

## *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 38**  
**Medicare/short-stay hospital utilization**

	1985	1990	2003	2004
<b>Discharges</b>				
Total in millions	10.5	10.5	12.7	13.0
Rate per 1,000 enrollees <sup>1</sup>	347	313	315	316
<b>Days of care</b>				
Total in millions	92	94	74	75
Rate per 1,000 enrollees <sup>1</sup>	3,016	2,805	1,845	1,834
<b>Average length of stay</b>				
All short-stay	8.7	9.0	5.9	5.8
Excluded units <sup>2</sup>	18.8	19.5	11.5	11.5
<b>Total charges per day</b>	<b>\$597</b>	<b>\$1,060</b>	<b>\$4,033</b>	<b>\$4,458</b>

<sup>1</sup>The population base is HI enrollment excluding HI enrollees residing in foreign countries. <sup>2</sup>Includes alcohol/drug, psychiatric, and rehabilitation units through 1990, and psychiatric and rehabilitation units for 2003 and 2004.

NOTES: Data may reflect underreporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; and no-pay Medicare secondary payer bills. Average length of stay data are shown in days. The data for 1990 through 2004 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with different update cycle.

SOURCE: CMS, Office of Information Services.

**Table 39**  
**Medicare long-term care/trends**

Calendar year	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
1985	315	10	1,576	51
1990	638	19	1,978	58
1995	1,240	33	3,457	93
2001	1,545	<sup>1</sup> 46	2,403	<sup>1</sup> 71
2002	1,622	<sup>1</sup> 47	2,544	<sup>1</sup> 73
2003	1,693	<sup>1</sup> 48	2,681	<sup>1</sup> 75

<sup>1</sup>Managed care enrollees excluded in determining rate.

SOURCE: CMS, Office of Research, Development, and Information.

**Table 40**  
**Medicare average length of stay/trends**

	Fiscal year					
	1984	1990	1995	2000	2003	2004
All short-stay hospitals	9.1	9.0	7.1	6.0	5.9	5.8
PPS hospitals	8.0	8.9	7.1	6.0	5.9	5.8
Excluded units	18.0	19.5	14.8	12.3	11.5	11.5

NOTES: Fiscal year data. Average length of stay is shown in days. For all short-stay and PPS hospitals, 1984 data are based on a 20-percent sample of Medicare HI enrollees. Data for 1990 through 2004 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Information Services, and the Office of Research, Development, and Information.

**Table 41**  
**Medicare persons served/trends**

	Calendar year				
	1975	1980	1985	2002	2003
Aged persons served per 1,000 enrollees					
HI and/or SMI	528	638	722	918	920
HI	221	240	219	232	231
SMI	536	652	739	968	970
Disabled persons served per 1,000 enrollees					
HI and/or SMI	450	594	669	851	859
HI	219	246	228	202	203
SMI	471	634	715	963	969

NOTES: Prior to 1998, data were obtained from the Annual Person Summary Record and were not yet modified to exclude persons enrolled in managed care. Beginning in 1998, utilization counts are based on a five-percent sample of fee-for-service beneficiaries and the rates are adjusted to exclude managed care enrollees.

SOURCES: CMS, Office of Information Services, and the Office of Research, Development, and Information.

**Table 42**  
**Medicare fee-for-service (FFS) persons served**

	Calendar year				
	1998	1999	2001	2002	2003
Numbers in millions					
<b>HI</b>					
Aged					
FFS Enrollees	27.3	27.0	28.3	29.1	29.7
Persons served	6.7	6.3	6.6	6.7	6.9
Rate per 1,000	243	232	233	232	231
Disabled					
FFS Enrollees	4.6	4.7	5.2	5.4	5.7
Persons served	1.0	0.9	1.0	1.1	1.2
Rate per 1,000	206	198	199	202	203
<b>SMI</b>					
Aged					
FFS Enrollees	26.2	25.9	27.0	27.8	28.3
Persons served	25.3	25.0	26.1	26.9	27.4
Rate per 1,000	964	966	968	968	970
Disabled					
FFS Enrollees	4.1	4.2	4.5	4.8	5.0
Persons served	3.8	3.9	4.3	4.6	4.9
Rate per 1,000	925	936	952	963	969

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.

SOURCE: CMS, Office of Research, Development, and Information.

**Table 43**  
**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 <sup>1</sup>	27,665	920	4,922	859
Boston	1,453	913	258	843
New York <sup>2</sup>	2,639	915	426	839
Philadelphia	2,802	928	476	858
Atlanta	5,926	944	1,261	899
Chicago	5,435	949	840	870
Dallas	3,042	922	557	890
Kansas City	1,518	954	246	895
Denver	823	948	121	846
San Francisco <sup>3</sup>	2,651	889	459	795
Seattle	950	943	166	847

<sup>1</sup>Includes utilization for residents of outlying territories, possessions and foreign countries.

<sup>2</sup>Excludes residents of Puerto Rico and Virgin Islands.

<sup>3</sup>Excludes residents of American Samoa, Guam, and Northern Mariana Islands.

NOTES: Data as of calendar year 2003 for persons served under HI and/or SMI. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development, and Information.

**Table 44**  
**Medicare/end stage renal disease (ESRD)**

	Calendar year		
	2001	2002	2003
Total enrollees <sup>1</sup>	317,460	336,545	350,085
Dialysis patients <sup>2</sup>	285,982	297,928	310,095
Outpatient	258,195	269,741	281,460
Home	27,787	28,187	28,635
Transplants performed <sup>3</sup>	14,628	14,714	15,589
Living related donor	4,236	4,044	4,217
Cadaveric donor	8,824	9,026	9,402
Living unrelated donor	1,568	1,644	1,970
Average dialysis payment rate	\$129	\$129	\$129
Hospital-based facilities	\$131	\$131	\$131
Freestanding facilities	\$127	\$127	\$127

<sup>1</sup>Medicare ESRD enrollees as of July 1.

<sup>2</sup>Includes Medicare and non-Medicare patients receiving dialysis as of December 31.

<sup>3</sup>Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: CMS, Office of Clinical Standards and Quality, and the Office of Research, Development, and Information.

**Table 45**  
**Medicaid/type of service**

	Fiscal year 2003 Medicaid beneficiaries In thousands
Total eligibles	55,182
Number using service:	
Total beneficiaries, any service <sup>1</sup>	51,971
Inpatient services	
General hospitals	5,217
Mental hospitals	104
Nursing facility services <sup>2</sup>	1,691
Intermediate care facility (MR) services <sup>3</sup>	114
Physician services	22,857
Dental services	8,510
Other practitioner services	5,746
Outpatient hospital services	15,511
Clinic services	10,162
Laboratory and radiological services	14,687
Home health services	1,184
Prescribed drugs	26,075
Personal care support services	779
Sterilization services	160
PCCM services	7,542
HMO capitation	21,324
PHP capitation	15,810
Targeted case management	2,468
Other services, unspecified	9,760
Additional service categories	7,094
Unknown	88

<sup>1</sup>Excludes summary records with unknown basis of eligibility, most of which are lump-sum payments not attributable to any one person. <sup>2</sup>Nursing facilities include: SNFs and all categories of ICF, other than "MR". "MR" indicates mentally retarded.

NOTES: "Total eligibles" based on preliminary data. Beginning in 1998, beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations.

SOURCE: CMS, Center for Medicaid and State Operations.

**Table 46**  
**Medicaid/units of service**

	Fiscal year 2003 units of service In thousands
<b>Inpatient hospital</b>	
Total discharges <sup>1</sup>	7,345
Beneficiaries discharged	5,217
Total days of care	34,743
<b>Nursing facility</b>	
Total days of care	493,911
<b>Intermediate care facility/mentally retarded</b>	
Total days of care	45,477

<sup>1</sup>Preliminary data.

NOTES: Data are derived from the MSIS 2003 State Summary Mart. Excludes territories.

SOURCE: CMS, Office of Research, Development, and Information.

**Table 47**  
**Medicare administrative expenses/trends**

Fiscal Year	Administrative expenses	
	Amount in millions	As a percent of benefit payments
<b>HI Trust Fund</b>		
1967	\$89	3.5
1970	149	3.1
1975	259	2.5
1980	497	2.1
1985	813	1.7
1990	774	1.2
1995	1,300	1.1
2000 <sup>1</sup>	2,350	1.8
2004 <sup>1</sup>	2,920	1.8
2005 <sup>1</sup>	2,850	1.6
<b>SMI Trust Fund<sup>1</sup></b>		
1967	<sup>2</sup> 135	20.3
1970	217	11.0
1975	405	10.8
1980	593	5.8
1985	922	4.2
1990	1,524	3.7
1995	1,722	2.7
2000	1,780	2.0
2004	2,817	2.1
2005	2,914	1.9

<sup>1</sup>Includes non-expenditure transfers for Health Care Fraud and Abuse Control.

<sup>2</sup>Includes expenses paid in fiscal years 1966 and 1967. <sup>3</sup>Starting in FY 2004 includes the transactions of the Part D account.

SOURCE: CMS, Office of the Actuary.

**Table 48**  
**Medicare contractors**

	Intermediaries	Carriers
Blue Cross/Blue Shield	22	15
Other	2	5

NOTE: Data as of May 2006.

SOURCE: CMS, Office of Financial Management.

**Table 49**  
**Medicare appeals**

	Intermediary reconsiderations	Carrier reviews
Number processed	21,177	2,967,983
Percent with increased payments <sup>1</sup>	32.8	70.2

<sup>1</sup>Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 2005.

SOURCE: CMS, Office of Financial Management.

**Table 50**  
**Medicare physician/supplier claims assignment rates**

	2000	2001	2002	2003	2004	2005
	in thousands					
Claims total	720.5	766.8	822.0	860.7	922.2	951.6
Claims assigned	705.7	752.5	808.6	847.8	909.9	940.7
Claims unassigned	15.3	14.2	13.3	12.9	12.3	10.9
Percent assigned	97.9	98.1	98.4	98.5	98.7	98.9

NOTE: Historical data revised from earlier year editions.

SOURCE: CMS, Office of Financial Management

**Table 51**  
**Medicare claims processing**

	Intermediaries	Carriers
Claims processed in millions	185.6	979.9
Total PM costs in millions	\$386.1	\$1,103.0
Total MIP costs in millions	\$453.7	\$259.8
Claims processing costs in millions	\$246.8	\$748.5
Claims processing unit costs	\$0.88	\$0.52
Range		
High	\$1.57	\$1.05
Low	\$0.67	\$0.39

NOTES: Data for fiscal year 2005. PM= Program Management. MIP= Medicare Integrity Program. Beginning in FY 2002, provider enrollment has been removed from the claims processing costs and unit costs.

SOURCE: CMS, Office of Financial Management.

**Table 52**  
**Medicare claims received**

	Claims received
Intermediary claims received in thousands	185,442
	Percent of total
Inpatient hospital	8.3
Outpatient hospital	50.5
Home health agency	6.7
Skilled nursing facility	2.7
Other	31.7
Carrier claims received in thousands	951,551
	Percent of total
Assigned	98.9
Unassigned	1.1

NOTE: Data for calendar year 2005.

SOURCE: CMS, Office of Financial Management.

**Table 53**  
**Medicare charge reductions**

	Assigned	Unassigned
Claims approved		
Number in millions	816.9	9.4
Percent reduced	74.7	70.9
Total covered charges		
Amount in millions	\$228,809	\$986
Percent reduced	44.8	15.4
Amount reduced per claim	\$167.96	\$22.89

NOTES: Data for calendar year 2005. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Office of Financial Management.

**Table 54**  
**Medicaid administration**

	Fiscal year	
	2003	2004
	In millions	
Total payments computable for Federal funding <sup>1</sup>	\$13,584	\$14,486
Federal share <sup>1</sup>		
Family planning	32	31
Design, development or installation of MMIS <sup>2</sup>	470	382
Skilled professional medical personnel	367	374
Operation of an approved MMIS <sup>2</sup>	1,071	1,081
All other	5,577	6,005
Mechanized systems not approved under MMIS <sup>2</sup>	85	146
Total Federal Share	\$7,602	8,019
Net adjusted Federal share <sup>3</sup>	\$7,580	\$8,048

<sup>1</sup>Source: Form CMS-64. (Net Expenditures Reported--Administration).

<sup>2</sup>Medicaid Management Information System.

<sup>3</sup>Includes CMS adjustments.

Sources: CMS, Center for Medicaid and State Operations