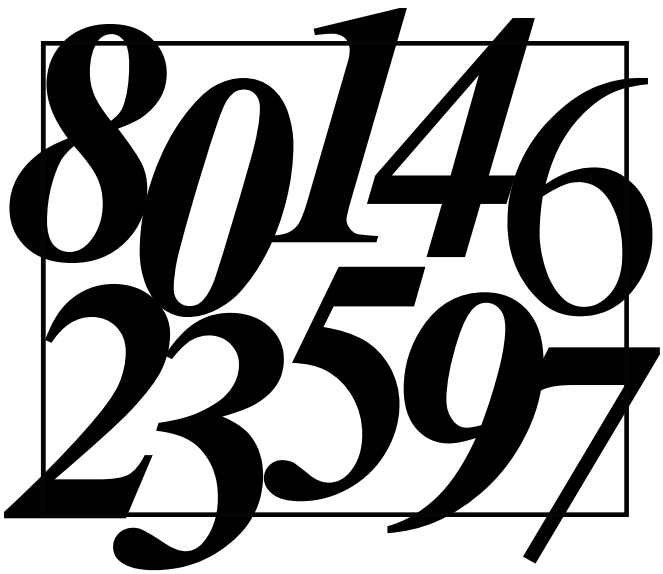
2012 CMS Statistics



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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

Office of Enterprise Management
C. Mark Loper, Director

Office of Information Products and Data Analysis
Niall Brennan, Director
Christine Cox, Acting Deputy Director

Publication Coordinator
Maria Diacogiannis

Publication Staff
James Krometis

Press inquiries should be directed to the CMS Media Relations Group, (202) 690-6145 or press@cms.hhs.gov

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

Data availability:
http://www.cms.gov/Research-Statistics-Data-and-Systems/Research-Statistics-Data-and-Systems.html

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

Preface

This reference booklet provides significant summary information about health expenditures and Centers for Medicare & Medicaid Services (CMS) programs. The information presented was the most current available at the time of publication 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 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**
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 50.7 million in 2012, a 165 percent increase. (I.1)
- On average, the number of Medicaid monthly enrollees in 2012 is estimated to be about 56.6 million, the largest group being children (27.9 million or 49.3 percent). (I.16)
- In 2009, about 20.3 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 448.2 thousand in 2011, an increase of 307 percent. (I.5)
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 8.4 million beneficiaries in 2011, an increase of about 200 percent. (I.19)

- By 2011, nearly 29.5 million Medicare enrollees had Part D drug coverage, 60.5 percent of all enrollees, and an additional 6.2 million had RDS. (I.10 & I.12)

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,552 in December 1990 to 6,172 in December 2011. Total inpatient hospital beds have dropped from 32.8 beds per 1,000 enrolled in 1990 to 19.1 in 2011, a decrease of 42 percent. (II.1)
- In the past decade, the total number of Medicare certified beds in short-stay hospitals has decreased to about 784,000 in 2011 from 970,000 in 1990. The average number of short-stay hospital beds per 1,000 enrolled in 2011 is 16.2 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 11,930 in 2011. (II.5 & II.6)

Expenditures

- National health expenditures (NHE) were $2,593.6 billion in 2010, 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 2011, total net Federal outlays for CMS programs were $770.9 billion, 21.4 percent of the Federal budget. (III.1)
- Medicare Part A benefit payments are projected to increase to $257.8 billion for fiscal year 2012 up from $255.2 billion for fiscal year 2011, and Medicare Part B benefit payments are projected to increase to $231.6 billion for fiscal year 2012 up from $225.9 billion for fiscal year 2011. (III.5)
- Medicare skilled nursing facility benefit payments are projected to increase to $32.2 billion for fiscal year 2012 up from $28.4 billion in 2011. (III.6)
- National health expenditures per person were $211 in 1965 and grew steadily to reach $8,402 by 2010. (III.7)

Utilization of Medicare and Medicaid services

- Between 1985 and 2010, the number of short-stay hospital discharges increased from 10.5 million to 12.4 million, an increase of 18 percent. (IV.1)
- The PPS short-stay hospital average length of stay decreased significantly from 8.7 days in 1985 to 5.1 days in 2010, a decrease of 41 percent. (IV.3)

- About 32.9 million persons received a reimbursed service under Medicare fee-for-service during 2010. Comparably, almost 60.4 million persons used Medicaid services or had a premium paid on their behalf in 2009. (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 919 per 1,000 enrolled in 2010. (IV.4)
- 7.5 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2010. (IV.6a)
- 31.4 million persons received reimbursable fee-for-services physician services under Medicare during 2010. 22.4 million persons received reimbursable physician services under Medicaid during 2009. (IV.6a & IV.9)
- 23.7 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2010. During 2009, 16.2 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 2010. 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 2009. (IV.6a & IV.9)
- Almost 26 million persons received prescribed drugs under Medicaid during 2009. (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
2008	45.5	37.9	7.6
2009	46.6	38.8	7.8
2010	47.7	39.6	8.0
2011	48.7	40.4	8.3
2012	50.7	41.9	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 2000-2012 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on 2012 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	50.2	49.8	46.1	36.8	45.8	4.0	0.3
Aged persons	41.5	41.2	38.4	--	38.1	3.1	0.3
Disabled persons	8.7	8.7	7.7	--	7.7	1.0	0.0

NOTES: Projected average monthly enrollment during fiscal year 2012. Aged/disabled split of Part D enrollment not available. Based on 2012 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	48,849	21,983	26,867
Aged	40,474	17,615	22,859
65-74 years	21,889	10,267	11,622
75-84 years	12,857	5,468	7,389
85 years and over	5,728	1,880	3,848
Disabled	8,375	4,367	4,008
Under 45 years	1,923	1,031	892
45-54 years	2,534	1,315	1,219
55-64 years	3,918	2,021	1,897
White	40,169	18,085	22,084
Black	5,062	2,179	2,883
All Other	3,430	1,615	1,815
Native American	216	97	120
Asian/Pacific	999	433	566
Hispanic	1,281	602	679
Other	934	483	450
Unknown Race	189	104	85

NOTES: Data as of July 1, 2011. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.

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

Table I.4
Medicare Part D enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	29,543	12,198	17,345
Aged			
65-74 years	12,378	5,317	7,061
75-84 years	7,838	3,011	4,827
85 years and over	3,442	956	2,486
Disabled			
Under 45 years	1,674	880	794
45-54 years	1,709	870	839
55-64 years	2,501	1,163	1,338

NOTES: Data for calendar year 2011, as reported on the Part D Denominator File. Totals may not add due to rounding.

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

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
2011	448.2	448.0	427.2

NOTE: Data as of July 1 of each year.

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

Table I.6
Medicare ESRD enrollment/demographics

	Number of enrollees (in thousands)
All persons	499.7
Age	
Under 35 years	26.7
35-44 years	42.2
45-64 years	203.0
65 years and over	227.9
Sex	
Male	283.7
Female	216.0
Race	
White	263.5
Other	232.7
Unknown	3.5

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2011.

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

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

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	670	1,686	11,728	13,415
Local CCPs	511	1,199	10,271	11,470
PFFS	22	131	385	516
1876 Cost	20	196	199	394
1833 Cost (HCPP)	11	58	--	58
PACE	87	--	23	23
Other plans[2]	19	103	850	953
Total PDPs[1]	83	--	19,777	19,777
Total	753	1,686	31,506	33,192

[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 2012.
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	311,592	47,741	15.3
Boston	14,492	2,461	17.0
New York	28,286	4,393	15.5
Philadelphia	30,048	4,912	16.3
Atlanta	61,762	10,319	16.7
Chicago	51,864	8,256	15.9
Dallas	39,061	5,286	13.5
Kansas City	13,787	2,267	16.4
Denver	11,008	1,446	13.1
San Francisco	48,273	6,448	13.4
Seattle	13,010	1,952	15.0

[1]Preliminary annual estimate July 1, 2011 resident population.

[2]Medicare enrollment file data are as of July 1, 2011. 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 Analysis; 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	48,849	36,458	12,391
Boston	2,461	2,034	428
New York	5,098	3,515	1,583
Philadelphia	4,912	3,699	1,213
Atlanta	10,319	7,900	2,419
Chicago	8,256	6,207	2,049
Dallas	5,286	4,237	1,049
Kansas City	2,267	1,896	371
Denver	1,446	1,072	374
San Francisco	6,466	4,149	2,316
Seattle	1,952	1,367	585

NOTES: Data as of July 1, 2011. 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 Analysis.

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

	Total	Fee-for-Service	Managed Care
		In thousands	
All persons	48,849	36,458	12,391
Aged	40,474	29,627	10,847
65-74 years	21,889	15,997	5,892
75-84 years	12,857	9,232	3,625
85 years and over	5,728	4,398	1,330
Disabled	8,375	6,831	1,544
Under 45 years	1,923	1,698	225
45-54 years	2,534	2,101	432
55-64 years	3,918	3,032	887
Male	21,983	16,622	5,360
Female	26,867	19,836	7,031
White	40,169	30,118	10,051
Black	5,062	3,728	1,333
All Other	3,430	2,452	978
Native American	216	192	25
Asian/Pacific	999	742	257
Hispanic	1,281	871	411
Other	934	648	285
Unknown Race	189	159	30

NOTES: Data as of July 1, 2011. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.

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

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]	48,849	29,543	60.5
Boston	2,461	1,443	58.6
New York	5,098	3,079	60.4
Philadelphia	4,912	2,850	58.0
Atlanta	10,319	6,359	61.6
Chicago	8,256	4,843	58.7
Dallas	5,286	3,117	59.0
Kansas City	2,267	1,461	64.4
Denver	1,446	859	59.4
San Francisco	6,466	4,367	67.5
Seattle	1,952	1,153	59.1

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

NOTE: Data for calendar year 2011 as reported on the Part D Denominator file.
SOURCE: CMS, Office of Information Products and Data Analysis.

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]	29,543	18,712	10,831
Boston	1,443	1,045	398
New York	3,079	1,618	1,461
Philadelphia	2,850	1,868	982
Atlanta	6,359	4,118	2,240
Chicago	4,843	3,437	1,406
Dallas	3,117	2,156	961
Kansas City	1,461	1,125	337
Denver	859	539	320
San Francisco	4,367	2,129	2,237
Seattle	1,153	667	486

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

NOTE: Data for calendar year 2011 as reported on the Part D Denominator file.

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

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]	35,751	29,543	6,208
Boston	1,817	1,443	374
New York	3,903	3,079	824
Philadelphia	3,457	2,850	607
Atlanta	7,563	6,359	1,204
Chicago	6,295	4,843	1,452
Dallas	3,744	3,117	627
Kansas City	1,666	1,461	205
Denver	999	859	140
San Francisco	4,937	4,367	570
Seattle	1,352	1,153	199

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

NOTE: Data for calendar year 2011 as reported on the Part D Denominator file.

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

Table I.13
Projected Population[1]

	2010	2020	2040	2060	2080	2100
			In millions			
Total	315	343	391	428	469	509
Under 20	85	89	97	105	113	120
20-64	189	198	213	232	252	269
65 years and over	41	56	80	90	104	119

[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 2012 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	21.6
2050[1]	20.4	22.2
2060[1]	21.0	22.7
2070[1]	21.5	23.1
2080[1]	22.0	23.6
2090[1]	22.4	24.0
2100[1]	22.9	24.5

[1]Projected.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2012 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
2009	78.6	78.8	74.7
2010[1]	78.7	79.0	75.1
		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
2009	19.2	19.2	17.8
2010[1]	19.2	19.2	17.8

[1]Preliminary data for calendar year 2010.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Reports, Vol. 60, No. 4, January 11, 2012.

Table I.16
Medicaid and CHIP enrollment

	Fiscal year					
	1990	1995	2000	2005	2011	2012
	Average monthly enrollment in millions					
Total	22.9	34.2	34.5	46.5	55.6	56.6
Age 65 years and over	3.1	3.7	3.7	4.6	4.8	5.0
Blind/Disabled	3.8	5.8	6.7	8.1	9.7	9.8
Children	10.7	16.5	16.2	22.3	27.4	27.9
Adults	4.9	6.7	6.9	10.6	12.6	12.9
Other Title XIX[1]	0.5	0.6	NA	NA	NA	NA
Territories	NA	0.8	0.9	1.0	1.0	1.0
CHIP	NA	NA	2.0	4.4	5.6	5.9
	Unduplicated annual enrollment in millions					
Total	NA	43.3	44.2	58.7	70.3	71.7
Age 65 years and over	NA	4.4	4.3	5.5	5.7	5.9
Blind/Disabled	NA	6.5	7.5	9.0	10.8	10.9
Children	NA	21.3	20.9	27.8	34.5	35.0
Adults	NA	9.4	10.6	15.4	18.4	18.9
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	8.7	9.2

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

NOTES: Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty-related recipients who are not disabled. Medicaid enrollment excludes Medicaid expansion CHIP programs. CHIP numbers include adults covered under waivers. Medicaid and CHIP figures for FY 2011-2012 are estimates from the President's FY 2013 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	62.2	100.0
Age	62.2	100.0
Under 21	32.6	52.4
21-64 years	23.4	37.6
65 years and over	6.1	9.9
Unknown	0.1	0.2
Sex	62.2	100.0
Male	25.4	40.9
Female	36.7	58.9
Unknown	0.1	0.2
Race	62.2	100.0
White, not Hispanic	25.4	40.9
Black, not Hispanic	13.6	21.9
Am. Indian/Alaskan Native	0.8	1.2
Asian	1.9	3.1
Hawaiian/Pacific Islander	0.6	1.0
Hispanic	15.5	24.8
Other	0.2	0.3
Unknown	4.3	6.8

NOTES: Fiscal Year 2009 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. Excludes the Children's Health Insurance Program (CHIP).

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

Table I.18
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	307,007	62,234	20.3
Boston	14,430	3,040	21.1
New York	28,249	6,181	21.9
Philadelphia	29,491	4,852	16.5
Atlanta	60,580	11,933	19.7
Chicago	51,767	9,888	19.1
Dallas	37,861	7,593	20.1
Kansas City	13,611	2,185	16.1
Denver	10,788	1,324	12.3
San Francisco	47,496	13,192	27.8
Seattle	12,734	2,045	16.1

[1]Estimated July 1, 2009 population.
[2]Persons ever enrolled in Medicaid during fiscal year 2009.

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 the Children's Health Insurance Program (CHIP).

SOURCES: CMS, Office of Information Products and Data Analysis; 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]	2011[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	8,388
Aged	2,483	2,449	3,632	4,879
Disabled	363	504	1,917	3,509
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	18.7
Aged	11.4	10.0	11.1	13.0
Disabled	18.7	18.9	40.2	48.2

[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 Analysis.

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	2011
Total hospitals	6,522	5,985	6,169	6,172
Beds in thousands	1,105	991	928	926
Beds per 1,000 enrollees[1]	32.8	25.3	19.6	19.1
Short-stay	5,549	4,900	3,566	3,549
Beds in thousands	970	873	785	784
Beds per 1,000 enrollees[1]	28.8	22.3	16.6	16.2
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	1,292
Beds in thousands	135	118	113	112
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 Analysis.

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	4,880	16.8	1,292	2.3
Boston	186	13.5	65	4.0
New York	309	17.6	75	2.4
Philadelphia	366	14.7	133	2.7
Atlanta	914	17.4	233	1.9
Chicago	866	18.1	190	1.9
Dallas	780	19.5	335	3.8
Kansas City	456	20.4	62	2.0
Denver	311	18.0	46	2.6
San Francisco	483	15.0	124	1.7
Seattle	209	12.2	29	1.4

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2011. Rates based on number of hospital insurance enrollees as of July 1, 2011, residing in U.S. and its territories.

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

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

Total participating hospitals	6,172
Short-term hospitals	3,549
Psychiatric units	1,156
Rehabilitation units	927
Swing bed units	522
Psychiatric	509
Long-term	437
Rehabilitation	235
Childrens	93
Religious non-medical	18
Critical access	1,331
Non-participating Hospitals	741
Emergency	389
Federal	352
All SNFs/SNF-NFs/NFs only	15,697
All SNFs/SNF-NFs	15,132
Title 18 Only SNF	784
Hospital-based	250
Free-standing	534
Title 18/19 SNF/NF	14,348
Hospital-based	631
Free-standing	13,717
Title 19 only NFs	565
Hospital-based	113
Free-standing	452
All ICF-MR facilities	6,449

NOTES: Data as of December 31, 2011. Numbers may differ from other reports and program memoranda.

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

Table II.4
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs	Nursing Facilities	ICF-MRs
All regions[1]	15,132	565	6,449
Boston	960	10	139
New York	999	2	586
Philadelphia	1,375	43	378
Atlanta	2,628	55	693
Chicago	3,324	121	1,506
Dallas	2,020	71	1,553
Kansas City	1,380	140	200
Denver	588	42	108
San Francisco	1,420	59	1,206
Seattle	438	22	80

[1]Includes outlying areas.

NOTE: Data as of December 2011.

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

Table II.5
Other Medicare providers and suppliers/trends

	1980	1990	2010	2011
Home health agencies	2,924	5,661	10,914	11,930
Independent and Clinical Lab Improvement Act Facilities	NA	4,828	224,679	229,611
End stage renal disease facilities	999	1,987	5,631	5,766
Outpatient physical therapy and/or speech pathology	419	1,144	2,536	2,351
Portable X-ray	216	435	561	577
Rural health clinics	391	517	3,845	3,940
Comprehensive outpatient rehabilitation facilities	NA	184	354	298
Ambulatory surgical centers	NA	1,165	5,316	5,335
Hospices	NA	772	3,509	3,630

NOTES: Facility data for 1980 are as of July 1. Facility data for 1990, 2010 and 2011 are as of December 31.

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

Table II.6
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,549	15,132	11,930
		Percent of total	
Non-profit	59.5	25.1	16.6
Proprietary	21.7	68.8	77.3
Government	18.8	6.0	6.1

NOTES: Data as of December 31, 2011. Facilities certified for Medicare are deemed to meet Medicaid standards.

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

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

	1980	1990	2000	2010	2011
Hospitals					
Number of PIP	2,276	1,352	869	547	521
Percent of total participating	33.8	20.6	14.4	8.9	8.4
Skilled nursing facilities					
Number of PIP	203	774	1,236	381	355
Percent of total participating	3.9	7.3	8.3	2.5	2.3
Home health agencies					
Number of PIP	481	1,211	1,038	114	141
Percent of total participating	16.0	21.0	14.4	1.0	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	1,058,469
Primary Care	214,082
Surgical Specialties	104,215
Medical Specialties	132,408
Anesthesiology	38,438
Obstetrics/Gynecology	33,555
Pathology	11,983
Psychiatry	27,638
Radiology	36,922
Emergency Medicine	40,394
Non-Physician Practitioners	264,676
Limited Licensed Practitioners	92,488
Ambulance Service Supplier	10,638
Other and Unknown	51,032
Durable Medical Equipment Suppliers	95,673

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

NOTE: Data for calendar year 2011, as reported on the fee-for-service claims.

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

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 2010	Fiscal year 2011
	$ in billions	
Gross domestic product (current dollars)	$14,651.0	$14,958.6
Total Federal outlays[1]	3,456.2	3,603.1
Percent of gross domestic product	23.6%	24.1%
Dept. of Health and Human Services[1]	854.2	891.2
Percent of Federal Budget	24.7%	24.7%
CMS Budget (Federal Outlays)		
Medicare benefit payments	518.8	558.0
SMI transfer to Medicaid[2]	0.5	0.7
Medicaid benefit payments	262.7	259.6
Medicaid State and local admin.	10.1	11.4
Medicaid offsets[3]	-0.5	-0.7
Children's Health Ins. Prog.	7.9	8.5
CMS program management	3.1	3.2
Other Medicare admin. expenses[4]	2.1	2.5
State Eligibility Determinations, for Part D	0.0	0.0
Quality improvement organizations[5]	0.3	0.3
Health Care Fraud and Abuse Control	1.2	1.4
State Grants and Demonstrations[6]	0.5	5.6
User Fees and Reimbursables	0.2	0.4
Total CMS outlays (unadjusted)	806.9	850.8
Offsetting receipts[7]	-74.2	-79.9
Total net CMS outlays	732.7	770.9
Percent of Federal budget	21.2%	21.4%

[1]Net of offsetting receipts.

[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($515.3 million in FY 2010 and $703 million in FY 2011).

[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
2011	1,011.0	566.9	432.2	11.9

[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	2011
Annually		Amounts in billions		
CMS program outlays	$5.1	$57.8	$915	$981
Federal outlays	NA	47.2	793	828
Medicare[1]	3.2	33.9	518	557
HI	2.5	23.8	250	260
SMI	0.7	10.1	209	231
Transitional Assistance[2]	NA	NA	0	0
Prescription (Part D)	NA	NA	59	66
Medicaid[3]	1.9	23.9	386	412
Federal share	NA	13.2	266	262
CHIP[4]	NA	NA	11	12
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 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 2010 Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$383,368	$259,876
Boston	23,868	15,085
New York	61,707	37,356
Philadelphia	37,651	24,771
Atlanta	63,061	47,014
Chicago	61,681	42,232
Dallas	44,251	32,716
Kansas City	15,044	10,881
Denver	8,630	5,945
San Francisco	53,960	34,703
Seattle	13,515	9,173

[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 Analysis.

Table III.5
Medicare benefit outlays

	Fiscal Year		
	2010	2011	2012
	In billions		
Part A benefit payments	$245.2	$255.2	$257.8
Aged	205.0	213.5	214.6
Disabled	40.2	41.7	43.2
Part B benefit payments	204.9	225.9	231.6
Aged	167.5	184.1	187.7
Disabled	37.4	41.8	43.9
Part D	63.6	70.6	62.1

NOTES: Based on FY 2012 Trustees Report. Part A benefits include additional payments for HIT, CBC, IPAB, ACO, MIF, 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 2012 benefit payments[1] in millions	Percent distribution
Total Part A[2,3]	$257,844	100.0
Inpatient hospital	139,538	54.1
Skilled nursing facility	32,226	12.5
Home health agency[4]	7,410	2.9
Hospice	14,879	5.8
Managed care	63,790	24.7
Total Part B[3]	231,579	100.0
Physician/other suppliers[5]	71,085	30.7
DME	8,819	3.8
Other carrier	20,315	8.8
Outpatient hospital	33,549	14.5
Home health agency[4]	12,246	5.3
Other intermediary	16,638	7.2
Laboratory	9,510	4.1
Managed care	59,418	25.7
Total Part D	62,064	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 FY 2012 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	2010
National total in billions	$724.3	$1,377.2	$2,593.6
Percent of GDP	12.5	13.8	17.9
Per capita amount	$2,854	$4,878	$8,402
Sponsor	Percent of Total		
Private Business	24.6	25.1	20.6
Household	34.9	31.5	28.0
Other Private Revenues	7.9	7.8	6.6
Governments	32.6	35.5	44.9
Federal Government	17.3	19.0	28.6
State and local government	15.3	16.5	16.2

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		
	2008	2009	2010
	In billions		
Total medical assistance payments[1]	$334.2	$360.3	$383.4
	Percent of total		
Inpatient services	15.2	15.0	14.7
General hospitals	14.2	14.1	13.8
Mental hospitals	1.1	0.9	0.9
Nursing facility services	14.6	13.9	13.0
Intermediate care facility (MR) services	3.7	3.8	3.5
Community-based long term care svs.[2]	14.0	14.4	14.1
Prescribed drugs[3]	4.6	4.3	4.1
Physician and other practitioner services	4.1	3.9	4.1
Dental services	1.2	1.3	1.4
Outpatient hospital services	3.8	4.1	4.0
Clinic services[4]	3.0	3.1	2.8
Laboratory and radiological services	0.4	0.4	0.5
Early and periodic screening	0.3	0.3	0.4
Case management services	0.9	0.8	0.9
Capitation payments (non-Medicare)	21.5	22.8	23.8
Medicare premiums	3.3	3.1	3.3
Disproportionate share hosp. payments	5.1	4.9	4.6
Other services	5.9	5.7	6.6
Collections[5]	-1.6	-2.0	-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		
	2009	2010	2011
	In millions		
Total	$8,022.8	$8,007.1	$8,079.9
Workers Compensation[1]	1,232.5	1,613.1	1,245.4
Working Aged	3,583.3	3,259.1	3,567.3
ESRD	375.5	343.6	343.0
Auto	248.2	325.1	271.1
Disability	2,231.5	2,021.8	2,184.0
Liability	323.8	424.4	447.9
VA/Other	28.2	19.9	21.2

[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 2010 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$383.4	100.0
Age 65 years and over	73.7	19.2
Blind/disabled	160.7	41.9
Dependent children under 21 years of age	72.8	19.0
Adults in families with dependent children	51.4	13.4
Disproportionate share hospital and other unallocated payments	24.9	6.5

[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]	
	2010	2011[3]
	In thousands	
Total	$11,434,585	$10,819,106
Medical/surgical supplies	191,310	197,954
Hospital beds	254,632	239,966
Oxygen and supplies	2,207,174	2,095,394
Wheelchairs	1,384,515	1,048,227
Prosthetic/orthotic devices	2,287,949	2,331,013
Drugs admin. through DME[4]	619,302	637,100
Parenteral and enteral nutrition	723,351	670,434
Other DME	3,766,354	3,599,017

[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 2011 are preliminary through March 2012.
[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 Analysis.

Table III.12
National health care/type of expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$2,593.6	$8,402	35.7	20.2	15.5
Health Consumption Expenditures	2,444.6	7,919	37.9	21.5	16.4
Personal health care	2,186.0	7,082	39.6	22.6	17.0
Hospital care	814.0	2,637	46.6	27.8	18.7
Prof. services	688.6	2,231	26.8	18.8	8.0
Phys./clinical	515.5	1,670	30.6	22.2	8.3
Other Professional	68.4	221	28.2	21.1	7.1
Dental	104.8	339	7.3	0.2	7.1
Other Health Residential & Personal Care	128.5	416	56.4	3.7	52.7
Nursing Care Facilities & Continuing Care Retirement Communities	143.1	464	53.8	22.3	31.5
Home Health	70.2	227	82.2	44.9	37.3
Retail outlet sales	341.6	1,106	27.8	20.5	7.3
Admin. Net Cost, & public health	258.6	838	23.4	11.9	11.5
Investment	149.0	483	--	--	--

NOTE: Data are as of calendar year 2010.
SOURCE: CMS, Office of the Actuary.

Table III.13
Personal health care/payment source

	Calendar Year			
	1980	1990	2000	2010
	In billions			
Total	$255.8	$724.3	$1,377.2	$2,593.6
	Percent			
Total	100.0	100.0	100.0	100.0
Out of pocket	22.8	19.1	14.7	11.6
Health Insurance	55.6	60.7	66.8	72.1
Private Health Insurance	27.0	32.3	33.4	32.7
Medicare	14.6	15.2	16.3	20.2
Medicaid (Title XIX)	10.2	10.2	14.6	15.5
Total CHIP (Title XIX & XXI)	0.0	0.0	0.2	0.4
Department of Defense	1.5	1.4	1.0	1.5
Depart. of Veteran's Affairs	2.2	1.5	1.4	1.8
Other 3rd Party Payers & Programs	11.2	10.7	9.0	7.4

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	2010
Discharges				
Total in millions	10.5	10.5	13.0	12.4
Rate per 1,000 enrollees[1]	347	320	361	348
Days of care				
Total in millions	92	94	75	67
Rate per 1,000 enrollees[1]	3,016	2,866	2,073	1,879
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	$7,423

[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 2010 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 Office of Information Products and Data Analysis.

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]
2009	1,808	52 [1]	3,281	93 [1]
2010	1,839	52 [1]	3,605	100 [1]

[1]Managed care enrollees excluded in determining rate.

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

Table IV.3
Medicare average length of stay/trends

	Fiscal Year				
	1990	1995	2000	2009	2010
All short-stay and excluded units					
Short-stay PPS units	9.0	7.1	6.0	5.2	5.1
Short-stay hospital non-PPS units	8.9	7.1	6.0	5.1	5.1
Excluded units	19.5	14.8	12.3	11.9	11.8

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2010 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 Office of Information Products and Data Analysis.

Table IV.4
Medicare persons served/trends

	Calendar Year					
	1975	1985	1995	2000	2005	2010
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	916	923	919
HI	221	219	218	232	234	237
SMI	536	739	858	965	979	988
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	835	865	897
HI	219	228	212	196	205	213
SMI	471	715	837	943	977	1,007

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 Office of Information Products and Data Analysis.

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

	Year				
	2005	2007	2008	2009	2010
HI					
Aged					
FFS Enrollees	30.0	28.8	28.6	28.6	29.0
Persons served	7.0	6.7	6.6	6.4	6.9
Rate per 1,000	234	231	229	224	237
Disabled					
FFS Enrollees	6.3	6.3	6.4	6.4	6.6
Persons served	1.3	1.3	1.3	1.3	1.4
Rate per 1,000	205	204	202	204	213
SMI					
Aged					
FFS Enrollees	28.4	26.9	26.4	26.2	26.4
Persons served	27.8	26.6	26.2	25.9	26.1
Rate per 1,000	979	989	990	986	988
Disabled					
FFS Enrollees	5.5	5.5	5.5	5.6	5.8
Persons served	5.4	5.5	5.5	5.6	5.8
Rate per 1,000	977	999	1,001	1,005	1,007

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 Analysis.

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]	26,927	919	5,939	897
Boston	1,453	911	343	880
New York	2,549	886	519	844
Philadelphia	2,766	931	584	900
Atlanta	5,879	948	1,456	936
Chicago	4,946	973	1,079	917
Dallas	3,084	921	718	907
Kansas City	1,463	948	304	923
Denver	824	937	146	895
San Francisco	2,980	887	585	842
Seattle	967	895	204	856

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

NOTES: Data as of calendar year 2010 for persons served under HI and/or SMI. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

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

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	32,866	26,927	5,939
Part A	8,267	6,857	1,410
Inpatient hospital	7,485	6,123	1,362
Skilled nursing facility	1,839	1,683	157
Home health agency	1,722	1,508	215
Hospice	1,157	1,096	62
Part B	31,923	26,113	5,809
Physician/supplier	31,415	25,764	5,651
Outpatient	23,667	19,248	4,419
Home health agency	1,883	1,624	258

NOTES: Data are as of calendar year 2010. Persons served represents estimates of beneficiaries receiving services under fee-for-service during the calendar year.

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

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

Year	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
1991	182,235	142,652	39,583
1997	282,697	220,090	62,607
1998	300,420	233,526	66,894
1999	317,530	245,999	71,531
2000	334,144	258,682	75,462
2001	350,313	270,839	79,474
2002	365,967	282,006	83,961
2003	378,451	292,247	86,204
2004	393,928	302,115	91,813
2005	408,782	312,037	96,745
2006	425,026	323,184	101,842
2007	440,343	334,051	106,292
2008	455,063	345,303	110,393
2009	470,063	355,742	114,321

SOURCE: United States Renal Data System.

Table IV.8
Medicare end stage renal disease (ESRD)
by treatment modalities and demographics, 2008

	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
Total -- all patients	455,696	345,303	110,393
Age			
0-19 years	3,322	1,422	1,900
20-64 years	261,582	181,794	79,788
65-74 years	106,582	83,210	23,372
75 years and over	84,210	78,877	5,333
Sex			
Male	258,104	191,487	66,617
Female	197,590	153,814	43,776
Race			
White	274,838	195,235	79,603
Black	151,655	127,915	23,740
Native American	6,068	4,921	1,147
Asian/Pacific	20,696	15,507	5,189
Other/Unknown	2,439	1,725	714

SOURCE: United States Renal Data System.

Table IV.9
Medicaid/type of service

	Fiscal year 2009 Medicaid beneficiaries
	In thousands
Total eligibles	62,234
Number using service:	
Total beneficiaries, any service[1]	60,439
Inpatient services	
General hospitals	5,407
Mental hospitals	112
Nursing facility services[2]	1,645
Intermediate care facility (MR) services[3]	101
Physician services	22,447
Dental services	10,521
Other practitioner services	5,307
Outpatient hospital services	16,173
Clinic services	12,512
Laboratory and radiological services	16,002
Home health services	1,084
Prescribed drugs	25,992
Personal care support services	1,117
Sterilization services	123
PCCM capitation	7,734
HMO capitation	30,134
PHP capitation	21,623
Targeted case management	2,471
Other services, unspecified	10,736
Additional service categories[4]	7,170
Unknown	166

[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 7.2 million beneficiaries, not unduplicated.

NOTE: Beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations. Excludes Children's Health Insurance Program (CHIP).

SOURCE: CMS, Center for Medicaid, CHIP and Survey & Certification.

Table IV.10
Medicaid/units of service

	Fiscal year 2009 units of service
	In thousands
Inpatient hospital	
Total discharges	7,802
Beneficiaries discharged	5,407
Total days of care	48,675
Nursing facility	
Total days of care	391,781
Intermediate care facility/mentally retarded	
Total days of care	38,950

NOTES: Data are derived from the MSIS 2009 State Summary Mart and are based on reported States. Excludes territories and Children's Health Insurance Program (CHIP).

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

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
2008[1]	3,231	1.4[2]
2009	3,343	1.4
2010	3,328	1.4
2011	3,927	1.5
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	1.5[2]
2009	3,317	1.3
2010	3,513	1.3
2011	3,833	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	3	6
Other	1	1

NOTES: Data for FY 2012. Numbers do not include MACs or DMACs.

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	91,505	233,951	1,994,060
Percent Reversed (Includes Fully & Partially Reversed Cases)	18.2	50.5	51.5

NOTES: Data for fiscal year 2011. Data presented in cases.

SOURCE: CMS, Center for Medicare.

Table V.4
Medicare physician/supplier claims assignment rates

	2000	2005	2008	2009	2010	2011
	In millions					
Claims total	720.5	951.6	974.7	978.2	972.7	986.5
Claims assigned	705.7	940.7	966.5	970.3	965.7	980.0
Claims unassigned	15.3	10.9	8.2	7.9	7.0	6.5
Percent assigned	97.9	98.9	99.2	99.2	99.3	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, Center for Medicare.

Table V.5
Medicare claims processing

	Fiscal year 2011
Intermediary claims processed in millions	199.1
Carrier claims processed in millions[1]	989.8

[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	200.5
	Percent of total
Inpatient hospital	7.7
Outpatient hospital	59.1
Home health agency	7.8
Skilled nursing facility	3.1
Other	22.3
Carrier claims received in millions	972.1
	Percent of total
Assigned	99.4
Unassigned	0.6

NOTE: Data for calendar year 2011.

SOURCE: CMS, Center for Medicare.

Table V.7
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	876.7	5.4
Percent reduced	94.5	86.5
Total covered charges		
Amount in millions	$312,931	$640
Percent reduced	60.0	19.9
Amount reduced per claim	$214.30	$23.45

NOTES: Data for calendar year 2011. 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	
	2010	2011
	In millions	
Total payments computable for Federal funding[1]	$17,931	$19,493
Federal share[1]		
Family planning	34	32
Design, development or Installation of MMIS[2]	339	364
Skilled professional Medical personnel	431	483
Operation of an approved MMIS[2]	1,270	1,367
All other	7,621	8,501
Mechanized systems not approved under MMIS[2]	109	191
Total Federal Share	$9,804	$10,938
Net adjusted Federal share[3]	$9,794	$10,878

[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 Analysis.

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	2010	2011	2012
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 2012)		None[1]	
Voluntary HI monthly premium[2]		$451.00	

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/12)	$1,156/benefit period
Regular coinsurance days (1/1/12)	$289/day for 61st thru 90th day
Lifetime reserve days (1/1/12)	$578/day (60 non-renewable days)
SNF coinsurance days (1/1/12)	$144.50/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/12)	$451/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 (1/1/12)	$140 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/12)	$99.90/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. 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 2012 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	$99.90
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$40.00	$139.90
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$99.90	$199.80
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$159.80	$259.70
Greater than $214,000	Greater than $428,000	$219.80	$319.70

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	$99.90
Greater than $85,000 and less than or equal to $129,000	$159.80	$259.70
Greater than $129,000	$219.80	$319.70

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part D Standard Benefits

Deductible (1/1/2012)	$320 in charges/year
Initial coverage limit (1/1/2012)	$2,930 in charges/year
Out-of-pocket threshold (1/1/2012)	$4,700 in charges/year
Base beneficiary premium (1/1/2012)[1]	$31.08/month

Medicaid financing

1. Federal contributions (ranging from 50 to 74 percent for fiscal year 2012)
2. State contributions (ranging from 26 to 50 percent for fiscal year 2012)

[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 2012, the average premium rate paid by beneficiaries is estimated to be about $30.

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

SOURCE: CMS, Office of the Actuary.

Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2012

I. Boston	FMAP
Connecticut	50.00
Maine	63.27
Massachusetts	50.00
New Hampshire	50.00
Rhode Island	52.12
Vermont	57.58
III. Philadelphia	
Delaware	54.17
Dist. of Columbia	70.00
Maryland	50.00
Pennsylvania	55.07
Virginia	50.00
West Virginia	72.62
V. Chicago	
Illinois	50.00
Indiana	66.96
Michigan	66.14
Minnesota	50.00
Ohio	64.15
Wisconsin	60.53
VII. Kansas City	
Iowa	60.71
Kansas	56.91
Missouri	63.45
Nebraska	56.64
IX. San Francisco	
Arizona	67.30
California	50.00
Hawaii	50.48
Nevada	56.20
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	68.62
Florida	56.04
Georgia	66.16
Kentucky	71.18
Mississippi	74.18
North Carolina	65.28
South Carolina	70.24
Tennessee	66.36
VI. Dallas	
Arkansas	70.71
Louisiana	61.09
New Mexico	69.36
Oklahoma	63.88
Texas	58.22
VIII. Denver	
Colorado	50.00
Montana	66.11
North Dakota	55.40
South Dakota	59.13
Utah	70.99
Wyoming	50.00
X. Seattle	
Alaska	50.00
Idaho	70.23
Oregon	62.91
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 and Human Services
Centers for Medicare & Medicaid Services
Office of Information Products and Data Analysis
CMS Pub. No. 03504 June 2012