2005 CMS Statistics

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HEALTH AND HUMAN SERVICES

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Preface

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

The data are organized as follows:

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Glossary of Acronyms for Data Source Attribution

CMM	Center for Medicare Management
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
HCFA	Health Care Financing Administration
OACT	Office of the Actuary
OFM	Office of Financial Management
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 42.1 million in 2005, a 120 percent increase.
- On average, the number of Medicaid enrollees in 2005 is estimated to be about 44.7 million, the largest group being children (21.7 million or 48.5 percent).
- In 2002, 17.9 percent of the population was enrolled in the Medicaid program.
- Medicare enrollees with end-stage renal disease increased from 66.7 thousand in 1980 to 359.4 thousand in 2004, an increase of 439 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 6.3 million beneficiaries in 2003, an increase of about 122 percent.

- About 7.2 million persons on average were dually eligible for both Medicare and Medicaid in FY 2002.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,770 in December 1975 to 6,117 in December 2004. Total inpatient hospital beds have dropped from 46.5 beds per 1,000 enrolled in 1975 to 22.9 in 2004, a decrease of 51 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 821,000. (NOTE: A portion of this decline is due to the reclassification of some short-stay hospitals as critical access hospitals.)

- The number of psychiatric hospitals grew to about 400 by 1976, where it remained until the start of the prospective payment system (PPS) in 1983. After PPS, the number increased to over 700 in the early 1990's and has since dropped to 470.

- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, generally increased thereafter to over 15,000 in the late 1990's and again decreased, reaching 14,986 in 2004.

- The number of participating home health agencies has fluctuated considerably over the years, most recently almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed.

The number decreased sharply but has since stablized, reaching 7,519 in 2004.

Expenditures

- National health expenditures were $1,678.9 billion in 2003, 15.3 percent of the gross domestic product.

- In 2004, total net Federal outlays for CMS programs were $449.9 billion, 19.6 percent of the Federal budget.

- Medicare skilled nursing facility benefit payments increased from $15.7 billion in 2004 to $17.0 billion in 2005.

- Medicare home health agency benefit payments increased slightly between 2004 and 2005 from $10.5 billion to $12.5 billion.

- National health expenditures per person were $205 in 1965 and grew steadily to reach $5,670 by 2003.

Utilization of Medicare and Medicaid services

- Between 1990 and 2003, the number of short-stay hospital discharges increased from 10.5 million to 12.7 million, an increase of 21 percent.

- The short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.9 days in 2003, a decrease of 34 percent. Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 11.5 days in 2003, a decrease of 41 percent.

- About 31.8 million persons received a reimbursed service under Medicare fee-for-service during 2002. Comparably, almost 46 million persons used Medicaid services or had a premium paid on their behalf in 2002.

- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 918 per 1,000 enrolled in 2002.

- 7.4 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2002.

- 31.0 million persons received reimbursable fee-for-service physician services under Medicare during 2002. 21.0 million persons received reimbursable physician services under Medicaid during 2002.

- 23.0 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2002. During 2002, 14.2 million persons received Medicaid reimbursable outpatient hospital services.

- Over 1.6 million persons received care in SNFs covered by Medicare during 2002. 1.5 million persons received care in nursing facilities, which include SNFs and all other nursing facilities other than mentally retarded, covered by Medicaid during 2002.

- 23.9 million persons received prescribed drugs under Medicaid during 2002.

Populations

Information about persons covered by Medicare, Medicaid, or SCHIP

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

Table 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
July		In millions	
1966	19.1	19.1	--
1970	20.5	20.5	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
1997	38.4	33.6	4.8
1998	38.8	33.8	5.0
Average monthly			
1999	39.1	33.9	5.2
2000	39.6	34.2	5.4
2001	40.0	34.4	5.6
2002	40.4	34.6	5.8
2003[1]	40.9	34.9	6.0
2004[1]	41.5	35.3	6.2
2005[1]	42.1	35.6	6.5

[1]Projected.

NOTES: Data for 1966-1998 are as of July. Data for 1999-2005 represent average monthly enrollment. Numbers may not add to totals because of rounding.

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

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
			In millions			
All persons	42.1	41.7	39.2	38.8	2.9	0.4
Aged persons	35.6	35.2	33.5	33.1	2.1	0.4
Disabled persons	6.5	6.5	5.7	5.7	0.8	([1])

[1]Number less than 500.

NOTE: Average monthly enrollment during fiscal year 2005.

SOURCE: CMS, Office of the Actuary.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	41,087	17,937	23,150
Aged	35,008	14,625	20,382
65-74 years	17,860	8,218	9,642
75-84 years	12,585	5,051	7,533
85 years and over	4,563	1,356	3,207
Disabled	6,079	3,311	2,768
Under 45 years	1,709	965	744
45-54 years	1,886	1,032	854
55-64 years	2,485	1,314	1,170
White	34,690	15,132	19,557
Black	3,968	1,684	2,284
All Other	2,344	1,090	1,254
Native American	150	68	83
Asian/Pacific	634	275	359
Hispanic	952	450	503
Other	607	298	309
Unknown Race	85	30	55

NOTES: Data as of July 1, 2003. Numbers may not add to totals because of rounding.

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

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
		In thousands	
Year			
1980	66.7	66.3	64.9
1990	172.0	170.6	163.7
1995	257.0	255.0	245.1
2000[1]	291.8	291.3	273.1
2001[1]	315.7	315.4	295.4
2002[1]	336.5	336.2	315.1
2003[1]	350.1	347.3	332.3
2004[1]	359.4	359.3	341.2

[1]Denominator File; estimated person years.

NOTE: Data as of July 1.

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

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	405.0
Age	
Under 35 years	27.8
35-44 years	39.8
45-64 years	155.3
65 years and over	182.1
Sex	
Male	223.3
Female	181.6
Race	
White	222.8
Other	180.5
Unknown	1.7

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2004.

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

Table 6
Medicare managed care

	Number of Plans	Enrollees (in thousands)
Total prepaid	340	5,740
Medicare Advantage	209	5,014
TEFRA Cost	29	322
Demos and/or PPOs	54	297
HCPPs Part B	15	96
PACE	33	11
Percent of total Medicare beneficiaries		13.6

NOTES: Data as of June 1, 2005. Percent of total Medicare beneficiaries based on average monthly enrollment during fiscal year 2005. Numbers may not add to totals because of rounding.

SOURCE: CMS, Center for Beneficiary Choices.

Table 7
Medicare enrollment/CMS region

	Resident population[1]	Medicare enrollees[2]	Enrollees as percent of population
	In thousands		
All regions	290,810	40,161	13.8
Boston	14,205	2,160	15.2
New York	27,828	3,983	14.3
Philadelphia	28,450	4,270	15.0
Atlanta	55,600	8,382	15.1
Chicago	50,897	7,191	14.1
Dallas	34,728	4,234	12.2
Kansas City	13,111	2,017	15.4
Denver	9,719	1,149	11.8
San Francisco	44,564	5,256	11.8
Seattle	11,706	1,514	12.9

[1]Estimated July 1, 2003 resident population.
[2]Medicare denominator enrollment file data are as of July 1, 2003.

NOTES: Resident population is a provisional estimate. The 2003 resident population data for Outlying Areas, Puerto Rico, and the Virgin Islands are not available.

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

Table 8
Social security population/projected[1]

	2000	2010	2020	2040	2060	2080
	In millions					
Total	291.0	318.1	342.6	377.8	400.2	421.6
Under 20	83.5	85.5	88.4	90.9	94.2	97.1
20-64	171.7	192.3	199.9	209.6	218.0	226.4
65 years and over	35.9	40.4	54.3	77.4	87.9	98.1

[1]As of July 1.

SOURCE: SSA, Office of the Actuary.

Table 9
Period life expectancy at age 65/trends

	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]	16.6	19.2
2020[1]	17.2	19.7
2030[1]	17.8	20.3
2040[1]	18.4	20.9
2050[1]	18.9	21.4
2060[1]	19.5	21.9
2070[1]	20.0	22.4
2080[1]	20.5	22.9

[1]Preliminary.

SOURCE: Social Security Administration, Office of the Actuary.

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

Calendar Year	All Races	White	Black
		At Birth	
1950	68.2	69.1	60.8
1980	73.7	74.4	68.1
1985	74.7	75.3	69.3
1990	75.4	76.1	69.1
1995	75.8	76.5	69.6
2002[1]	77.3	77.7	72.3
		At Age 65	
1950	13.9	NA	13.9
1980	16.4	16.5	15.1
1985	16.7	16.8	15.2
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2002[1]	18.2	18.2	16.6

[1]Preliminary.

SOURCE: Public Health Service, Health United States, 2004.

Table 11
Medicaid and SCHIP enrollment

	Fiscal year					
	1990	1995	2000	2003	2004	2005
	Average monthly enrollment in millions					
Total	22.9	33.4	34.8	42.0	43.7	44.7
Age 65 years and over	3.1	3.7	3.9	4.1	4.2	4.2
Blind/Disabled	3.8	5.8	6.8	7.5	7.7	7.7
Children	10.7	16.5	16.3	20.4	21.2	21.7
Adults	4.9	6.7	7.8	10.0	10.7	11.1
Other Title XIX	0.5	0.6	NA	NA	NA	NA
SCHIP	NA	NA	2.1	3.8	3.9	4.2
	Unduplicated annual enrollment in millions					
Total	NA	42.5	44.3	53.7	56.1	57.3
Age 65 years and over	NA	4.4	4.5	4.7	4.8	4.9
Blind/Disabled	NA	6.5	7.6	8.3	8.5	8.6
Children	NA	21.3	21.2	26.5	27.6	28.2
Adults	NA	9.4	11.0	14.1	15.1	15.6
Other Title XIX	NA	0.9	NA	NA	NA	NA
SCHIP	NA	NA	3.4	5.8	5.9	6.2

NOTES: Some totals for 1990 and later years may not equal the sum of categories because of rounding. Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty level recipients who are not disabled. Projections for fiscal years 2003-2005 were prepared by the Office of the Actuary for the President's 2006 budget.

In 1997, the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories. Medicaid data after 2001 exclude enrollees in outlying territories and possessions.

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

Table 12
Medicaid eligibles/demographics

	Fiscal year 2002 Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	51.5	100.0
Age	51.5	100.0
Under 21	27.8	54.0
21-64 years	18.0	35.0
65 years and over	5.5	10.8
Unknown	0.1	0.3
Sex	51.5	100.0
Male	20.7	40.2
Female	30.7	59.6
Unknown	0.3	0.3
Race	51.5	100.0
White, not Hispanic	22.5	43.6
Black, not Hispanic	12.2	23.8
Am. Indian/Alaskan Native	0.7	1.4
Asian	1.2	2.4
Hawaiian/Pacific Islander	0.6	1.2
Hispanic	10.8	21.0
Other	0.1	0.2
Unknown	3.4	6.5

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

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

Table 13
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	287,974	51,499	17.9
Boston	14,134	2,516	17.8
New York	27,709	5,123	18.5
Philadelphia	28,248	3,851	13.6
Atlanta	54,872	10,460	19.1
Chicago	50,660	7,698	15.2
Dallas	34,261	5,941	17.3
Kansas City	13,046	2,029	15.6
Denver	9,623	1,034	10.7
San Francisco	43,851	10,789	24.6
Seattle	11,571	2,059	17.8

[1]Estimated July 1, 2002 population. [2]Persons ever enrolled in Medicaid during fiscal year 2002.

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 14
Medicaid beneficiaries/State buy-ins for Medicare

	1975[1]	1980[1]	2002[2]	2003[2]
Type of Beneficiary	In thousands			
All buy-ins	2,846	2,954	5,991	6,326
Aged	2,483	2,449	3,832	4,014
Disabled	363	504	2,159	2,311
	Percent of SMI enrollees			
All buy-ins	12.0	10.9	15.1	16.4
Aged	11.4	10.0	11.3	12.1
Disabled	18.7	18.9	40.4	44.0

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

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

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

Providers/Suppliers

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

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

Table 15
Inpatient hospitals/trends

	1990	1995	2003	2004
Total hospitals	6,522	6,376	6,057	6,117
Beds in thousands	1,105	1,056	952	950
Beds per 1,000 enrollees[1]	32.8	28.4	23.4	22.9
Short-stay	5,549	5,252	4,101	3,951
Beds in thousands	970	926	827	821
Beds per 1,000 enrollees[1]	28.8	24.9	20.3	19.8
Psychiatric	674	682	478	470
Beds in thousands	99	86	57	56
Beds per 1,000 enrollees[1]	2.9	2.3	1.4	1.4
Other non-short-stay	299	442	1,478	1,696
Beds in thousands	35	45	67	73
Beds per 1,000 enrollees[1]	1.0	1.2	1.6	1.8

[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 16
Medicare assigned claims/CMS region

	Net assignment rates		
	2002	2003	2004
All regions	98.4	98.5	98.7
Boston	99.8	99.9	99.9
New York	98.4	98.7	98.8
Philadelphia	98.6	98.8	99.0
Atlanta	98.8	98.8	98.9
Chicago	98.1	98.1	98.3
Dallas	98.4	98.6	98.7
Kansas City	97.8	98.0	98.3
Denver	97.5	97.7	97.8
San Francisco	99.2	99.2	99.3
Seattle	92.1	99.4	95.2

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

Table 17
Medicare hospital and SNF/NF/ICF facility counts

Total hospitals	6,111
Short-term hospitals	3,874
Psychiatric units	1,339
Rehabilitation units	1,008
Swing bed units	680
Psychiatric	467
Long-term	363
Rehabilitation	217
Childrens	80
Religious non-medical	16
Critical access	1,094
Non-participating Hospitals	941
Emergency	556
Federal	385
All SNFs/SNF-NFs/NFs only	16,094
All skilled nursing facilities	14,980
SNFs	861
Hospital-based	443
Free-standing	418
SNF/NFs combination	14,119
Hospital-based	857
Free-standing	13,262
Title 19 only NFs	1,114
Hospital-based	158
Free-standing	956
All ICF-MR facilities	6,462

NOTES: The table is designed to give a "snapshot" as of the end of April 2005 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, CMM, CMSO, and ORDI.

Table 18
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	14,986	1,156	6,521
Boston	1,035	21	162
New York	1,016	2	687
Philadelphia	1,370	70	412
Atlanta	2,607	103	688
Chicago	3,265	289	1,507
Dallas	1,874	252	1,540
Kansas City	1,334	243	187
Denver	583	56	90
San Francisco	1,444	89	1,167
Seattle	450	31	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 2004.

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

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	2003	2004
Home health agencies	2,242	2,924	6,928	7,519
Clinical Lab Improvement Act Facilities	NA	NA	176,947	189,340
End stage renal disease facilities	NA	999	4,309	4,618
Outpatient physical therapy	117	419	2,961	2,971
Portable X-ray	132	216	641	608
Rural health clinics	NA	391	3,306	3,536
Comprehensive outpatient rehabilitation facilities	NA	NA	587	635
Ambulatory surgical centers	NA	NA	3,597	4,136
Hospices	NA	NA	2,323	2,645

NOTES: Facility data for selected years 1975-1980 are as of July 1. Facility data for 2003 and 2004 are as of December 31, respectively.

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

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,951	14,986	7,519
		Percent of total	
Non-profit	60.8	27.9	29.6
Proprietary	18.0	67.1	58.1
Government	21.2	5.0	12.3

NOTES: Data as of December 31, 2004. Facilities certified for Medicare are deemed to meet Medicaid standards. Percent distribution may not add to 100 percent due to rounding.

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

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	2001	2003	2004
Hospitals					
Number of PIP	2,276	3,242	754	657	626
Percent of total participating	33.8	48.3	12.5	10.9	10.8
Skilled nursing facilities					
Number of PIP	203	224	1,161	1,001	526
Percent of total participating	3.9	3.4	7.9	6.7	3.5
Home health agencies					
Number of PIP	481	931	42	44	46
Percent of total participating	16.0	16.0	0.1	0.1	0.1

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

SOURCE: CMS, Office of Financial Management.

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

	April 2005	
	Number	Percent
All Part B Practitioners	987,619	100.0
Physician Specialties	618,183	62.6
Primary Care	226,778	23.0
Medical Specialties	99,332	10.1
Surgical Specialties	102,689	10.4
Emergency Medicine	32,676	3.3
Anesthesiology	35,498	3.6
Radiology	34,867	3.5
Pathology	13,069	1.3
Obstetrics/Gynecology	36,464	3.7
Psychiatry	36,533	3.7
Other and Unknown	277	0.0
Limited Licensed Practitioners	117,034	11.9
Non-physician Practitioners	252,402	25.6

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

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

Table 23
Part B practitioners/CMS region

	Active practitioners (in thousands)	Practitioners per 100,000 population
All regions	[1]987.6	336
Boston	75.4	530
New York	124.6	391
Philadelphia	102.8	359
Atlanta	173.6	308
Chicago	166.8	326
Dallas	95.5	272
Kansas City	47.3	358
Denver	35.0	356
San Francisco	123.8	274
Seattle	42.8	361

[1]Non-Federal physicians only. Includes physicians, limited licensed and non-physician practitioners. Unknown provider states distributed.

NOTES: Physicians as of April 2005. Civilian population as of July 1, 2004.

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

Table 24
Inpatient hospitals/CMS region

	Short-stay hospitals	Beds per 1,000 enrollees	Non Short-stay facilities	Beds per 1,000 enrollees
All regions	3,951	19.8	2,166	3.1
Boston	168	14.9	96	5.0
New York	332	22.2	84	3.0
Philadelphia	357	18.5	159	3.4
Atlanta	816	19.9	322	2.5
Chicago	654	21.7	402	2.9
Dallas	645	22.8	403	4.6
Kansas City	235	21.8	270	4.4
Denver	159	18.5	185	5.0
San Francisco	465	15.5	134	1.4
Seattle	120	13.9	111	2.9

NOTES: Data as of December 31, 2004. Rates based on number of hospital insurance enrollees as of July 1, 2004.

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

Expenditures

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

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

Table 25
CMS and total Federal outlays

	Fiscal year 2003	Fiscal year 2004
	$ in billions	
Gross domestic product (current dollars)	$10,838.8	$11,552.8
Total Federal outlays[1]	2,159.9	2,292.2
Percent of gross domestic product	19.9	19.8
Dept. of Health and Human Services[1]	505.3	543.4
Percent of Federal Budget	23.4	23.7
CMS Budget (Federal Outlays)		
Medicare benefit payments	272.6	295.4
SMI transfer to Medicaid[2]	0.1	0.2
Medicaid benefit payments	152.8	168.3
Medicaid State and local admin.	8.0	8.1
Medicaid offsets[3]	-0.1	-0.2
State Children's Health Ins. Prog.	4.4	4.6
CMS program management	2.4	2.7
Other Medicare admin. expenses[4]	1.3	1.4
Quality improvement organizations[5]	0.4	0.4
Health Care Fraud and Abuse Control	1.0	1.1
State Grants and Demonstrations[6]	0.0	0.0
User Fees and Reimbursables	0.1	0.1
Total CMS outlays (unadjusted)	442.9	482.1
Offsetting receipts[7]	-28.5	-32.2
Total net CMS outlays	414.4	449.9
Percent of Federal budget	19.2	19.6

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($112.1 million in FY 2003 and $168.2 million in FY 2004).
[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]Grants and demonstrations under the Ticket to Work and Work Incentives Improvement Act (P.L. 106-170), the qualified high risk pools under the Trade Act of 2002 (P.L. 107-210), and for FY2004, the pilot background checks under the Medicare Modernization Act of 2003 (P.L. 108-173). Outlays for these programs amounted to $15million in FY 2003 and $48 million in FY 2004, and are included in total CMS outlays.
[7]Almost entirely Medicare premiums. Also includes offsetting collections for user fee and reimbursable activities.

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

SOURCE: CMS, Office of Financial Management.

Table 26
Program expenditures/trends

	Total	Medicare[1] in billions	Medicaid[2]	SCHIP[3]
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
2003	558.8	277.8	274.8	6.2
2004	605.2	301.1	297.5	6.6

[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) activity, Quality Improvement Organizations (QIOs), the SMI transfer to Medicaid for Medicare Part B premium assistance for low income Medicare beneficiaries and, beginning in 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 Medicare beneficiaries. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays. Please note that SCHIP-related Medicaid began to be financed under Title XXI in FY 2001.

SOURCE: CMS, Office of Financial Management.

Table 27
Benefit outlays by program

	1967	1968	2003	2004
Annually	Amounts in billions			
CMS program outlays	$5.1	$8.4	$504	$589
Federal outlays	NA	6.7	430	468
Medicare[1]	3.2	5.1	273	295
HI	2.5	3.7	151	164
SMI	0.7	1.4	122	131
Transitional Assistance[4]	NA	NA	NA	0
Medicaid[2]	1.9	3.3	261	287
Federal share	NA	1.6	153	168
SCHIP[3]	NA	NA	6	7
Federal share	NA	NA	4	5

[1]The Medicare benefit amounts reflect gross outlays (i.e., not net of offsetting premiums). These amounts exclude outlays for the SMI transfer to Medicaid for premium assistance and the Quality Improvement Organizations (QIOs). [2]The Medicaid amounts include total computable outlays (Federal and State shares) for benefits and outlays for the Vaccines for Children program. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays as reported by the States on line 4 of the CMS-21. Please note that SCHIP-related Medicaid expansions began to be financed under SCHIP (Title XXI) in FY 2001. [4]The Medicare Modernization Act of 2003 (P.L. 108-173) provided funds for transitional assistance to low-income beneficiaries under the transitional Prescription Drug Card program. Outlays for this benefit began in the third quarter of FY 2004, and totalled $216 million for that fiscal year.

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

SOURCE: CMS, Office of Financial Management.

Table 28
Program benefit payments/CMS region

	Fiscal year 2003 benefit payments	
	Medicaid	
	Total payments computable for Federal funding	Net expenditures reported Federal share[1]
	In millions	
All regions	$262,576	$153,424
Boston	16,022	8,732
New York	48,549	24,982
Philadelphia	24,292	13,854
Atlanta	44,201	29,100
Chicago	41,311	23,628
Dallas	26,491	17,692
Kansas City	10,768	6,769
Denver	5,498	3,427
San Francisco	36,133	19,798
Seattle	9,310	5,442

[1]Excludes CMS adjustments.

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

SOURCES: CMS, OFM, OACT, and CMSO.

Table 29
Medicare benefit outlays

	Fiscal year		
	2003	2004	2005
	In billions		
HI benefit payments	$153.1	$163.8	$178.9
Aged	132.4	141.3	154.2
Disabled	20.7	22.5	24.7
SMI benefit payments	119.5	131.4	146.0
Aged	100.5	109.9	121.7
Disabled	18.9	21.4	24.3

NOTES: Based on FY 2006 President's Budget. Benefit estimates do not reflect proposed legislation. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Office of the Actuary.

Table 30
Medicare/type of benefit

	Fiscal year 2005 benefit payments[1] in millions	Percent distribution
Total HI[2]	$178,889	100.0
Inpatient hospital	119,398	66.7
Skilled nursing facility	16,976	9.5
Home health agency[3]	6,152	3.4
Hospice	8,599	4.8
Managed care	27,764	15.5
Total SMI[2]	145,975	100.0
Physician/other suppliers	56,096	38.4
DME	8,136	5.6
Other carrier	14,731	10.1
Outpatient hospital	18,573	12.7
Home health agency[3]	6,370	4.4
Other intermediary	11,213	7.7
Laboratory	6,281	4.3
Managed care	24,573	16.8

[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 reflects the actual outlays as reported by the Treasury.

NOTES: Based on FY 2006 President's Budget. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, OACT and OFM

Table 31
National health care/trends

	Calendar year			
	1965	1980	2002	2003
National total in billions	$41.0	$245.8	$1,553.0	$1,678.9
Percent of GDP	5.7	8.8	14.9	15.3
Per capita amount	$205	$1,067	$5,440	$5,670
Source of funds	Percent of total			
Private	75.1	57.3	54.1	54.4
Public	24.9	42.7	45.9	45.6
Federal	11.4	29.0	32.5	32.3
State/local	13.5	13.6	13.4	13.3

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

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

Table 32
Medicaid/type of service

	Fiscal year		
	2001	2002	2003
	In billions		
Total medical assistance payments[1]	$216.2	$246.3	$262.6
	Percent of total		
Inpatient services	13.6	13.9	14.1
General hospitals	12.5	12.6	12.7
Mental hospitals	1.2	1.3	1.3
Nursing facility services	19.8	18.8	17.0
Intermediate care facility (MR) services	4.8	4.4	4.4
Community-based long term care svs.[2]	9.6	9.7	10.6
Prescribed drugs[3]	9.1	9.5	10.3
Physician services	3.6	3.6	3.7
Dental services	1.0	1.1	1.2
Outpatient hospital services	3.7	4.0	3.8
Clinic services[4]	2.8	2.9	2.8
Laboratory and radiological services	0.3	0.3	0.3
Early and periodic screening	0.4	0.4	0.4
Targeted case management services	0.9	1.0	1.1
Capitation payments (non-Medicare)	15.4	16.0	17.2
Medicare premiums	2.1	2.1	2.1
Disproportionate share hosp. payments	7.2	6.2	4.9
Other services	5.0	5.1	5.8
Adjustments[5]	0.6	0.9	0.3

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

SOURCES: CMS, CMSO, and OACT.

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

	Workers Comp.	Working Aged	ESRD	Auto	Disability	Total
2002	106.2	1,942.7	199.5	296.5	1,508.5	4,278.5
2003	122.2	2,146.7	206.1	273.9	1,604.1	4,593.3
2004	113.3	2,296.8	232.7	265.2	1,640.4	4,829.0

NOTES: Fiscal year data. In millions of dollars. FYs 2002 through 2004 totals include liability amounts of $225.0, $240.3, and $280.6 million, respectively.

SOURCE: CMS, OFM.

Table 34
Medicaid/payments by eligibility status

	Fiscal year 2003 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$262.6	100.0
Age 65 years and over	63.8	24.3
Blind/disabled	110.5	42.1
Dependent children under 21 years of age	43.4	16.5
Adults in families with dependent children	30.4	11.6
DSH and other unallocated	14.6	5.5

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

SOURCE: CMS, Office of the Actuary.

Table 35
Medicare/DME/POS[1]

Category	Allowed Charges[2]	
	2002	2003
	In thousands	
Total	$8,270,229	$9,823,217
Medical/surgical supplies	1,108,461	1,238,970
Hospital beds	485,890	529,103
Oxygen and supplies	2,206,641	2,435,365
Wheelchairs	1,421,244	1,842,963
Prosthetic/orthotic devices	1,111,417	1,379,186
Drugs admin. through DME	1,082,507	1,351,581
Other DME	854,068	1,046,049

[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.

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

Table 36
National health care/type of expenditure

	National total in billions	Per capita amount	Percent Paid: Total	Medicare	Medicaid
Total	$1,678.9	$5,670	32.8	16.9	15.9
Health serv/suppl.	1,614.2	5,452	34.1	17.5	16.5
Personal health care	1,440.8	4,866	36.3	19.1	17.3
Hospital care	515.9	1,742	47.2	30.3	16.9
Prof. services	542.0	1,831	27.2	14.9	12.3
Phys./clinical	369.7	1,249	27.0	19.9	7.1
Nursing/home hlth.	150.8	509	58.1	17.6	40.4
Retail outlet sales	232.1	784	19.3	4.8	14.5
Admn. and pub. hlth.	173.5	586	15.3	4.7	10.6
Investment	64.6	218	--	--	--

NOTES: Data are as of calendar year 2003.

SOURCE: CMS, Office of the Actuary.

Table 37
Personal health care/payment source

	Calendar year 1970	1980	2002	2003
		In billions		
Total	$63.2	$214.6	$1,235.5	$1,440.8
		Percent		
Total	100.0	100.0	100.0	100.0
Private funds	64.8	59.7	56.2	56.2
Private health insurance	22.3	28.3	35.4	36.0
Out-of-pocket	39.7	27.1	16.3	16.0
Other private	2.8	4.3	4.4	4.2
Public funds	35.2	40.3	43.8	43.8
Federal	22.9	29.3	33.5	33.3
State and local	12.3	11.1	10.3	10.5

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

SOURCE: CMS, Office of the Actuary.

Utilization

Information about the use of health care services

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

Table 38
Medicare/short-stay hospital utilization

	1985	1990	2002	2003
Discharges				
Total in millions	10.5	10.5	12.5	12.7
Rate per 1,000 enrollees[1]	347	313	314	315
Days of care				
Total in millions	92	94	74	74
Rate per 1,000 enrollees[1]	3,016	2,805	1,860	1,845
Average length of stay				
All short-stay	8.7	9.0	5.9	5.9
Excluded units[2]	18.8	19.5	11.7	11.5
Total charges per day	$597	$1,060	$3,506	$4,033

[1]The population base is HI enrollment excluding HI enrollees residing in foreign countries. [2]Includes alcohol/drug, psychiatric, and rehabilitation units through 1990, and psychiatric and rehabilitation units for 2002 and 2003.

NOTES: Data may reflect under reporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; and no-pay Medicare secondary payer bills. Average length of stay data are shown in days. The data for 1990 through 2003 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with different update cycle.

SOURCE: CMS, Office of Information Services.

Table 39
Medicare long-term care/trends

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

[1]Managed care enrollees excluded in determining rate.

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

Table 40
Medicare average length of stay/trends

	Fiscal year					
	1984	1990	1995	2000	2002	2003
All short-stay hospitals	9.1	9.0	7.1	6.0	5.9	5.9
PPS hospitals	8.0	8.9	7.1	6.0	5.9	5.9
Excluded units	18.0	19.5	14.8	12.3	11.7	11.5

NOTES: Fiscal year data. Average length of stay is shown in days. For all short-stay and PPS hospitals, 1984 data are based on a 20-percent sample of Medicare HI enrollees. Data for 1990 through 2003 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different update cycle.

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

Table 41
Medicare persons served/trends

	Calendar year				
	1975	1980	1985	2000	2002
Aged persons served per 1,000 enrollees					
HI and/or SMI	528	638	722	916	918
HI	221	240	219	232	232
SMI	536	652	739	965	968
Disabled persons served per 1,000 enrollees					
HI and/or SMI	450	594	669	835	851
HI	219	246	228	196	202
SMI	471	634	715	943	963

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

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

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

	Calendar year				
	1998	1999	2000	2001	2002
	Numbers in millions				
HI					
Aged					
FFS Enrollees	27.3	27.0	27.4	28.3	29.1
Persons served	6.7	6.3	6.4	6.6	6.7
Rate per 1,000	243	232	232	233	232
Disabled					
FFS Enrollees	4.6	4.7	4.9	5.2	5.4
Persons served	1.0	0.9	1.0	1.0	1.1
Rate per 1,000	206	198	196	199	202
SMI					
Aged					
FFS Enrollees	26.2	25.9	26.2	27.0	27.8
Persons served	25.3	25.0	25.3	26.1	26.9
Rate per 1,000	964	966	965	968	968
Disabled					
FFS Enrollees	4.1	4.2	4.3	4.5	4.8
Persons served	3.8	3.9	4.1	4.3	4.6
Rate per 1,000	925	936	943	952	963

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

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

Table 43
Medicare persons served/CMS region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	27,117	918	4,637	851
Boston	1,411	912	242	832
New York[2]	2,626	914	412	834
Philadelphia	2,875	924	460	847
Atlanta	5,801	944	1,187	894
Chicago	5,359	947	794	864
Dallas	2,957	919	518	876
Kansas City	1,494	956	231	895
Denver	800	946	115	833
San Francisco[3]	2,540	890	428	791
Seattle	926	941	154	842

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

NOTES: Data as of calendar year 2002 for persons served under HI and/or SMI. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

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

Table 44
Medicare/end stage renal disease (ESRD)

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

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

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

Table 45
Medicaid/type of service

	Fiscal year 2002 Medicaid beneficiaries
	In thousands
Total eligibles	51,499
Number using service:	
Total beneficiaries, any service[1]	45,777
Inpatient services	
General hospitals	4,744
Mental hospitals	96
Nursing facility services[2]	1,497
Intermediate care facility (MR) services[3]	115
Physician services	20,996
Dental services	7,679
Other practitioner services	5,459
Outpatient hospital services	14,193
Clinic services	9,125
Laboratory and radiological services	13,415
Home health services	1,035
Prescribed drugs	23,909
Personal care support services	5,511
Sterilization services	145
PCCM services	6,917
Capitated payment services	24,507
Other care	10,600

[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 all categories of ICF, other than "MR". [3]"MR" indicates mentally retarded.

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

SOURCE: CMS, Center for Medicaid and State Operations.

Table 46
Medicaid/units of service

	Fiscal year 2002 units of service
	In thousands
Inpatient hospital	
Total discharges	9,205
Beneficiaries discharged	5,046
Total days of care	35,006
Nursing facility	
Total days of care	476,358
Intermediate care facility/mentally retarded	
Total days of care	48,592

NOTES: Data are derived from the MSIS 2002 State Summary Mart. 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 47
Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1967	$89	3.5
1970	149	3.1
1975	259	2.5
1980	497	2.1
1985	813	1.7
1990	774	1.2
1995	1,300	1.1
2000	[1]2,350	1.8
2003	[1]2,542	1.7
2004	[1]3,033	1.8
SMI Trust Fund		
1967	[2]135	20.3
1970	217	11.0
1975	405	10.8
1980	593	5.8
1985	922	4.2
1990	1,524	3.7
1995	1,722	2.7
2000	1,780	2.0
2003	2,356	1.9
2004	2,686	2.0

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

NOTE: Fiscal year data.

SOURCE: CMS, Office of the Actuary.

Table 48
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	23	15
Other	2	5

NOTE: Data as of May 2005.

SOURCE: CMS, Office of Financial Management.

Table 49
Medicare appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	22,073	3,107,750
Percent with increased payments[1]	32.9	68.2

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 2004.

SOURCE: CMS, Office of Financial Management.

Table 50
Medicare physician/supplier claims assignment rates

	2000	2001	2002	2003
	in thousands			
Claims total	720.5	766.8	822.0	860.7
Claims assigned	615.9	665.2	722.8	759.8
Claims unassigned	12.8	12.1	11.4	11.1
Percent assigned	85.5	86.8	88.0	88.3

SOURCE: CMS, Office of Financial Management

Table 51
Medicare claims processing

	Intermediaries	Carriers
Claims processed in millions	179.2	949.7
Total PM costs in millions	$388.4	$1,137.6
Total MIP costs in millions	$449.0	$263.2
Claims processing costs in millions	$243.7	$780.1
Claims processing unit costs	$0.88	$0.55
Range		
High	$1.64	$1.28
Low	$0.73	$0.60

NOTES: Data for fiscal year 2004. PM= Program Management. MIP= Medicare Integrity Program. Beginning in FY 2002, provider enrollment has been removed from the claims processing costs and unit costs.

SOURCE: CMS, Office of Financial Management.

Table 52
Medicare claims received

	Claims received
Intermediary claims received in thousands	181,141
	Percent of total
Inpatient hospital	8.7
Outpatient hospital	47.9
Home health agency	6.4
Skilled nursing facility	2.6
Other	34.3
Carrier claims received in thousands	922,197
	Percent of total
Assigned	98.7
Unassigned	1.3

NOTE: Data for calendar year 2004.

SOURCE: CMS, Office of Financial Management.

Table 53
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	781.0	10.0
Percent reduced	89.8	83.0
Total covered charges		
Amount in millions	$208,027	$1,009
Percent reduced	52.9	16.3
Amount reduced per claim	$156.95	$19.83

NOTES: Data for calendar year 2004. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Office of Financial Management.

Table 54
Medicaid administration

	Fiscal year	
	2002	2003
	In thousands	
Total payments computable for Federal funding[1]	$11,931,761	$13,583,787
Federal share[1]		
Family planning	$24,246	$31,627
Design, development or installation of MMIS[2]	248,448	470,462
Skilled professional medical personnel	370,312	366,951
Operation of an approved MMIS[2]	1,006,146	1,071,169
Other financial participation	4,875,267	5,576,621
Mechanized systems not approved under MMIS[2]	76,930	84,876
Total administration	$6,601,349	$7,601,706
Net adjusted Federal share[3]	$6,976,026	$7,579,625

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

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

Reference

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

Program financing

Medicare/source of income

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

*Contribution rate	2003	2004	2005
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2005) None[1]

Voluntary HI Premium[2]

Monthly Premium (CY 2005): $375

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

Part B Premium

Monthly Basic Premium (CY 2005): $78.20

Medicaid/financing

1. Federal contributions (ranging from 50 to 77.08 percent for fiscal year 2005)
2. State contributions (ranging from 22.92 to 50 percent for fiscal year 2005)

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

SOURCE: CMS, Office of the Actuary.

Medicare deductible and coinsurance amounts

Part A (effective date)	Amount
Inpatient hospital deductible (1/1/05)	$912/benefit period
Regular coinsurance days (1/1/05)	$228/day for 61st thru 90th day
Lifetime reserve days (1/1/05)	$456/day (60 nonrenewable days)
SNF coinsurance days (1/1/05)	$114.00/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/05)	$375/month $206/month if have at least 30 quarters of coverage
Limitations:	
Inpatient psychiatric hospital days	190 nonrenewable days
Part B (effective date)	**Amount**
Deductible (1/1/05)[1]	$110 in reasonable charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Premium (1/1/05)	$78.20/month
Limitations:	
Outpatient treatment for mental illness	No limitations

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

SOURCE: CMS, Office of the Actuary.

Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2005

	Region	FMAP
I.	**Boston**	**FMAP**
	Connecticut	50
	Maine	65
	Massachusetts	50
	New Hampshire	50
	Rhode Island	55
	Vermont	60
II.	**New York**	**FMAP**
	New Jersey	50
	New York	50
	Puerto Rico	50
	Virgin Islands	50
	Canada	--
III.	**Philadelphia**	
	Delaware	50
	Dist. of Columbia	70
	Maryland	50
	Pennsylvania	54
	Virginia	50
	West Virginia	75
IV.	**Atlanta**	
	Alabama	71
	Florida	59
	Georgia	60
	Kentucky	70
	Mississippi	77
	North Carolina	64
	South Carolina	70
	Tennessee	65
V.	**Chicago**	
	Illinois	50
	Indiana	63
	Michigan	57
	Minnesota	50
	Ohio	60
	Wisconsin	58
VI.	**Dallas**	
	Arkansas	75
	Louisiana	71
	New Mexico	74
	Oklahoma	70
	Texas	61
VII.	**Kansas City**	
	Iowa	64
	Kansas	61
	Missouri	61
	Nebraska	60
VIII.	**Denver**	
	Colorado	50
	Montana	72
	North Dakota	67
	South Dakota	66
	Utah	72
	Wyoming	58
IX.	**San Francisco**	
	Arizona	67
	California	50
	Hawaii	58
	Nevada	56
	American Samoa	50
	Guam	50
	N. Mariana Islands	50
X.	**Seattle**	
	Alaska	58
	Idaho	71
	Oregon	61
	Washington	50

SOURCE: CMS, Center for Medicaid and State Operations.