[2]Benefit payments reflect transfer made in 2008 to correct for the misallocation of benefits that occurred between 2005 and 2007.

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

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

SOURCE: CMS, Office of the Actuary.

Table V.2
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	14	12
Other	2	2

NOTES: Data for FY 2009. Numbers do not include MACs or DMACs.

SOURCE: CMS, Office of Financial Management.

Table V.3
Medicare Redeterminations

	Intermediary Redeterminations (Part A Cases Involved)	Intermediary Redeterminations (Part B Cases Involved)	Carrier Redeterminations (Part B Cases Involved)
Number Processed	45,831	171,956	1,989,013
Percent Reversed	30.3	50.2	53.0
(Includes Fully & Partially Reversed Cases)			

NOTES: Data for fiscal year 2009. Data presented in cases.

SOURCE: CMS, Office of Financial Management.

Table V.4
Medicare physician/supplier claims assignment rates

	2000	2005	2006	2007	2008	2009
	In millions					
Claims total	720.5	951.6	944.9	944.3	974.7	978.2
Claims assigned	705.7	940.7	935.1	935.8	966.5	970.3
Claims unassigned	15.3	10.9	9.8	8.6	8.2	7.9
Percent assigned	97.9	98.9	99.0	99.1	99.2	99.2

NOTE: Fiscal year data.

SOURCE: CMS, Office of Financial Management.

Table V.5
Medicare claims processing

	Fiscal year 2009
Intermediary claims processed in millions	191.7
Carrier claims processed in millions[1]	999.5

[1]Includes replicate claims (as reported in prior years).

SOURCE: CMS, Office of Financial Management.

Table V.6
Medicare claims received

	Claims received
Intermediary claims received in millions	192.7
	Percent of total
Inpatient hospital	8.0
Outpatient hospital	57.4
Home health agency	8.1
Skilled nursing facility	3.2
Other	23.3
Carrier claims received in millions	974.7
	Percent of total
Assigned	99.2
Unassigned	0.8

NOTE: Data for calendar year 2009.

SOURCE: CMS, Office of Financial Management.

Table V.7
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	867.9	6.7
Percent reduced	93.0	88.1
Total covered charges		
Amount in millions	$291,066	$746
Percent reduced	59.3	19.1
Amount reduced per claim	$214.00	$24.29

NOTES: Data for calendar year 2009. 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 V.8
Medicaid administration

	Fiscal year	
	2008	2009
	In millions	
Total payments computable for Federal funding[1]	$17,693	$16,233
Federal share[1]		
Family planning	35	36
Design, development or Installation of MMIS[2]	317	320
Skilled professional Medical personnel	457	475
Operation of an approved MMIS[2]	1,207	1,278
All other	7,476	7,752
Mechanized systems not approved under MMIS[2]	131	136
Total Federal Share	$9,623	$8,852
Net adjusted Federal share[3]	$9,589	$10,055

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

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

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	2008	2009	2010
	Percent		
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 2010)	None[1]		
Voluntary HI monthly premium[2]	$461.00		

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/10)	$1,100/benefit period
Regular coinsurance days (1/1/10)	$275/day for 61st thru 90th day
Lifetime reserve days (1/1/10)	$550/day (60 non-renewable days)
SNF coinsurance days (1/1/10)	$137.50/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/10)	$461/month; $254/mo. with at least 30 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 $254 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.

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 (1/1/10)	$155 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/10)	$110.50/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.

Medicare Part B (continued)

Listed below are the 2010 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	$110.50
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$44.20	$154.70
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$110.50	$221.00
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$176.80	$287.30
Greater than $214,000	Greater than $428,000	$243.10	$353.60

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	$110.50
Greater than $85,000 and less than or equal to $129,000	$176.80	$287.30
Greater than $129,000	$243.10	$353.60

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part D Standard Benefits

Deductible (1/1/2010)	$310 in charges/year
Initial coverage limit (1/1/2010)	$2,830 in charges/year
Out-of-pocket threshold (1/1/2010)	$4,550 in charges/year
Base beneficiary premium (1/1/2010)[1]	$31.94/month

Medicaid financing

1. Federal contributions (ranging from 58 to 84 percent for fiscal year 2010)
2. State contributions (ranging from 16 to 42 percent for fiscal year 2010)

[1]The base beneficiary premium was calculated based on a national average plan bid. The actual premiums that a beneficiary pays vary according to the plan in which the beneficiary is enrolled. For 2010, the average premium rate paid by beneficiaries is estimated to be about $30.

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 Medicaid Federal medical assistance percentages (FMAP) fiscal year 2010

I. Boston	FMAP
Connecticut	50.00
Maine	64.99
Massachusetts	50.00
New Hampshire	50.00
Rhode Island	52.63
Vermont	58.73

II. New York	FMAP
New Jersey	50.00
New York	50.00
Puerto Rico	50.00
Virgin Islands	50.00
Canada	--

III. Philadelphia	
Delaware	50.21
Dist. of Columbia	70.00
Maryland	50.00
Pennsylvania	54.81
Virginia	50.00
West Virginia	74.04

IV. Atlanta	
Alabama	68.01
Florida	54.98
Georgia	65.10
Kentucky	70.96
Mississippi	75.67
North Carolina	65.13
South Carolina	70.32
Tennessee	65.57

V. Chicago	
Illinois	50.17
Indiana	65.93
Michigan	63.19
Minnesota	50.00
Ohio	63.42
Wisconsin	60.21

VI. Dallas	
Arkansas	72.78
Louisiana	67.61
New Mexico	71.35
Oklahoma	64.43
Texas	58.73

VII. Kansas City	
Iowa	63.51
Kansas	60.38
Missouri	64.51
Nebraska	60.56

VIII. Denver	
Colorado	50.00
Montana	67.42
North Dakota	63.01
South Dakota	62.72
Utah	71.68
Wyoming	50.00

IX. San Francisco	
Arizona	65.75
California	50.00
Hawaii	54.24
Nevada	50.16
American Samoa	50.00
Guam	50.00
N. Mariana Islds	50.00

X. Seattle	
Alaska	51.43
Idaho	69.40
Oregon	62.74
Washington	50.12

SOURCE: DHHS, Assistant Secretary for Planning and Evaluation.

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Centers for Medicare & Medicaid Services
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