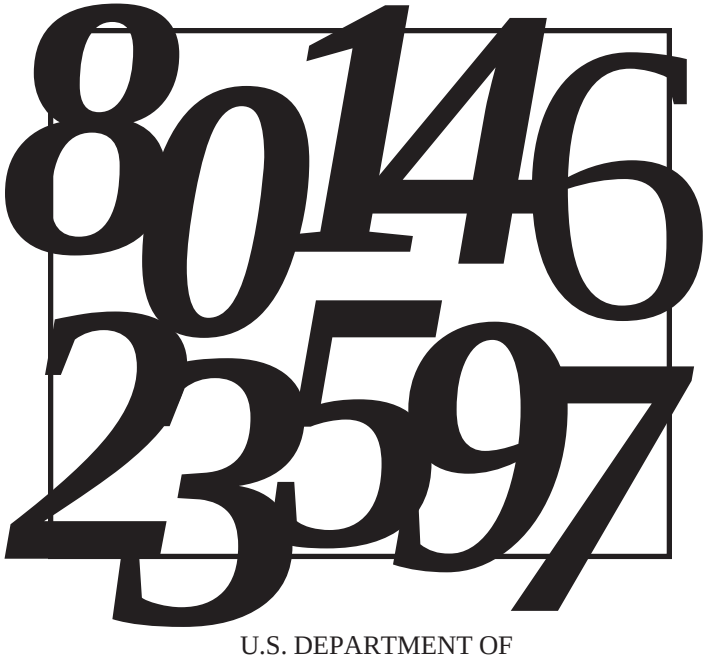
2009 CMS Statistics



U.S. DEPARTMENT OF
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. 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

CMM	**Center for Medicare Management**
CMS	**Centers for Medicare & Medicaid Services**
CMSO	**Center for Medicaid and State Operations**
OACT	**Office of the Actuary**
ORDI	**Office of Research, Development, and Information**
SSA	**Social Security Administration**

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Research, Development, and Information
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Highlights

Growth in CMS programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 45.9 million in 2009, a 140 percent increase.
- On average, the number of Medicaid monthly enrollees in 2009 is estimated to be about 51.1 million, the largest group being children (24.9 million or 48.7 percent).
- In 2006, about 20.1 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 410.6 thousand in 2008, an increase of 516 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 7.5 million beneficiaries in 2008, an increase of about 168 percent.

- By 2009, nearly 26.8 million Medicare enrollees had Part D drug coverage, 58.1 percent of all enrollees, and an additional 6.4 million had RDS.
- About 8.0 million persons were dually eligible for both Medicare and Medicaid as of July 1, 2007.
- As of March 2009, the proportion of female Medicare Part D enrollees aged 85 years and over was 14.4 percent, nearly double that of the 7.6 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 6,171 in December 2008. Total inpatient hospital beds have dropped from 46.5 beds per 1,000 enrolled in 1975 to 20.6 in 2008, a decrease of 56 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 792,000. (NOTE: This includes a reclassification of some short-stay hospitals as critical access hospitals. There were about 30,000 critical access hospital beds in 2008.)
- 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 9,407 in 2008.

Expenditures

- National health expenditures (NHE) were $2,241.2 billion in 2007, comprising 16.2 percent of the gross domestic product (GDP). Comparably, NHE amounted to $1,973.3 billion, or 15.9 percent of the GDP in 2005.
- In 2008, total net Federal outlays for CMS programs were $599.5 billion, 20.1 percent of the Federal budget.
- Medicare skilled nursing facility benefit payments increased from $22.6 billion in 2008 to about $25.5 billion in 2009.
- Medicare home health agency benefit payments increased slightly between 2008 and 2009 from $16.4 billion to $17.3 billion.
- National health expenditures per person were $211 in 1965 and grew steadily to reach $7,421 by 2007.

Utilization of Medicare and Medicaid services

- Between 1990 and 2007, the number of short-stay hospital discharges increased from 10.5 million to 12.3 million, an increase of 17 percent.
- The PPS short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.3 days in 2007, a decrease of 41 percent.

Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 11.8 days in 2007, a decrease of 39 percent.

- About 32.4 million persons received a reimbursed service under Medicare fee-for-service during 2007. Comparably, almost 57.5 million persons used Medicaid services or had a premium paid on their behalf in 2006.
- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 921 per 1,000 enrolled in 2007.
- 7.3 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2007.
- 31.5 million persons received reimbursable fee-for-service physician services under Medicare during 2007. 23.1 million persons received reimbursable physician services under Medicaid during 2006.
- 23.6 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2007. During 2006, 15.8 million persons received Medicaid reimbursable outpatient hospital services.
- Over 1.8 million persons received care in SNFs covered by Medicare during 2007. 1.7 million persons received care in nursing facilities, which include SNFs and all other nursing facilities other than mentally retarded, covered by Medicaid during 2006.
- Over 27 million persons received prescribed drugs under Medicaid during 2006.

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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
July		In millions	
1966	19.1	19.1	--
1970	20.4	20.4	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
Average monthly			
2000	39.7	34.3	5.4
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

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 2000-2009 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on FY 2010 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	45.7	45.4	42.3	32.9	42.0	3.4	0.4
Aged persons	38.2	37.9	35.7	--	35.3	2.6	0.4
Disabled persons	7.5	7.5	6.7	--	6.7	0.8	0.0

NOTES: Projected average monthly enrollment during fiscal year 2009. Aged/disabled split of Part D enrollment not available. Based on FY 2010 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	45,412	20,212	25,200
Aged	37,896	16,254	21,642
65-74 years	19,884	9,280	10,605
75-84 years	12,744	5,298	7,446
85 years and over	5,268	1,677	3,591
Disabled	7,516	3,957	3,559
Under 45 years	1,825	985	840
45-54 years	2,352	1,238	1,115
55-64 years	3,338	1,734	1,604
White	37,778	16,825	20,953
Black	4,585	1,961	2,624
All Other	2,979	1,399	1,580
Native American	194	87	107
Asian/Pacific	848	367	480
Hispanic	1,121	525	596
Other	816	420	396
Unknown Race	71	27	44

NOTES: Data as of July 1, 2008. 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	26,752	10,862	15,890
Aged			
65-74 years	11,014	4,694	6,320
75-84 years	7,333	2,699	4,634
85 years and over	3,110	829	2,281
Disabled			
Under 45 years	1,457	779	678
45-54 years	1,681	869	811
55-64 years	2,157	990	1,166

NOTES: Data as of March 2009, as recorded in MIIR. 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

	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
2005[1]	371.2	371.1	351.9
2006[1]	385.4	385.2	365.0
2007[1]	395.8	395.7	374.9
2008[1]	410.6	410.5	388.9

[1]Denominator File; estimated person years.

NOTES: Data prior to 2000 are as of July 1; estimated person years 2000-2008.

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	458.4
Age	
Under 35 years	26.9
35-44 years	42.0
45-64 years	181.9
65 years and over	207.6
Sex	
Male	258.1
Female	200.3
Race	
White	247.1
Other	208.8
Unknown	2.5

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2008.

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]	752	1,662	9,300	10,962
Local CCPs	545	423	7,326	7,749
PFFS	69	1,005	1,389	2,394
Demos	15	1	4	5
1876 Cost	22	101	186	286
1833 Cost (HCPP)	12	67	--	67
PACE	66	--	16	16
Other plans[2]	24	65	379	444
Total PDPs[1]	96	--	17,448	17,448
Total	848	1,662	26,748	28,409

[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, RPPOs, and RFB-PFFS.

NOTE: Data as of April 2009.

SOURCE: CMS, Center for Drug and Health Plan Choice.

Table I.8

Medicare enrollment/CMS region

	Resident population[1]	Medicare enrollees[2]	Enrollees as percent of population
	In thousands		
All regions	304,060	44,385	14.6
Boston	14,304	2,315	16.2
New York	28,173	4,174	14.8
Philadelphia	29,130	4,634	15.9
Atlanta	59,801	9,514	15.9
Chicago	51,616	7,782	15.1
Dallas	37,220	4,840	13.0
Kansas City	13,500	2,162	16.0
Denver	10,622	1,319	12.4
San Francisco	47,145	5,886	12.5
Seattle	12,549	1,761	14.0

[1]Estimated July 1, 2008 resident population. [2]Medicare enrollment file data are as of July 1, 2008. 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	45,412	35,320	10,092
Boston	2,315	1,954	361
New York	4,825	3,534	1,291
Philadelphia	4,634	3,536	1,098
Atlanta	9,514	7,675	1,838
Chicago	7,782	6,215	1,567
Dallas	4,840	4,022	817
Kansas City	2,162	1,855	306
Denver	1,319	1,011	307
San Francisco	5,901	3,887	2,014
Seattle	1,761	1,274	487

NOTES: Data as of July 1, 2008. 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]	46,044	26,752	58.1
Boston	2,336	1,323	56.6
New York	4,876	2,784	57.1
Philadelphia	4,688	2,616	55.8
Atlanta	9,654	5,702	59.1
Chicago	7,870	4,289	54.5
Dallas	4,927	2,856	58.0
Kansas City	2,183	1,373	62.9
Denver	1,342	789	58.8
San Francisco	6,007	3,998	66.5
Seattle	1,795	1,007	56.1

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

NOTE: Data as of March 2009, as recorded in MIIR.

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]	26,752	17,470	9,282
Boston	1,323	969	354
New York	2,784	1,559	1,226
Philadelphia	2,616	1,694	922
Atlanta	5,702	3,921	1,781
Chicago	4,289	3,027	1,262
Dallas	2,856	2,064	791
Kansas City	1,373	1,088	285
Denver	789	511	278
San Francisco	3,998	2,008	1,989
Seattle	1,007	623	384

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

NOTES: Data as of March 2009, as recorded in MIIR.

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]	33,192	26,752	6,440
Boston	1,708	1,323	385
New York	3,618	2,784	834
Philadelphia	3,243	2,616	628
Atlanta	6,968	5,702	1,266
Chicago	5,872	4,289	1,584
Dallas	3,466	2,856	610
Kansas City	1,587	1,373	214
Denver	930	789	141
San Francisco	4,574	3,998	577
Seattle	1,210	1,007	203

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

NOTES: Data as of March 2009, as recorded in MIIR.

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	77.0	77.6	71.9
2004	77.8	78.3	73.1
2005	77.8	78.3	73.2
		At Age 65	
1950	13.9	NA	13.9
1980	16.4	16.5	15.1
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2000	18.0	18.0	16.2
2004	18.7	18.7	17.1
2005	18.7	18.8	17.2

SOURCE: Public Health Service, Health United States, 2008.

Table I.16
Medicaid and CHIP enrollment

	Fiscal year					
	1990	1995	2000	2005	2008	2009
	Average monthly enrollment in millions					
Total	22.9	34.2	34.5	46.5	48.2	51.1
Age 65 years and over	3.1	3.7	3.7	4.6	4.6	4.7
Blind/Disabled	3.8	5.8	6.7	8.1	8.3	8.6
Children	10.7	16.5	16.2	22.3	23.3	24.9
Adults	4.9	6.7	6.9	10.6	11.0	11.9
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	5.1	5.9
	Unduplicated annual enrollment in millions					
Total	NA	43.3	44.3	58.4	61.3	65.2
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	9.3	9.5
Children	NA	21.3	21.1	28.1	29.3	31.3
Adults	NA	9.4	10.5	15.1	16.2	17.5
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	7.9	9.2

[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 2010 Budget. Enrollment for Territories for FY 2000 and later is estimated. Numbers may not add to totals because of rounding.

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

Table I.17
Medicaid eligibles/demographics

	Fiscal year 2006 Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	59.6	100.0
Age	59.6	100.0
Under 21	32.3	54.2
21-64 years	21.1	35.4
65 years and over	6.1	10.2
Unknown	0.1	0.2
Sex	59.6	100.0
Male	24.2	40.6
Female	35.3	59.3
Unknown	0.1	0.1
Race	59.6	100.0
White, not Hispanic	25.0	41.9
Black, not Hispanic	13.8	23.1
Am. Indian/Alaskan Native	0.8	1.3
Asian	1.7	2.8
Hawaiian/Pacific Islander	0.6	1.0
Hispanic	14.2	23.9
Other	0.1	0.2
Unknown	3.4	5.7

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

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

Table 1.18
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	298,363	59,906	20.1
Boston	14,233	2,623	18.4
New York	28,007	6,161	22.0
Philadelphia	28,861	4,587	15.9
Atlanta	58,260	11,650	20.0
Chicago	51,308	9,435	18.4
Dallas	35,921	7,326	20.4
Kansas City	13,316	2,232	16.8
Denver	10,218	1,251	12.2
San Francisco	46,059	12,554	27.3
Seattle	12,179	2,087	17.1

[1]Estimated July 1, 2006 population.
[2]Persons ever enrolled in Medicaid during fiscal year 2006. Includes fiscal year 2004 enrollment for Maine.

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]	2008[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	7,514
Aged	2,483	2,449	3,632	4,491
Disabled	363	504	1,917	3,023
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	17.9
Aged	11.4	10.0	11.1	12.7
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	2007	2008
Total hospitals	6,522	5,985	6,163	6,171
Beds in thousands	1,105	991	934	930
Beds per 1,000 enrollees[1]	32.8	25.3	21.3	20.6
Short-stay	5,549	4,900	3,675	3,658
Beds in thousands	970	873	797	792
Beds per 1,000 enrollees[1]	28.8	22.3	18.1	17.6
Critical access hospitals	NA	NA	1,288	1,302
Beds in thousands	---	---	30	30
Beds per 1,000 enrollees[1]	---	---	0.7	0.7
Other non-short-stay	973	1,085	1,200	1,211
Beds in thousands	135	118	108	108
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		
	2006	2007	2008
All regions	99.0	99.1	99.2
Boston	([1])	([1])	([1])
New York	98.8	99.0	99.1
Philadelphia	99.4	99.7	99.7
Atlanta	99.1	99.3	99.3
Chicago	98.7	98.9	99.0
Dallas	99.1	99.2	99.5
Kansas City	98.8	99.0	99.1
Denver	98.3	99.0	99.2
San Francisco	99.3	99.4	99.5
Seattle	97.2	96.2	96.6

[1] No carriers in the Boston region.

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

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

Total participating hospitals	6,167
Short-term hospitals	3,637
Psychiatric units	1,230
Rehabilitation units	969
Swing bed units	551
Psychiatric	495
Long-term	411
Rehabilitation	224
Childrens	78
Religious non-medical	16
Critical access	1,306
Non-participating Hospitals	756
Emergency	406
Federal	350
All SNFs/SNF-NFs/NFs only	15,732
All SNFs/SNF-NFs	15,051
Title 18 Only SNF	798
Hospital-based	312
Free-standing	486
Title 18/19 SNF/NF	14,253
Hospital-based	718
Free-standing	13,535
Title 19 only NFs	681
Hospital-based	130
Free-standing	551
All ICF-MR facilities	6,446

NOTES: The table is designed to give a "snapshot" as of April 2009 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 II.4
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	15,032	695	6,435
Boston	976	13	151
New York	1,018	2	572
Philadelphia	1,373	42	405
Atlanta	2,608	64	646
Chicago	3,310	154	1,520
Dallas	1,942	109	1,567
Kansas City	1,366	169	195
Denver	582	45	89
San Francisco	1,413	72	1,210
Seattle	444	25	80

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

NOTE: Data as of December 2008.

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

Table II.5
Other Medicare providers and suppliers/trends

	1975	1980	2007	2008
Home health agencies	2,242	2,924	9,024	9,407
Independent and Clinical Lab Improvement Act Facilities	NA	NA	206,065	210,872
End stage renal disease facilities	NA	999	5,095	5,317
Outpatient physical therapy and/or speech patholgy	117	419	2,915	2,781
Portable X-ray	132	216	550	547
Rural health clinics	NA	391	3,781	3,757
Comprehensive outpatient rehabilitation facilities	NA	NA	539	476
Ambulatory surgical centers	NA	NA	4,964	5,174
Hospices	NA	NA	3,255	3,346

NOTES: Facility data for selected years 1975 and 1980 are as of July 1. Facility data for 2007 and 2008 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	3,658	15,032	9,407
		Percent of total	
Non-profit	60.2	26.4	21.5
Proprietary	20.2	68.1	69.5
Government	19.6	5.5	9.0

NOTES: Data as of December 31, 2008. 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	2007	2008
Hospitals					
Number of PIP	2,276	1,352	869	565	620
Percent of total participating	33.8	20.6	14.4	9.1	10.0
Skilled nursing facilities					
Number of PIP	203	774	1,236	462	747
Percent of total participating	3.9	7.3	8.3	3.1	5.0
Home health agencies					
Number of PIP	481	1,211	1,038	85	86
Percent of total participating	16.0	21.0	14.4	0.9	0.9

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
Part B practitioners active in patient care/selected years

	July 2007	
	Number	Percent
All Part B Practitioners	1,087,845	100.0
Physician Specialties	667,340	61.3
Primary Care	246,314	22.6
Medical Specialties	108,694	10.0
Surgical Specialties	108,031	9.9
Emergency Medicine	36,644	3.4
Anesthesiology	38,358	3.5
Radiology	37,595	3.5
Pathology	13,984	1.3
Obstetrics/Gynecology	38,515	3.5
Psychiatry	38,921	3.6
Other and Unknown	284	0.0
Limited Licensed Practitioners	126,006	11.6
Non-physician Practitioners	294,499	27.1

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

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

Table II.9
Part B practitioners/CMS region

	Active practitioners	Practitioners per 100,000 population
All regions	1,245,003[1]	413
Boston	96,484	676
New York	147,395	527
Philadelphia	133,101	459
Atlanta	221,727	374
Chicago	211,442	410
Dallas	118,319	323
Kansas City	62,890	469
Denver	46,248	444
San Francisco	151,680	325
Seattle	55,717	449

[1]Includes non-Federal physicians, limited licensed, and non-physician practitioners. Practitioners with multi-State practices are duplicated in the enumeration for each State in which they operate.

NOTES: Physicians as of July 2007. Civilian population as of July 1, 2007. Resident population for outlying areas and the Virgin Islands are not available.

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

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	4,960	18.2	1,211	2.4
Boston	190	19.1	69	4.6
New York	326	19.7	74	2.6
Philadelphia	370	16.0	134	2.9
Atlanta	928	18.8	213	2.0
Chicago	876	19.8	182	1.9
Dallas	779	20.5	313	3.8
Kansas City	467	22.4	56	2.0
Denver	313	19.3	41	2.7
San Francisco	499	16.4	106	1.7
Seattle	212	13.8	24	1.4

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2008. Rates based on number of hospital insurance enrollees as of July 1, 2008, 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 2007	Fiscal year 2008
	$ in billions	
Gross domestic product (current dollars)	$13,642.3	$14,222.3
Total Federal outlays[1]	2,728.9	2,982.9
Percent of gross domestic product	20.0%	21.0%
Dept. of Health and Human Services[1]	672.0	700.5
Percent of Federal Budget	24.6%	23.5%
CMS Budget (Federal Outlays)		
Medicare benefit payments	434.6	454.3
SMI transfer to Medicaid[2]	0.4	0.4
Medicaid benefit payments	181.1	191.5
Medicaid State and local admin.	9.5	9.9
Medicaid offsets[3]	-0.4	-0.4
Children's Health Ins. Prog.	6.0	6.9
CMS program management	2.9	3.1
Other Medicare admin. expenses[4]	1.9	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	1.0	1.1
State Grants and Demonstrations[6]	1.3	0.4
User Fees and Reimbursables	0.2	0.6
Total CMS outlays (unadjusted)	638.9	670.3
Offsetting receipts[7]	-65.6	-70.8
Total net CMS outlays	573.3	599.5
Percent of Federal budget	21.0%	20.1%

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($358.7 million in FY 2007 and $396.6 million in FY 2008).
[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), the qualified high risk pools under the Trade Act of 2002 (P.L. 107-210), and emergency health services for undocumented aliens (P.L. 108-173). Outlays for these previously small programs had risen to the $1 billion range by FY 2007, primarily reflecting Katrina hurricane relief outlays.
[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
2008	822.8	460.9	351.8	10.0

[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 FY 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	2008
Annually		Amounts in billions		
CMS program outlays	$5.1	$8.4	$642	$797
Federal outlays	NA	6.7	512	652
Medicare[1]	3.2	5.1	333	454
HI	2.5	3.7	183	223
SMI	0.7	1.4	150	186
Transitional Assistance[2]	NA	NA	1	0
Prescription (Part D)	NA	NA	NA	44
Medicaid[3]	1.9	3.3	302	334
Federal share	NA	1.6	173	192
CHIP[4]	NA	NA	7	10
Federal share	NA	NA	5	7

[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. Its FY 2008 benefit outlays for payment adjustments totalled $42 thousand.
[3]The Medicaid amounts include total computable outlays (Federal and State shares) for 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 2007 Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$315,772	$179,980
Boston	20,271	10,556
New York	53,328	26,734
Philadelphia	30,619	16,832
Atlanta	52,671	34,063
Chicago	50,827	28,336
Dallas	34,436	22,407
Kansas City	12,598	7,712
Denver	6,546	3,890
San Francisco	43,876	23,414
Seattle	10,599	6,036

[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		
	2007	2008	2009
	In billions		
Part A benefit payments	$204.0	$217.8	$236.8
Aged	172.9	184.3	200.1
Disabled	31.1	33.5	36.7
Part B benefit payments	172.7	183.3	195.9
Aged	143.0	151.4	161.5
Disabled	29.7	31.9	34.5
Part D	51.0	46.6	58.3

NOTES: Based on FY 2010 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 2009 benefit payments[1] in millions	Percent distribution
Total Part A[2]	$236,764	100.0
Inpatient hospital	136,780	57.8
Skilled nursing facility	25,478	10.8
Home health agency[3]	6,840	2.9
Hospice	12,514	5.3
Managed care	55,152	23.3
Total Part B[2]	195,922	100.0
Physician/other suppliers	60,350	30.8
DME	8,812	4.5
Other carrier	16,575	8.5
Outpatient hospital	24,495	12.5
Home health agency[3]	10,450	5.3
Other intermediary	14,273	7.3
Laboratory	7,675	3.9
Managed care	53,291	27.2
Total Part D	58,320	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 as reported to date by the Treasury.

NOTES: Based on FY 2010 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	2007
National total in billions	$42.2	$253.4	$1,353.2	$2,241.2
Percent of GDP	5.9	9.1	13.8	16.2
Per capita amount	$211	$1,100	$4,789	$7,421
Source of funds		Percent of total		
Private	75.1	58.0	55.9	53.8
Public	24.9	42.0	44.1	46.2
Federal	11.4	28.2	30.9	33.7
State/local	13.5	13.7	13.2	12.6

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		
	2005	2006	2007
	In billions		
Total medical assistance payments[1]	$300.7	$299.0	$315.8
	Percent of total		
Inpatient services	15.5	15.3	16.3
General hospitals	14.0	14.3	15.1
Mental hospitals	1.6	1.1	1.2
Nursing facility services	15.4	16.0	15.0
Intermediate care facility (MR) services	4.2	4.3	3.9
Community-based long term care svs.[2]	12.1	13.4	13.6
Prescribed drugs[3]	10.2	5.6	4.7
Physician services	4.1	4.2	3.9
Dental services	1.1	1.1	1.1
Outpatient hospital services	4.1	3.9	4.2
Clinic services[4]	3.0	3.1	3.0
Laboratory and radiological services	0.4	0.4	0.4
Early and periodic screening	0.4	0.4	0.3
Targeted case management services	1.0	1.0	0.9
Capitation payments (non-Medicare)	16.8	18.6	19.7
Medicare premiums	2.7	3.1	3.3
Disproportionate share hosp. payments	5.7	5.7	5.1
Other services	5.0	5.6	6.3
Collections[5]	-1.7	-1.8	-1.7

[1]Excludes payments under CHIP.
[2] Comprised of home health, home and community-based waivers, personal care and home and community-based services for functionally disabled elderly.
[3] Net of prescription drug rebates.
[4] Federally qualified health clinics, rural health clinics, and other clinics.
[5] Includes third party liability, probate, fraud and abuse, overpayments, and other collections.

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

SOURCES: CMS, CMSO, and OACT.

Table III.9
Medicare savings attributable to secondary payer provisions by type of provision

	Fiscal Year		
	2006	2007	2008
	In millions		
Total	$6,088.6	$6,505.0	$6,787.5
Workers Compensation[1]	93.1	877.2	1,053.3
Working Aged	2,980.6	2,919.0	3,033.3
ESRD	298.6	278.1	315.6
Auto	243.7	233.2	293.3
Disability	2,033.7	1,938.9	1,982.8
Liability	410.3	232.2	82.0
VA/Other	28.6	26.3	27.2

[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 2007 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$315.8	100.0
Age 65 years and over	71.0	22.5
Blind/disabled	127.0	40.2
Dependent children under 21 years of age	57.3	18.1
Adults in families with dependent children	39.8	12.6
DSH and other unallocated	20.7	6.5

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

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

SOURCE: CMS, Office of the Actuary.

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

BETOS Category	Allowed Charges[2]	
	2007	2008[3]
	In thousands	
Total	$10,527,332	$10,615,908
Medical/surgical supplies	151,399	174,545
Hospital beds	292,407	271,731
Oxygen and supplies	2,828,809	2,810,737
Wheelchairs	1,293,760	1,437,937
Prosthetic/orthotic devices	1,904,133	1,972,002
Drugs admin. through DME	901,412	651,362
Other DME	3,155,412	3,297,594

[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 2008 are preliminary through March 2009.

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	$2,241.2	$7,421	33.9	19.2	14.7
Health serv/suppl.	2,098.1	6,947	36.3	20.6	15.7
Personal health care	1,878.3	6,219	38.0	21.8	16.2
Hospital care	696.5	2,306	45.4	28.2	17.2
Prof. services	702.1	2,325	28.5	15.7	12.8
Phys./clinical	478.8	1,585	27.0	20.1	6.9
Nursing/home hlth.	190.4	630	64.2	24.7	39.5
Retail outlet sales	289.3	958	26.0	19.5	6.5
Admn. and pub. hlth.	219.8	728	21.4	9.8	11.6
Investment	143.1	474	--	--	--

NOTE: Data are as of calendar year 2007.

SOURCE: CMS, Office of the Actuary.

Table III.13
Personal health care/payment source

	Calendar year			
	1980	1990	2000	2007
	In billions			
Total	$214.8	$607.6	$1,139.2	$1,878.3
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	59.9	61.1	57.3	54.7
Private health insurance	28.5	33.7	35.4	36.2
Out-of-pocket	27.1	22.4	16.9	14.3
Other private	4.3	5.0	5.0	4.2
Public funds	40.1	38.9	42.7	45.3
Federal	29.0	28.4	32.5	35.3
State and local	11.1	10.4	10.3	10.0

NOTE: 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	2007
Discharges				
Total in millions	10.5	10.5	13.0	12.3
Rate per 1,000 enrollees[1]	347	320	361	350
Days of care				
Total in millions	92	94	75	69
Rate per 1,000 enrollees[1]	3,016	2,866	2,073	1,976
Average length of stay				
All short-stay	8.7	9.0	5.7	5.6
Excluded units	18.8	19.5	11.5	11.8
Total charges per day	$597	$1,060	$4,882	$5,752

[1]Beginning in 1990, the population base for the denominator is the July 1 HI 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 2007 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with different update cycle.

SOURCES: CMS, Office of Information Services, and 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]
2006	1,838	52[1]	3,026	84[1]
2007	1,828	52[1]	3,100	87[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	2006	2007
All short-stay and excluded units					
Short-stay PPS units	9.0	7.1	6.0	5.3	5.3
Short-stay non-PPS units	8.9	7.1	6.0	5.3	5.2
Excluded units	19.5	14.8	12.3	11.7	11.8

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2007 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	2006	2007
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	916	932	921
HI	221	219	218	232	234	231
SMI	536	739	858	965	994	989
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	835	877	875
HI	219	228	212	196	205	204
SMI	471	715	837	943	998	999

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				
	2003	2004	2005	2006	2007
	Numbers in millions				
HI					
Aged					
FFS Enrollees	29.7	30.0	30.0	29.3	28.8
Persons served	6.9	6.9	7.0	6.8	6.7
Rate per 1,000	231	231	234	234	231
Disabled					
FFS Enrollees	5.7	6.0	6.3	6.2	6.3
Persons served	1.2	1.2	1.3	1.3	1.3
Rate per 1,000	203	203	205	205	204
SMI					
Aged					
FFS Enrollees	28.3	28.4	28.4	27.5	26.9
Persons served	27.4	27.6	27.8	27.3	26.6
Rate per 1,000	970	972	979	994	989
Disabled					
FFS Enrollees	5.0	5.3	5.5	5.4	5.5
Persons served	4.9	5.1	5.4	5.4	5.5
Rate per 1,000	969	965	977	998	999

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 enrolless 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]	26,874	921	5,531	875
Boston	1,449	910	310	859
New York[2]	2,475	903	463	853
Philadelphia	2,793	939	533	881
Atlanta	5,864	953	1,400	919
Chicago	5,093	958	971	886
Dallas	3,044	935	666	897
Kansas City	1,470	953	284	915
Denver	811	948	136	881
San Francisco[3]	2,764	880	540	811
Seattle	964	928	191	857

[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 2007 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	182,203	142,521	39,682
1996	265,681	206,854	58,827
1997	282,710	219,854	62,856
1998	300,450	233,262	67,188
1999	317,553	245,677	71,876
2000	334,134	258,278	75,856
2001	350,276	270,332	79,944
2002	365,909	281,364	84,545
2003	378,295	291,464	86,831
2004	393,565	301,042	92,523
2005	407,941	310,389	97,552
2006	422,087	319,319	102,768

SOURCE: United States Renal Data System.

Table IV.8
Medicare end stage renal disease (ESRD)
by treatment modalities and demographics, 2005

	Medicare Entitled: Total	Dialysis Patients	Transplant Patients
Total--all patients	407,941	310,389	97,552
Age			
0-19 years	3,675	1,570	2,105
20-64 years	238,207	163,041	75,166
65-74 years	91,265	74,219	17,046
75 years and over	74,794	71,559	3,235
Sex			
Male	228,296	169,869	58,427
Female	179,643	140,519	39,124
Race			
White	246,864	175,224	71,640
Black	134,945	114,821	20,124
Native American	5,488	4,481	1,007
Asian/Pacific	17,214	12,961	4,253
Other/Unknown	3,430	2,902	528

SOURCE: United States Renal Data System.

Table IV.9
Medicaid/type of service

	Fiscal year 2006 Medicaid beneficiaries
	In thousands
Total eligibles	59,600
Number using service:	
Total beneficiaries, any service[1]	57,459
Inpatient services	
General hospitals	6,237
Mental hospitals	137
Nursing facility services[2]	1,712
Intermediate care facility (MR) services[3]	107
Physician services	23,084
Dental services	9,447
Other practitioner services	5,810
Outpatient hospital services	15,844
Clinic services	11,758
Laboratory and radiological services	16,065
Home health services	1,187
Prescribed drugs	27,085
Personal care support services	917
Sterilization services	177
PCCM capitation	8,530
HMO capitation	26,062
PHP capitation	20,244
Targeted case management	2,718
Other services, unspecified	10,030
Additional service categories[4]	7,798
Unknown	67

[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 7.8 million beneficiaries, not unduplicated.

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

SOURCE: CMS, Center for Medicaid and State Operations.

Table IV.10
Medicaid/units of service

	Fiscal year 2006 units of service
	In thousands
Inpatient hospital	
Total discharges	7,895
Beneficiaries discharged	6,237
Total days of care	50,826
Nursing facility	
Total days of care	431,306
Intermediate care facility/mentally retarded	
Total days of care	44,099

NOTES: Data are derived from the MSIS 2006 State Summary Mart and are based on reported States. FY 2006 data for Maine were not submitted. 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	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
2006[1]	3,086	1.7
2007[1]	2,636	1.3
2008[1]	3,231	1.4 [2]
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
2006	3,108	1.6
2007	3,398	1.5
2008	3,419	1.6 [2]

[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	20	15
Other	2	3

NOTES: Data for FY 2008. Numbers do not include MACs or DMACs.

SOURCE: CMS, Office of Financial Management.

Table V.3
Medicare Redeterminations

	Cases Involved		
	Intermediary		Carrier
	Part A	Part B	Part B
Number Processed	73,777	177,230	1,947,165
Percent Reversed (Includes Fully & Partially Reversed Cases)	28.2	54.0	55.3

NOTES: Data for fiscal year 2008. Data presented in cases.

SOURCE: CMS, Office of Financial Management.

Table V.4

Medicare physician/supplier claims assignment rates

	2000	2004	2005	2006	2007	2008
	In millions					
Claims total	720.5	922.2	951.6	944.9	944.3	974.7
Claims assigned	705.7	909.9	940.7	935.1	935.8	966.5
Claims unassigned	15.3	12.3	10.9	9.8	8.6	8.2
Percent assigned	97.9	98.7	98.9	99.0	99.1	99.2

NOTE: Fiscal year data.

SOURCE: CMS, Office of Financial Management.

Table V.5
Medicare claims processing

	Intermediaries	Carriers
Claims processed in millions	188.6	995.2[1]
Total PM costs in millions	$557.2	$1,414.0
Total MIP costs in millions	$467.1	$240.0
Claims processing costs in millions	$399.7	$1,027.6[2]
Claims processing unit costs	$0.66	0.38[3]
Range		
High	$1.63	$1.27
Low	$0.31	$0.25

[1]Excludes replicate claims. [2]Beginning in FY 2002, provider enrollment has been removed from the claims processing costs and unit costs. [3]Beginning in FY 2007, standard system costs have been removed from contractor claims processing costs and unit costs and paid directly to the providers.

NOTES: Data for fiscal year 2008. PM= Program Management. MIP= Medicare Integrity Program. FY 2008 PM costs include an estimate of $103.9M for MAC/DMAC and MIP costs include a MAC/DMAC estimate of $17.1M. Since MACs do not report by traditional categories, unit costs do not include MACs/DMACs.

SOURCE: CMS, Office of Financial Management.

Table V.6
Medicare claims received

	Claims received
Intermediary claims received in millions	189.7
	Percent of total
Inpatient hospital	8.2
Outpatient hospital	57.4
Home health agency	7.7
Skilled nursing facility	3.2
Other	23.5
Carrier claims received in millions	979.3
	Percent of total
Assigned	99.2
Unassigned	0.8

NOTE: Data for calendar year 2008.

SOURCE: CMS, Office of Financial Management.

Table V.7
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	851.3	6.9
Percent reduced	92.9	88.1
Total covered charges		
Amount in millions	$279,428	$774
Percent reduced	58.7	18.7
Amount reduced per claim	$192.69	$20.95

NOTES: Data for calendar year 2008. 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	
	2007	2008
	In millions	
Total payments computable for Federal funding[1]	$16,421	$17,693
Federal share[1]		
Family planning	29	35
Design, development or installation of MMIS[2]	292	317
Skilled professional medical personnel	422	457
Operation of an approved MMIS[2]	1,192	1,207
All other	6,952	7,476
Mechanized systems not approved under MMIS[2]	84	131
Total Federal Share	$8,971	$9,623
Net adjusted Federal share[3]	$8,978	$9,589

[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	2007	2008	2009
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 2009)		None[1]	
Voluntary HI monthly premium[2]		$443.00	

Part A (effective date)	Amount
Inpatient hospital deductible (1/1/09)	$1,068/benefit period
Regular coinsurance days (1/1/09)	$267/day for 61st thru 90th day
Lifetime reserve days (1/1/09)	$534/day (60 non-renewable days)
SNF coinsurance days (1/1/09)	$133.50/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/09)	$443/month; $244/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 $244 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 (1/1/09)	$135 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/09)	$96.40/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 2009 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	$96.40
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$38.50	$134.90
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$96.30	$192.70
Greater than $160,000 and less than or equal to $213,000	Greater than $320,000 and less than or equal to $426,000	$154.10	$250.50
Greater than $213,000	Greater than $426,000	$211.90	$308.30

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 return from their spouse.

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	$96.40
Greater than $85,000 and less than or equal to $128,000	$154.10	$250.50
Greater than $128,000	$211.90	$308.30

SOURCE: CMS, Office of the Actuary.

Medicare Part D Standard Benefits

Deductible (1/1/2009)	$295 in charges/year
Initial coverage limit (1/1/2009)	$2,700 in charges/year
Out-of-pocket threshold (1/1/2009)	$4,350 in charges/year
Base beneficiary premium (1/1/2009)[1]	$30.36/month

Medicaid financing

1. Federal contributions (ranging from 50 to 76 percent for fiscal year 2009)
2. State contributions (ranging from 24 to 50 percent for fiscal year 2009)

[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 2009, the average premium rate paid by beneficiaries is estimated to be about $28.

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.