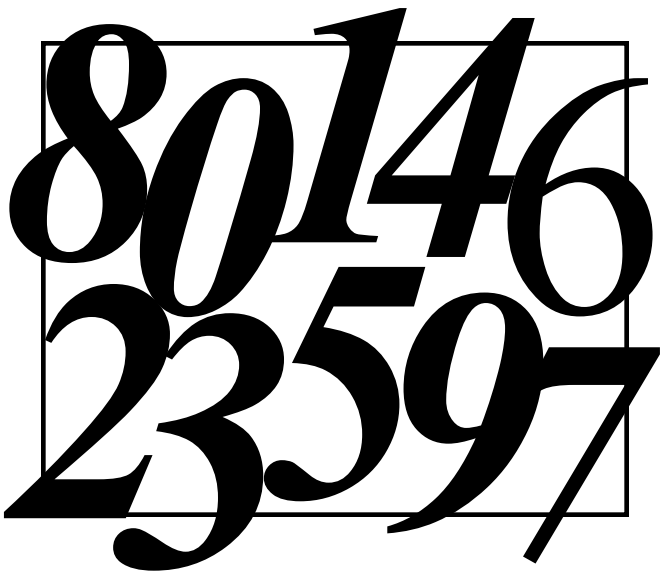
2013 CMS Statistics



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 and may not always reflect changes due to recent legislation. 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

AFDC	**Aid to Families with Dependent Children**
BETOS	**Berenson-Eggers Type of Service**
CAHs	**Critical Access Hospitals**
CBC	**Community-Based Care**
CCPs	**Coordinated Care Plans**
CHIP	**Children's Health Insurance Program**
CM	**Center for Medicare**
CMCS	**Center for Medicaid and CHIP Services**
CMS	**Centers for Medicare & Medicaid Services**
DHHS	**Department of Health & Human Services**
DME MACs	**DME Medicare Administrative Contractors**
DME	**Durable Medical Equipment**
DSH	**Disproportionate Share Hospital**
EPFFS	**Employer Direct Private Fee-For-Service**

Glossary of Acronyms (continued)

ESRD	**End Stage Renal Disease**
FFS	**Fee-For-Service**
GDP	**Gross Domestic Product**
HCPP	**Health Care Prepayment Plan**
HI	**Hospital Insurance**
HIT	**Health Information Technology**
HMO	**Health Maintenance Organization**
ICF-MR	**Intermediate Care Facility For Mentally Retarded**
IPAB	**Independent Payment Advisory Board**
MA	**Medicare Advantage**
MACs	**Medicare Administrative Contractors**
MA-PD	**Medicare Advantage Prescription Drug Plans**
MEDPAR	**Medicare Provider Analysis and Review**
MIF	**Medicare Improvement Fund**
MSA	**Medical Savings Account**
MSIS	**Medicaid Statistical Information System**

Glossary of Acronyms (continued)

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

Highlights

Growth in CMS programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 52.3 million in 2013, a 174 percent increase. (I.1)
- On average, the number of Medicaid monthly enrollees in 2013 is estimated to be about 57.4 million, the largest group being children (27.9 million or 48.6 percent). (I.16)
- In 2010, 21 percent of the population was at some point enrolled in the Medicaid program. (I.18)
- Medicare enrollees with end-stage renal disease increased from 110.0 thousand in 1985 to 454.6 thousand in 2012, an increase of 313 percent. (I.5)
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 8.7 million beneficiaries in 2012, an increase of about 211 percent. (I.19)

- By 2012, nearly 31.9 million Medicare enrollees had Part D drug coverage, 62.7 percent of all enrollees, and an additional 5.6 million had RDS. (I.10 & I.12)

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,522 in December 1990 to 6,170 in December 2012. Total inpatient hospital beds have dropped from 32.8 beds per 1,000 enrolled in 1990 to 18.4 in 2012, a decrease of 44 percent. (II.1)
- In the past decade, the total number of Medicare certified beds in short-stay hospitals has decreased to about 787,000 in 2012 from 970,000 in 1990. The average number of short-stay hospital beds per 1,000 enrolled in 2012 is 15.6 down from 28.8 in 1990. (II.1)
- 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. (II.3 & II.4)
- 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 12,253 in 2012. (II.5 & II.6)

Expenditures

- National health expenditures (NHE) were $2,700.7 billion in 2011, comprising 17.9 percent of the gross domestic product (GDP). Comparably, NHE amounted to $724.3 billion, or 12.5 percent of the GDP in 1990. (III.7)
- In 2012, total net Federal outlays for CMS programs were $732.4 billion, 20.7 percent of the Federal budget. (III.1)
- Medicare Part A benefit payments are projected to increase to $264.5 billion for fiscal year 2013 up from $253.9 billion for fiscal year 2012, and Medicare Part B benefit payments are projected to increase to $248.4 billion for fiscal year 2013 up from $226.9 billion for fiscal year 2012. (III.5)
- Medicare hospice benefit payments are projected to increase to $15.6 billion for fiscal year 2013 up from $14.9 billion in 2012. (III.6)
- National health expenditures per person were $211 in 1965 and grew steadily to reach $8,680 by 2011. (III.7)

Utilization of Medicare and Medicaid services

- Between 1985 and 2011, the number of short-stay hospital discharges increased from 10.5 million to 11.5 million, an increase of 10 percent. (IV.1)
- The PPS short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.1 days in 2011, a decrease of 43 percent. (IV.3)

- About 32.8 million persons received a reimbursed service under Medicare fee-for-service during 2011. Comparably, almost 63.4 million persons used Medicaid services or had a premium paid on their behalf in 2010. (IV.6a & IV.9)
- The ratio of Medicare aged users of any type of covered service has grown from 528 per 1,000 enrolled in 1975 to 898 per 1,000 enrolled in 2011. (IV.4)
- 6.8 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2011. (IV.6a)
- 31.8 million persons received reimbursable fee-for-services physician services under Medicare during 2011. 23.5 million persons received reimbursable physician services under Medicaid during 2010. (IV.6a & IV.9)
- 24.2 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2011. During 2010, 15.5 million persons received Medicaid reimbursable outpatient hospital services. (IV.6a & IV.9)
- Over 1.8 million persons received care in SNFs covered by Medicare during 2011. 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 2010. (IV.6a & IV.9)
- Over 28 million persons received prescribed drugs under Medicaid during 2010. (IV.9)

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
2000	39.7	34.3	5.4
Average monthly			
2005	42.6	35.8	6.8
2009	46.6	38.8	7.8
2010	47.7	39.6	8.1
2011	48.9	40.5	8.4
2012	50.7	42.1	8.5
2013	52.3	43.5	8.8

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 2000-2013 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on 2013 Trustees Report.

SOURCE: CMS, Office of the Actuary.

Table I.2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI		HI and SMI	HI only	SMI only
			Part B	Part D			
			In millions				
All persons	51.9	51.5	47.6	38.5	47.2	4.3	0.4
Aged persons	43.2	42.8	39.8	--	39.5	3.3	0.4
Disabled persons	8.7	8.7	7.8	--	7.8	0.9	0.0

NOTES: Projected average monthly enrollment during fiscal year 2013. Aged/disabled split of Part D enrollment not available. Based on 2013 Trustees Report. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of the Actuary.

Table I.3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	50,829	22,976	27,853
Aged	42,204	18,484	23,721
65-74 years	23,396	10,994	12,402
75-84 years	12,951	5,546	7,406
85 years and over	5,857	1,944	3,913
Disabled	8,624	4,492	4,132
Under 45 years	1,971	1,056	915
45-54 years	2,566	1,329	1,238
55-64 years	4,087	2,107	1,980
White	41,624	18,809	22,815
Black	5,282	2,280	3,003
All Other	3,621	1,707	1,914
Native American	226	101	125
Asian/Pacific	1,062	460	602
Hispanic	1,352	637	715
Other	982	509	472
Unknown Race	301	180	121

NOTES: Data as of July 1, 2012. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.

SOURCE: CMS, Office of Information Products and Data Analytics

Table I.4
Medicare Part D enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	31,867	13,277	18,590
Aged			
65-74 years	13,712	5,902	7,811
75-84 years	8,276	3,241	5,035
85 years and over	3,660	1,048	2,612
Disabled			
Under 45 years	1,729	906	823
45-54 years	1,774	901	873
55-64 years	2,716	1,280	1,436

NOTES: Data for calendar year 2012, as reported on the Part D Denominator File. Totals may not add due to rounding.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table I.5
Medicare ESRD enrollment/trends

Year	HI and/or SMI	HI	SMI
	In thousands		
1985	110.0	109.1	106.5
1990	172.1	170.6	163.7
1995	255.7	253.6	243.8
2000	290.9	290.4	272.8
2005	369.9	369.8	351.6
2010	436.9	436.8	416.1
2012	454.6	454.5	434.4

NOTE: Data as of July 1 of each year.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table I.6
Medicare ESRD enrollment/demographics

	Number of enrollees (in thousands)
All persons	503.4
Age	
Under 35 years	26.3
35-44 years	41.7
45-64 years	205.3
65 years and over	230.1
Sex	
Male	286.7
Female	216.7
Race	
White	262.1
Other	237.4
Unknown	3.9

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2012.

SOURCE: CMS, Office of Information Products and Data Analytics.

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

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	683	1,811	12,866	14,677
Local CCPs	526	1,326	11,341	12,667
PFFS	18	108	305	412
1876 Cost	18	223	214	437
1833 Cost (HCPP)	10	56	--	56
PACE	94	--	26	26
Other plans[2]	17	98	982	1,079
Total PDPs[1]	83	--	22,529	22,529
Total	766	1,811	35,396	37,206

[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, Pilot, and RPPOs.

NOTE: Data as of April 2013.
SOURCE: CMS, Center for Medicare.

Table I.8
Medicare enrollment/CMS region

	Resident population[1]	Medicare enrollees[2]	Enrollees as percent of population
	In thousands		
All regions	313,914	49,682	15.8
Boston	14,563	2,555	17.5
New York	28,435	4,536	16.0
Philadelphia	30,239	5,097	16.9
Atlanta	62,357	10,773	17.3
Chicago	51,946	8,559	16.5
Dallas	39,511	5,516	14.0
Kansas City	13,838	2,341	16.9
Denver	11,157	1,518	13.6
San Francisco	48,746	6,736	13.8
Seattle	13,124	2,050	15.6

[1]Preliminary annual estimate July 1, 2012 resident population.

[2]Medicare enrollment file data are as of July 1, 2012. Excludes beneficiaries living in territories, possessions, foreign countries, or with residence unknown.

NOTES: Resident population is a provisional estimate based on 50 States and the District of Columbia. Numbers may not add to totals because of rounding.
For regional breakouts, see Reference section.

SOURCES: CMS, Office of Information Products and Data Analytics; U.S. Bureau of the Census, Population Estimates Branch.

Table I.9
Medicare enrollment by enrollment type/CMS region

	Total Enrollees	Fee-for-Service Enrollees	Managed Care Enrollees
		In thousands	
All regions	50,829	37,214	13,614
Boston	2,555	2,088	467
New York	5,264	3,539	1,725
Philadelphia	5,097	3,811	1,286
Atlanta	10,773	8,055	2,718
Chicago	8,559	6,276	2,284
Dallas	5,516	4,304	1,213
Kansas City	2,341	1,928	413
Denver	1,518	1,109	410
San Francisco	6,755	4,310	2,445
Seattle	2,050	1,402	649

NOTES: Data as of July 1, 2012. 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 Information Products and Data Analytics.

Table I.9a
Medicare enrollment by health delivery/demographics

	Total	Fee-for-Service	Managed Care
		In thousands	
All persons	50,829	37,214	13,614
Aged	42,204	30,340	11,864
65-74 years	23,396	16,810	6,586
75-84 years	12,951	9,109	3,843
85 years and over	5,857	4,422	1,435
Disabled	8,624	6,874	1,750
Under 45 years	1,971	1,714	257
45-54 years	2,566	2,081	486
55-64 years	4,087	3,079	1,008
Male	22,976	17,060	5,915
Female	27,853	20,154	7,699
White	41,624	30,650	10,975
Black	5,282	3,789	1,493
All Other	3,621	2,530	1,091
Native American	226	199	27
Asian/Pacific	1,062	769	292
Hispanic	1,352	894	457
Other	982	667	315
Unknown Race	301	246	55

NOTES: Data as of July 1, 2012. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.

SOURCE: CMS, Office of Information Products and Data Analytics.

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]	50,829	31,867	62.7
Boston	2,555	1,571	61.5
New York	5,264	3,422	65.0
Philadelphia	5,097	3,038	59.6
Atlanta	10,773	6,835	63.4
Chicago	8,559	5,314	62.1
Dallas	5,516	3,329	60.3
Kansas City	2,341	1,540	65.8
Denver	1,518	926	61.0
San Francisco	6,755	4,633	68.6
Seattle	2,050	1,245	60.7

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

NOTE: Data for calendar year 2012 as reported on the Part D Denominator file.
SOURCE: CMS, Office of Information Products and Data Analytics.

Table I.11
Medicare Part D enrollment by plan type/CMS region

	Total Part D Enrollees	Total PDP Enrollees	Total MA-PD Enrollees
	In thousands		
All regions[1]	31,867	19,915	11,952
Boston	1,571	1,136	435
New York	3,422	1,801	1,622
Philadelphia	3,038	1,949	1,089
Atlanta	6,835	4,308	2,527
Chicago	5,314	3,757	1,556
Dallas	3,329	2,257	1,071
Kansas City	1,540	1,163	376
Denver	926	574	352
San Francisco	4,633	2,267	2,367
Seattle	1,245	692	553

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

NOTE: Data for calendar year 2012 as reported on the Part D Denominator file.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table I.12
Medicare Part D and RDS enrollment/CMS region

	Total Part D and RDS Enrollees	Total Part D Enrollees	Total RDS Enrollees
		In thousands	
All regions[1]	37,492	31,867	5,625
Boston	1,907	1,571	336
New York	4,103	3,422	680
Philadelphia	3,605	3,038	568
Atlanta	7,954	6,835	1,119
Chicago	6,571	5,314	1,257
Dallas	3,933	3,329	605
Kansas City	1,730	1,540	190
Denver	1,051	926	126
San Francisco	5,182	4,633	549
Seattle	1,433	1,245	188

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

NOTE: Data for calendar year 2012 as reported on the Part D Denominator file.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table I.13
Projected Population[1]

	2010	2020	2040	2060	2080	2100
			In millions			
Total	315	343	392	429	469	510
Under 20	85	88	98	105	112	120
20-64	188	198	212	232	252	268
65 years and over	41	57	82	93	106	122

[1] As of July 1.

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

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2013 Trustees Report Intermediate Alternative.

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

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1990	15.1	19.1
2000	15.9	19.0
2010	17.6	20.2
2020[1]	18.8	21.1
2030[1]	19.5	21.7
2040[1]	20.2	22.3
2050[1]	20.7	22.8
2060[1]	21.3	23.3
2070[1]	21.8	23.8
2080[1]	22.3	24.2
2090[1]	22.7	24.6
2100[1]	23.2	25.0

[1]Projected.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2013 Trustees Report Intermediate Alternative.

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

Calendar Year	All Races	White	Black
		At Birth	
1960	69.7	70.6	63.6
1980	73.7	74.4	68.1
1990	75.4	76.1	69.1
1995	75.8	76.5	69.6
2000	76.8	77.3	71.8
2005	77.6	78.0	73.0
2010	78.7	78.9	75.1
2011[1]	78.7	79.0	75.3
		At Age 65	
1960	14.3	14.4	13.9
1980	16.4	16.5	14.8
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2000	17.6	17.7	16.1
2005	18.4	18.5	16.9
2010	19.1	19.2	17.8
2011[1]	19.2	19.2	18.0

[1]Preliminary data for calendar year 2011.

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

Table I.16
Medicaid and CHIP enrollment

	Fiscal year					
	1995	2000	2005	2010	2012	2013
	Average monthly enrollment in millions					
Total	34.2	34.5	46.5	53.5	57.5	57.4
Age 65 years and over	3.7	3.7	4.6	4.7	5.1	5.2
Blind/Disabled	5.8	6.7	8.1	9.5	9.5	9.6
Children	16.5	16.2	22.3	26.3	28.2	27.9
Adults	6.7	6.9	10.6	12.1	13.7	13.7
Other Title XIX[1]	0.6	NA	NA	NA	NA	NA
Territories	0.8	0.9	1.0	1.0	1.0	1.0
CHIP	NA	2.0	5.9	5.4	5.7	5.9
	Unduplicated annual enrollment in millions					
Total	43.3	44.2	58.7	67.7	72.9	72.8
Age 65 years and over	4.4	4.3	5.5	5.6	6.0	6.1
Blind/Disabled	6.5	7.5	9.0	10.6	10.6	10.7
Children	21.3	20.9	27.8	33.0	35.4	35.0
Adults	9.4	10.6	15.4	17.6	20.0	20.1
Other Title XIX[1]	0.9	NA	NA	NA	NA	NA
Territories	0.8	0.9	1.0	1.0	1.0	1.0
CHIP	NA	3.4	6.8	8.0	8.3	8.6

[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 2012-2013 are estimates from the President's FY 2014 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 Center for Medicaid and CHIP Services.

Table I.17
Medicaid eligibles/demographics

	Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	66.1	100.0
Age	66.1	100.0
Under 21	34.5	52.2
21-64 years	25.2	38.1
65 years and over	6.3	9.6
Unknown	0.1	0.1
Sex	66.1	100.0
Male	27.3	41.3
Female	38.7	58.6
Unknown	0.1	0.2
Race	66.1	100.0
White, not Hispanic	27.2	41.1
Black, not Hispanic	14.3	21.6
Am. Indian/Alaskan Native	0.8	1.3
Asian	2.0	3.1
Hawaiian/Pacific Islander	0.6	1.0
Hispanic	16.3	24.7
Other	0.3	0.4
Unknown	4.6	6.9

NOTES: Fiscal Year 2010 data derived from MSIS State Summary Datamart. The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of the rounded components. Eligible is defined as anyone eligible and enrolled in the Medicaid program at some point during the fiscal year, regardless of duration of enrollment, receipt of a paid medical service, or whether or not a capitated premium for managed care or private health insurance coverage had been made. The outlying areas are not included. Excludes the Children's Health Insurance Program (CHIP). Race information is obtained from the states.

SOURCES: CMS, Office of Information Products and Data Analytics and Center for Medicaid and CHIP Services.

Table I.18
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	309,326	66,064	21.4
Boston	14,463	3,331	23.0
New York	28,203	6,584	23.3
Philadelphia	29,883	5,230	17.5
Atlanta	61,213	12,486	20.4
Chicago	51,747	10,585	20.5
Dallas	38,534	8,126	21.1
Kansas City	13,735	2,307	16.8
Denver	10,869	1,452	13.4
San Francisco	47,813	13,465	28.2
Seattle	12,867	2,498	19.4

[1]Estimated July 1, 2010 population.
[2]Persons ever enrolled in Medicaid during fiscal year 2010.

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. Excludes CHIP.

SOURCES: CMS, Office of Information Products and Data Analytics and Center for Medicaid and CHIP Services; 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]	2012[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	8,711
Aged	2,483	2,449	3,632	5,041
Disabled	363	504	1,917	3,670
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	18.7
Aged	11.4	10.0	11.1	12.9
Disabled	18.7	18.9	40.2	48.7

[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. Includes outlying areas, foreign countries, and unknown.

SOURCE: CMS, Office of Information Products and Data Analytics.

Providers/Suppliers

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

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

Table II.1
Inpatient hospitals/trends

	1990	2000	2010	2012
Total hospitals	6,522	5,985	6,169	6,170
Beds in thousands	1,105	991	928	931
Beds per 1,000 enrollees[1]	32.8	25.3	19.6	18.4
Short-stay	5,549	4,900	3,566	3,521
Beds in thousands	970	873	785	787
Beds per 1,000 enrollees[1]	28.8	22.3	16.6	15.6
Critical access hospitals	NA	NA	1,325	1,331
Beds in thousands	---	---	30	30
Beds per 1,000 enrollees[1]	---	---	0.6	0.6
Other non-short-stay	973	1,085	1,278	1,318
Beds in thousands	135	118	113	114
Beds per 1,000 enrollees[1]	4.0	3.0	2.4	2.3

[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 Information Products and Data Analytics.

Table II.2
Inpatient hospitals/CMS region

	Short-stay and CAH hospitals	Beds per 1,000 enrollees	Non Short-stay hospitals	Beds per 1,000 enrollees
All regions	4,852	16.2	1,318	2.3
Boston	184	12.8	65	4.0
New York	305	16.9	74	2.2
Philadelphia	363	14.0	132	2.6
Atlanta	902	16.7	239	1.8
Chicago	863	17.5	200	1.9
Dallas	780	19.2	345	3.9
Kansas City	456	19.8	62	1.9
Denver	312	17.2	48	2.6
San Francisco	478	14.5	124	1.7
Seattle	209	11.6	29	1.4

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2012. Rates based on number of hospital insurance enrollees as of July 1, 2012, residing in U.S. and its territories.

SOURCE: CMS, Office of Information Products and Data Analytics.

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

Total participating hospitals	6,170
Short-term hospitals	3,521
Psychiatric units	1,135
Rehabilitation units	918
Swing bed units	515
Psychiatric	527
Long-term	437
Rehabilitation	241
Children's	97
Religious non-medical	16
Critical access	1,331
Non-participating Hospitals	741
Emergency	389
Federal	352
All SNFs/SNF-NFs/NFs only	15,672
All SNFs/SNF-NFs	15,143
Title 18 Only SNF	788
Hospital-based	231
Free-standing	557
Title 18/19 SNF/NF	14,355
Hospital-based	619
Free-standing	13,736
Title 19 only NFs	529
Hospital-based	110
Free-standing	419
All ICF-MR facilities	6,428

NOTES: Data as of December 31, 2012. Numbers may differ from other reports and program memoranda.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table II.4
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs	Nursing Facilities	ICF-MRs
All regions[1]	15,143	529	6,428
Boston	948	10	136
New York	1,001	2	591
Philadelphia	1,369	42	368
Atlanta	2,636	51	695
Chicago	3,327	112	1,494
Dallas	2,034	58	1,549
Kansas City	1,386	132	201
Denver	588	41	108
San Francisco	1,417	60	1,206
Seattle	437	21	80

[1]Includes outlying areas.

NOTE: Data as of December 2012.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table II.5
Other Medicare providers and suppliers/trends

	1980	1990	2010	2012
Home health agencies	2,924	5,661	10,914	12,253
Independent and Clinical Lab Improvement Act Facilities	NA	4,828	224,679	235,408
End stage renal disease facilities	999	1,987	5,631	5,916
Outpatient physical therapy and/or speech pathology	419	1,144	2,536	2,248
Portable X-ray	216	435	561	573
Rural health clinics	391	517	3,845	4,001
Comprehensive outpatient rehabilitation facilities	NA	184	354	268
Ambulatory surgical centers	NA	1,165	5,316	5,349
Hospices	NA	772	3,509	3,782

NOTES: Facility data for 1980 are as of July 1. Facility data for 1990, 2010 and 2012 are as of December 31.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table II.6
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,521	15,143	12,253
		Percent of total	
Non-profit	59.3	24.9	15.8
Proprietary	21.4	69.2	78.7
Government	19.3	5.9	5.5

NOTES: Data as of December 31, 2012. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: CMS, Office of Information Products and Data Analytics.

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

	1980	1990	2000	2011	2012
Hospitals					
Number of PIP	2,276	1,352	869	521	568
Percent of total participating	33.8	20.6	14.4	8.4	9.2
Skilled nursing facilities					
Number of PIP	203	774	1,236	355	345
Percent of total participating	3.9	7.3	8.3	2.3	2.3
Home health agencies					
Number of PIP	481	1,211	1,038	141	141
Percent of total participating	16.0	21.0	14.4	1.2	1.2

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, Center for Medicare.

Table II.8
Medicare physicians/suppliers by specialty[1]

Total All Specialties	1,089,306
Primary Care	215,919
Surgical Specialties	104,955
Medical Specialties	136,858
Anesthesiology	39,121
Obstetrics/Gynecology	34,070
Pathology	12,070
Psychiatry	27,882
Radiology	37,245
Emergency Medicine	41,535
Non-Physician Practitioners	286,562
Limited Licensed Practitioners	93,306
Ambulance Service Supplier	10,571
Other and Unknown	49,212
Durable Medical Equipment Suppliers	92,895

[1]Physicians/Suppliers utilized by Medicare fee-for-service beneficiaries. Physicians may be counted in more than one specialty.

NOTE: Data for calendar year 2012, as reported on the fee-for-service claims.

SOURCE: CMS, Office of Information Products and Data Analytics.

Expenditures

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

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

Table III.1
CMS and total Federal outlays

	Fiscal year 2011	Fiscal year 2012
	$ in billions	
Gross domestic product (current dollars)	$14,958.6	$15,547.4
Total Federal outlays[1]	3,603.1	3,537.1
Percent of gross domestic product	24.1%	22.8%
Dept. of Health and Human Services[1]	891.2	848.1
Percent of Federal Budget	24.7%	24.0%
CMS Budget (Federal Outlays)		
Medicare benefit payments	558.0	546.7
SMI transfer to Medicaid[2]	0.5	0.6
Medicaid benefit payments	259.6	238.8
Medicaid State and local admin.	11.4	13.9
Medicaid offsets[3]	-0.5	-0.6
Children's Health Ins. Prog.	8.5	9.1
CMS program management	3.2	3.6
Other Medicare admin. expenses[4]	2.5	2.5
State Eligibility Determinations, for Part D	0.0	0.0
Quality improvement organizations[5]	0.3	0.4
Health Care Fraud and Abuse Control	1.4	1.5
State Grants and Demonstrations[6]	0.6	0.5
User Fees and Reimbursables	0.4	0.5
Total CMS outlays (unadjusted)	845.9	817.5
Offsetting receipts[7]	-79.9	-85.1
Total net CMS outlays	770.9	732.4
Percent of Federal budget	21.4%	20.7%

[1]Net of offsetting receipts.

[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($514 million in FY 2011 and $602 million fin FY 2012).

[3]SMI transfers for low-income premium assistance.

[4]Medicare administrative expenses of the Social Security Administration and other Federal agencies.

[5]Formerly peer review organizations (PROs).

[6]Includes grants and demonstrations for various free-standing programs, such as the Ticket to Work and Work Incentives Improvement Act (P.L. 106-170), emergency health services for undocumented aliens (P.L. 108-173), and Medicaid's Money Follows the Person Rebalancing Demonstration (P.L. 109-171).

[7]Almost entirely Medicare premiums. Also includes offsetting collections for user fee and reimbursable activities, as well as refunds to the trust funds.

SOURCE: CMS, Office of Financial Management.

Table III.2
Program expenditures/trends

	Total	Medicare[1]	Medicaid[2]	CHIP[3]
		$ in billions		
Fiscal year				
1980	$60.8	$35.0	$25.8	--
1990	182.2	109.7	72.5	--
2000	428.7	219.0	208.0	$1.7
2010	940.9	525.6	403.9	11.4
2012	995.2	553.9	428.5	12.8

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

[2]The Medicaid amounts include total computable outlays (Federal and State shares) for benefits and administration, the Federal and State shares of the cost of Medicaid survey/certification and State Medicaid fraud control units, and outlays for the Vaccines for Children program. These amounts do not include the SMI transfer to Medicaid for Medicare Part B premium assistance for low-income beneficiaries, nor do they include the Medicare Part D compensation to States for low-income eligibility determinations in the Part D Drug program.

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

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

SOURCE: CMS, Office of Financial Management.

Table III.3
Benefit outlays by program

	1967	1980	2010	2012
Annually		Amounts in billions		
CMS program outlays	$5.1	$57.8	$915	$979
Federal outlays	NA	47.2	793	799
Medicare[1]	3.2	33.9	518	552
HI	2.5	23.8	250	262
SMI	0.7	10.1	209	232
Prescription (Part D)	NA	NA	59	58
Medicaid[2]	1.9	23.9	386	414
Federal share	NA	13.2	266	238
CHIP[3]	NA	NA	11	13
Federal share	NA	NA	8	9

[1]The Medicare benefit amounts reflect gross outlays (i.e., not net of offsetting premiums). These amounts exclude outlays for the SMI transfer to Medicaid for premium assistance and the Quality Improvement Organizations (QIOs).

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

[3]The CHIP amounts reflect both Federal and State shares of Title XXI outlays as reported by the States on line 4 of the CMS-21. Please note that CHIP-related Medicaid expansions began to be financed under CHIP (Title XXI) in FY 2001.

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

SOURCE: CMS, Office of Financial Management.

Table III.4
Program benefit payments/CMS region

	Fiscal Year 2011 Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$407,478	$259,590
Boston	25,905	15,160
New York	63,238	35,897
Philadelphia	40,870	25,313
Atlanta	64,247	45,115
Chicago	62,152	40,666
Dallas	45,423	31,729
Kansas City	15,636	10,581
Denver	9,016	5,786
San Francisco	66,464	40,107
Seattle	14,526	9,236

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

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

SOURCE: CMS, Office of Information Products and Data Analytics.

Table III.5
Medicare benefit outlays

	Fiscal Year		
	2011	2012	2013
	In billions		
Part A benefit payments	$255.2	$253.9	$264.5
Aged	213.0	211.0	220.1
Disabled	42.2	42.8	44.4
Part B benefit payments	225.9	226.9	248.4
Aged	184.1	184.0	201.5
Disabled	41.8	42.9	46.8
Part D	70.6	60.6	69.2

NOTES: Based on 2013 Trustees Report. Part A benefits include additional payments for HIT, CBC, IPAB, ACO, and Sequester. 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 2013 benefit payments[1] in millions	Percent distribution
Total Part A[2,3]	$264,501	100.0
Inpatient hospital	139,404	52.7
Skilled nursing facility	28,853	10.9
Home health agency[4]	6,952	2.6
Hospice	15,642	5.9
Managed care	73,649	27.8
Total Part B[3]	248,371	100.0
Physician/other suppliers[5]	71,301	28.7
DME	8,343	3.4
Other carrier	20,823	8.4
Outpatient hospital	36,379	14.6
Home health agency[4]	12,053	4.9
Other intermediary	17,256	6.9
Laboratory	9,998	4.0
Managed care	72,220	29.1
Total Part D	69,213	100.0

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

NOTES: Based on 2013 Trustees Report. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Office of the Actuary.

Table III.7
National health care/trends

	Calendar Year		
	1990	2000	2011
National total in billions	$724.3	$1,377.2	$2,700.7
Percent of GDP	12.5	13.8	17.9
Per capita amount	$2,854	$4,878	$8,680
Sponsor	Percent of Total		
Private Business	24.6	25.1	20.6
Household	34.9	31.5	27.7
Other Private Revenues	7.9	7.8	6.6
Governments	32.6	35.5	45.0
Federal Government	17.3	19.0	27.6
State and local government	15.3	16.5	17.4

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

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

Table III.8
Medicaid/type of service

	Fiscal year		
	2009	2010	2011
	In billions		
Total medical assistance payments[1]	$360.3	$383.4	$407.5
	Percent of total		
Inpatient services	15.0	14.7	15.7
General hospitals	14.1	13.8	14.8
Mental hospitals	0.9	0.9	0.9
Nursing facility services	13.9	13.0	12.5
Intermediate care facility (MR) services	3.8	3.5	3.3
Community-based long term care svs.[2]	14.4	14.1	13.5
Prescribed drugs[3]	4.3	4.1	3.6
Physician and other practitioner services	3.9	4.1	4.0
Dental services	1.3	1.4	1.3
Outpatient hospital services	4.1	4.0	4.2
Clinic services[4]	3.1	2.8	2.7
Laboratory and radiological services	0.4	0.5	0.4
Early and periodic screening	0.3	0.4	0.3
Case management services	0.8	0.9	0.7
Capitation payments (non-Medicare)	22.8	23.8	25.2
Medicare premiums	3.1	3.3	3.5
Disproportionate share hosp. payments	4.9	4.6	4.2
Other services	5.7	6.6	6.6
Collections[5]	-2.0	-1.8	-1.8

[1]Excludes payments under CHIP.

[2]Comprised of home health, home and community-based waivers, personal care and home and community-based services for functionally disabled elderly.

[3]Net of prescription drug rebates.

[4]Federally qualified health clinics, rural health clinics, and other clinics.

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

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

SOURCES: CMS, CMCS, and OACT.

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

	Fiscal Year		
	2010	2011	2012
	In millions		
Total	$8,007.1	$8,079.9	$7,862.2
Workers Compensation[1]	1,613.1	1,245.4	1,841.9
Working Aged	3,259.1	3,567.3	3,126.5
ESRD	343.6	343.0	296.0
Auto	325.1	271.1	212.2
Disability	2,021.8	2,184.0	1,840.6
Liability	424.4	447.9	523.2
VA/Other	19.9	21.2	21.7

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

NOTES: Beginning FY 2011, includes Liability savings of the global settlements recovered by CMS. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table III.10
Medicaid/payments by eligibility status

	Fiscal year 2011 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$407.5	100.0
Age 65 years and over	77.3	19.0
Blind/disabled	169.2	41.5
Dependent children under 21 years of age	77.5	19.0
Adults in families with dependent children	57.8	14.2
Disproportionate share hospital and other unallocated payments	25.7	6.3

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

SOURCE: CMS, Office of the Actuary.

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

BETOS Category	Allowed Charges[2]	
	2011	2012[3]
	In thousands	
Total	$11,084,600	$11,144,547
Medical/surgical supplies	197,414	180,419
Hospital beds	241,217	227,135
Oxygen and supplies	2,117,521	1,890,012
Wheelchairs	1,050,881	1,126,941
Prosthetic/orthotic devices	2,348,602	2,429,161
Drugs admin. through DME[4]	632,835	702,342
Parenteral and enteral nutrition	689,749	667,576
Other DME	3,806,381	3,920,962

[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 2012 are preliminary through March 2013.
[4]Includes inhalation drugs administered through nebulizers only and does not include drugs administered through other DME such as infusion pumps.

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

SOURCE: CMS, Office of Information Products and Data Analytics.

Table III.12
National health care/type of expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$2,700.7	$8,680	35.6	20.5	15.1
Health Consumption Expenditures	2,547.2	8,187	37.8	21.8	16.0
Personal health care	2,279.3	7,326	39.3	22.9	16.4
Hospital care	850.6	2,734	44.9	27.2	17.8
Prof. services	723.1	2,324	27.3	19.4	7.9
Phys./clinical	541.4	1,740	31.2	22.9	8.3
Other Professional	73.2	235	28.4	21.7	6.6
Dental	108.4	349	7.0	0.3	6.7
Other Health Residential & Personal Care	133.1	428	55.8	3.8	52.0
Nursing Care Facilities & Continuing Care Retirement Communities	149.3	480	56.1	25.2	30.9
Home Health	74.3	239	81.3	44.2	37.1
Retail outlet sales	348.9	1,121	28.1	21.4	6.8
Admin., Net Cost, & public health	267.9	861	24.6	12.2	12.4
Investment	153.5	493	--	--	--

NOTE: Data are as of calendar year 2011.
SOURCE: CMS, Office of the Actuary.

Table III.13
Personal health care/payment source

	Calendar Year			
	1980	1990	2000	2011
	In billions			
Total	$217.2	$616.8	$1,165.4	$2,279.3
	Percent			
Total	100.0	100.0	100.0	100.0
Out of pocket	26.9	22.5	17.3	13.5
Health Insurance	60.7	65.4	72.5	78.1
Private Health Insurance	28.3	33.2	34.9	34.5
Medicare	16.7	17.4	18.6	22.9
Medicaid (Title XIX)	11.4	11.3	16.0	16.4
Total CHIP (Title XIX & XXI)	0.0	0.0	0.2	0.4
Department of Defense	1.8	1.7	1.1	1.6
Depart. of Veteran's Affairs	2.6	1.8	1.6	2.2
Other 3rd Party Payers & Programs	12.4	12.1	10.2	8.4

NOTES: Excludes administrative expenses, research, construction, and other types of spending that are not directed at patient care. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of the Actuary.

Utilization

Information about the use of health care services

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

Table IV.1
Medicare short-stay hospital utilization

	1985	1990	2005	2011
Discharges				
Total in millions	10.5	10.5	13.0	11.5
Rate per 1,000 enrollees[1]	347	320	361	318
Days of care				
Total in millions	92	94	75	62
Rate per 1,000 enrollees[1]	3,016	2,866	2,073	1,712
Average length of stay				
All short-stay	8.7	9.0	5.7	5.4
Excluded units	18.8	19.5	11.5	11.8
Total charges per day	$597	$1,060	$4,882	$7,833

[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 2011 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table IV.2
Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
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]
2010	1,839	52 [1]	3,605	100 [1]
2011	1,864	52 [1]	3,621	99 [1]

[1]Managed care enrollees excluded in determining rate.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table IV.3
Medicare average length of stay/trends

	Fiscal Year				
	1990	1995	2000	2010	2011
All short-stay and excluded units					
Short-stay PPS units	9.0	7.1	6.0	5.1	5.1
Short-stay hospital non-PPS units	8.9	7.1	6.0	5.1	5.3
Excluded units	19.5	14.8	12.3	11.8	11.8

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2011 are based on 100-percent MEDPAR stay record file. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table IV.4
Medicare persons served/trends

	Calendar Year					
	1975	1985	1995	2005	2010	2011
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	923	919	898
HI	221	219	218	234	237	217
SMI	536	739	858	979	988	987
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	865	897	904
HI	219	228	212	205	213	201
SMI	471	715	837	977	1,007	1,023

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. Persons served represents estimates of beneficiaries receiving services under fee-for-service during the calendar year.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table IV.5
Medicare fee-for-service (FFS) persons served

	Year				
	2005	2007	2008	2009	2011
HI					
Aged					
FFS Enrollees	30.0	28.8	28.6	28.6	29.3
Persons served	7.0	6.7	6.6	6.4	6.3
Rate per 1,000	234	231	229	224	217
Disabled					
FFS Enrollees	6.3	6.3	6.4	6.4	6.8
Persons served	1.3	1.3	1.3	1.3	1.4
Rate per 1,000	205	204	202	204	201
SMI					
Aged					
FFS Enrollees	28.4	26.9	26.4	26.2	26.6
Persons served	27.8	26.6	26.2	25.9	26.2
Rate per 1,000	979	989	990	986	987
Disabled					
FFS Enrollees	5.5	5.5	5.5	5.6	6.0
Persons served	5.4	5.5	5.5	5.6	6.1
Rate per 1,000	977	999	1,001	1,005	1,023

NOTES: Enrollment represents persons enrolled in Medicare fee-for-service as of July. Persons served represents estimates of beneficiaries receiving reimbursed services under fee-for-service during the calendar year. Rate is the ratio of persons served during the calendar year to the number of fee-for-service enrollees as of July 1 (the average monthly enrollment).

Fee-for-Service enrollees and persons served counts are in millions.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table IV.6
Medicare persons served/CMS region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	26,619	898	6,172	904
Boston	1,452	891	359	889
New York	2,472	855	525	840
Philadelphia	2,751	909	613	911
Atlanta	5,866	932	1,511	942
Chicago	4,771	956	1,131	928
Dallas	3,081	903	750	911
Kansas City	1,454	935	317	931
Denver	835	926	153	899
San Francisco	2,938	854	598	844
Seattle	981	877	213	860

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

NOTES: Data are based on estimates of beneficiaries receiving HI and/or SMI reimbursed services under fee-for-service during calendar year 2011. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table IV.6a
Medicare fee-for-service persons served by type of service

	Total persons served in thousands	Aged persons served in thousands	Disabled persons served in thousands
Parts A and/or B	32,791	26,619	6,172
Part A	7,719	6,350	1,370
Inpatient hospital	6,848	5,533	1,315
Skilled nursing facility	1,864	1,695	169
Home health agency	1,720	1,501	219
Hospice	1,213	1,148	66
Part B	32,347	26,240	6,107
Physician/supplier	31,792	25,862	5,931
Outpatient	24,162	19,503	4,660
Home health agency	1,901	1,637	264

NOTES: Data are as of calendar year 2011. Persons served represents estimates of beneficiaries receiving services under fee-for-service during the calendar year.

SOURCE: CMS, Office of Information Products and Data Analytics.

Table IV.7
Medicare end stage renal disease (ESRD) by treatment modalities

Year	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
1991	182,407	142,764	39,643
1998	300,620	233,681	66,939
1999	317,770	246,195	71,575
2000	334,434	258,930	75,504
2001	350,636	271,128	79,508
2002	366,322	282,335	83,987
2003	378,840	292,638	86,202
2004	394,435	302,588	91,847
2005	409,401	312,619	96,782
2006	425,790	323,911	101,879
2007	441,402	335,069	106,333
2008	457,373	346,874	110,499
2009	473,972	359,532	114,440
2010	488,938	370,372	118,566

SOURCE: United States Renal Data System.

Table IV.8
Medicare end stage renal disease (ESRD)
by treatment modalities and demographics, 2009

	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
Total -- all patients	473,972	359,532	114,440
Age			
0-19 years	3,253	1,412	1,841
20-64 years	270,065	189,015	81,050
65-74 years	112,324	86,905	25,419
75 years and over	88,330	82,200	6,130
Sex			
Male	268,793	199,827	68,966
Female	205,177	159,703	45,474
Race			
White	285,291	203,265	82,026
Black	157,890	132,900	24,990
Native American	6,336	5,154	1,182
Asian/Pacific	22,205	16,697	5,508
Other/Unknown	2,250	1,516	734

SOURCE: United States Renal Data System.

Table IV.9
Medicaid/type of service

	Fiscal year 2010 Medicaid beneficiaries
	In thousands
Total eligibles	66,064
Number using service:	
Total beneficiaries, any service[1]	63,382
Inpatient services	
General hospitals	4,525
Mental hospitals	118
Nursing facility services[2]	1,547
Intermediate care facility (MR) services[3]	100
Physician services	23,539
Dental services	11,875
Other practitioner services	5,833
Outpatient hospital services	15,518
Clinic services	13,207
Laboratory and radiological services	16,525
Home health services	1,134
Prescribed drugs	28,520
Personal care support services	1,144
Sterilization services	133
PCCM capitation	8,208
HMO capitation	32,812
PHP capitation	25,191
Targeted case management	2,526
Other services, unspecified	10,855
Additional service categories[4]	7,775
Unknown	136

[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.

NOTES: Data derived from MSIS State Summary Datamart. Beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations. Excludes CHIP.

SOURCES: CMS, Office of Information Products and Data Analytics and CMCS.

Table IV.10
Medicaid/units of service

	Fiscal year 2010 units of service
	In thousands
Inpatient hospital	
Total discharges	6,251
Beneficiaries discharged	4,525
Total days of care	34,485
Nursing facility	
Total days of care	345,794
Intermediate care facility/mentally retarded	
Total days of care	41,046

NOTES: Data are derived from the MSIS 2010 State Summary Datamart and are based on reported States. Excludes territories and CHIP.

SOURCES: CMS, Information Products and Data Analytics and CMCS.

Administrative/Operating

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

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

Table V.1
Medicare administrative expenses/trends

Fiscal Year	Administrative expenses: Amount in millions	Administrative expenses: As a percent of benefit payments
HI Trust Fund		
1967	$89	3.5
1970	149	3.1
1980	497	2.1
1990	774	1.2
1995	1,300	1.1
2000[1]	2,350	1.8
2005[1]	2,850	1.6
2009	3,343	1.4
2010	3,328	1.4
2011	3,927	1.5
2012	3,696	1.4
SMI Trust Fund[2]		
1967	135[3]	20.3
1970	217	11.0
1980	593	5.8
1990	1,524	3.7
1995	1,722	2.7
2000	1,780	2.0
2005	2,348	1.6
2009	3,317	1.3
2010	3,513	1.3
2011	3,833	1.3
2012	4,130	1.3

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

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

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

SOURCE: CMS, Office of the Actuary.

Table V.2
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	3	3
Other	1	0

NOTES: Data for FY 2013. Numbers do not include A/B MACs or DME MACs.

SOURCE: CMS, Center for Medicare.

Table V.3
Medicare Redeterminations

	Intermediary Redeterminations (Part A Cases Involved)	Intermediary Redeterminations (Part B Cases Involved)	Carrier Redeterminations (Part B Cases Involved)
Number Processed	309,359	222,581	2,306,650
Percent Reversed (Includes Fully & Partially Reversed Cases)	9.3	48.0	47.6

NOTES: Data for fiscal year 2012. Data presented in cases.

SOURCE: CMS, Center for Medicare.

Table V.4
Medicare physician/supplier claims assignment rates

	2000	2005	2009	2010	2011	2012
	In millions					
Claims total	720.5	951.6	978.2	972.7	986.5	1,022.4
Claims assigned	705.7	940.7	970.3	965.7	980.0	1,016.2
Claims unassigned	15.3	10.9	7.9	7.0	6.5	6.2
Percent assigned	97.9	98.9	99.2	99.3	99.3	99.4

NOTES: Calendar year data (Includes Carriers, Part B A/B MACs, DME MACs). Due to ongoing transition from Carriers to Part B MACs, this table has been altered to solely reflect assignment rates at the National level.

SOURCE: CMS, Center for Medicare.

Table V.5
Medicare claims processing

	Fiscal year 2012
Intermediary claims processed in millions	207.3
Carrier claims processed in millions[1]	1,011.9

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

SOURCE: CMS, Center for Medicare.

Table V.6
Medicare claims received

	Claims received
Intermediary claims received in millions	206.9
	Percent of total
Inpatient hospital	7.3
Outpatient hospital	60.0
Home health agency	7.6
Skilled nursing facility	2.9
Other	22.2
Carrier claims received in millions	1,003.2
	Percent of total
Assigned	99.4
Unassigned	0.6

NOTE: Data for calendar year 2012.

SOURCE: CMS, Center for Medicare.

Table V.7
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	894.0	5.0
Percent reduced	95.0	87.0
Total covered charges		
Amount in millions	$334,509	$602
Percent reduced	61.3	20.6
Amount reduced per claim	$229.27	$24.87

NOTES: Data for calendar year 2012. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Center for Medicare.

Table V.8
Medicaid administration

	Fiscal year	
	2011	2012
	In millions	
Total payments computable for Federal funding[1]	$19,493	$22,147
Federal share[1]		
Family planning	32	28
Design, development or Installation of MMIS[2]	364	509
Skilled professional medical personnel	483	405
Operation of an approved MMIS[2]	1,367	1,532
All other	8,501	11,152
Mechanized systems not approved under MMIS[2]	191	80
Total Federal Share	$10,938	$13,706
Net adjusted Federal share[3]	$10,878	$13,344

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

SOURCE: CMS, Office of Information Products and Data Analytics.

Reference

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

Program financing, cost sharing and limitations

Medicare/source of income			
Medicare Part A			
Hospital Insurance trust fund:			
1. Payroll taxes*			
2. Income from taxation of social security benefits			
3. Transfers from railroad retirement account			
4. General revenue for uninsured persons and military wage credits			
5. Premiums from voluntary enrollees			
6. Interest on investments			
*Contribution rate	2011	2012	2013
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 2013)		None[1]	
Voluntary HI monthly premium[2]		$441.00	

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/13)	$1,184/benefit period
Regular coinsurance days (1/1/13)	$296/day for 61st thru 90th day
Lifetime reserve days (1/1/13)	$592/day (60 non-renewable days)
SNF coinsurance days (1/1/13)	$148.00/day for 21st thru 100th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/13)[2]	$441/month; $243/mo. with 30-39 quarters of coverage
Limitations:	
Inpatient psychiatric hospitals	190 nonrenewable days

[1]The Omnibus Reconciliation Act of 1993 eliminated the Annual Maximum Taxable Earnings amounts for 1994 and later. For these years, the contribution rate is applied to all earnings in covered employment.

[2]Premium paid for voluntary participation of individuals aged 65 and over not otherwise entitled to hospital insurance and certain disabled individuals who have exhausted other entitlement. A reduced premium of $243 is available to individuals aged 65 and over who are not otherwise entitled to hospital insurance but who have, or whose spouse has or had, 30-39 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part B

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

Part B (effective date)	**Amount**
Deductible (1/1/13)	$147 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/13)	$104.90/month
Limitations:	
Outpatient treatment for mental illness	No limitations

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

SOURCE: CMS, Office of the Actuary.

Medicare Part B (continued)

Listed below are the 2013 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	$104.90
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$42.00	$146.90
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$104.90	$209.80
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$167.80	$272.70
Greater than $214,000	Greater than $428,000	$230.80	$335.70

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

Married beneficiaries who lived with their spouse and filed a separate tax return:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $129,000	$167.80	$272.70
Greater than $129,000	$230.80	$335.70

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part D Standard Benefits

Deductible (1/1/2013)	$325 in charges/year
Initial coverage limit (1/1/2013)	$2,970 in charges/year
Out-of-pocket threshold (1/1/2013)	$4,750 in charges/year
Base beneficiary premium (1/1/2013)[1]	$31.17/month

Medicaid financing

1. Federal contributions (ranging from 50 to 73 percent for fiscal year 2013)
2. State contributions (ranging from 27 to 50 percent for fiscal year 2013)

[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.

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

SOURCE: CMS, Office of the Actuary.

Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2013

I. Boston	FMAP
Connecticut	50.00
Maine	62.57
Massachusetts	50.00
New Hampshire	50.00
Rhode Island	51.26
Vermont	56.04
III. Philadelphia	
Delaware	55.67
Dist. of Columbia	70.00
Maryland	50.00
Pennsylvania	54.28
Virginia	50.00
West Virginia	72.04
V. Chicago	
Illinois	50.00
Indiana	67.16
Michigan	66.39
Minnesota	50.00
Ohio	63.58
Wisconsin	59.74
VII. Kansas City	
Iowa	59.59
Kansas	56.51
Missouri	61.37
Nebraska	55.76
IX. San Francisco	
Arizona	65.68
California	50.00
Hawaii	51.86
Nevada	59.74
American Samoa	55.00
Guam	55.00
N. Mariana Islds	55.00

II. New York	FMAP
New Jersey	50.00
New York	50.00
Puerto Rico	55.00
Virgin Islands	55.00
IV. Atlanta	
Alabama	68.53
Florida	58.08
Georgia	65.56
Kentucky	70.55
Mississippi	73.43
North Carolina	65.51
South Carolina	70.43
Tennessee	66.13
VI. Dallas	
Arkansas	70.17
Louisiana	61.24
New Mexico	69.07
Oklahoma	64.00
Texas	59.30
VIII. Denver	
Colorado	50.00
Montana	66.00
North Dakota	52.27
South Dakota	56.19
Utah	69.61
Wyoming	50.00
X. Seattle	
Alaska	50.00
Idaho	71.00
Oregon	62.44
Washington	50.00

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

SOURCE: DHHS, Assistant Secretary for Planning and Evaluation.

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Office of Information Products and Data Analytics
CMS Pub. No. 03504 August 2013