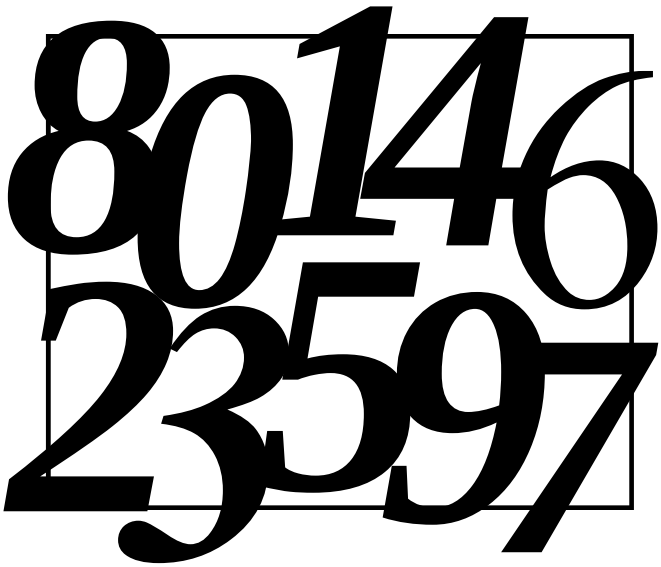
2015 CMS Statistics



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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 and may not always reflect changes due to recent legislation. Significant time lags may occur between the end of a data year and aggregation of data for that year. Similar reported statistics may differ because of differences in sources and/or methodology.

The data are organized as follows:

Glossary of Acronyms

AFDC	**Aid to Families with Dependent Children**
BETOS	**Berenson-Eggers Type of Service**
CAHs	**Critical Access Hospitals**
CBC	**Community-Based Care**
CCPs	**Coordinated Care Plans**
CHIP	**Children's Health Insurance Program**
CM	**Center for Medicare**
CMCS	**Center for Medicaid and CHIP Services**
CMS	**Centers for Medicare & Medicaid Services**
DHHS	**Department of Health & Human Services**
DME MACs	**DME Medicare Administrative Contractors**
DME	**Durable Medical Equipment**
DMEPOS	**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies**
ESRD	**End Stage Renal Disease**
FFS	**Fee-For-Service**

Glossary of Acronyms (continued)

GDP	**Gross Domestic Product**
HCPP	**Health Care Prepayment Plan**
HI	**Hospital Insurance (Part A)**
HIT	**Health Information Technology**
HMO	**Health Maintenance Organization**
ICF/IID	**Intermediate Care Facility for Individuals with Intellectual Disabilities**
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 (Part B)**
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 55.8 million in 2015, a 192 percent increase. (I.1)
- Medicare enrollees with end-stage renal disease increased from 110.0 thousand in 1985 to 496.9 thousand in 2014, an increase of 352 percent. (I.5)
- By 2014, over 37.7 million Medicare enrollees had Part D drug coverage, 69.7 percent of all enrollees, and an additional 2.7 million had RDS. (I.10 &I.12)
- On average, the number of Medicaid monthly enrollees in 2015 is estimated to be about 68.9 million, the largest group being children (29.6 million or 43.0 percent). (I.16)
- In 2012, 23 percent of the population was at some point enrolled in the Medicaid program. (I.18)

- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 9.3 million beneficiaries in 2014, an increase of about 232 percent. (I.19)

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,522 in December 1990 to 6,142 in December 2014. Total inpatient hospital beds have dropped from 32.8 beds per 1,000 enrolled in 1990 to 17.3 in 2014, a decrease of 47 percent. (II.1)
- The total number of Medicare certified beds in short-stay hospitals has decreased to about 784,000 in 2014 from 970,000 in 1990. The average number of short-stay hospital beds per 1,000 enrolled in 2014 is 14.6, down from 28.8 in 1990. (II.1)
- The number of hospice facilities increased from 772 in 1990 to 4,140 in 2014. (II.5)
- The number of participating home health agencies has fluctuated considerably over the years, almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed. The number decreased sharply but has since stabilized, reaching 12,268 in 2014. (II.5 & II.6)

Expenditures

- In fiscal year 2014, total net Federal outlays for CMS programs were $815.8 billion, 23.3 percent of the Federal budget. (III.1)
- Medicare Part A benefit payments are projected to increase to $268.1 billion for fiscal year 2015 up from $261.8 billion for fiscal year 2014, and Medicare Part B benefit payments are projected to increase to $272.9 billion for fiscal year 2015 up from $256.6 billion for fiscal year 2014. (III.5)
- Medicare hospice benefit payments are projected to be $16.1 billion for fiscal year 2015 down from $16.8 billion in 2014. (III.6)
- National health expenditures (NHE) were $2,919.1 billion in calendar year 2013, comprising 17.4 percent of the gross domestic product (GDP). Comparably, NHE amounted to $724.3 billion, or 12.1 percent of the GDP in calendar year 1990. NHE per person were $147 in calendar year 1960 and grew steadily to reach $9,255 by calendar year 2013. (III.7)

Utilization of Medicare and Medicaid services

- Between 1990 and 2014, the number of short-stay hospital discharges per 1,000 enrollees decreased from 320 to 280, a decrease of 13 percent. (IV.1)
- The PPS short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.0 days in 2014, a decrease of 44 percent. (IV.3)

- The ratio of Medicare aged users of any type of covered service has grown from 528 per 1,000 enrolled in 1975 to 890 per 1,000 enrolled in 2014. (IV.4)
- About 33.9 million persons received a reimbursed service under Medicare fee-for-service during 2014. Comparably, almost 63.3 million persons used Medicaid services or had a premium paid on their behalf in 2012. (IV.6a & IV.9)
- 6.4 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2014. (IV.6a)
- 32.7 million persons received reimbursable fee-for-services physician services under Medicare during 2014. 42.8 million persons received reimbursable physician services under Medicaid during 2012. (IV.6a & IV.9)
- 25.1 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2014. During 2012, 26.3 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 2014. 1.4 million persons received care in nursing facilities, which include SNFs and all other nursing facilities excluding ICF/IID, covered by Medicaid during 2012. (IV.6a & IV.9)
- Over 38 million persons received prescribed drugs under Medicaid during 2012. (IV.9)

Populations

Information about persons covered by Medicare, Medicaid, or CHIP

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

Table I.1
Medicare Enrollment/Trends

	Total Persons	Aged Persons	Disabled Persons
July		In millions	
1966	19.1	19.1	--
1970	20.4	20.4	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
Average monthly			
2000	39.7	34.3	5.4
2005	42.6	35.8	6.8
2010	47.7	39.6	8.1
2012	50.9	42.2	8.7
2013	52.5	43.6	8.8
2014	53.8	44.9	8.9
2015	55.8	46.8	9.1

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 calendar years 2000-2015 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on 2015 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	55.3	55.0	50.4	41.5	50.1	4.9	0.3
Aged persons	46.3	46.0	42.2	--	41.9	4.1	0.3
Disabled persons	9.0	9.0	8.2	--	8.2	0.8	0.0

NOTES: Projected average monthly enrollment during fiscal year 2015. Aged/disabled split of Part D enrollment not available. Based on 2015 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	54,096	24,560	29,536
Aged	45,312	20,019	25,293
65-74 years	25,124	11,828	13,295
75-84 years	13,723	5,981	7,743
85 years and over	6,465	2,210	4,255
Disabled	8,783	4,541	4,243
Under 45 years	1,929	1,035	894
45-54 years	2,467	1,265	1,203
55-64 years	4,386	2,240	2,146
White	40,904	18,536	22,368
Black	5,565	2,401	3,164
All Other	7,116	3,289	3,826
Native American	243	108	134
Asian/Pacific	1,616	725	892
Hispanic	4,798	2,230	2,567
Other	459	226	233
Unknown Race	511	333	178

NOTES: Person-year enrollee counts for 2014. Numbers may not add to totals because of rounding. Race information is based on Research Triangle Institute (RTI) race codes.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.4
Medicare Part D Enrollment/Demographics

	Total	Male	Female
		In thousands	
All persons	37,721	15,938	21,783
Aged			
65-74 years	16,543	7,156	9,387
75-84 years	9,992	4,087	5,905
85 years and over	4,555	1,406	3,150
Disabled			
Under 45 years	1,572	823	750
45-54 years	1,887	948	939
55-64 years	3,171	1,518	1,653

NOTES: Person-year enrollee counts for 2014 as reported in the CMS Chronic Conditions Data Warehouse. Totals may not add because of rounding.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.5
Medicare ESRD Enrollment/Trends

	HI and/or SMI	HI	SMI
		In thousands	
Year			
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
2014	496.9	493.8	472.5

NOTE: Data as of July 1 for years 1985-2010. Enrollee counts for 2014 are determined using a person-year methodology.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.6
Medicare ESRD Enrollment/Demographics

	Number of Enrollees (in thousands)
All persons	547.5
Age	
Under 35 years	24.5
35-44 years	40.5
45-64 years	210.6
65 years and over	271.9
Sex	
Male	312.1
Female	235.4
Race	
White	232.3
Black	184.1
Other	127.0
Unknown	4.1

NOTES: CMS Chronic Conditions Data Warehouse. Represents persons with ESRD ever enrolled during calendar year 2014.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.7
Medicare Advantage, Cost, PACE, Demo, & Prescription Drug

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	741	2,094	15,600	17,694
Local CCPs	507	1,543	13,598	15,140
PFFS	8	78	177	254
1876 Cost	16	297	269	566
1833 Cost (HCPP)	9	51	--	51
PACE	117	--	33	33
Other plans[2]	84	126	1,524	1,650
Total PDPs[1]	76	--	24,180	24,180
Total	817	2,094	39,781	41,875

[1]Totals include beneficiaries enrolled in employer/union-only group plans (contracts with "800 series" plan IDs). Where a beneficiary is enrolled in both an 1876 cost or PFFS plan and a PDP plan, both enrollments are reflected in these counts. [2]Includes MSA, Pilot, Medicare-Medicaid Plans, and RPPOs.

NOTE: Data as of October 2015.

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	318,857	52,882	16.6
Boston	14,681	2,699	18.4
New York	28,684	4,753	16.6
Philadelphia	30,535	5,385	17.6
Atlanta	63,573	11,535	18.1
Chicago	52,196	9,034	17.3
Dallas	40,537	5,903	14.6
Kansas City	13,956	2,459	17.6
Denver	11,499	1,644	14.3
San Francisco	49,793	7,246	14.6
Seattle	13,403	2,225	16.6

[1]Preliminary annual estimate July 1, 2014 resident population.
[2]Medicare enrollment data for 2014 are determined using a person-year methodology. 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 Enterprise Data and Analytics; U.S. Bureau of the Census, Population Estimates Branch.

Table I.9
Medicare Enrollment by Health Delivery/CMS Region

	Total Enrollees	Original Medicare Enrollees	MA and Other Health Plan Enrollees
		In thousands	
All regions	54,096	37,665	16,430
Boston	2,699	2,142	558
New York	5,520	3,564	1,956
Philadelphia	5,385	3,952	1,432
Atlanta	11,535	8,009	3,525
Chicago	9,034	6,199	2,836
Dallas	5,903	4,298	1,604
Kansas City	2,459	1,974	485
Denver	1,644	1,178	466
San Francisco	7,267	4,447	2,820
Seattle	2,225	1,481	743

NOTES: Person-year enrollee counts for 2014. Totals may not add because of rounding. Foreign residents and unknowns are not included in the regions, but included in the total figure.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.9a
Medicare Enrollment by Health Delivery/Demographics

	Total	Original Medicare	MA and Other Health Plans
		In thousands	
All persons	54,096	37,665	16,430
Aged	45,312	31,038	14,274
65-74 years	25,124	17,279	7,844
75-84 years	13,723	9,119	4,604
85 years and over	6,465	4,640	1,825
Disabled	8,783	6,627	2,156
Under 45 years	1,929	1,612	317
45-54 years	2,467	1,902	566
55-64 years	4,386	3,113	1,273
Male	24,560	17,433	7,127
Female	29,536	20,232	9,304
White	40,904	29,298	11,606
Black	5,565	3,743	1,822
All Other	7,116	4,226	2,890
Native American	243	210	33
Asian/Pacific	1,616	1,068	548
Hispanic	4,798	2,632	2,165
Other	459	315	144
Unknown Race	511	399	112

NOTES: Person-year enrollee counts for 2014. Numbers may not add to totals because of rounding. Race information based on Research Triangle Institute race codes.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.10
Medicare Part D Enrollment by CMS Region

	Total Medicare Enrollees	Total Part D Enrollees	% of Total Enrollees
		In thousands	
All regions[1]	54,096	37,721	69.7
Boston	2,699	1,805	66.9
New York	5,520	4,054	73.4
Philadelphia	5,385	3,572	66.3
Atlanta	11,535	8,191	71.0
Chicago	9,034	6,496	71.9
Dallas	5,903	3,979	67.4
Kansas City	2,459	1,753	71.3
Denver	1,644	1,090	66.3
San Francisco	7,267	5,341	73.5
Seattle	2,225	1,425	64.1

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

NOTE: Data for calendar year 2014 as reported in the CMS Chronic Conditions Data Warehouse.
SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.11
Medicare Part D Enrollment by Plan Type/CMS Region

	Total Part D Enrollees	Total PDP Enrollees	Total MA-PD Enrollees
		In thousands	
All regions[1]	37,721	23,437	14,284
Boston	1,805	1,289	517
New York	4,054	2,228	1,825
Philadelphia	3,572	2,385	1,186
Atlanta	8,191	4,922	3,269
Chicago	6,496	4,563	1,933
Dallas	3,979	2,645	1,334
Kansas City	1,753	1,320	433
Denver	1,090	679	411
San Francisco	5,341	2,620	2,721
Seattle	1,425	774	651

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

NOTE: Data for calendar year 2014 as reported in the CMS Chronic Conditions Data Warehouse.
SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.12

Medicare Part D and RDS Enrollment/CMS Region

	Total Part D and RDS Enrollees	Total Part D Enrollees	Total RDS Enrollees
		In thousands	
All regions[1]	40,379	37,721	2,657
Boston	2,042	1,805	237
New York	4,351	4,054	298
Philadelphia	3,845	3,572	273
Atlanta	8,665	8,191	474
Chicago	7,000	6,496	504
Dallas	4,256	3,979	278
Kansas City	1,833	1,753	80
Denver	1,154	1,090	64
San Francisco	5,634	5,341	293
Seattle	1,583	1,425	157

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

NOTE: Data for calendar year 2014 as reported in the CMS Chronic Conditions Data Warehouse. Totals may not add because of rounding.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table I.13

Projected Population[1]

	2010	2020	2040	2060	2080	2100
			In millions			
Total	315	342	392	430	471	511
Under 20	86	88	98	105	113	121
20-64	188	198	212	232	251	269
65 years and over	41	56	82	93	106	121

[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 2015 Trustees Report Intermediate Alternative.

Table I.14
Period Life Expectancy at Age 65,
Historical and Projected

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1990	15.1	19.1
2000	15.9	19.0
2010	17.6	20.2
2020[1]	18.8	21.1
2030[1]	19.5	21.7
2040[1]	20.1	22.2
2050[1]	20.7	22.8
2060[1]	21.3	23.3
2070[1]	21.8	23.7
2080[1]	22.2	24.2
2090[1]	22.7	24.6
2100[1]	23.1	25.0

[1] Projected.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2015 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
2000	76.8	77.3	71.8
2005	77.6	78.0	73.0
2010	78.7	78.9	75.1
2011	78.7	79.0	75.3
2012	78.8	79.1	75.5
2013	78.8	79.1	75.5
		At Age 65	
1960	14.3	14.4	13.9
1980	16.4	16.5	15.1
1990	17.2	17.3	15.4
2000	17.6	17.7	16.1
2005	18.4	18.5	16.9
2010	19.1	19.2	17.8
2011	19.2	19.2	18.0
2012	19.3	19.3	18.1
2013	19.3	19.3	18.1

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

Table I.16
Medicaid and CHIP Enrollment

	Fiscal Year					
	1995	2000	2005	2010	2014	2015
	Average monthly enrollment in millions					
Total	34.2	34.5	46.5	53.5	64.8	68.9
Age 65 years and over	3.7	3.7	4.6	4.7	5.4	5.6
Blind/Disabled	5.8	6.7	8.1	9.5	9.8	10.2
Children	16.5	16.2	22.3	26.3	29.4	29.6
Adults	6.7	6.9	10.6	12.1	19.2	22.4
Other Title XIX[1]	0.6	NA	NA	NA	NA	NA
Territories	0.8	0.9	1.0	1.0	1.0	1.0
CHIP	NA	2.0	5.9	5.4	6.0	5.8

[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 and CHIP programs. CHIP numbers include adults covered under waivers. Medicaid and CHIP figures for FY 2014-2015 are estimates from the President's FY 2016 budget. Enrollment for Territories for FY 2000 and later is estimated. Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of the Actuary, and the Center for Medicaid and CHIP Services.

Table I.17
Medicaid Eligibles/Demographics

	Medicaid Eligibles	Percent Distribution
	In millions	
Total eligibles	70.9	100.0
Age	70.9	100.0
Under 21	35.3	49.9
21-64 years	27.2	38.4
65 years and over	6.7	9.5
Unknown	1.6	2.2
Sex	70.9	100.0
Male	29.6	41.8
Female	41.2	58.1
Unknown	0.1	0.1
Race	70.9	100.0
White, not Hispanic	28.5	40.3
Black, not Hispanic	15.5	21.8
Am. Indian/Alaskan Native	0.9	1.2
Asian	2.4	3.3
Hawaiian/Pacific Islander	0.7	0.9
Hispanic	17.5	24.7
Other	0.3	0.5
Unknown	5.1	7.2

NOTES: Fiscal Year 2012 data derived from MSIS Granular Database. The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of rounded components. Eligible is defined as anyone eligible and enrolled in the Medicaid program at some point during the fiscal year regardless of duration of enrollment, receipt of a paid medical service, or whether or not a capitated premium for managed care or private health insurance coverage has been made. Age groups are determined using the eligible's age at the end of the fiscal year. Excludes beneficiaries ever enrolled in separate Title XXI Children's Health Insurance Program (CHIP). Excludes data for Colorado, Idaho, and Maine, and includes partial data for Arizona and Washington, D.C.

SOURCE: CMS, Center for Medicaid and CHIP Services.

Table I.18
Medicaid Eligibles/CMS Region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	305,996	70,895	23.2
Boston	13,250	2,964	22.4
New York	28,483	7,452	26.2
Philadelphia	30,264	5,828	19.3
Atlanta	62,387	13,582	21.8
Chicago	51,953	11,767	22.6
Dallas	39,550	9,206	23.3
Kansas City	13,843	2,578	18.6
Denver	5,973	830	13.9
San Francisco	48,767	14,453	29.6
Seattle	11,526	2,235	19.4

[1]Estimated July 1, 2012 population.

[2]Persons ever enrolled in Medicaid during fiscal year 2012.

NOTES: Numbers may not add to totals because of rounding. Excludes data for Colorado, Idaho, and Maine, and includes partial data for Arizona and Washington, D.C. Excludes enrollees ever enrolled in separate Title XXI Children's Health Insurance Program (CHIP).

SOURCES: CMS, Center for Medicaid and CHIP Services; U.S. Department of Commerce, Bureau of the Census.

Table I.19
Medicaid Beneficiaries/State Buy-Ins for Medicare

	1975 [1]	1980 [1]	2000 [2]	2014 [2]
Type of Beneficiary	In thousands			
All buy-ins	2,846	2,954	5,549	9,273
Aged	2,483	2,449	3,632	5,340
Disabled	363	504	1,917	3,932
	Percent of SMI enrollees			
All buy-ins	12.0	10.9	14.9	18.5
Aged	11.4	10.0	11.1	12.7
Disabled	18.7	18.9	40.2	48.1

[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, Office of Enterprise Data and Analytics.

Providers/Suppliers

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

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

Table II.1
Inpatient Hospitals/Trends

	1990	2000	2010	2014
Total hospitals	6,522	5,985	6,169	6,142
Beds in thousands	1,105	991	928	931
Beds per 1,000 enrollees[1]	32.8	25.3	19.6	17.3
Short-stay	5,549	4,900	3,566	3,466
Beds in thousands	970	873	785	784
Beds per 1,000 enrollees[1]	28.8	22.3	16.6	14.6
Critical access hospitals	NA	NA	1,325	1,334
Beds in thousands	---	---	30	31
Beds per 1,000 enrollees[1]	---	---	0.6	0.6
Other non-short-stay	973	1,085	1,278	1,342
Beds in thousands	135	118	113	116
Beds per 1,000 enrollees[1]	4.0	3.0	2.4	2.2

[1]Based on number of total HI enrollees as of July 1 for years 1990, 2000, and 2010. Based on person-year HI enrollee count for 2014.

NOTES: Facility data are as of December 31 and represent essentially those facilities eligible to participate at the start of the next calendar year. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.2
Inpatient Hospitals/CMS Region

	Short-stay and CAH hospitals	Beds per 1,000 enrollees	Non Short-stay hospitals	Beds per 1,000 enrollees
All regions	4,800	15.2	1,342	2.2
Boston	178	11.9	64	3.5
New York	300	15.9	73	2.1
Philadelphia	360	13.3	131	2.4
Atlanta	883	15.6	249	1.8
Chicago	857	16.5	204	1.8
Dallas	764	17.9	350	3.8
Kansas City	460	18.9	62	1.8
Denver	312	16.0	50	2.5
San Francisco	475	13.3	130	1.6
Seattle	211	10.8	29	1.4

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2014. Rates based on person-year hospital insurance enrollee count for 2014.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.3
Medicare Hospital and SNF/NF/ICF Facility Counts

Total participating hospitals	6,142
Short-term hospitals	3,466
Psychiatric units	1,114
Rehabilitation units	915
Swing bed units	502
Psychiatric	551
Long-term	423
Rehabilitation	255
Children's	98
Religious non-medical	15
Critical access	1,334
Non-participating Hospitals	788
Emergency	436
Federal	352
All SNFs/SNF-NFs/NFs only	15,637
All SNFs/SNF-NFs	15,179
Title 18 Only SNF	767
Hospital-based	188
Free-standing	579
Title 18/19 SNF/NF	14,412
Hospital-based	573
Free-standing	13,839
Title 19 only NFs	458
Hospital-based	102
Free-standing	356
All ICF/IID facilities	6,323

NOTES: Data as of December 31, 2014. Numbers may differ from other reports and program memoranda.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.4
Long-Term Facilities/CMS Region

	Title XVIII and XVIII/XIX SNFs	Nursing Facilities	ICF/IIDs
All regions [1]	15,179	458	6,323
Boston	934	9	123
New York	995	2	586
Philadelphia	1,366	39	389
Atlanta	2,649	44	697
Chicago	3,346	94	1,387
Dallas	2,050	50	1,552
Kansas City	1,405	113	200
Denver	591	35	111
San Francisco	1,406	54	1,198
Seattle	437	18	80

[1] Includes outlying areas.

NOTE: Data as of December 2014.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.5
Other Medicare Providers and Suppliers/Trends

	1980	1990	2010	2014
Home health agencies	2,924	5,661	10,914	12,268
Independent and Clinical Lab Improvement Act Facilities	NA	4,828	224,679	250,247
End stage renal disease facilities	999	1,987	5,631	6,374
Outpatient physical therapy and/or speech pathology	419	1,144	2,536	2,102
Portable X-ray	216	435	561	536
Rural health clinics	391	517	3,845	4,062
Comprehensive outpatient rehabilitation facilities	NA	184	354	216
Ambulatory surgical centers	NA	1,165	5,316	5,444
Hospices	NA	772	3,509	4,140

NOTES: Facility data for 1980 are as of July 1. Facility data for 1990, 2010, and 2014 are as of December 31.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.6
Selected Facilities/Type of Control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,466	15,179	12,268
		Percent of total	
Non-profit	59.5	23.9	15.2
Proprietary	21.3	70.6	79.8
Government	19.2	5.5	4.9

NOTES: Data as of December 31, 2014. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.7
Periodic Interim Payment (PIP) Facilities/Trends

	1980	1990	2000	2012	2014
Hospitals					
Number of PIP	2,276	1,352	869	568	478
Percent of total participating	33.8	20.6	14.4	9.2	7.8
Skilled nursing facilities					
Number of PIP	203	774	1,236	345	332
Percent of total participating	3.9	7.3	8.3	2.3	2.2
Home health agencies					
Number of PIP	481	1,211	1,038	141	146
Percent of total participating	16.0	21.0	14.4	1.2	1.2

NOTES: 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 Part A MAC meets specified processing time standards.

SOURCE: CMS, Center for Medicare.

Table II.8
Medicare Non-Institutional Providers by Specialty[1]

	Count
Total Providers	1,173,802
Primary Care	221,469
Surgical Specialties	108,447
Medical Specialties	142,488
Anesthesiology	40,453
Obstetrics/Gynecology	34,606
Radiology	36,713
Emergency Medicine	44,399
Non-Physician Practitioners	332,556
Limited Licensed Practitioners	104,702
All Other Providers	131,570

[1] Providers utilized by Original Medicare beneficiaries for all Part B non-institutional provider services. Providers may be counted in more than one specialty classification, but are reported as a single provider in the "Total Providers" count.

NOTE: Data for calendar year 2014, as reported on the Original Medicare claims.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table II.9
Medicare DMEPOS Providers by Specialty[1]

	Count
Total DMEPOS Providers	88,033
Pharmacy	50,338
Medical Supply Company	11,257
Optometry	6,276
Podiatry	5,575
Individual Certified Prosthetist/Orthotist	2,704
Optician	2,460
All Other DMEPOS Providers	9,895

[1]Providers utilized by Original Medicare beneficiaries for all Part B non-institutional DMEPOS services. Providers may be counted in more than one specialty classification, but are reported as a single provider in the "Total DMEPOS Providers" count.

NOTE: Data for calendar year 2014, as reported on the Original Medicare claims.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Expenditures

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

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

Table III.1
CMS and Total Federal Outlays

	Fiscal year 2013	Fiscal year 2014
	$ in billions	
Gross domestic product (current dollars)	$16,618.6	$17,244.0
Total Federal outlays[1]	3,454.6	3,506.1
Percent of gross domestic product	20.8%	20.3%
Dept. of Health and Human Services[1]	886.3	936.0
Percent of Federal Budget	25.7%	26.7%
CMS Budget (Federal Outlays)		
Medicare benefit payments	577.4	591.3
SMI transfer to Medicaid[2]	0.5	0.7
Medicaid benefit payments	248.8	301.5
Medicaid State and local admin.	14.5	15.2
Medicaid offsets[3]	-0.5	-0.7
Children's Health Ins. Prog.	9.5	9.0
CMS program management	3.7	3.6
Other Medicare admin. expenses[4]	2.0	2.0
State Eligibility Determinations, for Part D	0.0	0.0
Quality Improvement Organizations[5]	0.5	0.5
Health Care Fraud and Abuse Control	1.6	1.4
State Grants and Demonstrations[6]	0.5	0.5
User Fees and Reimbursables	0.7	0.5
Total CMS outlays (unadjusted)	844.7	910.3
Offsetting receipts[7]	-97.0	-94.5
Total net CMS outlays	747.7	815.8
Percent of Federal budget	21.6%	23.3%

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($477 million in FY 2013 and $688 million in FY 2014).
[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
2014	1,082.0	598.7	470.3	13.0

[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
Annual Benefit Outlays by Program

	1967	1980	2010	2014
	Amounts in billions			
CMS program outlays	$5.1	$57.8	$915	$1,081
Federal outlays	NA	47.2	793	891
Medicare[1]	3.2	33.9	518	598
HI	2.5	23.8	250	271
SMI	0.7	10.1	209	262
Prescription (Part D)	NA	NA	59	65
Medicaid[2]	1.9	23.9	386	470
Federal share	NA	13.2	266	284
CHIP[3]	NA	NA	11	13
Federal share	NA	NA	8	9

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

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

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

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

SOURCE: CMS, Office of Financial Management.

Table III.4
Program Benefit Payments/CMS Region

	Fiscal Year 2013 Net Expenditures Reported[1]	
	Medicaid	
	Total Payments Computable for Federal funding	Federal Share
	In millions	
All regions	$433,131	$248,800
Boston	26,805	13,956
New York	64,834	32,757
Philadelphia	42,670	23,556
Atlanta	67,823	44,435
Chicago	68,180	40,640
Dallas	46,561	29,266
Kansas City	16,822	10,134
Denver	10,214	5,812
San Francisco	73,363	39,201
Seattle	15,859	9,043

[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 Enterprise Data and Analytics.

Table III.5
Medicare Benefit Outlays

	Fiscal Year		
	2013	2014	2015
	In billions		
Part A benefit payments	$261.8	$261.8	$268.1
Aged	217.9	217.6	223.2
Disabled	43.9	44.2	44.9
Part B benefit payments	243.1	256.6	272.9
Aged	197.1	207.9	221.5
Disabled	45.9	48.7	51.3
Part D	68.0	72.2	83.8

NOTES: Based on 2015 Trustees Report. Part A benefits include additional payments for HIT, CBC, IPAB, and Sequester. Part B benefits include additional payments for HIT, IPAB, and Sequester. Part D benefits include additional payments for IPAB. 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 2015 Benefit Payments[1] in millions	Percent Distribution
Total Part A[2,3]	$268,084	100.0
Inpatient hospital	136,415	50.9
Skilled nursing facility	29,928	11.2
Home health agency[4]	6,865	2.6
Hospice	16,056	6.0
Managed care	78,821	29.4
Total Part B[3,5]	272,877	100.0
Physician/other suppliers[6]	69,199	25.4
DME	6,502	2.4
Other carrier	21,184	7.8
Outpatient hospital	43,574	16.0
Home health agency[4]	11,491	4.2
Other intermediary	19,459	7.1
Laboratory	8,534	3.1
Managed care	92,934	34.1
Total Part D[7]	83,845	100.0

[1]Includes the effects of regulatory items and recent legislation but not proposed law. [2]Includes HIT, CBC, IPAB, 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 HIT, IPAB, and Sequester expenditures. [6]Includes payments made for HIT. [7]Includes payments made for IPAB.

NOTES: Based on 2015 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	2013
National total in billions	$724.3	$1,378.0	$2,919.1
Percent of GDP	12.1	13.4	17.4
Per capita amount	$2,855	$4,881	$9,255
Sponsor		Percent of total	
Private Business	24.6	25.1	20.9
Household	34.9	31.5	28.2
Other Private Revenues	7.9	7.8	7.5
Governments	32.6	35.5	43.4
Federal government	17.3	19.0	25.9
State and local government	15.3	16.5	17.4

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

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

Table III.8
Medicaid/Type of Service

	Fiscal Year		
	2011	2012	2013
	In billions		
Total medical assistance payments[1]	$407.5	$408.8	$433.1
	Percent of Total		
Inpatient services	15.7	14.5	14.5
General hospitals	14.8	13.7	13.7
Mental hospitals	0.9	0.8	0.8
Nursing facility services	12.5	12.3	11.7
ICF/IID services	3.3	3.3	2.8
Community-based long term care svs.[2]	13.5	13.5	13.0
Prescribed drugs[3]	3.6	2.1	1.5
Physician and other practitioner services	4.0	3.5	3.3
Dental services	1.3	1.1	0.9
Outpatient hospital services	4.2	3.8	3.9
Clinic services[4]	2.7	2.6	2.4
Laboratory and radiological services	0.4	0.4	0.4
Early and periodic screening	0.3	0.3	0.3
Case management services	0.7	0.7	0.7
Capitation payments (non-Medicare)	25.2	29.1	31.9
Medicare premiums	3.5	3.3	3.2
Disproportionate share hosp. payments	4.2	4.2	3.8
Other services	6.6	7.2	7.4
Collections[5]	-1.8	-2.0	-1.6

[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		
	2012	2013	2014
	In millions		
Total	$7,862.2	$8,925.8	$8,199.9
Workers' Compensation[1]	1,841.9	1,888.5	1,711.7
Working Aged	3,126.5	3,838.4	3,545.8
ESRD	296.0	303.1	270.9
Auto	212.2	190.1	172.9
Disability	1,840.6	2,119.6	1,996.8
Liability	523.2	566.3	488.5
VA/Other	21.7	19.8	13.3

[1]Includes Workers' Compensation set-asides.

NOTES: 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 2013 Medical Assistance Payments	Percent Distribution
	In billions	
Total[1]	$433.1	100.0
Age 65 years and over	81.5	18.8
Blind/disabled	175.2	40.4
Dependent children under 21 years of age	78.2	18.0
Adults in families with dependent children	64.5	14.9
Disproportionate share hospital and other unallocated payments[2]	33.8	7.8

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

[2]Includes collections, prior period adjustments, and payments to territories.

SOURCE: CMS, Office of the Actuary.

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

BETOS Category	Allowed Charges[2]	
	2013	2014
	In thousands	
Total	$10,147,264	$8,686,710
Medical/surgical supplies	193,817	204,469
Hospital beds	183,537	119,600
Oxygen and supplies	1,679,612	1,429,545
Wheelchairs	806,018	617,261
Prosthetic/orthotic devices	2,444,878	2,363,720
Drugs admin. through DME[3]	770,702	827,574
Parenteral and enteral nutrition	604,248	512,214
Other DME	3,464,453	2,612,327

[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]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 reassignment of selected procedures, services, and supplies. Data for 2013 and 2014 as reported in the CMS Chronic Conditions Data Warehouse.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table III.12
National Health Care/Type of Expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$2,919.1	$9,255	35.5	20.1	15.4
Health Consumption Expenditures	2,754.5	8,733	37.6	21.3	16.3
Personal health care	2,468.6	7,826	38.9	22.3	16.6
Hospital care	936.9	2,970	43.4	25.9	17.5
Prof. services	777.9	2,466	27.2	19.1	8.1
Phys./clinical	586.7	1,860	30.7	22.2	8.5
Other Professional	80.2	254	28.7	22.5	6.2
Dental	111.0	352	7.2	0.4	6.8
Other Health Residential & Personal Care	148.2	470	59.1	3.4	55.7
Nursing Care Facilities & Continuing Care Retirement Communities	155.8	494	52.3	22.2	30.1
Home Health	79.8	253	79.6	43.1	36.5
Retail outlet sales	370.0	1,173	30.0	23.0	7.0
Admn., Net Cost, and public health	286.0	907	25.8	12.3	13.5
Investment	164.6	522	--	--	--

NOTE: Data are as of calendar year 2013.

SOURCE: CMS, Office of the Actuary.

Table III.13
Personal Health Care/Payment Source

	Calendar Year			
	1980	1990	2000	2013
	In billions			
Total	$217.2	$616.8	$1,165.7	$2,468.6
	Percent			
Total	100.0	100.0	100.0	100.0
Out of pocket	26.9	22.5	17.3	13.7
Health Insurance	60.7	65.4	72.5	77.3
Private Health Insurance	28.3	33.2	34.9	34.3
Medicare	16.7	17.4	18.6	22.3
Medicaid (Title XIX)	11.4	11.3	16.0	16.6
Total CHIP (Title XIX and Title XXI)	--	--	0.2	0.5
Department of Defense	1.8	1.7	1.1	1.5
Department of Veterans Affairs	2.6	1.8	1.6	2.2
Other Third Party Payers and Programs	12.4	12.1	10.2	9.0

NOTES: Excludes administrative expenses, the net cost of insurance, non-commercial medical research, investment in structures and equipment, and public health expenditures. 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

	1990	2000	2013	2014
Discharges				
Total in millions	10.5	11.7	10.7	10.4
Rate per 1,000 enrollees[1]	320	362	289	280
Days of care				
Total in millions	94	70	58	56
Rate per 1,000 enrollees[1]	2,866	2,175	1,548	1,500
Average length of stay				
All short-stay	9.0	6.0	5.4	5.4
Excluded units	19.5	12.3	11.9	11.9
Total charges per day	$1,060	$2,720	$8,873	$9,338

[1]The population base for the denominator is the July 1 HI Original Medicare enrollment for years 1990 and 2000. For 2013 and 2014, the HI Original Medicare enrollee counts are based on a person-year methodology.

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. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.2
Medicare Long-Term Care/Trends

	Skilled Nursing Facilities		Home Health Agencies	
	Persons Served in thousands	Served per 1,000 enrollees	Persons Served in thousands	Served per 1,000 enrollees
Calendar year				
1985	315	10	1,576	51
1990	638	19	1,978	58
1995	1,233	37	3,468	103
2000	1,468	45[1]	2,461	75[1]
2005	1,847	51[1]	2,976	81[1]
2010	1,839	52[1]	3,605	100[1]
2014	1,827	49[1]	3,601	96[1]

[1]Managed care enrollees excluded in determining rate.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.3
Medicare Average Length of Stay/Trends

	Fiscal Year				
	1990	1995	2000	2010	2014
All short-stay and excluded units					
Short-stay PPS units	9.0	7.1	6.0	5.1	5.0
Short-stay hospital non-PPS units	8.9	7.1	6.0	5.1	5.6
Excluded units	19.5	14.8	12.3	11.8	11.9

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2014 are based on 100-percent MEDPAR stay record file. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.4
Medicare Persons Served/Trends

	Calendar Year					
	1975	1985	1995	2005	2010	2014
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	923	919	890
HI	221	219	218	234	237	197
SMI	536	739	858	979	988	979
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	865	897	943
HI	219	228	212	205	213	198
SMI	471	715	837	977	1,007	1,028

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, the rates were adjusted to exclude managed care enrollees. Persons served represents estimates of beneficiaries receiving services under Original Medicare during the calendar year.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.5
Original Medicare Persons Served

	Year				
	2010	2011	2012	2013	2014
HI					
Aged					
Original Medicare Enrollees	29.0	29.3	30.0	30.5	30.7
Persons served	6.9	6.3	6.3	6.2	6.1
Rate per 1,000	237	217	208	202	197
Disabled					
Original Medicare Enrollees	6.6	6.8	6.9	6.7	6.6
Persons served	1.4	1.4	1.4	1.3	1.3
Rate per 1,000	213	201	196	197	198
SMI					
Aged					
Original Medicare Enrollees	26.4	26.6	27.0	27.6	27.8
Persons served	26.1	26.2	26.7	27.0	27.2
Rate per 1,000	988	987	989	977	979
Disabled					
Original Medicare Enrollees	5.8	6.0	6.0	6.1	6.0
Persons served	5.8	6.1	6.2	6.2	6.2
Rate per 1,000	1,007	1,023	1,027	1,019	1,028

NOTES: For years 2010-2012, enrollment represents persons enrolled in Original Medicare as of July. For 2013 and 2014, Medicare enrollment is based on a person-year methodology. Persons served represents counts of beneficiaries receiving reimbursed services under Original Medicare during the calendar year. Rate is the ratio of persons served during the calendar year to the number of Original Medicare enrollees.

Original Medicare enrollees and persons served counts are in millions.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.6
Medicare Persons Served/CMS Region

	Aged Persons Served in thousands	Served per 1,000 Enrollees	Disabled Persons Served in thousands	Served per 1,000 Enrollees
All Regions[1]	27,634	890	6,251	943
Boston	1,533	878	376	948
New York	2,513	847	518	870
Philadelphia	2,928	893	639	949
Atlanta	6,018	927	1,482	975
Chicago	4,832	967	1,174	976
Dallas	3,107	887	745	935
Kansas City	1,503	919	325	961
Denver	926	923	168	966
San Francisco	3,196	845	598	897
Seattle	1,063	862	225	906

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

NOTES: Data are based on counts of beneficiaries receiving HI and/or SMI reimbursed services under Original Medicare during calendar year 2014. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.6a
Original Medicare 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	33,885	27,634	6,251
Part A	7,372	6,061	1,312
Inpatient hospital	6,383	5,134	1,248
Skilled nursing facility	1,827	1,650	177
Home health agency	1,657	1,440	217
Hospice	1,331	1,257	73
Part B	33,401	27,211	6,190
Physician/supplier	32,745	26,745	6,000
Outpatient	25,083	20,280	4,803
Home health agency	1,945	1,677	268

NOTES: Data are as of calendar year 2014. Persons served represents counts of beneficiaries receiving services under Original Medicare during the calendar year.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Table IV.7
Medicare End Stage Renal Disease (ESRD) by Treatment Modalities

	Medicare Entitled		
Year	Total	Dialysis Patients	Transplant Patients
1991	180,625	141,069	39,556
1999	316,167	244,869	71,298
2000	332,885	257,686	75,199
2001	349,207	270,016	79,191
2002	364,956	281,327	83,629
2003	377,592	291,782	85,810
2004	393,301	301,866	91,435
2005	408,378	312,008	96,370
2006	425,039	323,545	101,494
2007	441,030	334,995	106,035
2008	457,660	347,212	110,448
2009	475,292	360,537	114,755
2010	492,713	373,483	119,230
2011	507,324	383,420	123,904

SOURCE: United States Renal Data System.

Table IV.8
Medicare End Stage Renal Disease (ESRD)
by Treatment Modalities and Demographics, 2010

	Medicare Entitled		
	Total	Dialysis Patients	Transplant Patients
Total--all patients	492,713	373,483	119,230
Age			
0-19 years	3,196	1,452	1,744
20-64 years	278,262	195,727	82,535
65-74 years	118,721	90,823	27,898
75 years and over	92,534	85,481	7,048
Sex			
Male	280,229	208,505	71,724
Female	212,484	164,978	47,506
Race			
White	295,864	211,046	84,818
Black	164,299	137,796	26,503
Native American	6,646	5,428	1,218
Asian/Pacific	23,830	17,901	5,929
Other/Unknown	2,074	1,312	762

SOURCE: United States Renal Data System.

Table IV.9
Medicaid/Type of Service

	Fiscal year 2012 Medicaid Beneficiaries
	In thousands
Total eligibles	70,895
Number using service:	
Total beneficiaries, any service[1]	63,312
Inpatient services	
General hospitals	7,601
Mental hospitals	42
Nursing facility services[2]	1,415
ICF/IID services	95
Physician services	42,770
Dental services	18,223
Other practitioner services	9,399
Outpatient hospital services	26,292
Clinic services	15,744
Laboratory and radiological services	28,131
Home health services	1,696
Prescribed drugs	38,695
Personal care support services	1,189
Sterilization services	285
PCCM capitation	9,266
HMO capitation	39,360
PHP capitation	19,301
Targeted case management	2,579
Other services, unspecified	15,873
Additional service categories	12,848
Unknown	524

[1]Excludes gross adjustment claims for services received by individual patients that come in the form of a lump sum payment covering services to more than one patient. [2]All nursing facility services. Unlike Medicare there is no distinction for SNFs.

NOTES: The methodology used is different from previous updates for this table, and data were derived from the MSIS Granular Database. Beneficiary counts include Medicaid eligibles enrolled in fee-for-service and Medicaid managed care. Excludes data for Colorado, Idaho, and Maine and includes partial data for Arizona and Washington, D.C. Excludes CHIP.

SOURCE: CMS, Center for Medicaid and CHIP Services.

Table IV.10
Medicaid/Units of Service

	Fiscal Year 2012 Units of Service
	In thousands
Inpatient hospital	
Total discharges	7,536
Beneficiaries discharged	6,778
Total days of care	43,765
Nursing facility	
Total days of care	290,962
ICF/IID	
Total days of care	26,733

NOTES: Data are derived from the MSIS Granular Database. Service counts produced using inpatient and long term care original fee-for-service and Medicaid managed care claims. Excludes enrollees ever enrolled in separate Title XXI CHIP program and beneficiaries that had claims but no matching Medicaid enrollment in 2012. Excludes data for Colorado, Idaho, and Maine, and includes partial data for Arizona and Washington, D.C.

SOURCE: CMS, Center for Medicaid and CHIP Services.

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

	Administrative Expenses	
Fiscal Year	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
2010	3,328	1.4
2012	3,696	1.5
2013	4,135	1.6
2014	4,332	1.7
SMI Trust Fund[2]		
1967	135[3]	20.3
1970	217	11.0
1980	593	5.8
1990	1,524	3.7
1995	1,722	2.7
2000	1,780	2.0
2005	2,348	1.6
2010	3,513	1.3
2012	4,130	1.4
2013	3,756	1.2
2014	4,297	1.3

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

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

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

SOURCE: CMS, Office of Actuary.

Table V.2
Medicare Administrative Contractors

	Number
A/B MACs	13
DME MACs	4

NOTE: Data as of August 2015.

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	385,016	229,134	2,624,982
Percent Reversed (Includes Fully & Partially Reversed Cases)	12.3	46.3	39.2

NOTES: Data for fiscal year 2014. Data presented in cases.

SOURCE: CMS, Center for Medicare.

Table V.4
Medicare Physician/Supplier Claims Assignment Rates

	2000	2005	2010	2012	2013	2014
	In millions					
Claims total	720.5	951.6	972.7	1,003.2	994.6	995.2
Claims assigned	705.7	940.7	965.7	997.4	989.2	989.9
Claims unassigned	15.3	10.9	7.0	5.8	5.4	5.3
Percent assigned	97.9	98.9	99.3	99.4	99.5	99.5

NOTE: Calendar year data (includes Carriers, Part B A/B MACs, DME MACs). Due to the 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 2014
Part A claims processed in millions	210.0
Part B claims processed in millions[1]	1,003.0

[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	211.3
	Percent of total
Inpatient hospital	7.0
Outpatient hospital	54.6
Home health agency	7.3
Skilled nursing facility	2.7
Other	28.4
Carrier claims received in millions	990.4
	Percent of total
Assigned	99.5
Unassigned	0.5

NOTE: Data for calendar year 2014.

SOURCE: CMS, Center for Medicare.

Table V.7
Medicare Charge Reductions

	Assigned	Unassigned
Claims approved		
Number in millions	880.6	4.2
Percent reduced	95.1	79.0
Total covered charges		
Amount in millions	$347,953	$519
Percent reduced	63.4	21.6
Amount reduced per claim	$250.34	$26.78

NOTES: Data for calendar year 2014. Charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Center for Medicare.

Table V.8
Medicaid Administration

	Fiscal Year	
	2013	2014
	In millions	
Total payments computable for Federal funding[1]	$22,938	$24,418
Federal share[1]		
Family Planning	32	30
Design, development or installation of MMIS[2]	533	663
Skilled professional medical personnel	440	487
Operation of an approved MMIS[2]	1,550	1,569
All other	11,588	12,359
Mechanized systems not approved under MMIS[2]	73	85
Total Federal Share	$14,216	$15,193
Net adjusted Federal share[3]	$13,682	$14,675

[1]Source: Form CMS-64. (Net Expenditures Reported—Administration).

[2]Medicaid Management Information System.

[3]Includes CMS adjustments.

SOURCE: CMS, Office of Enterprise Data and Analytics.

Reference

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

Program Financing, Cost Sharing and Limitations

Medicare/Source of Income

Medicare Part A

Hospital Insurance trust fund:

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

*Contribution rate	2014	2015	2016
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2016)	None[1]
Voluntary HI monthly premium[2]	$411.00

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/16)	$1,288/benefit period
Regular coinsurance days (1/1/16)	$322/day for 61st through 90th day
Lifetime reserve days (1/1/16)	$644/day (60 non-renewable days)
SNF coinsurance days (1/1/16)	$161/day for 21st through 100th day
Blood deductible	first 3 pints/calendar year
Voluntary hospital insurance premium (1/1/16)[2]	$411/month; $226/mo. with 30-39 quarters of coverage
Limitations:	
Inpatient psychiatric hospitals	190 nonrenewable days

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

[2]Premium paid for voluntary participation of individuals aged 65 and over not otherwise entitled to hospital insurance and certain disabled individuals who have exhausted other entitlement. A reduced premium of $226 is available to individuals aged 65 and over who are not otherwise entitled to hospital insurance but who have, or whose spouse has or had, 30-39 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

Program Financing, Cost Sharing and Limitations

Medicare Part B

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

Part B (effective date)	**Amount**
Deductible (1/1/16)	$166 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/16)	$104.90/month
Limitations:	
Outpatient treatment for mental illness	No limitations

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

SOURCE: CMS, Office of the Actuary.

Medicare Part B (continued)

Listed below are the 2016 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	$121.80
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$48.70	$170.50
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$121.80	$243.60
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$194.90	$316.70
Greater than $214,000	Greater than $428,000	$268.00	$389.80

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	$121.80
Greater than $85,000 and less than or equal to $129,000	$194.90	$316.70
Greater than $129,000	$268.00	$389.80

SOURCE: CMS, Office of the Actuary.

Program Financing, Cost Sharing and Limitations

Medicare Part D Standard Benefits

Deductible (1/1/2016)	$360 in charges/year
Initial coverage limit (1/1/2016)	$3,310 in charges/year
Out-of-pocket threshold (1/1/2016)	$4,850 in charges/year
Base beneficiary premium (1/1/2016)[1]	$34.10/month

Medicaid Financing

1. Federal contributions (ranging from 50 to 74 percent for fiscal year 2016)
2. State contributions (ranging from 26 to 50 percent for fiscal year 2016)

[1]The base beneficiary premium was calculated based on a national average plan bid. The actual premium that a beneficiary pays varies according to the plan in which the beneficiary is enrolled.

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

SOURCE: CMS, Office of the Actuary.

Geographical Jurisdictions of CMS Regional Offices and Medicaid Federal Medical Assistance Percentages (FMAP) fiscal year 2016

I. Boston	FMAP
Connecticut	50.00
Maine	62.67
Massachusetts	50.00
New Hampshire	50.00
Rhode Island	50.42
Vermont	53.90
III. Philadelphia	
Delaware	54.83
Dist. of Columbia	70.00
Maryland	50.00
Pennsylvania	52.01
Virginia	50.00
West Virginia	71.42
V. Chicago	
Illinois	50.89
Indiana	66.60
Michigan	65.60
Minnesota	50.00
Ohio	62.47
Wisconsin	58.23
VII. Kansas City	
Iowa	54.91
Kansas	55.96
Missouri	63.28
Nebraska	51.16
IX. San Francisco	
Arizona	68.92
California	50.00
Hawaii	53.98
Nevada	64.93
American Samoa	55.00
Guam	55.00
N. Mariana Islds	55.00

II. New York	FMAP
New Jersey	50.00
New York	50.00
Puerto Rico	55.00
Virgin Islands	55.00
IV. Atlanta	
Alabama	69.87
Florida	60.67
Georgia	67.55
Kentucky	70.32
Mississippi	74.17
North Carolina	66.24
South Carolina	71.08
Tennessee	65.05
VI. Dallas	
Arkansas	70.00
Louisiana	62.21
New Mexico	70.37
Oklahoma	60.99
Texas	57.13
VIII. Denver	
Colorado	50.72
Montana	65.24
North Dakota	50.00
South Dakota	51.61
Utah	70.24
Wyoming	50.00
X. Seattle	
Alaska	50.00
Idaho	71.24
Oregon	64.38
Washington	50.00

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

SOURCE: DHHS, Assistant Secretary for Planning and Evaluation.

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Office of Enterprise Data and Analytics
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