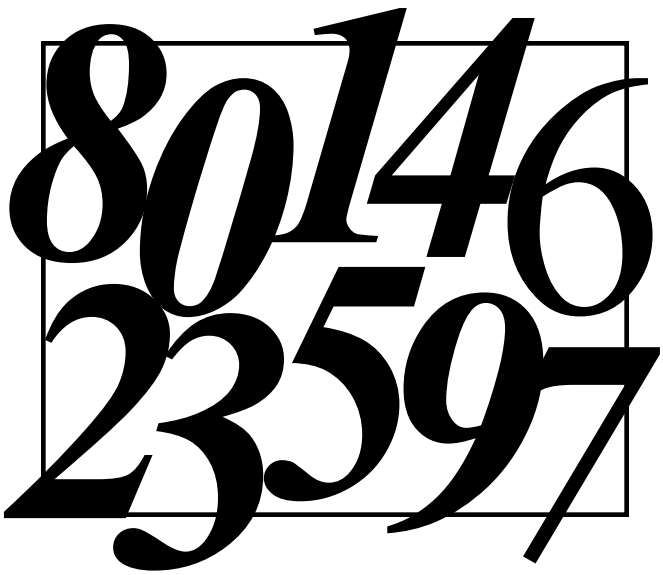
2011 CMS Statistics



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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

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, CHIP and Survey & Certification**
CMS	**Centers for Medicare & Medicaid Services**
CSP	**Center for Strategic Planning**
DHHS	**Department of Health and Human Services**
DMACs	**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**
HCCP	**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 48.9 million in 2011, a 156 percent increase.
- On average, the number of Medicaid monthly enrollees in 2011 is estimated to be about 56.1 million, the largest group being children (28.3 million or 50.4 percent).
- In 2008, about 19.9 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 438.2 thousand in 2010, an increase of 557 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 8.0 million beneficiaries in 2010, an increase of about 186 percent.

- By 2011, nearly 28.0 million Medicare enrollees had Part D drug coverage, 58.8 percent of all enrollees, and an additional 6.7 million had RDS.
- About 8.5 million persons were dually eligible for both Medicare and Medicaid as of July 1, 2009.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,552 in December 1990 to 6,169 in December 2010. Total inpatient hospital beds have dropped from 32.8 beds per 1,000 enrolled in 1990 to 19.6 in 2010, a decrease of 40 percent.
- In the past decade, the total number of Medicare certified beds in short-stay hospitals has decreased to about 785,000 in 2010 from 970,000 in 1990. The average number of short-stay hospital beds per enrollee in 2010 is 16.6 down from 28.8 in 1990.
- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, generally increased thereafter to over 15,000 in the late 1990s, and remains currently at this level.
- The number of participating home health agencies has fluctuated considerably over the years, almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed. The number decreased sharply but has since stabilized, reaching 10,914 in 2010.

Expenditures

- National health expenditures (NHE) were $2,486.3 billion in 2009, comprising 17.6 percent of the gross domestic product (GDP). Comparably, NHE amounted to $724.0 billion, or 12.5 percent of the GDP in 1990.
- In 2010, total net Federal outlays for CMS programs were $732.7 billion, 21.2 percent of the Federal budget.
- Medicare Part A benefit payments are projected to increase to $258.7 billion for fiscal year 2011 up from $245.2 billion for fiscal year 2010, and Medicare Part B benefit payments are projected to increase to $227.6 billion for fiscal year 2011 up from $204.9 billion for fiscal year 2010.
- Medicare Part D benefit payments are projected to increase to $68.9 billion for fiscal year 2011 up from $63.5 billion for fiscal year 2010.
- Medicare skilled nursing facility benefit payments are projected to increase to $28.4 billion for fiscal year 2011 up from $26.3 billion in 2010.
- National health expenditures per person were $211 in 1965 and grew steadily to reach $8,086 by 2009.

Utilization of Medicare and Medicaid services

- Between 1990 and 2009, the number of short-stay hospital discharges increased from 10.5 million to 11.7 million, an increase of 11 percent.
- The PPS short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.2 days in 2009, a decrease of 42 percent.

- About 31.9 million persons received a reimbursed service under Medicare fee-for-service during 2009. Comparably, almost 58.8 million persons used Medicaid services or had a premium paid on their behalf in 2008.
- The ratio of Medicare aged users of any type of covered service has grown from 528 per 1,000 enrolled in 1975 to 908 per 1,000 enrolled in 2009.
- 6.9 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2009.
- 31.0 million persons received reimbursable fee-for-services physician services under Medicare during 2009. 21.7 million persons received reimbursable physician services under Medicaid during 2008.
- 23.3 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2009. During 2008, 14.8 million persons received Medicaid reimbursable outpatient hospital services.
- Over 1.8 million persons received care in SNFs covered by Medicare during 2009. 1.6 million persons received care in nursing facilities, which include SNFs and all other nursing facilities other than mentally retarded, covered by Medicaid during 2008.
- Over 24 million persons received prescribed drugs under Medicaid during 2008.

Populations

Information about persons covered by Medicare, Medicaid, or CHIP

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

Table I.1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
		In millions	
July			
1966	19.1	19.1	--
1970	20.4	20.4	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
Average monthly			
2000	39.7	34.3	5.4
2007	44.4	37.0	7.4
2008	45.5	37.9	7.6
2009	46.6	38.8	7.8
2010	47.5	39.6	7.9
2011	48.9	40.4	8.5

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 2000-2011 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on 2011 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	48.6	48.2	44.8	35.2	44.4	3.8	0.4
Aged persons	40.2	39.9	37.3	--	36.9	2.9	0.4
Disabled persons	8.3	8.3	7.4	--	7.4	0.9	0.0

NOTES: Projected average monthly enrollment during fiscal year 2011. Aged/disabled split of Part D enrollment not available. Based on 2011 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	47,664	21,360	26,304
Aged	39,631	17,167	22,464
65-74 years	21,234	9,946	11,288
75-84 years	12,785	5,398	7,387
85 years and over	5,612	1,823	3,789
Disabled	8,033	4,193	3,840
Under 45 years	1,865	1,000	864
45-54 years	2,477	1,289	1,189
55-64 years	3,691	1,904	1,787
White	39,381	17,661	21,719
Black	4,890	2,099	2,791
All Other	3,270	1,539	1,731
Native American	209	94	116
Asian/Pacific	948	412	537
Hispanic	1,221	573	648
Other	891	461	430
Unknown Race	123	61	62

NOTES: Data as of July 1, 2010. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.

SOURCE: CMS, Center for Strategic Planning.

Table I.4
Medicare Part D enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	28,033	11,481	16,551
Aged			
65-74 years	11,647	4,993	6,654
75-84 years	7,536	2,841	4,695
85 years and over	3,297	895	2,402
Disabled			
Under 45 years	1,621	857	765
45-54 years	1,631	834	797
55-64 years	2,301	1,062	1,239

NOTES: Data for calendar year 2010, as reported on the Part D Denominator File. Totals may not add due to rounding.

SOURCE: CMS, Center for Strategic Planning.

Table I.5
Medicare ESRD enrollment/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
2008[1]	410.6	410.5	388.9
2009[1]	424.7	424.6	402.9
2010[1]	438.2	438.1	416.2

[1]Denominator File; estimated person years.

NOTES: Data prior to 2000 are as of July 1; estimated person years 2000-2010.

SOURCE: CMS, Center for Strategic Planning.

Table I.6
Medicare ESRD enrollment/demographics

	Number of enrollees (in thousands)
All persons	486.9
Age	
Under 35 years	26.7
35-44 years	42.1
45-64 years	196.4
65 years and over	221.6
Sex	
Male	276.7
Female	210.2
Race	
White	260.0
Other	223.8
Unknown	3.1

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2010.

SOURCE: CMS, Center for Strategic Planning.

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

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	665	1,528	10,709	12,237
Local CCPs	509	851	9,198	10,049
PFFS	28	146	437	583
1876 Cost	20	163	197	359
1833 Cost (HCPP)	11	61	--	61
PACE	76	--	20	20
Other plans[2]	21	308	856	1,165
Total PDPs[1]	84	--	18,599	18,599
Total	749	1,528	29,307	30,835

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

[2]Includes MSA, EPFFS, Pilot, and RPPOs.
NOTE: Data as of April 2011.
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	309,051	46,585	15.1
Boston	14,474	2,411	16.7
New York	28,311	4,315	15.2
Philadelphia	29,650	4,818	16.2
Atlanta	61,010	10,034	16.4
Chicago	51,812	8,094	15.6
Dallas	38,411	5,136	13.4
Kansas City	13,687	2,234	16.3
Denver	10,928	1,403	12.8
San Francisco	47,898	6,251	13.0
Seattle	12,870	1,889	14.7

[1]Preliminary annual estimate July 1, 2010 resident population.

[2]Medicare enrollment file data are as of July 1, 2010. 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, Center for Strategic Planning; 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	47,664	35,910	11,754
Boston	2,411	1,985	427
New York	5,002	3,493	1,509
Philadelphia	4,818	3,619	1,199
Atlanta	10,034	7,756	2,278
Chicago	8,094	6,260	1,834
Dallas	5,136	4,138	998
Kansas City	2,234	1,873	361
Denver	1,403	1,042	361
San Francisco	6,268	4,053	2,215
Seattle	1,889	1,319	570

NOTES: Data as of July 1, 2010. 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, Center for Strategic Planning.

Table I.9a
Medicare enrollment by enrollment type/demographics

	Total	Fee-for-Service	Managed Care
		In thousands	
All persons	47,664	35,910	11,754
Aged	39,631	29,291	10,340
65-74 years	21,234	15,648	5,586
75-84 years	12,785	9,291	3,494
85 years and over	5,612	4,352	1,259
Disabled	8,033	6,619	1,414
Under 45 years	1,865	1,657	208
45-54 years	2,477	2,075	402
55-64 years	3,691	2,887	803
Male	21,360	16,281	5,079
Female	26,304	19,629	6,675
White	39,381	29,801	9,580
Black	4,890	3,633	1,257
All Other	3,270	2,370	900
Native American	209	186	24
Asian/Pacific	948	716	232
Hispanic	1,221	840	381
Other	891	628	264
Unknown Race	123	106	17

NOTES: Data as of July 1, 2010. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.

SOURCE: CMS, Center for Strategic Planning.

Table I.10
Medicare Part D enrollment by CMS region

	Total Medicare Enrollees	Total Part D Enrollees	Percent of Total Enrollees
	In thousands		
All regions[1]	47,664	28,033	58.8
Boston	2,411	1,380	57.2
New York	5,002	2,939	58.8
Philadelphia	4,818	2,730	56.7
Atlanta	10,034	6,027	60.1
Chicago	8,094	4,449	55.0
Dallas	5,136	2,984	58.1
Kansas City	2,234	1,418	63.5
Denver	1,403	825	58.8
San Francisco	6,268	4,179	66.7
Seattle	1,889	1,091	57.8

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

NOTE: Data for calendar year 2010 as reported on the Part D Denominator file.
SOURCE: CMS, Center for Strategic Planning.

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]	28,033	17,844	10,188
Boston	1,380	986	394
New York	2,939	1,564	1,375
Philadelphia	2,730	1,783	947
Atlanta	6,027	3,962	2,065
Chicago	4,449	3,139	1,310
Dallas	2,984	2,083	901
Kansas City	1,418	1,100	318
Denver	825	517	308
San Francisco	4,179	2,055	2,123
Seattle	1,091	646	445

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

NOTE: Data for calendar year 2010 as reported on the Part D Denominator file.

SOURCE: CMS, Center for Strategic Planning.

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]	34,767	28,033	6,734
Boston	1,777	1,380	397
New York	3,803	2,939	865
Philadelphia	3,380	2,730	650
Atlanta	7,314	6,027	1,287
Chicago	6,139	4,449	1,691
Dallas	3,637	2,984	653
Kansas City	1,638	1,418	220
Denver	972	825	147
San Francisco	4,783	4,179	604
Seattle	1,304	1,091	213

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

NOTE: Data for calendar year 2010 as reported on the Part D Denominator file.

SOURCE: CMS, Center for Strategic Planning.

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

	2010	2020	2040	2060	2080	2100
			In millions			
Total	315	343	391	430	471	512
Under 20	85	90	98	106	113	121
20-64	189	198	214	234	253	271
65 years and over	41	56	80	90	105	120

[1]As of July 1.

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

SOURCE: SSA, Office of the Actuary, based on the 2011 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	17.5	19.9
2020[1]	18.5	20.5
2030[1]	19.2	21.1
2040[1]	19.8	21.7
2050[1]	20.3	22.3
2060[1]	20.9	22.8
2070[1]	21.4	23.3
2080[1]	21.9	23.8
2090[1]	22.4	24.3
2100[1]	22.8	24.7

[1]Projected.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2011 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	77.4	77.9	72.8
2006	77.7	78.2	73.2
2007	77.9	78.4	73.6
		At Age 65	
1960	14.3	14.4	13.9
1980	16.4	16.5	15.1
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2000	17.6	17.7	16.1
2005	18.2	18.3	16.8
2006	18.5	18.6	17.1
2007	18.6	18.7	17.2

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Health United States, 2010.

Table I.16
Medicaid and CHIP enrollment

	Fiscal year					
	1990	1995	2000	2005	2010	2011
	Average monthly enrollment in millions					
Total	22.9	34.2	34.5	46.5	53.9	56.1
Age 65 years and over	3.1	3.7	3.7	4.6	4.8	4.9
Blind/Disabled	3.8	5.8	6.7	8.1	9.5	9.6
Children	10.7	16.5	16.2	22.3	26.8	28.3
Adults	4.9	6.7	6.9	10.6	11.9	12.2
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	5.4	5.7
	Unduplicated annual enrollment in millions					
Total	NA	43.3	44.2	58.7	67.7	70.4
Age 65 years and over	NA	4.4	4.3	5.5	5.6	5.7
Blind/Disabled	NA	6.5	7.5	9.0	10.5	10.7
Children	NA	21.3	20.9	27.8	33.3	35.3
Adults	NA	9.4	10.6	15.4	17.3	17.8
Other Title XIX[1]	NA	0.9	NA	NA	NA	NA
Territories	NA	0.8	0.9	1.0	1.0	1.0
CHIP	NA	NA	3.4	6.8	8.5	9.0

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

NOTES: Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty-related recipients who are not disabled. Medicaid enrollment excludes Medicaid expansion CHIP programs. CHIP numbers include adults covered under waivers. Medicaid and CHIP figures for FY 2010-2011 are estimates from the President's FY 2012 Budget. Enrollment for Territories for FY 2000 and later is estimated. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of the Actuary.

Table I.17
Medicaid eligibles/demographics

	Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	60.9	100.0
Age	60.9	100.0
Under 21	32.8	53.9
21-64 years	21.9	36.0
65 years and over	6.0	9.9
Unknown	0.1	0.2
Sex	60.9	100.0
Male	24.8	40.8
Female	35.9	59.0
Unknown	0.1	0.2
Race	60.9	100.0
White, not Hispanic	25.0	41.1
Black, not Hispanic	13.6	22.3
Am. Indian/Alaskan Native	0.8	1.3
Asian	1.8	2.9
Hawaiian/Pacific Islander	0.6	1.0
Hispanic	14.8	24.4
Other	0.2	0.3
Unknown	4.1	6.7

NOTES: Fiscal Year 2008 data 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. Race information is obtained from the states.

SOURCE: CMS, Center for Strategic Planning.

Table I.18
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	304,177	60,867	19.9
Boston	14,365	3,009	20.9
New York	28,122	6,039	21.5
Philadelphia	29,277	4,766	16.3
Atlanta	59,968	11,383	19.0
Chicago	51,607	9,757	18.9
Dallas	37,231	7,593	20.4
Kansas City	13,522	2,185	16.2
Denver	10,597	1,259	11.9
San Francisco	46,930	12,829	27.3
Seattle	12,559	2,047	16.3

[1]Estimated July 1, 2008 population.
[2]Persons ever enrolled in Medicaid during fiscal year 2008.

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, Center for Strategic Planning; 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]	2010[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	8,006
Aged	2,483	2,449	3,632	4,704
Disabled	363	504	1,917	3,302
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	18.3
Aged	11.4	10.0	11.1	12.8
Disabled	18.7	18.9	40.2	47.1

[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, Center for Strategic Planning.

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	2009	2010
Total hospitals	6,522	5,985	6,172	6,169
Beds in thousands	1,105	991	926	928
Beds per 1,000 enrollees[1]	32.8	25.3	20.1	19.6
Short-stay	5,549	4,900	3,606	3,566
Beds in thousands	970	873	785	785
Beds per 1,000 enrollees[1]	28.8	22.3	17.0	16.6
Critical access hospitals	NA	NA	1,311	1,325
Beds in thousands	---	---	30	30
Beds per 1,000 enrollees[1]	---	---	0.7	0.6
Other non-short-stay	973	1,085	1,255	1,278
Beds in thousands	135	118	111	113
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, Center for Strategic Planning.

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	4,891	17.2	1,278	2.4
Boston	186	13.7	66	4.2
New York	308	18.0	74	2.5
Philadelphia	367	15.1	136	2.8
Atlanta	907	17.7	229	2.1
Chicago	872	18.6	189	1.9
Dallas	785	19.8	335	3.8
Kansas City	459	21.4	62	2.0
Denver	311	18.4	44	2.6
San Francisco	487	15.5	116	1.6
Seattle	209	12.7	27	1.4

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2010. Rates based on number of hospital insurance enrollees as of July 1, 2010, residing in U.S. and its territories.

SOURCE: CMS, Center for Strategic Planning.

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

Total participating hospitals	6,178
Short-term hospitals	3,573
Psychiatric units	1,171
Rehabilitation units	932
Swing bed units	512
Psychiatric	508
Long-term	436
Rehabilitation	232
Childrens	84
Religious non-medical	17
Critical access	1,328
Non-participating Hospitals	754
Emergency	403
Federal	351
All SNFs/SNF-NFs/NFs only	15,712
All SNFs/SNF-NFs	15,107
Title 18 Only SNF	795
Hospital-based	263
Free-standing	532
Title 18/19 SNF/NF	14,312
Hospital-based	654
Free-standing	13,658
Title 19 only NFs	605
Hospital-based	116
Free-standing	489
All ICF-MR facilities	6,459

NOTES: The table is designed to give a "snapshot" as of May 2011 of institutional providers participating in the program by type of provider (short term, long term, rehab., etc.). Numbers may differ from other reports and program memoranda.

SOURCES: CMS, CM, and CMCS.

Table II.4
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs	Nursing Facilities	ICF-MRs
All regions[1]	15,084	624	6,424
Boston	968	11	145
New York	1,002	2	577
Philadelphia	1,376	44	392
Atlanta	2,621	63	673
Chicago	3,325	135	1,497
Dallas	1,974	98	1,562
Kansas City	1,376	144	193
Denver	592	41	100
San Francisco	1,411	65	1,203
Seattle	439	21	82

[1]Includes outlying areas.

NOTE: Data as of December 2010.

SOURCE: CMS, Center for Strategic Planning.

Table II.5
Other Medicare providers and suppliers/trends

	1980	1990	2009	2010
Home health agencies	2,924	5,661	10,184	10,914
Independent and Clinical Lab Improvement Act Facilities	NA	4,828	218,139	224,679
End stage renal disease facilities	999	1,987	5,476	5,631
Outpatient physical therapy and/or speech pathology	419	1,144	2,640	2,536
Portable X-ray	216	435	546	561
Rural health clinics	391	517	3,752	3,845
Comprehensive outpatient rehabilitation facilities	NA	184	406	354
Ambulatory surgical centers	NA	1,165	5,260	5,316
Hospices	NA	772	3,405	3,509

NOTES: Facility data for 1980 are as of July 1. Facility data for 1990, 2009 and 2010 are as of December 31.

SOURCE: CMS, Center for Strategic Planning.

Table II.6
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,566	15,084	10,914
		Percent of total	
Non-profit	59.8	25.6	18.2
Proprietary	21.3	68.3	74.8
Government	18.9	6.1	7.0

NOTES: Data as of December 31, 2010. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: CMS, Center for Strategic Planning.

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

	1980	1990	2000	2009	2010
Hospitals					
Number of PIP	2,276	1,352	869	574	547
Percent of total participating	33.8	20.6	14.4	9.3	8.9
Skilled nursing facilities					
Number of PIP	203	774	1,236	460	381
Percent of total participating	3.9	7.3	8.3	3.1	2.5
Home health agencies					
Number of PIP	481	1,211	1,038	86	114
Percent of total participating	16.0	21.0	14.4	0.8	1.0

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.

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 2009	Fiscal year 2010
	$ in billions	
Gross domestic product (current dollars)	$14,119.0	$14,651.0
Total Federal outlays[1]	3,517.7	3,456.2
Percent of gross domestic product	24.9%	23.6%
Dept. of Health and Human Services[1]	796.3	854.2
Percent of Federal Budget	22.6%	24.7%
CMS Budget (Federal Outlays)		
Medicare benefit payments	497.4	518.8
SMI transfer to Medicaid[2]	0.4	0.5
Medicaid benefit payments	240.6	262.7
Medicaid State and local admin.	10.3	10.1
Medicaid offsets[3]	-0.4	-0.5
Children's Health Ins. Prog.	7.5	7.9
CMS program management	3.0	3.1
Other Medicare admin. expenses[4]	2.1	2.1
State Eligibility Determinations, for Part D	0.0	0.0
Quality improvement organizations[5]	0.4	0.3
Health Care Fraud and Abuse Control	1.1	1.2
State Grants and Demonstrations[6]	0.5	0.5
User Fees and Reimbursables	0.3	0.2
Total CMS outlays (unadjusted)	763.2	806.9
Offsetting receipts[7]	-74.2	-74.2
Total net CMS outlays	689.0	732.7
Percent of Federal budget	19.6%	21.2%

[1]Net of offsetting receipts.

[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($449.4 million in FY 2009 and $515.3 million in FY 2010).

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

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

[5]Formerly peer review organizations (PROs).

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

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

SOURCE: CMS, Office of Financial Management.

Table III.2
Program expenditures/trends

	Total	Medicare[1]	Medicaid[2]	CHIP[3]
		$ in billions		
Fiscal year				
1980	$60.8	$35.0	$25.8	--
1990	182.2	109.7	72.5	--
2000	428.7	219.0	208.0	$1.7
2005	664.0	339.4	317.2	7.4
2010	940.9	525.6	403.9	11.4

[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 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	2005	2010
Annually	Amounts in billions			
CMS program outlays	$5.1	$57.8	$642	$915
Federal outlays	NA	47.2	512	793
Medicare[1]	3.2	33.9	333	518
HI	2.5	23.8	183	250
SMI	0.7	10.1	150	209
Transitional Assistance[2]	NA	NA	1	0
Prescription (Part D)	NA	NA	NA	59
Medicaid[3]	1.9	23.9	302	386
Federal share	NA	13.2	173	266
CHIP[4]	NA	NA	7	11
Federal share	NA	NA	5	8

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

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

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

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

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

SOURCE: CMS, Office of Financial Management.

Table III.4
Program benefit payments/CMS region

	Fiscal Year 2009 Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$360,316	$238,887
Boston	24,855	15,312
New York	58,240	34,418
Philadelphia	34,390	22,143
Atlanta	58,850	43,239
Chicago	57,246	38,384
Dallas	39,671	28,781
Kansas City	14,543	10,179
Denver	7,792	5,257
San Francisco	52,228	32,816
Seattle	12,502	8,357

[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, Center for Strategic Planning.

Table III.5
Medicare benefit outlays

	Fiscal Year		
	2009	2010	2011
	In billions		
Part A benefit payments	$234.3	$245.2	$258.7
Aged	196.8	205.2	215.8
Disabled	37.5	40.0	42.8
Part B benefit payments	200.2	204.9	227.6
Aged	164.2	167.5	185.2
Disabled	35.9	37.3	42.3
Part D	56.6	63.5	68.9

NOTES: Based on FY 2011 Trustees Report. Part A benefits include additional payments for HIT, CBC, IPAB, and MIF. 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 2011 benefit payments[1] in millions	Percent distribution
Total Part A[2,3]	$258,682	100.0
Inpatient hospital	139,704	54.0
Skilled nursing facility	28,383	11.0
Home health agency[4]	7,084	2.7
Hospice	13,924	5.4
Managed care	69,587	26.9
Total Part B[3]	227,583	100.0
Physician/other suppliers[5]	68,129	29.9
DME	8,521	3.7
Other carrier	18,130	8.0
Outpatient hospital	32,094	14.1
Home health agency[4]	12,022	5.3
Other intermediary	16,745	7.4
Laboratory	8,708	3.8
Managed care	63,235	27.8
Total Part D	68,891	100.0

[1]Includes the effects of regulatory items and recent legislation but not proposed law.
[2]Includes HIT, CBC, IPAB, and MIF 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 FY 2011 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	2009
National total in billions	$724.0	$1,378.0	$2,486.3
Percent of GDP	12.5	13.8	17.6
Per capita amount	$2,853	$4,878	$8,086
Sponsor	Percent of Total		
Private Business	24.6	25.1	20.8
Household	34.9	31.5	28.5
Other Private Revenues	7.9	8.0	7.1
Governments	32.6	35.4	43.6
Federal Government	17.3	18.9	27.3
State and local government	15.3	16.5	16.3

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

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

Table III.8
Medicaid/type of service

	Fiscal year		
	2007	2008	2009
	In billions		
Total medical assistance payments[1]	$315.8	$334.2	$360.3
	Percent of total		
Inpatient services	16.3	15.2	15.0
General hospitals	15.1	14.2	14.1
Mental hospitals	1.2	1.1	0.9
Nursing facility services	15.0	14.6	13.9
Intermediate care facility (MR) services	3.9	3.7	3.8
Community-based long term care svs.[2]	13.6	14.0	14.4
Prescribed drugs[3]	4.7	4.6	4.3
Physician services	3.9	4.1	3.9
Dental services	1.1	1.2	1.3
Outpatient hospital services	4.2	3.8	4.1
Clinic services[4]	3.0	3.0	3.1
Laboratory and radiological services	0.4	0.4	0.4
Early and periodic screening	0.3	0.3	0.3
Targeted case management services	0.9	0.9	0.8
Capitation payments (non-Medicare)	19.7	21.5	22.8
Medicare premiums	3.3	3.3	3.1
Disproportionate share hosp. payments	5.1	5.1	4.9
Other services	6.3	5.9	5.7
Collections[5]	-1.7	-1.6	-2.0

[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		
	2008	2009	2010
	In millions		
Total	$6,787.5	$8,022.8	$8,007.1
Workers Compensation[1]	1,053.3	1,232.5	1,613.1
Working Aged	3,033.3	3,583.3	3,259.1
ESRD	315.6	375.5	343.6
Auto	293.3	248.2	325.1
Disability	1,982.8	2,231.5	2,021.8
Liability	82.0	323.8	424.4
VA/Other	27.2	28.2	19.9

[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 2009 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$359.6	100.0
Age 65 years and over	73.1	20.3
Blind/disabled	148.8	41.4
Dependent children under 21 years of age	69.0	19.2
Adults in families with dependent children	47.2	13.1
Disproportionate share hospital and other unallocated payments	21.4	6.0

[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]	
	2009	2010[3]
	In thousands	
Total	$11,013,456	$11,386,584
Medical/surgical supplies	196,233	198,461
Hospital beds	251,869	252,346
Oxygen and supplies	2,147,163	2,187,421
Wheelchairs	1,372,416	1,378,307
Prosthetic/orthotic devices	2,184,036	2,307,373
Drugs admin. through DME[4]	559,278	604,182
Parenteral and enteral nutrition	721,597	708,744
Other DME	3,580,865	3,749,749

[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 2010 are preliminary through March 2011.
[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, Center for Strategic Planning.

Table III.12
National health care/type of expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$2,486.3	$8,086	35.2	20.2	15.0
Health Consumption Expenditures	2,330.1	7,578	37.6	21.6	16.0
Personal health care	2,089.9	6,797	39.1	22.5	16.5
Hospital care	759.1	2,469	47.0	29.0	17.9
Prof. services	674.9	2,195	25.9	18.3	7.6
Phys./clinical	505.9	1,645	29.5	21.6	7.9
Other Professional	66.8	217	27.2	20.5	6.8
Dental	102.2	332	7.3	0.3	7.0
Other Health Residential & Personal Care	122.6	399	56.3	3.7	52.5
Nursing Care Facilities & Continuing Care Retirement Communities	137.0	445	53.3	20.4	32.8
Home Health	68.3	222	79.3	43.7	35.6
Retail outlet sales	328.0	1,067	27.2	19.8	7.4
Admin. Net Cost, & public health	240.2	781	24.7	12.9	11.8
Investment	156.2	508	0.0	--	--

NOTE: Data are as of calendar year 2009.
SOURCE: CMS, Office of the Actuary.

Table III.13
Personal health care/payment source

	Calendar Year			
	1980	1990	2000	2009
	In billions			
Total	$217.1	$616.6	$1,164.0	$2,089.9
	Percent			
Total	100.0	100.0	100.0	100.0
Out of pocket	26.9	22.5	17.4	14.3
Health Insurance	60.8	65.4	72.4	77.3
Private Health Insurance	28.3	33.2	34.9	34.1
Medicare	16.7	17.4	18.5	22.5
Medicaid (Title XIX)	11.4	11.3	16.1	16.5
Total CHIP (Title XIX & XXI)	0.0	0.0	0.2	0.5
Department of Defense	1.8	1.7	1.1	1.6
Depart. of Veteran's Affairs	2.6	1.8	1.6	2.0
Other 3rd Party Payers & Programs	12.3	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	2009
Discharges				
Total in millions	10.5	10.5	13.0	11.7
Rate per 1,000 enrollees[1]	347	320	361	336
Days of care				
Total in millions	92	94	75	65
Rate per 1,000 enrollees[1]	3,016	2,866	2,073	1,860
Average length of stay				
All short-stay	8.7	9.0	5.7	5.5
Excluded units	18.8	19.5	11.5	11.9
Total charges per day	$597	$1,060	$4,882	$6,770

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

NOTES: Data may reflect underreporting due to a variety of reasons, including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; no-pay Medicare secondary payer bills; and for certain years, discharges where the beneficiary received services out of State. The data for 1990 through 2009 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with a different update cycle.

SOURCES: CMS, Office of Information Services, and Center for Strategic Planning.

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]
2008	1,841	53 [1]	3,172	90 [1]
2009	1,808	52 [1]	3,281	93 [1]

[1]Managed care enrollees excluded in determining rate.

SOURCE: CMS, Center for Strategic Planning.

Table IV.3
Medicare average length of stay/trends

	Fiscal Year				
	1990	1995	2000	2008	2009
All short-stay and excluded units					
Short-stay PPS units	9.0	7.1	6.0	5.3	5.2
Short-stay hospital non-PPS units	8.9	7.1	6.0	5.3	5.1
Excluded units	19.5	14.8	12.3	12.0	11.9

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2009 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.

SOURCES: CMS, Office of Information Services, and Center for Strategic Planning.

Table IV.4
Medicare persons served/trends

	Calendar Year					
	1975	1985	1995	2000	2005	2009
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	916	923	908
HI	221	219	218	232	234	224
SMI	536	739	858	965	979	986
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	835	865	882
HI	219	228	212	196	205	204
SMI	471	715	837	943	977	1,005

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.

SOURCES: CMS, Office of Information Services, and Center for Strategic Planning.

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

	Calendar Year				
	2005	2006	2007	2008	2009
HI					
Aged					
FFS Enrollees	30.0	29.3	28.8	28.6	28.6
Persons served	7.0	6.8	6.7	6.6	6.4
Rate per 1,000	234	234	231	229	224
Disabled					
FFS Enrollees	6.3	6.2	6.3	6.4	6.4
Persons served	1.3	1.3	1.3	1.3	1.3
Rate per 1,000	205	205	204	202	204
SMI					
Aged					
FFS Enrollees	28.4	27.5	26.9	26.4	26.2
Persons served	27.8	27.3	26.6	26.2	25.9
Rate per 1,000	979	994	989	990	986
Disabled					
FFS Enrollees	5.5	5.4	5.5	5.5	5.6
Persons served	5.4	5.4	5.5	5.5	5.6
Rate per 1,000	977	998	999	1,001	1,005

NOTES: Enrollment represents persons enrolled in Medicare fee-for-service as of July. Persons served represents estimates of beneficiaries receiving 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, Center for Strategic Planning.

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]	26,255	908	5,673	882
Boston	1,416	898	326	867
New York	2,490	864	498	816
Philadelphia	2,681	919	551	888
Atlanta	5,811	944	1,404	920
Chicago	4,799	954	1,009	895
Dallas	3,011	916	693	901
Kansas City	1,443	941	292	913
Denver	801	930	140	884
San Francisco	2,849	870	563	827
Seattle	937	891	194	843

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

NOTES: Data as of calendar year 2009 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, Center for Strategic Planning.

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	31,927	26,255	5,673
Part A	7,722	6,409	1,313
Inpatient hospital	6,942	5,677	1,266
Skilled nursing facility	1,808	1,662	146
Home health agency	1,710	1,509	200
Hospice	1,085	1,027	58
Part B	31,473	25,866	5,607
Physician/supplier	30,971	25,519	5,451
Outpatient	23,303	19,062	4,241
Home health agency	1,746	1,515	230

NOTES: Data are as of calendar year 2009. Persons served represents estimates of beneficiaries receiving services under fee-for-service during the calendar year.

SOURCE: CMS, Center for Strategic Planning.

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

Year	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
1991	182,171	142,574	39,597
1997	282,672	219,976	62,696
1998	300,400	233,408	66,992
1999	317,505	245,862	71,643
2000	334,122	258,521	75,601
2001	350,292	270,652	79,640
2002	365,943	281,769	84,174
2003	378,409	291,990	86,419
2004	393,859	301,786	92,073
2005	408,652	311,626	97,026
2006	424,761	322,589	102,172
2007	439,765	333,184	106,581
2008	453,443	342,848	110,595

SOURCE: United States Renal Data System.

Table IV.8
Medicare end stage renal disease (ESRD)
by treatment modalities and demographics, 2007

	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
Total -- all patients	439,765	333,184	106,581
Age			
0-19 years	3,469	1,446	2,023
20-64 years	254,149	175,319	78,830
65-74 years	101,217	80,086	21,131
75 years and over	80,929	76,332	4,597
Sex			
Male	247,993	183,849	64,144
Female	191,772	149,335	42,437
Race			
White	265,728	188,490	77,238
Black	145,964	123,319	22,645
Native American	5,903	4,782	1,121
Asian/Pacific	19,460	14,595	4,865
Other/Unknown	2,710	1,998	712

SOURCE: United States Renal Data System.

Table IV.9
Medicaid/type of service

	Fiscal year 2008 Medicaid beneficiaries
	In thousands
Total eligibles	60,867
Number using service:	
Total beneficiaries, any service[1]	58,771
Inpatient services	
General hospitals	5,259
Mental hospitals	109
Nursing facility services[2]	1,616
Intermediate care facility (MR) services[3]	102
Physician services	21,661
Dental services	9,821
Other practitioner services	5,165
Outpatient hospital services	14,789
Clinic services	11,857
Laboratory and radiological services	15,612
Home health services	1,144
Prescribed drugs	24,579
Personal care support services	1,079
Sterilization services	138
PCCM capitation	8,728
HMO capitation	28,863
PHP capitation	20,566
Targeted case management	2,437
Other services, unspecified	10,155
Additional service categories[4]	7,584
Unknown	90

[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 7.6 million beneficiaries, not unduplicated.

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

SOURCE: CMS, CMCS.

Table IV.10
Medicaid/units of service

	Fiscal year 2008 units of service
	In thousands
Inpatient hospital	
Total discharges	7,588
Beneficiaries discharged	5,259
Total days of care	38,172
Nursing facility	
Total days of care	466,939
Intermediate care facility/mentally retarded	
Total days of care	38,576

NOTES: Data are derived from the MSIS 2008 State Summary Mart and are based on reported States. Excludes territories.

SOURCE: CMS, Center for Strategic Planning.

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
2008[1]	3,231	1.4[2]
2009	3,343	1.4
2010	3,328	1.3
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
2008	3,419	1.6[2]
2009	3,318	1.3
2010	3,514	1.3

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

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

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

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

SOURCE: CMS, Office of the Actuary.

Table V.2
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	8	9
Other	2	2

NOTES: Data for FY 2011. Numbers do not include MACs or DMACs.

SOURCE: CMS, Office of Financial Management.

Table V.3
Medicare Redeterminations

	Intermediary Redeterminations (Part A Cases Involved)	Intermediary Redeterminations (Part B Cases Involved)	Carrier Redeterminations (Part B Cases Involved)
Number Processed	44,652	188,221	1,939,374
Percent Reversed (Includes Fully & Partially Reversed Cases)	20.8	49.9	49.1

NOTES: Data for fiscal year 2010. Data presented in cases.

SOURCE: CMS, Office of Financial Management.

Table V.4
Medicare physician/supplier claims assignment rates

	2000	2005	2007	2008	2009	2010
	In millions					
Claims total	720.5	951.6	944.3	974.7	978.2	972.7
Claims assigned	705.7	940.7	935.8	966.5	970.3	965.7
Claims unassigned	15.3	10.9	8.6	8.2	7.9	7.0
Percent assigned	97.9	98.9	99.1	99.2	99.2	99.3

NOTES: Calendar year data (Includes Carriers, Part 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, Office of Financial Management.

Table V.5
Medicare claims processing

	Fiscal year 2010
Intermediary claims processed in millions	195.6
Carrier claims processed in millions[1]	981.5

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

SOURCE: CMS, Office of Financial Management.

Table V.6
Medicare claims received

	Claims received
Intermediary claims received in millions	196.4
	Percent of total
Inpatient hospital	8.0
Outpatient hospital	58.0
Home health agency	8.0
Skilled nursing facility	3.1
Other	22.9
Carrier claims received in millions	973.8
	Percent of total
Assigned	99.3
Unassigned	0.7

NOTE: Data for calendar year 2010.

SOURCE: CMS, Office of Financial Management.

Table V.7
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	872.3	5.9
Percent reduced	93.7	86.4
Total covered charges		
Amount in millions	$301,389	$669
Percent reduced	59.6	18.7
Amount reduced per claim	$206.09	$21.25

NOTES: Data for calendar year 2010. 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	
	2009	2010
	In millions	
Total payments computable for Federal funding[1]	$16,233	$17,931
Federal share[1]		
Family planning	36	34
Design, development or Installation of MMIS[2]	320	339
Skilled professional Medical personnel	475	431
Operation of an approved MMIS[2]	1,278	1,270
All other	7,752	7,621
Mechanized systems not approved under MMIS[2]	136	109
Total Federal Share	$8,852	$9,804
Net adjusted Federal share[3]	$10,055	$9,794

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

SOURCE: CMS, Center for Strategic Planning.

Reference

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

Program financing, cost sharing and limitations

Medicare/source of income

Medicare Part A

Hospital Insurance trust fund:

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

*Contribution rate	2008	2010	2011
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2011)	None[1]
Voluntary HI monthly premium[2]	$450.00

Part A (effective date)	Amount
Inpatient hospital deductible (1/1/11)	$1,132/benefit period
Regular coinsurance days (1/1/11)	$283/day for 61st thru 90th day
Lifetime reserve days (1/1/11)	$566/day (60 non-renewable days)
SNF coinsurance days (1/1/11)	$141.50/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/11)	$450/month; $248/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 $248 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 (1/1/11)	$162 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/11)	$115.40/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 2011 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	$115.40
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$46.16	$161.56
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$115.40	$230.80
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$184.64	$300.04
Greater than $214,000	Greater than $428,000	$253.88	$369.28

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	$115.40
Greater than $85,000 and less than or equal to $129,000	$184.64	$300.04
Greater than $129,000	$253.88	$369.28

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part D Standard Benefits

Deductible (1/1/2011)	$310 in charges/year
Initial coverage limit (1/1/2011)	$2,840 in charges/year
Out-of-pocket threshold (1/1/2011)	$4,550 in charges/year
Base beneficiary premium (1/1/2011)[1]	$32.34/month

Medicaid financing

1. Federal contributions (ranging from 56 to 81 percent for fiscal year 2011)
2. State contributions (ranging from 19 to 44 percent for fiscal year 2011)

[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 2011, the average premium rate paid by beneficiaries is estimated to be about $31.

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 2011

I. Boston	FMAP
Connecticut	50.00
Maine	63.80
Massachusetts	50.00
New Hampshire	50.00
Rhode Island	52.97
Vermont	58.71
III. Philadelphia	
Delaware	53.15
Dist. of Columbia	70.00
Maryland	50.00
Pennsylvania	55.64
Virginia	50.00
West Virginia	73.24
V. Chicago	
Illinois	50.20
Indiana	66.52
Michigan	65.79
Minnesota	50.00
Ohio	63.69
Wisconsin	60.16
VII. Kansas City	
Iowa	62.63
Kansas	59.05
Missouri	63.29
Nebraska	58.44
IX. San Francisco	
Arizona	65.85
California	50.00
Hawaii	51.79
Nevada	51.61
American Samoa	50.00
Guam	50.00
N. Mariana Islds	50.00

II. New York	FMAP
New Jersey	50.00
New York	50.00
Puerto Rico	50.00
Virgin Islands	50.00
IV. Atlanta	
Alabama	68.54
Florida	55.45
Georgia	65.33
Kentucky	71.49
Mississippi	74.73
North Carolina	64.71
South Carolina	70.04
Tennessee	65.85
VI. Dallas	
Arkansas	71.37
Louisiana	63.61
New Mexico	69.78
Oklahoma	64.94
Texas	60.56
VIII. Denver	
Colorado	50.00
Montana	66.81
North Dakota	60.35
South Dakota	61.25
Utah	71.13
Wyoming	50.00
X. Seattle	
Alaska	50.00
Idaho	68.85
Oregon	62.85
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.

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