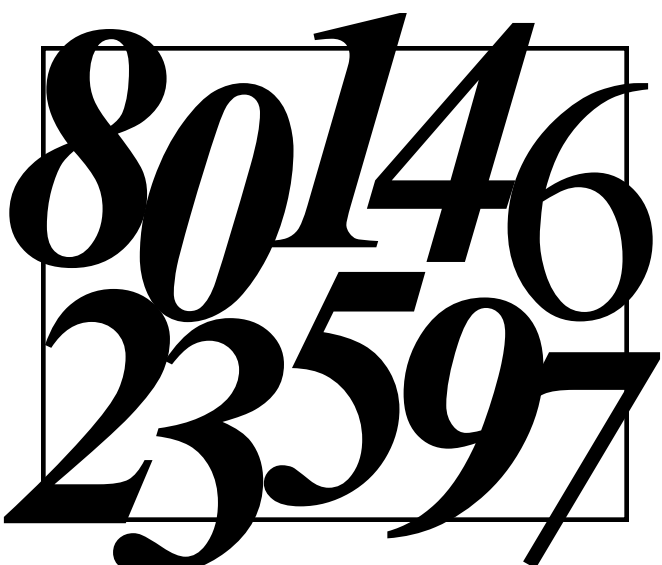
2014 CMS Statistics



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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**
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 54.0 million in 2014, a 183 percent increase. (I.1)

- Medicare enrollees with end-stage renal disease increased from 110.0 thousand in 1985 to 462.2 thousand in 2013, an increase of 320 percent. (I.5)

- On average, the number of Medicaid monthly enrollees in 2014 is estimated to be about 64.9 million, the largest group being children (29.5 million or 45.5 percent). (I.16)

- In 2010, 22 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 8.9 million beneficiaries in 2013, an increase of about 218 percent. (I.19)

- By 2013, over 35.7 million Medicare enrollees had Part D drug coverage, 68.1 percent of all enrollees, and an additional 3.3 million had RDS. (I.10 & I.12)

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,522 in December 1990 to 6,164 in December 2013. Total inpatient hospital beds have dropped from 32.8 beds per 1,000 enrolled in 1990 to 18.1 in 2013, a decrease of 45 percent. (II.1)
- In the past decade, the total number of Medicare certified beds in short-stay hospitals has decreased to about 789,000 in 2013 from 970,000 in 1990. The average number of short-stay hospital beds per 1,000 enrolled in 2013 is 15.3 down from 28.8 in 1990. (II.1)
- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, generally increased thereafter to over 15,000 in the late 1990s, and remains currently at this level. (II.3 & II.4)
- The number of participating home health agencies has fluctuated considerably over the years, almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed. The number decreased sharply but has since stabilized, reaching 12,459 in 2013. (II.5 & II.6)

Expenditures

- National health expenditures (NHE) were $2,793.4 billion in 2012, comprising 17.2 percent of the gross domestic product (GDP). Comparably, NHE amounted to $724.3 billion, or 12.1 percent of the GDP in 1990. NHE per person were $147 in 1960 and grew steadily to reach $8,915 by 2012. (III.7)
- In 2013, total net Federal outlays for CMS programs were $747.7 billion, 21.6 percent of the Federal budget. (III.1)
- Medicare Part A benefit payments are projected to increase to $264.4 billion for fiscal year 2014 up from $261.8 billion for fiscal year 2013, and Medicare Part B benefit payments are projected to increase to $256.2 billion for fiscal year 2014 up from $243.1 billion for fiscal year 2013. (III.5)
- Medicare hospice benefit payments are projected to increase to $16.8 billion for fiscal year 2014 up from $15.6 billion in 2013. (III.6)

Utilization of Medicare and Medicaid services

- Between 1985 and 2012, the number of short-stay hospital discharges increased from 10.5 million to 11.2 million, an increase of 6.7 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 2012, a decrease of 44 percent. (IV.3)

- About 33.3 million persons received a reimbursed service under Medicare fee-for-service during 2012. Comparably, almost 64.2 million persons used Medicaid services or had a premium paid on their behalf in 2011. (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 892 per 1,000 enrolled in 2012. (IV.4)
- 6.7 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2012. (IV.6a)
- 32.3 million persons received reimbursable fee-for-services physician services under Medicare during 2012. 22.3 million persons received reimbursable physician services under Medicaid during 2011. (IV.6a & IV.9)
- 24.7 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2012. During 2011, 15.2 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 2012. 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 2011. (IV.6a & IV.9)
- Over 28 million persons received prescribed drugs under Medicaid during 2011. (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
Average monthly			
2000	39.7	34.3	5.4
2005	42.6	35.8	6.8
2010	47.7	39.6	8.1
2011	48.9	40.5	8.4
2012	50.9	42.2	8.6
2013	52.3	43.5	8.8
2014	54.0	45.0	9.0

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 2000-2014 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on 2014 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	53.6	53.2	49.0	40.3	48.6	4.6	0.3
Aged persons	44.6	44.3	41.0	--	40.6	3.7	0.3
Disabled persons	8.9	8.9	8.0	--	8.0	0.9	0.0

NOTES: Projected average monthly enrollment during fiscal year 2014. Aged/disabled split of Part D enrollment not available. Based on 2014 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	52,456	23,783	28,673
Aged	43,614	19,192	24,422
65-74 years	24,552	11,546	13,005
75-84 years	13,117	5,653	7,464
85 years and over	5,945	1,993	3,952
Disabled	8,843	4,591	4,251
Under 45 years	1,995	1,069	926
45-54 years	2,575	1,326	1,248
55-64 years	4,273	2,196	2,076
White	42,711	19,341	23,370
Black	5,490	2,372	3,118
All Other	3,811	1,794	2,017
Native American	236	106	131
Asian/Pacific	1,127	488	639
Hispanic	1,424	672	753
Other	1,023	529	494
Unknown Race	443	276	168

NOTES: Data as of July 1, 2013. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.
SOURCE: CMS, Office of Information Products and Data Analytics

Table I.4
Medicare Part D enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	35,740	15,041	20,699
Aged			
65-74 years	15,818	6,847	8,971
75-84 years	9,260	3,710	5,550
85 years and over	4,069	1,214	2,855
Disabled			
Under 45 years	1,764	921	842
45-54 years	1,820	919	902
55-64 years	3,010	1,430	1,580

NOTES: Data for calendar year 2013, as reported on the Part D Denominator File. Totals may not add because of rounding.

SOURCE: CMS, Office of Information Products and Data 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
2013	462.2	462.1	442.0

NOTE: Data as of July 1 of each year.

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

Table I.6
Medicare ESRD enrollment/demographics

	Number of enrollees (in thousands)
All persons	511.9
Age	
Under 35 years	25.6
35-44 years	41.3
45-64 years	206.0
65 years and over	239.0
Sex	
Male	292.3
Female	219.6
Race	
White	263.9
Other	243.6
Unknown	4.4

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2013.

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

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

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	730	1,947	14,086	16,033
Local CCPs	545	1,427	12,481	13,908
PFFS	12	95	211	306
1876 Cost	16	255	227	482
1833 Cost (HCPP)	9	53	--	53
PACE	104	--	29	29
Other plans[2]	44	117	1,138	1,255
Total PDPs[1]	85	--	23,350	23,350
Total	815	1,947	37,437	39,384

[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 April 2014.
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	316,129	51,274	16.2
Boston	14,619	2,626	18.0
New York	28,550	4,641	16.3
Philadelphia	30,390	5,239	17.2
Atlanta	62,884	11,160	17.7
Chicago	52,083	8,792	16.9
Dallas	39,969	5,710	14.3
Kansas City	13,897	2,398	17.3
Denver	11,335	1,581	14.0
San Francisco	49,153	6,989	14.2
Seattle	13,249	2,137	16.1

[1]Preliminary annual estimate July 1, 2013 resident population.

[2]Medicare enrollment file data are as of July 1, 2013. Excludes beneficiaries living in territories, possessions, foreign countries, or with residence unknown.

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

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

Table I.9
Medicare enrollment by health delivery/CMS region

	Total Enrollees	Fee-for-Service Enrollees	Managed Care Enrollees
		In thousands	
All regions	52,456	37,587	14,869
Boston	2,626	2,124	502
New York	5,391	3,547	1,844
Philadelphia	5,239	3,892	1,348
Atlanta	11,160	8,088	3,072
Chicago	8,792	6,308	2,484
Dallas	5,710	4,275	1,435
Kansas City	2,398	1,953	445
Denver	1,581	1,151	431
San Francisco	7,009	4,396	2,613
Seattle	2,137	1,446	691

NOTES: Data as of July 1, 2013. 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 Information Products and Data Analytics.

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

	Total	Fee-for-Service	Managed Care
		In thousands	
All persons	52,456	37,587	14,869
Aged	43,614	30,716	12,897
65-74 years	24,552	17,292	7,260
75-84 years	13,117	9,022	4,095
85 years and over	5,945	4,402	1,543
Disabled	8,843	6,871	1,972
Under 45 years	1,995	1,705	290
45-54 years	2,575	2,037	538
55-64 years	4,273	3,128	1,144
Male	23,783	17,320	6,464
Female	28,673	20,267	8,406
White	42,711	30,825	11,886
Black	5,490	3,827	1,663
All Other	3,811	2,583	1,229
Native American	236	206	30
Asian/Pacific	1,127	790	337
Hispanic	1,424	907	517
Other	1,023	678	345
Unknown Race	443	352	91

NOTES: Data as of July 1, 2013. Numbers may not add to totals because of rounding. Race information obtained from the Enrollment Database.

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

Table I.10
Medicare Part D enrollment by CMS region

	Total Medicare Enrollees	Total Part D Enrollees	Percent of Total Enrollees
	In thousands		
All regions[1]	52,456	35,740	68.1
Boston	2,626	1,717	65.4
New York	5,391	3,884	72.0
Philadelphia	5,239	3,382	64.6
Atlanta	11,160	7,717	69.2
Chicago	8,792	6,135	69.8
Dallas	5,710	3,797	66.5
Kansas City	2,398	1,676	69.9
Denver	1,581	998	63.1
San Francisco	7,009	5,074	72.4
Seattle	2,137	1,345	62.9

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

NOTE: Data for calendar year 2013 as reported on the Part D Denominator file.
SOURCE: CMS, Office of Information Products and Data Analytics.

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

	Total Part D Enrollees	Total PDP Enrollees	Total MA-PD Enrollees
	In thousands		
All regions[1]	35,740	22,686	13,054
Boston	1,717	1,246	471
New York	3,884	2,140	1,744
Philadelphia	3,382	2,244	1,139
Atlanta	7,717	4,842	2,875
Chicago	6,135	4,443	1,692
Dallas	3,797	2,593	1,204
Kansas City	1,676	1,268	408
Denver	998	620	378
San Francisco	5,074	2,540	2,534
Seattle	1,345	740	605

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

NOTE: Data for calendar year 2013 as reported on the Part D Denominator file.

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

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

	Total Part D and RDS Enrollees	Total Part D Enrollees	Total RDS Enrollees
		In thousands	
All regions[1]	39,013	35,740	3,273
Boston	1,979	1,717	262
New York	4,232	3,884	349
Philadelphia	3,732	3,382	349
Atlanta	8,342	7,717	625
Chicago	6,798	6,135	663
Dallas	4,104	3,797	307
Kansas City	1,784	1,676	108
Denver	1,103	998	105
San Francisco	5,409	5,074	336
Seattle	1,509	1,345	165

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

NOTE: Data for calendar year 2013 as reported on the Part D Denominator file.

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

Table I.13
Projected Population[1]

	2010	2020	2040	2060	2080	2100
			In millions			
Total	315	343	393	431	473	514
Under 20	85	88	99	106	114	122
20-64	188	198	212	232	253	270
65 years and over	41	57	82	93	106	122

[1] As of July 1.

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

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2014 Trustees Report Intermediate Alternative.

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

Year	Male	Female
	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]	19.6	21.7
2040[1]	20.2	22.3
2050[1]	20.7	22.8
2060[1]	21.3	23.3
2070[1]	21.8	23.8
2080[1]	22.3	24.2
2090[1]	22.8	24.6
2100[1]	23.2	25.0

[1]Projected.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2014 Trustees Report Intermediate Alternative.

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

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

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	2013	2014
	Average monthly enrollment in millions					
Total	34.2	34.5	46.5	53.5	57.4	64.9
Age 65 years and over	3.7	3.7	4.6	4.7	5.2	5.4
Blind/Disabled	5.8	6.7	8.1	9.5	9.6	9.8
Children	16.5	16.2	22.3	26.3	27.9	29.5
Adults	6.7	6.9	10.6	12.1	13.7	19.2
Other Title XIX[1]	0.6	NA	NA	NA	NA	NA
Territories	0.8	0.9	1.0	1.0	1.0	1.0
CHIP	NA	2.0	5.9	5.4	5.9	6.0
	Unduplicated annual enrollment in millions					
Total	43.3	44.2	58.7	67.7	72.8	80.6
Age 65 years and over	4.4	4.3	5.5	5.6	6.1	6.3
Blind/Disabled	6.5	7.5	9.0	10.6	10.7	10.9
Children	21.3	20.9	27.8	33.0	35.0	35.4
Adults	9.4	10.6	15.4	17.6	20.1	27.1
Other Title XIX[1]	0.9	NA	NA	NA	NA	NA
Territories	0.8	0.9	1.0	1.0	1.0	1.0
CHIP	NA	3.4	6.8	8.0	8.6	9.6

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

NOTES: Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty-related recipients who are not disabled. Medicaid enrollment excludes Medicaid expansion CHIP programs. CHIP numbers include adults covered under waivers. Medicaid and CHIP figures for FY 2013-2014 are estimates from the President's FY 2015 Budget. Enrollment for Territories for FY 2000 and later is estimated. Numbers may not add to totals because of rounding.

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

Table I.17
Medicaid eligibles/demographics

	Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	66.2	100.0
Age	66.2	100.0
Under 21	34.0	51.3
21-64 years	25.8	39.0
65 years and over	6.3	9.6
Unknown	0.1	0.1
Sex	66.2	100.0
Male	27.4	41.4
Female	38.7	58.4
Unknown	0.1	0.1
Race	66.2	100.0
White, not Hispanic	26.5	40.1
Black, not Hispanic	14.6	22.1
Am. Indian/Alaskan Native	0.7	1.1
Asian	2.2	3.3
Hawaiian/Pacific Islander	0.6	1.0
Hispanic	16.7	25.2
Other	0.3	0.4
Unknown	4.6	6.9

NOTES: Fiscal Year 2011 data derived from MSIS State Summary Datamart. The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of the rounded components. Eligible is defined as anyone eligible and enrolled in the Medicaid program at some point during the fiscal year, regardless of duration of enrollment, receipt of a paid medical service, or whether or not a capitated premium for managed care or private health insurance coverage had been made. The outlying areas are not included. Excludes the Children's Health Insurance Program (CHIP). Race information is obtained from the states. Data for the following states are excluded: Idaho, Kansas, Maine, Oklahoma, and Utah.

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

Table I.18
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	299,201	66,180	22.1
Boston	13,190	3,060	23.2
New York	28,339	6,881	24.3
Philadelphia	30,070	5,507	18.3
Atlanta	61,763	13,021	21.1
Chicago	51,853	11,094	21.4
Dallas	35,233	7,720	21.9
Kansas City	10,916	1,976	18.1
Denver	8,192	1,202	14.7
San Francisco	48,232	13,494	28.0
Seattle	11,413	2,226	19.5

[1]Estimated July 1, 2011 population.
[2]Persons ever enrolled in Medicaid during fiscal year 2011.

NOTES: Numbers may not add to totals because of rounding. Exclude data for Idaho, Kansas, Maine, Oklahoma, Utah, Puerto Rico, Virgin Islands and Outlying Areas. Excludes CHIP.

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

Table I.19
Medicaid beneficiaries/State buy-ins for Medicare

	1975[1]	1980[1]	2000[2]	2013[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	8,949
Aged	2,483	2,449	3,632	5,158
Disabled	363	504	1,917	3,791
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	18.7
Aged	11.4	10.0	11.1	12.8
Disabled	18.7	18.9	40.2	48.8

[1]Beneficiaries for whom the State paid the SMI premium during the year.
[2]Beneficiaries in person years.

NOTES: Numbers may not add to totals because of rounding. Includes outlying areas, foreign countries, and unknown.

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

Providers/Suppliers

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

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

Table II.1
Inpatient hospitals/trends

	1990	2000	2010	2013
Total hospitals	6,522	5,985	6,169	6,164
Beds in thousands	1,105	991	928	934
Beds per 1,000 enrollees[1]	32.8	25.3	19.6	18.1
Short-stay	5,549	4,900	3,566	3,506
Beds in thousands	970	873	785	789
Beds per 1,000 enrollees[1]	28.8	22.3	16.6	15.3
Critical access hospitals	NA	NA	1,325	1,329
Beds in thousands	---	---	30	30
Beds per 1,000 enrollees[1]	---	---	0.6	0.6
Other non-short-stay	973	1,085	1,278	1,329
Beds in thousands	135	118	113	115
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.

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

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

Table II.2
Inpatient hospitals/CMS region

	Short-stay and CAH hospitals	Beds per 1,000 enrollees	Non Short-stay hospitals	Beds per 1,000 enrollees
All regions	4,835	15.9	1,329	2.2
Boston	183	12.4	64	3.7
New York	302	16.4	72	2.1
Philadelphia	364	13.7	131	2.5
Atlanta	892	16.1	244	1.8
Chicago	864	17.1	206	1.9
Dallas	773	18.8	347	3.8
Kansas City	458	19.4	63	1.9
Denver	315	16.6	48	2.5
San Francisco	473	13.9	125	1.6
Seattle	211	11.2	29	1.4

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2013. Rates based on number of hospital insurance enrollees as of July 1, 2013, residing in U.S. and its territories.

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

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

Total participating hospitals	6,164
Short-term hospitals	3,506
Psychiatric units	1,128
Rehabilitation units	914
Swing bed units	513
Psychiatric	541
Long-term	430
Rehabilitation	245
Children's	98
Religious non-medical	15
Critical access	1,329
Non-participating Hospitals	740
Emergency	388
Federal	352
All SNFs/SNF-NFs/NFs only	15,651
All SNFs/SNF-NFs	15,156
Title 18 Only SNF	772
Hospital-based	201
Free-standing	571
Title 18/19 SNF/NF	14,384
Hospital-based	600
Free-standing	13,784
Title 19 only NFs	495
Hospital-based	102
Free-standing	393
All ICF-MR facilities	6,374

NOTES: Data as of December 31, 2013. Numbers may differ from other reports and program memoranda.

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

Table II.4
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs	Nursing Facilities	ICF-MRs
All regions[1]	15,156	495	6,374
Boston	945	10	133
New York	1,000	2	586
Philadelphia	1,366	40	373
Atlanta	2,644	48	691
Chicago	3,338	103	1,443
Dallas	2,034	59	1,549
Kansas City	1,392	122	202
Denver	588	36	108
San Francisco	1,411	56	1,209
Seattle	438	19	80

[1]Includes outlying areas.

NOTE: Data as of December 2013.

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

Table II.5
Other Medicare providers and suppliers/trends

	1980	1990	2010	2013
Home health agencies	2,924	5,661	10,914	12,459
Independent and Clinical Lab Improvement Act Facilities	NA	4,828	224,679	244,427
End stage renal disease facilities	999	1,987	5,631	6,145
Outpatient physical therapy and/or speech pathology	419	1,144	2,536	2,172
Portable X-ray	216	435	561	556
Rural health clinics	391	517	3,845	4,026
Comprehensive outpatient rehabilitation facilities	NA	184	354	233
Ambulatory surgical centers	NA	1,165	5,316	5,368
Hospices	NA	772	3,509	3,941

NOTES: Facility data for 1980 are as of July 1. Facility data for 1990, 2010 and 2013 are as of December 31.

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

Table II.6
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,506	15,156	12,459
		Percent of total	
Non-profit	59.4	24.4	15.3
Proprietary	21.2	69.6	79.6
Government	19.4	6.0	5.2

NOTES: Data as of December 31, 2013. Facilities certified for Medicare are deemed to meet Medicaid standards.

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

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

	1980	1990	2000	2012	2013
Hospitals					
Number of PIP	2,276	1,352	869	568	551
Percent of total participating	33.8	20.6	14.4	9.2	8.9
Skilled nursing facilities					
Number of PIP	203	774	1,236	345	654
Percent of total participating	3.9	7.3	8.3	2.3	4.3
Home health agencies					
Number of PIP	481	1,211	1,038	141	160
Percent of total participating	16.0	21.0	14.4	1.2	1.3

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	1,226,728
Primary Care	219,536
Surgical Specialties	106,075
Medical Specialties	141,189
Anesthesiology	39,825
Obstetrics/Gynecology	34,581
Pathology	12,174
Psychiatry	28,130
Radiology	37,597
Emergency Medicine	43,048
Non-Physician Practitioners	308,994
Limited Licensed Practitioners	93,929
Ambulance Service Supplier	10,529
Other and Unknown	59,782
Durable Medical Equipment Suppliers	91,339

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

NOTE: Data for calendar year 2013, as reported on the fee-for-service claims.

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

Expenditures

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

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

Table III.1
CMS and total Federal outlays

	Fiscal year 2012	Fiscal year 2013
	$ in billions	
Gross domestic product (current dollars)	$15,547.4	$16,618.6
Total Federal outlays[1]	3,537.1	3,454.6
Percent of gross domestic product	22.8%	20.8%
Dept. of Health and Human Services[1]	848.1	886.3
Percent of Federal Budget	24.0%	25.7%
CMS Budget (Federal Outlays)		
Medicare benefit payments	546.7	577.4
SMI transfer to Medicaid[2]	0.6	0.5
Medicaid benefit payments	238.8	248.8
Medicaid State and local admin.	13.9	14.5
Medicaid offsets[3]	-0.6	-0.5
Children's Health Ins. Prog.	9.1	9.5
CMS program management	3.6	3.7
Other Medicare admin. expenses[4]	2.5	2.0
State Eligibility Determinations, for Part D	0.0	0.0
Quality Improvement Organizations[5]	0.4	0.5
Health Care Fraud and Abuse Control	1.5	1.6
State Grants and Demonstrations[6]	0.5	0.5
User Fees and Reimbursables	0.5	0.7
Total CMS outlays (unadjusted)	817.5	844.7
Offsetting receipts[7]	-85.1	-97.0
Total net CMS outlays	732.4	747.7
Percent of Federal budget	20.7%	21.6%

[1]Net of offsetting receipts.

[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($602 million in FY 2012 and $477 million in FY 2013).

[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
2013	1,062.7	587.6	461.5	13.6

[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	2013
Annually	Amounts in billions			
CMS program outlays	$5.1	$57.8	$915	$1,038
Federal outlays	NA	47.2	793	861
Medicare[1]	3.2	33.9	518	587
HI	2.5	23.8	250	273
SMI	0.7	10.1	209	249
Prescription (Part D)	NA	NA	59	65
Medicaid[2]	1.9	23.9	386	437
Federal share	NA	13.2	266	265
CHIP[3]	NA	NA	11	14
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 2012 Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$408,855	$235,071
Boston	25,843	13,366
New York	63,377	31,831
Philadelphia	40,942	22,610
Atlanta	66,507	43,118
Chicago	64,928	38,870
Dallas	46,504	29,116
Kansas City	16,348	10,020
Denver	9,514	5,471
San Francisco	60,150	32,269
Seattle	14,742	8,399

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

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

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

Table III.5
Medicare benefit outlays

	Fiscal Year		
	2012	2013	2014
	In billions		
Part A benefit payments	$253.9	$261.8	$264.4
Aged	211.1	217.7	219.8
Disabled	42.7	44.1	44.6
Part B benefit payments	226.9	243.1	256.2
Aged	183.9	197.1	208.0
Disabled	43.0	45.9	48.1
Part D	60.6	68.0	73.3

NOTES: Based on 2014 Trustees Report. Benefits include additional payments for: Part A - HIT, CBC, IPAB, and Sequester; Part B—HIT, IPAB, 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 2014 benefit payments[1] in millions	Percent distribution
Total Part A[2,3]	$264,431	100.0
Inpatient hospital	136,141	51.5
Skilled nursing facility	30,141	11.4
Home health agency[4]	6,932	2.6
Hospice	16,830	6.4
Managed care	74,387	28.1
Total Part B[3,5]	256,164	100.0
Physician/other suppliers[6]	71,079	27.7
DME	6,427	2.5
Other carrier	20,925	8.2
Outpatient hospital	40,204	15.7
Home health agency[4]	11,420	4.5
Other intermediary	16,530	6.5
Laboratory	7,918	3.1
Managed care	81,660	31.9
Total Part D	73,282	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.
NOTES: Based on 2014 Trustees Report. Benefits by type of service are estimated and are subject to change. Totals may not equal the sum of rounded components.
SOURCE: CMS, Office of the Actuary.

Table III.7
National health care/trends

	Calendar Year		
	1990	2000	2012
National total in billions	$724.3	$1,377.2	$2,793.4
Percent of GDP	12.1	13.4	17.2
Per capita amount	$2,855	$4,878	$8,915
	Percent of Total		
Sponsor			
Private Business	24.6	25.1	20.7
Household	34.9	31.5	28.4
Other Private Revenues	7.9	7.8	6.9
Governments	32.6	35.5	44.0
Federal Government	17.3	19.0	26.2
State and local government	15.3	16.5	17.8

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		
	2010	2011	2012
	In billions		
Total medical assistance payments[1]	$383.4	$407.5	$408.8
	Percent of total		
Inpatient services	14.7	15.7	14.5
General hospitals	13.8	14.8	13.7
Mental hospitals	0.9	0.9	0.8
Nursing facility services	13.0	12.5	12.3
Intermediate care facility (MR) services	3.5	3.3	3.3
Community-based long term care svs.[2]	14.1	13.5	13.5
Prescribed drugs[3]	4.1	3.6	2.1
Physician and other practitioner services	4.1	4.0	3.5
Dental services	1.4	1.3	1.1
Outpatient hospital services	4.0	4.2	3.8
Clinic services[4]	2.8	2.7	2.6
Laboratory and radiological services	0.5	0.4	0.4
Early and periodic screening	0.4	0.3	0.3
Case management services	0.9	0.7	0.7
Capitation payments (non-Medicare)	23.8	25.2	29.1
Medicare premiums	3.3	3.5	3.3
Disproportionate share hosp. payments	4.6	4.2	4.2
Other services	6.6	6.6	7.2
Collections[5]	-1.8	-1.8	-2.0

[1]Excludes payments under CHIP.

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

[3]Net of prescription drug rebates.

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

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

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

SOURCES: CMS, CMCS, and OACT.

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

	Fiscal Year		
	2011	2012	2013
	In millions		
Total	$8,079.9	$7,862.2	$8,925.8
Workers' Compensation[1]	1,245.4	1,841.9	1,888.5
Working Aged	3,567.3	3,126.5	3,838.4
ESRD	343.0	296.0	303.1
Auto	271.1	212.2	190.1
Disability	2,184.0	1,840.6	2,119.6
Liability	447.9	523.2	566.3
VA/Other	21.2	21.7	19.8

[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 2012 Medical Assistance payments	Percent distribution
	In billions	
Total[1]	$408.8	100.0
Age 65 years and over	81.2	19.9
Blind/disabled	162.2	39.7
Dependent children under 21 years of age	74.1	18.1
Adults in families with dependent children	65.2	15.9
Disproportionate share hospital and other unallocated payments	26.1	6.4

[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]	
	2012	2013
	In thousands	
Total	$11,210,013	$9,950,043
Medical/surgical supplies	181,972	196,596
Hospital beds	229,058	184,596
Oxygen and supplies	1,922,711	1,686,760
Wheelchairs	1,116,466	809,947
Prosthetic/orthotic devices	2,436,679	2,461,710
Drugs admin. through DME[3]	706,202	777,077
Parenteral and enteral nutrition	685,752	594,625
Other DME	3,931,173	3,238,732

[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.

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

Table III.12
National health care/type of expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$2,793.4	$8,915	35.6	20.5	15.1
Health Consumption Expenditures	2,633.4	8,404	37.7	21.7	16.0
Personal health care	2,360.4	7,533	39.2	22.8	16.4
Hospital care	882.3	2,816	44.9	27.2	17.7
Prof. services	752.3	2,401	27.0	19.3	7.7
Phys./clinical	565.0	1,803	30.7	22.7	8.1
Other Professional	76.4	244	28.4	22.2	6.2
Dental	110.9	354	6.9	0.3	6.6
Other Health Residential & Personal Care	138.2	441	56.4	3.7	52.7
Nursing Care Facilities & Continuing Care Retirement Communities	151.5	484	53.3	22.7	30.6
Home Health	77.8	248	80.6	43.4	37.2
Retail outlet sales	358.3	1,143	29.0	22.2	6.8
Admin., Net Cost, & public health	272.9	871	25.4	12.6	12.8
Investment	160.0	511	--	--	--

NOTE: Data are as of calendar year 2012.
SOURCE: CMS, Office of the Actuary.

Table III.13
Personal health care/payment source

	Calendar Year			
	1980	1990	2000	2012
	In billions			
Total	$217.2	$616.8	$1,165.4	$2,360.4
	Percent			
Total	100.0	100.0	100.0	100.0
Out of pocket	26.9	22.5	17.3	13.9
Health Insurance	60.7	65.4	72.5	77.5
Private Health Insurance	28.3	33.2	34.9	34.2
Medicare	16.7	17.4	18.6	22.8
Medicaid (Title XIX)	11.4	11.3	16.0	16.4
Total CHIP (Title XIX & XXI)	—	—	0.2	0.5
Department of Defense	1.8	1.7	1.1	1.6
Depart. of Veterans Affairs	2.6	1.8	1.6	2.1
Other 3rd Party Payers & Programs	12.4	12.1	10.2	8.6

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	2012
Discharges				
Total in millions	10.5	10.5	13.0	11.2
Rate per 1,000 enrollees[1]	347	320	361	303
Days of care				
Total in millions	92	94	75	60
Rate per 1,000 enrollees[1]	3,016	2,866	2,073	1,614
Average length of stay				
All short-stay	8.7	9.0	5.7	5.3
Excluded units	18.8	19.5	11.5	11.8
Total charges per day	$597	$1,060	$4,882	$8,350

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

NOTES: Data may reflect underreporting due to a variety of reasons, including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; no-pay Medicare secondary payer bills; and for certain years, discharges where the beneficiary received services out of State. The data for 1990 through 2012 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with a different update cycle.

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

Table IV.2
Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
1985	315	10	1,576	51
1990	638	19	1,978	58
1995	1,233	37	3,468	103
2000	1,468	45 [1]	2,461	75 [1]
2005	1,847	51 [1]	2,976	81 [1]
2010	1,839	52 [1]	3,605	100 [1]
2012	1,840	50 [1]	3,617	97 [1]

[1]Managed care enrollees excluded in determining rate.

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

Table IV.3
Medicare average length of stay/trends

	Fiscal Year				
	1990	1995	2000	2010	2012
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	5.3
Excluded units	19.5	14.8	12.3	11.8	11.8

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2012 are based on 100-percent MEDPAR stay record file. Data may differ from other sources or from the same source with a different update cycle.

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

Table IV.4
Medicare persons served/trends

	Calendar Year					
	1975	1985	1995	2005	2010	2012
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	923	919	892
HI	221	219	218	234	237	208
SMI	536	739	858	979	988	989
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	865	897	907
HI	219	228	212	205	213	196
SMI	471	715	837	977	1,007	1,027

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 fee-for-service during the calendar year.

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

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

	Year				
	2008	2009	2010	2011	2012
HI					
Aged					
FFS Enrollees	28.6	28.6	29.0	29.3	30.0
Persons served	6.6	6.4	6.9	6.3	6.3
Rate per 1,000	229	224	237	217	208
Disabled					
FFS Enrollees	6.4	6.4	6.6	6.8	6.9
Persons served	1.3	1.3	1.4	1.4	1.4
Rate per 1,000	202	204	213	201	196
SMI					
Aged					
FFS Enrollees	26.4	26.2	26.4	26.6	27.0
Persons served	26.2	25.9	26.1	26.2	26.7
Rate per 1,000	990	986	988	987	989
Disabled					
FFS Enrollees	5.5	5.6	5.8	6.0	6.0
Persons served	5.5	5.6	5.8	6.1	6.2
Rate per 1,000	1,001	1,005	1,007	1,023	1,027

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

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

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

Table IV.6
Medicare persons served/CMS region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	27,078	892	6,236	907
Boston	1,487	887	370	898
New York	2,488	852	523	848
Philadelphia	2,818	901	622	912
Atlanta	5,964	925	1,514	942
Chicago	4,805	953	1,149	932
Dallas	3,115	897	752	906
Kansas City	1,471	928	319	930
Denver	862	922	161	925
San Francisco	3,051	848	607	854
Seattle	1,001	868	217	873

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

NOTES: Data are based on estimates of beneficiaries receiving HI and/or SMI reimbursed services under fee-for-service during calendar year 2012. Numbers may not add to totals because of rounding.

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

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

	Total persons served in thousands	Aged persons served in thousands	Disabled persons served in thousands
Parts A and/or B	33,313	27,078	6,236
Part A	7,604	6,254	1,350
Inpatient hospital	6,685	5,394	1,291
Skilled nursing facility	1,840	1,670	170
Home health agency	1,703	1,482	221
Hospice	1,275	1,204	71
Part B	32,838	26,669	6,168
Physician/supplier	32,289	26,292	5,997
Outpatient	24,669	19,916	4,753
Home health agency	1,914	1,646	269

NOTES: Data are as of calendar year 2012. Persons served represents estimates of beneficiaries receiving services under fee-for-service during the calendar year.

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

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

	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 2011 Medicaid beneficiaries
	In thousands
Total eligibles	66,180
Number using service:	
Total beneficiaries, any service[1]	64,207
Inpatient services	
General hospitals	4,879
Mental hospitals	113
Nursing facility services[2]	1,571
Intermediate care facility (MR) services[3]	91
Physician services	22,253
Dental services	12,146
Other practitioner services	5,237
Outpatient hospital services	15,184
Clinic services	13,391
Laboratory and radiological services	15,851
Home health services	1,077
Prescribed drugs	28,343
Personal care support services	1,089
Sterilization services	119
PCCM capitation	8,292
HMO capitation	35,587
PHP capitation	23,947
Targeted case management	2,265
Other services, unspecified	11,000
Additional service categories[4]	7,561
Unknown	58

[1]Excludes summary records with unknown basis of eligibility, most of which are lump-sum payments not attributable to any one person.
[2]Nursing facilities include: SNFs and other facilities formerly classified as ICF, other than "MR".
[3]"MR" indicates mentally retarded.
[4]Additional services not shown separately sum to 7.6 million beneficiaries, not unduplicated.

NOTES: Data derived from MSIS State Summary Datamart. Beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations. Excludes CHIP. Excludes data for Idaho, Kansas, Maine, Utah, and Oklahoma.

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

Table IV.10
Medicaid/units of service

	Fiscal year 2011 units of service
	In thousands
Inpatient hospital	
Total discharges	6,861
Beneficiaries discharged	4,879
Total days of care	40,117
Nursing facility	
Total days of care	347,031
Intermediate care facility/mentally retarded	
Total days of care	32,828

NOTES: Data are derived from the MSIS 2011 State Summary Datamart and are based on reported States. Excludes territories and CHIP. Excludes data for Idaho, Kansas, Maine, Utah, and Oklahoma.

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

Administrative/Operating

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

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

Table V.1
Medicare administrative expenses/trends

Fiscal Year	Administrative expenses: Amount in millions	Administrative expenses: As a percent of benefit payments
HI Trust Fund		
1967	$89	3.5
1970	149	3.1
1980	497	2.1
1990	774	1.2
1995	1,300	1.1
2000[1]	2,350	1.8
2005[1]	2,850	1.6
2010	3,328	1.4
2011	3,927	1.5
2012	3,696	1.4
2013	4,135	1.6
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
2011	3,833	1.3
2012	4,130	1.3
2013	3,756	1.1

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

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

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

SOURCE: CMS, Office of the Actuary.

Table V.2
Medicare administrative contractors

	Number
A/B MACs	12
DME MACs	4

NOTE: Data as of February 2014.

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	530,904	203,860	2,403,063
Percent Reversed (Includes Fully & Partially Reversed Cases)	8.8	45.2	40.9

NOTES: Data for fiscal year 2013. Data presented in cases.

SOURCE: CMS, Center for Medicare.

Table V.4
Medicare physician/supplier claims assignment rates

	2000	2005	2010	2011	2012	2013
			In millions			
Claims total	720.5	951.6	972.7	972.1	1,003.2	994.6
Claims assigned	705.7	940.7	965.7	965.9	997.4	989.2
Claims unassigned	15.3	10.9	7.0	6.2	5.8	5.4
Percent assigned	97.9	98.9	99.3	99.4	99.4	99.5

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

SOURCE: CMS, Center for Medicare.

Table V.5
Medicare claims processing

	Fiscal year 2013
Intermediary claims processed in millions	207.6
Carrier claims processed in millions[1]	1,006.3

[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	209.7
	Percent of total
Inpatient hospital	7.2
Outpatient hospital	60.5
Home health agency	7.4
Skilled nursing facility	2.8
Other	22.1
Carrier claims received in millions	994.6
	Percent of total
Assigned	99.5
Unassigned	0.5

NOTE: Data for calendar year 2013.

SOURCE: CMS, Center for Medicare.

Table V.7
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	885.6	4.6
Percent reduced	94.8	86.6
Total covered charges		
Amount in millions	$336,488	$553
Percent reduced	62.5	21.0
Amount reduced per claim	$237.48	$25.30

NOTES: Data for calendar year 2013 . 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	
	2012	2013
	In millions	
Total payments computable for Federal funding[1]	$22,147	$22,938
Federal share[1]		
Family planning	28	32
Design, development or Installation of MMIS[2]	509	533
Skilled professional medical personnel	405	440
Operation of an approved MMIS[2]	1,532	1,550
All other	11,152	11,588
Mechanized systems not approved under MMIS[2]	80	73
Total Federal Share	$13,706	$14,216
Net adjusted Federal share[3]	$13,344	$13,682

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

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

Reference

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

Program financing, cost sharing and limitations

Medicare/source of income

Medicare Part A

Hospital Insurance trust fund:

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

*Contribution rate	2012	2013	2014
	Percent		
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2014) None[1]

Voluntary HI monthly premium[2] $426.00

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/14)	$1,216/benefit period
Regular coinsurance days (1/1/14)	$304/day for 61st thru 90th day
Lifetime reserve days (1/1/14)	$608/day (60 non-renewable days)
SNF coinsurance days (1/1/14)	$152.00/day for 21st thru 100th day
Blood deductible	first 3 pints/calendar year
Voluntary hospital insurance premium (1/1/14)[2]	$426/month; $234/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 $234 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 (1/1/14)	$147 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/14)	$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 2014 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	Less than or equal to $170,000	$0.00	$104.90
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$42.00	$146.90
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$104.90	$209.80
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$167.80	$272.70
Greater than $214,000	Greater than $428,000	$230.80	$335.70

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

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

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part D Standard Benefits

Deductible (1/1/2014)	$310 in charges/year
Initial coverage limit (1/1/2014)	$2,850 in charges/year
Out-of-pocket threshold (1/1/2014)	$4,550 in charges/year
Base beneficiary premium (1/1/2014)[1]	$32.42/month

Medicaid financing

1. Federal contributions (ranging from 50 to 73 percent for fiscal year 2014)
2. State contributions (ranging from 27 to 50 percent for fiscal year 2014)

[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 2014

I. Boston	FMAP
Connecticut	50.00
Maine	61.55
Massachusetts	50.00
New Hampshire	50.00
Rhode Island	50.11
Vermont	55.11

III. Philadelphia	
Delaware	55.31
Dist. of Columbia	70.00
Maryland	50.00
Pennsylvania	53.52
Virginia	50.00
West Virginia	71.09

V. Chicago	
Illinois	50.00
Indiana	66.92
Michigan	66.32
Minnesota	50.00
Ohio	63.02
Wisconsin	59.06

VII. Kansas City	
Iowa	57.93
Kansas	56.91
Missouri	62.03
Nebraska	54.74

IX. San Francisco	
Arizona	67.23
California	50.00
Hawaii	51.85
Nevada	63.10
American Samoa	55.00
Guam	55.00
N. Mariana Islds	55.00

II. New York	FMAP
New Jersey	50.00
New York	50.00
Puerto Rico	55.00
Virgin Islands	55.00

IV. Atlanta	
Alabama	68.12
Florida	58.79
Georgia	65.93
Kentucky	69.83
Mississippi	73.05
North Carolina	65.78
South Carolina	70.57
Tennessee	65.29

VI. Dallas	
Arkansas	70.10
Louisiana	60.98
New Mexico	69.20
Oklahoma	64.02
Texas	58.69

VIII. Denver	
Colorado	50.00
Montana	66.33
North Dakota	50.00
South Dakota	53.54
Utah	70.34
Wyoming	50.00

X. Seattle	
Alaska	50.00
Idaho	71.64
Oregon	63.14
Washington	50.00

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

SOURCE: DHHS, Assistant Secretary for Planning and Evaluation.

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