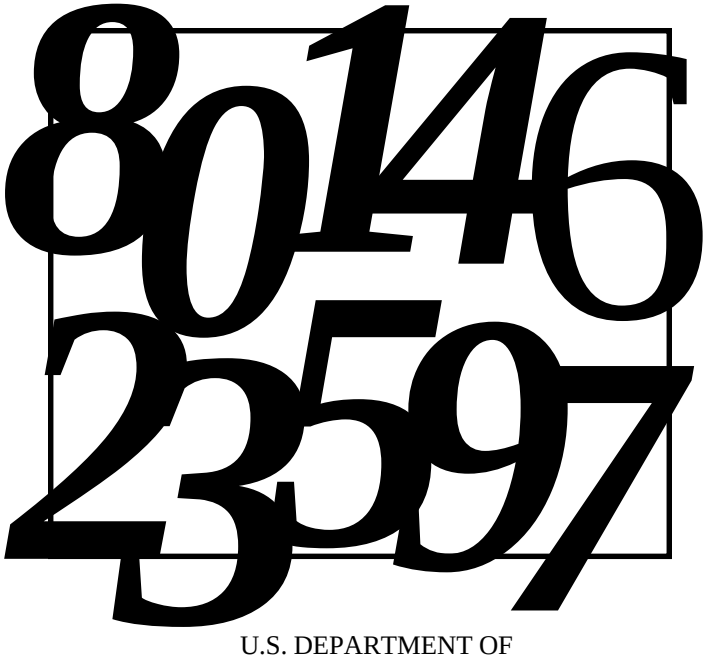
2003 CMS Statistics



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Preface

This reference booklet provides significant summary information about health expenditures and Centers for Medicare & Medicaid Services (CMS) programs. The information presented was the most current available at the time of publication. Significant time lags may occur between the end of a data year and aggregation of data for that year.

The data are organized as follows:

Highlights

Growth in CMS programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 40.6 million in 2002, a 113 percent increase.
- On average, the number of Medicaid enrollees in 2002 is estimated to be about 39.9 million, the largest group being children (18.4 million or 46 percent).
- In 2000, 12.3 percent of the population was enrolled in the Medicaid program.
- Medicare enrollees with end-stage renal disease increased from just under 67 thousand in 1980 to 356 thousand in 2001, an increase of 431 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to over 5.7 million beneficiaries in 2001, an increase of about 104 percent.

- The average number of dually entitled persons (that is, persons covered by both Medicare and Medicaid) during 2000 amounted to about 6.4 million persons.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,770 in December 1975 to 6,002 in December 2002. Total inpatient hospital beds have dropped from 46.5 beds per 1,000 enrolled in 1975 to 24.5 in 2002, a decrease of 47 percent.

- The total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaked at 1,025,000 in 1984-86. Since that time, the number has dropped to 844,000. (NOTE: A portion of this decline is due to the reclassification of some short-stay hospitals as critical access hospitals.)

- The number of psychiatric hospitals grew to about 400 by 1976, where it remained until the start of the prospective payment system (PPS) in 1983. After PPS, the number increased to over 700 in the early 1990's and has since dropped to 494.

- 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 1990's and again decreased, reaching 14,755 in 2001.

- The number of participating home health agencies has fluctuated considerably over the years, most recently

almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed, and then decreasing by a third to just over 6,800.

Expenditures

- National health expenditures were $1,424.5 billion in 2001, 14.1 percent of the gross domestic product.

- In 2002, total CMS program outlays were $377.2 billion, 18.6 percent of the Federal budget.

- Medicare skilled nursing facility benefit payments declined from $14.2 billion in 2002 to $13.6 billion in 2003.

- Medicare home health agency benefit payments increased between 2002 and 2003 from $12.2 billion to $13.6 billion.

- National health expenditures per person were $205 in 1965 and grew steadily to reach $5,035 by 2001.

Utilization of Medicare and Medicaid services

- Between 1990 and 2001, the number of short-stay hospital discharges increased from 10.5 million to 12.2 million, an increase of 16 percent.

- The short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 6.0 days in 2001, a decrease of 33 percent. Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 12.0 days in 2001, a decrease of 38 percent.

- About 30 million persons received a reimbursed service under Medicare fee-for-service during 2000. Comparably, almost 43 million persons used Medicaid services or had a premium paid on their behalf in 2000.
- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 916 per 1,000 enrolled in 2000.
- 6.9 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2000.
- 28.8 million persons received reimbursable fee-for-service physician services under Medicare during 2000. 19.1 million persons received reimbursable physician services under Medicaid during 2000.
- 21.0 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2000. During 2000, 13.2 million persons received Medicaid reimbursable outpatient hospital services.
- 1.5 million persons received care in SNFs covered by Medicare during 2000. 1.7 million persons received care in nursing facilities, which include SNFs and all other intermediate care facilities other than mentally retarded, covered by Medicaid during 2000.
- 20.5 million persons received prescribed drugs under Medicaid during 2000.

Populations

Information about persons covered by Medicare, Medicaid, or SCHIP

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 SCHIP. 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 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
July		In millions	
1966	19.1	19.1	--
1970	20.5	20.5	--
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
1997	38.4	33.6	4.8
1998	38.8	33.8	5.0
Average monthly			
1999	39.2	33.9	5.2
2000	39.7	34.3	5.4
2001	40.0	34.4	5.6
2002[1]	40.6	34.6	6.0
2003[1]	41.0	34.9	6.1

[1]Projected.

NOTES: Data for 1966-1998 are as of July. Data for 1999-2003 represent average monthly enrollment. Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of Information Services and Office of the Actuary.

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
			In millions			
All persons	40.0	39.6	37.7	37.3	2.3	0.4
Aged persons	34.4	34.0	32.7	32.3	1.7	0.4
Disabled persons	5.6	5.6	5.0	5.0	0.6	([1])

[1]Number less than 500.

NOTE: Average monthly enrollment during calendar year 2001.

SOURCE: CMS, Office of the Actuary.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	40,026	17,353	22,673
Aged	34,457	14,261	20,196
65-74 years	17,764	8,111	9,654
75-84 years	12,304	4,879	7,425
85 years and over	4,389	1,271	3,117
Disabled	5,569	3,092	2,476
Under 45 years	1,658	958	701
45-54 years	1,728	963	764
55-64 years	2,183	1,171	1,012
White	34,015	14,726	19,289
Black	3,801	1,609	2,193
All Other	2,111	985	1,126
Native American	67	33	35
Asian/Pacific	570	249	321
Hispanic	922	438	485
Other	551	266	286
Unknown Race	99	34	65

NOTES: Data as of July 1, 2001. Numbers may not add to totals because of rounding.

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

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
		In thousands	
Year			
1980	66.7	66.3	64.9
1990	172.0	170.6	163.7
1995	257.0	255.0	245.1
1997	233.7	233.7	221.4
1998	249.8	249.8	236.0
1999[1]	270.4	270.4	254.7
2000[1]	291.8	291.3	273.1
2001[1]	315.7	315.4	295.4

[1]Denominator File; estimated person years.

NOTE: Data as of July 1.

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

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	356.3
Age	
Under 35 years	28.9
35-44 years	39.8
45-64 years	133.8
65 years and over	153.8
Sex	
Male	193.7
Female	162.6
Race	
White	199.9
Other	155.3
Unknown	1.2

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2001.

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

Table 6
Medicare managed care

	Number of Plans	Enrollees (in thousands)
Total prepaid	227	5,522
Medicare + Choice Programs	157	4,987
TEFRA Cost	30	290
Demonstrations (incl. PACE)	25	141
HCPPs[1] Part B	15	104
Percent of total Medicare beneficiaries		13.8

[1]Health care prepayment plans/group practice prepayment plans.

NOTES: Data as of August 1, 2002. Percent of total Medicare beneficiaries based on average monthly enrollment during calendar year 2002. Numbers may not add to totals because of rounding.

SOURCE: CMS, Center for Beneficiary Choices.

Table 7
Medicare enrollment/CMS region

	Resident[1] population	Medicare[2] enrollees	Enrollees as percent of population
	In thousands		
All regions	284,797	39,134	13.7
Boston	14,022	2,127	15.2
New York	27,495	3,916	14.2
Philadelphia	28,020	4,185	14.9
Atlanta	54,158	8,129	15.0
Chicago	50,336	7,051	14.0
Dallas	33,771	4,100	12.1
Kansas City	12,961	1,990	15.4
Denver	9,477	1,114	11.8
San Francisco	43,138	5,064	11.7
Seattle	11,417	1,458	12.8

[1]Estimated July 1, 2001 resident population.
[2]Medicare denominator enrollment file data are as of July 1, 2001.

NOTES: Resident population is a provisional estimate. The 2001 resident population data for Outlying Areas, Puerto Rico, and the Virgin Islands are not available.

SOURCES: CMS, Office of Research, Development, and Information; U.S. Bureau of the Census, Population Division, Population Estimates Branch.

Table 8
Aged population/projected

	1998	2000	2025	2050	2075	2100
	In millions					
65 years and over	34.9	35.2	60.5	76.9	90.9	102.2
75 years and over	16.1	16.6	24.6	40.6	49.6	57.8
85 years and over	4.2	4.4	5.9	14.6	17.7	22.5

SOURCE: Social Security Administration, Office of the Actuary.

Table 9
Life expectancy at age 65/trends

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1985	14.4	18.6
1990	15.0	19.0
1995	15.3	19.0
2000[1]	15.7	19.0
2010[2]	16.4	19.4
2020[2]	17.0	20.0
2030[2]	17.7	20.6
2040[2]	18.3	21.2
2050[2]	18.8	21.8
2060[2]	19.4	22.4
2070[2]	19.9	22.9

[1]Preliminary. [2]Projected.

SOURCE: Social Security Administration, Office of the Actuary.

Table 10
Life expectancy at birth and at age 65 by race/trends

Calendar Year	All Races	White	Black
		At Birth	
1950	68.2	69.1	60.7
1980	73.7	74.4	68.1
1985	74.7	75.3	69.3
1990	75.4	76.1	69.1
1995	75.8	76.5	69.6
2000[1]	76.9	77.4	71.8
		At Age 65	
1950	13.9	NA	13.9
1980	16.4	16.5	15.1
1985	16.7	16.8	15.2
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2000[1]	17.9	17.9	16.2

[1]Preliminary.
SOURCE: Public Health Service, Health United States, 2002.

Table 11
Medicaid and SCHIP enrollment

	Fiscal year					
	1990	1995	2000	2001	2002	2003
	Person Years in millions					
Total	22.9	33.4	34.8	37.7	39.9	41.4
Age 65 years and over	3.1	3.7	3.9	4.0	4.2	4.3
Blind/Disabled	3.8	5.8	6.8	7.2	7.5	7.8
Children	10.7	16.5	16.3	17.5	18.4	19.1
Adults	4.9	6.7	7.8	8.9	9.8	10.3
Other Title XIX	0.5	0.6	NA	NA	NA	NA
SCHIP	NA	NA	2.1	3.0	4.2	4.8
	Eligibles in millions					
Total	NA	42.5	44.3	48.1	51.0	53.0
Age 65 years and over	NA	4.4	4.5	4.7	4.9	5.0
Blind/Disabled	NA	6.5	7.6	8.0	8.4	8.6
Children	NA	21.3	21.2	22.7	23.9	24.8
Adults	NA	9.4	11.0	12.6	13.9	14.6
Other Title XIX	NA	0.9	NA	NA	NA	NA
SCHIP	NA	NA	3.4	4.8	6.4	7.1

NOTES: Totals may not add due to rounding. 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 level recipients who are not disabled. Enrollment projections for fiscal years 2000-2003 were prepared by the Office of the Actuary for the President's 2004 budget.

In 1997 (not shown), the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories. SCHIP includes both Medicaid expansion groups and separate State programs. Medicaid children totals exclude Medicaid expansion groups under SCHIP.

SOURCES: CMS, Office of Information Services, Office of the Actuary, and the Center for Medicaid and State Operations.

Table 12
Medicaid beneficiaries/demographics

	Fiscal year 2000 Medicaid beneficiaries	Percent distribution
	In millions	
Total beneficiaries	44.6	100.0
Age	44.6	100.0
Under 21	24.6	55.0
21-64 years	15.0	33.6
65 years and over	5.0	11.1
Unknown	0.1	0.2
Sex	44.6	100.0
Male	17.7	39.7
Female	26.8	60.1
Unknown	0.1	0.2
Race	44.6	100.0
White, not Hispanic	19.6	43.9
Black, not Hispanic	11.3	25.3
American Indian/Alaska Native	0.6	1.4
Asian/Pacific Islander	1.0	2.2
Hispanic	8.8	19.8
Other	0.2	0.4
Unknown	3.1	6.9

NOTES: The percent distribution is based on rounded numbers. Totals do not necessarily equal the sum of rounded components. Prior to 1998, beneficiaries or recipients included Medicaid eligibles for whom a payment to a provider was made. Beginning in FY 1998, Medicaid recipients were redefined to include those eligibles for whom a capitated payment was made.

SOURCES: CMS, Center for Medicaid and State Operations, Office of Information Services, and the Office of Research, Development, and Information.

Table 13
Medicaid enrollment/CMS region

	Resident[1] population	Medicaid[2] enrollment	Enrollment as percent of population
	In thousands		
All regions	282,224	34,776	12.3
Boston	13,952	1,817	13.0
New York	27,433	3,435	12.5
Philadelphia	27,870	2,959	10.6
Atlanta	53,444	6,924	13.0
Chicago	50,161	4,942	9.9
Dallas	33,380	3,578	10.7
Kansas City	12,940	1,337	10.3
Denver	9,364	629	6.7
San Francisco	42,409	7,073	16.7
Seattle	11,271	1,280	11.4

[1]Estimated July 1, 2000 population. [2]Medicaid person years for fiscal year 2000.

NOTES: Numbers may not add to totals because of rounding. Resident population is a provisional estimate. Excludes data for Puerto Rico, Virgin Islands and Outlying Areas.

SOURCES: CMS, Office of the Actuary. U.S. Department of Commerce, Bureau of the Census.

Table 14
Medicaid beneficiaries/State buy-ins for Medicare

	1975[1]	1980[1]	2000[2]	2001[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	5,744
Aged	2,483	2,449	3,632	3,714
Disabled	363	504	1,917	2,031
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	15.2
Aged	11.4	10.0	11.1	11.3
Disabled	18.7	18.9	40.2	41.2

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

NOTES: Numbers may not add to totals because of rounding. Percent calculated using July enrollment.

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

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 15
Inpatient hospitals/trends

	1975	1980	2001	2002
Total hospitals	6,770	6,736	6,031	6,002
Beds in thousands	1,137	1,145	983	969
Beds per 1,000 enrollees[1]	46.5	41.1	25.4	24.5
Short-stay	6,093	6,065	4,704	4,429
Beds in thousands	902	990	863	844
Beds per 1,000 enrollees[1]	36.9	35.6	22.3	21.3
Psychiatric	387	411	519	494
Beds in thousands	197	127	69	67
Beds per 1,000 enrollees[1]	8.1	4.6	1.8	1.7
Other long-stay	290	256	808	1,079
Beds in thousands	38	38	51	58
Beds per 1,000 enrollees[1]	1.6	1.4	1.3	1.5

[1] Based on number of total HI enrollees, excluding residents of foreign countries, as of July 1.

NOTES: Facility data as of December. Facilities certified for Medicare are deemed to meet Medicaid standards. Hospitals formerly classified as short-stay and now defined as critical access are included in other long-stay.

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

Table 16
Medicare assigned claims/CMS region

	Net assignment rates		
	1999	2000	2001
All regions	97.6	97.9	98.1
Boston	98.4	98.5	99.8
New York	97.6	97.9	98.2
Philadelphia	98.3	98.5	98.5
Atlanta	97.8	98.2	98.4
Chicago	97.7	97.9	98.1
Dallas	97.4	97.9	98.2
Kansas City	96.9	97.3	97.5
Denver	96.4	96.8	97.2
San Francisco	98.5	98.7	99.1
Seattle	89.0	89.8	91.0

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

Table 17
Medicare hospital and unit status

Total hospitals	6,018
Hospitals under Prospective Payment Systems (PPS)	4,412
Short-stay hospitals (SSH)	4,196
PPS hospitals receiving special consideration	1,068
Regional referral centers	201
Sole community hospitals	568
Sole community/regional referral center	81
Medicare dependent hospitals	218
SSH PPS hosp. not receiving special consideration	3,128
Hospitals and units under inpatient rehabilitation PPS	
Rehabilitation hospitals	216
Rehabilitation units	936
Non-PPS hospitals	1,606
Categorically exempt	1,484
Psychiatric	493
Religious non-medical	15
Childrens	75
Other long-term	270
Critical Access	631
Alcohol/drug	0
Other reasons exempt	122
Short-stay hospitals in waiver State (Maryland)	67
Short-stay Indian Health Service hospitals	44
Cancer hospitals	11
Total excluded units	
Psychiatric	1,436

NOTE: Data as of August 2002.

SOURCES: CMS, Center for Medicare Management; Center for Medicaid and State Operations; Office of Clinical Standards and Quality; Office of Information Services.

Table 18
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	14,755	1,951	6,752
Boston	1,065	45	179
New York	1,036	4	757
Philadelphia	1,394	118	454
Atlanta	2,582	178	705
Chicago	3,219	482	1,654
Dallas	1,736	487	1,518
Kansas City	1,190	431	191
Denver	590	66	89
San Francisco	1,469	101	1,122
Seattle	474	39	83

[1]Skilled nursing facilities.
[2]Institutions for mentally retarded.
[3]All regions' totals include U.S. Possessions and Territories.

NOTE: Data as of December 2001.

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

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	2001	2002
Home health agencies	2,242	2,924	7,099	6,813
Clinical Lab Improvement Act Facilities	NA	NA	168,333	173,807
End stage renal disease facilities	NA	999	3,991	4,113
Outpatient physical therapy	117	419	2,874	2.836
Portable X-ray	132	216	675	644
Rural health clinics	NA	391	3,334	3,283
Comprehensive outpatient rehabilitation facilities	NA	NA	518	524
Ambulatory surgical centers	NA	NA	3,147	3,371
Hospices	NA	NA	2,267	2,275

NOTES: Facility data for selected years 1975-1980 are as of July 1. Facility data for 2001 and 2002 are as of December 2000 and December 2001, respectively.

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

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	4,429	14,755	6,813
		Percent of total	
Non-profit	60.2	28.5	35.4
Proprietary	14.9	66.3	49.0
Government	24.9	5.2	15.5

NOTES: Data as of December 2001. Facilities certified for Medicare are deemed to meet Medicaid standards. Percent distribution may not add to 100 percent due to rounding.

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

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	1999	2000	2001
Hospitals					
Number of PIP	2,276	3,242	915	869	754
Percent of total participating	33.8	48.3	15.3	14.4	12.5
Skilled nursing facilities					
Number of PIP	203	224	1,387	1,236	1,161
Percent of total participating	3.9	3.4	9.3	8.3	7.9
Home health agencies					
Number of PIP	481	931	1,122	1,038	42
Percent of total participating	16.0	16.0	14.3	14.4	0.1

NOTES: Data from 1985 to date are as of September; 1980 data are as of December. These are facilities receiving periodic interim payments (PIP) under Medicare. Effective for claims received on or after July 1, 1987, the Omnibus Budget Reconciliation Act of 1986 eliminates PIP for many PPS hospitals when the servicing intermediary meets specified processing time standards.

SOURCE: CMS, Office of Financial Management.

Table 22
Physicians active in patient care/selected years

	January 2001		April 2002	
	Number	Percent	Number	Percent
Active in Patient Care	865,479	100.0	888,061	100.0
Medical Specialties	171,894	19.9	176,822	19.9
Surgical Specialties	153,036	17.7	153,479	17.3
Other Specialties	88,613	10.2	89,507	10.1
Family and General Practice	101,449	11.7	102,640	11.6
Emergency Medicine	26,341	3.0	27,786	3.1
Pediatrics	26,079	3.0	25,793	2.9
Non-physician specialties	297,967	34.4	306,953	34.6
Miscellaneous	NA	--	5,082	0.6

NOTES: Includes physicians, doctors of osteopathy, and limited licensed practitioners. Totals include physicians with unknown specialty.

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

Table 23
Physicians/CMS region

	Physicians active in patient care	Physicians per 100,000 population
All regions	[1]888,061	312
Boston	65,708	469
New York	108,000	345
Philadelphia	98,082	350
Atlanta	149,552	276
Chicago	152,109	302
Dallas	86,875	257
Kansas City	43,094	333
Denver	29,935	316
San Francisco	116,611	270
Seattle	37,905	332

[1]Non-Federal physicians only. Includes physicians, doctors of osteopathy, and limited licensed practitioners. Total includes unknown geographic area.

NOTES: Physicians as of April 2002. Civilian population as of July 1, 2001.

SOURCES: CMS, Unique Physician Identification Number Directory; Office of Research, Development, and Information, and the Bureau of the Census.

Table 24
Inpatient hospitals/CMS region

	Short-stay hospitals	Beds per 1,000 enrollees	Long-stay facilities	Beds per 1,000 enrollees
All regions	4,429	21.3	1,573	3.1
Boston	180	15.8	86	5.2
New York	346	24.0	83	4.5
Philadelphia	384	19.7	144	4.1
Atlanta	878	21.6	232	2.3
Chicago	780	23.7	248	2.7
Dallas	668	23.0	300	4.1
Kansas City	311	24.2	190	3.8
Denver	218	20.9	116	4.2
San Francisco	493	19.1	114	1.6
Seattle	171	16.0	60	2.0

NOTES: Data as of December 2001. Rates based on number of hospital insurance enrollees as of July 1, 2001.

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

Expenditures

Information about spending for health care services by Medicare, Medicaid, SCHIP, 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 25
CMS and total Federal outlays

	Fiscal year 2001	Fiscal year 2002
	$ in billions	
Gross domestic product (current dollars)	$10,224.9	$10,678.7
Total Federal outlays[1]	1,863.9	2,032.5
Percent of gross domestic product	18.2	19.0
Dept. of Health and Human Services[1]	426.4	461.4
Percent of Federal Budget	22.9	22.7
CMS Budget (Federal Outlays)		
Medicare benefit payments	236.5	246.8
Medicare quinquennial adjustment[2]	1.2	0.0
SMI transfer to Medicaid[3]	0.1	0.1
Medicaid benefit payments	124.4	139.1
Medicaid State and local admin.	6.3	7.7
Medicaid offsets[4]	-1.3	-0.1
State Children's Health Ins. Prog.[5]	3.7	3.9
CMS program management	2.2	2.5
Other Medicare admin. expenses[6]	1.1	1.3
Quality improvement organizations[7]	0.3	0.5
Health Care Fraud and Abuse Control	0.9	1.0
Total outlays (unadjusted)	375.4	402.8
Medicare premiums	-23.7	-25.6
Total net outlays	351.7	377.2
Percent of Federal budget	18.9	18.6

[1]Net of offsetting receipts.
[2]For military service wage credits.
[3]Reflects the SMI transfer of $60 million in FY 2001 and $65 million in FY 2002 to Medicaid for premium assistance.
[4]Medicaid adjustments in FY 2001 include the SMI transfer of $60 million to Medicaid for premium assistance and the SCHIP transfer of $1.2 billion to reimburse the Medicaid program for the cost of SCHIP-related Medicaid expansions in fiscal years before FY 2001. Medicaid adjustments for FY 2002 include the SMI transfer of $65 million to Medicaid.
[5]The FY 2001 SCHIP amount includes the transfer of $1.2 billion to Medicaid.
[6]Medicare administrative expenses of the Social Security Administration and other Federal agencies.
[7]Formerly peer review organizations (PROs).

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

SOURCE: CMS, Office of Financial Management.

Table 26
Program expenditures/trends

	Total	Medicare[1] in billions	Medicaid[2]	SCHIP[3]
Fiscal year				
1980	$60.8	$35.0	$25.8	--
1990	182.2	109.7	72.5	--
2001	464.7	242.4	217.0	$5.3
2002	501.8	252.0	244.0	5.8

[1]Medicare amounts reflect gross outlays (i.e., not net of offsetting premiums). These amounts include outlays for benefits, administration, the Health Care Fraud and Abuse Control (HCFAC) activity and the SMI transfer to Medicaid for premium assistance. [2]The Medicaid amounts include (1) total computable expenditures (Federal and State shares) for benefits and administration as reported by the States on line 11 of the CMS-64; (2) the Federal and State shares of the cost of Medicaid survey/certification and State Medicaid fraud control units; and (3) outlays for the Vaccines for Children program. The SCHIP-related medicaid expansions began to be financed under Title XXI in FY 2001. The FY 2001 Medicaid amount is reduced to reflect the transfer of $1.2 billion from Title XXI to Title XIX to reimburse the Medicaid program for the cost of SCHIP-related Medicaid expansions in fiscal years before FY 2001. The FY 2001 and FY 2002 Medicaid amounts are reduced by $60 million and $65 million, respectively, to reflect the SMI transfer to Medicaid for premium assistance. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays. In FY 2001, the SCHIP amount includes the cost of SCHIP-related Medicaid expansions. These expansions began to be financed under Title XXI in FY 2001. Also, in FY 2001, the SCHIP amount includes the transfer of $1.2 billion to Title XIX to reimburse the Medicaid program for the cost of SCHIP-related Medicaid expansions in fiscal years before FY 2001.

SOURCE: CMS, Office of Financial Management.

Table 27
Benefit outlays by program

	1967	1968	2001	2002
Annually	Amounts in billions			
CMS program outlays	$5.1	$8.4	$459	$497
Federal outlays	NA	6.7	364	390
Medicare[1]	3.2	5.1	237	247
HI	2.5	3.7	136	141
SMI	0.7	1.4	101	106
Medicaid[2]	1.9	3.3	217	244
Federal share	NA	1.6	123	139
SCHIP[3]	NA	NA	5	6
Federal share	NA	NA	4	4

[1]The Medicare benefit amounts reflect gross outlays (i.e., not net of offsetting premiums). These amounts do not include SMI transfer to Medicaid for premium assistance or QIOs. [2]The Medicaid amounts include total computable expenditures (Federal and State shares) for benefits and outlays for the Vaccines for Children program. In FY 2001, the Medicaid amounts exclude the cost of SCHIP-related Medicaid expansions. These expansions began to be financed under SCHIP (Title XXI) in FY 2001. Also, the FY 2001 Medicaid amounts are reduced to reflect the transfer of $1.2 billion from Title XXI to Title XIX to reimburse the Medicaid program for the costs of SCHIP-related Medicaid expansions in fiscal years before FY 2001. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays as reported by the States on line 4 of the CMS-21. SCHIP-related Medicaid expansions began to be financed under SCHIP (Title XXI) in FY 2001. Also, in FY 2001, the SCHIP amounts include the transfer of $1.2 billion to Title XIX to reimburse the Medicaid program for the costs of SCHIP-related Medicaid expansions in fiscal years before FY 2001.

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

SOURCE: CMS, Office of Financial Management.

Table 28
Program benefit payments/CMS region

	Fiscal year 2001 benefit payments		
		Medicaid	
	Medicare	Total payments computable for Federal funding	Net expenditures reported Federal share[1]
		In millions	
All regions	$236,493	$216,158	$123,285
Boston	12,179	13,811	7,262
New York	28,799	38,810	19,459
Philadelphia	26,765	20,322	11,274
Atlanta	51,729	36,885	23,586
Chicago	37,797	35,238	19,764
Dallas	26,882	21,126	13,916
Kansas City	9,896	9,286	5,689
Denver	5,906	4,572	2,799
San Francisco	30,239	27,874	14,863
Seattle	6,302	8,234	4,672

[1]Excludes CMS adjustments.

NOTES: Data from Form CMS-64 -- Line 11, Net Expenditures Reported. Medical assistance only. Territories are at capped levels. Excludes the State Childrens' Health Insurance Program (SCHIP). Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS, Office of Financial Management, Office of the Actuary, and the Center for Medicaid and State Operations.

Table 29
Medicare benefit outlays

	Fiscal year		
	2001	2002	2003
	In billions		
HI benefit payments	$136.0	$140.8	$146.9
Aged	118.5	122.3	127.3
Disabled	17.5	18.5	19.6
SMI benefit payments	100.5	106.0	109.7
Aged	86.0	90.1	93.0
Disabled	14.5	15.9	16.7

NOTES: Based on FY 2003 Mid-Session Review. Benefit estimates do not reflect proposed legislation. Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS, Office of Financial Management, and the Office of the Actuary.

Table 30
Medicare/type of benefit

	Fiscal year 2003 benefit payments in millions	Percent distribution
Total HI	$146,884	100.0
Inpatient hospital	103,976	70.8
Skilled nursing facility	13,636	9.3
Home health agency	6,033	4.1
Hospice	4,019	2.7
Managed care	19,220	13.1
Total SMI	109,660	100.0
Physician/other suppliers	61,044	55.7
Outpatient hospital	19,525	17.8
Home health agency	7,557	6.9
Laboratory	4,949	4.5
Managed care	16,585	15.1

NOTES: Based on FY 2003 Mid-Session Review. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS, Office of Financial Management and the Office of the Actuary.

Table 31
National health care/trends

	Calendar year			
	1965	1980	2000	2001
National total in billions	$41.0	$245.8	$1,310.0	$1,424.5
Percent of GDP	5.7	8.8	13.3	14.1
Per capita amount	$205	$1,067	$4,672	$5,035
Source of funds	Percent of total			
Private	75.1	57.3	54.9	54.6
Public	24.9	42.7	45.1	45.4
Federal	11.4	29.0	31.7	31.9
State/local	13.5	13.6	13.4	13.5

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 32
Medicaid/type of service

	Fiscal year		
	1999	2000	2001
	In billions		
Total medical assistance payments[1]	$180.5	$194.7	$214.9
	Percent of total		
Inpatient services	14.1	14.1	13.7
General hospitals	12.8	12.8	12.5
Mental hospitals	1.3	1.3	1.2
Nursing facility services	20.2	20.3	19.9
Intermediate care facility (MR) services	5.3	5.1	4.8
Community-based long term care svs.[2]	9.1	9.4	9.7
Prescribed drugs[3]	7.6	8.5	9.2
Physician services	3.6	3.5	3.6
Dental services	0.9	0.9	1.0
Outpatient hospital services	3.6	3.7	3.7
Clinic services[4]	2.9	2.9	2.9
Laboratory and radiological services	0.3	0.3	0.3
Early and periodic screening	0.4	0.4	0.4
Targeted case management services	0.8	0.9	0.9
Capitation payments (non-Medicare)	15.1	15.3	15.5
Medicare premiums	2.3	2.1	2.1
Disproportionate share hosp. payments	8.6	7.4	7.2
Other services	5.0	4.9	5.0

[1]Excludes payments under SCHIP. [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.

NOTE: Data from Form CMS-64--Line 6, Total Current Expenditures.

SOURCE: CMS, Center for Medicaid and State Operations.

Table 33
Medicare savings attributable to secondary payor provisions/type of provision

	Workers Comp.	Working Aged	ESRD	Auto	Disability	Total
1999	$97.1	$1,700.0	$162.9	$241.0	$1,156.5	$3,554.6
2000	103.2	1,353.3	166.7	241.3	1,026.5	3,120.4
2001	95.9	1,626.2	172.1	251.5	1,278.2	3,644.3

NOTES: Fiscal year data. In millions of dollars. FYs 1999 through 2001 totals include liability amounts of $197.5 million, $229.4 million and $220.3, respectively. Total includes other amounts not broken out in detail.

SOURCE: CMS, Office of Financial Management.

Table 34
Medicaid/payments by eligibility status

	Fiscal year 2001 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$216.1	100.0
Age 65 years and over	57.2	26.5
Blind/disabled	83.8	38.8
Dependent children under 21 years of age	34.4	15.9
Adults in families with dependent children	24.0	11.1
DSH and other unallocated	16.7	7.7

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

SOURCE: CMS, Office of the Actuary.

Table 35
Medicare/durable medical equipment[1]

Category	Allowed Charges[2]	
	2000	2001
	In thousands	
Total	$6,760,326	$7,726,922
Surgical dressings	48,386	37,741
Supplies/accessories	99,769	327,273
Capped rental	1,265,667	1,537,863
Customized items	60	49
Oxygen	1,770,111	1,959,620
Prosthetics/orthotics	997,467	933,571
Inexpensive/routine	866,035	1,066,079
Items with frequent maintenance	154,751	133,180
Other	123,968	163,926
Parenteral/enteral	723,019	719,725
DME to admin. drugs	711,094	847,894

[1]Data are for calendar year.
[2]The allowed charge is the Medicare approved payment reported on a line item on the physician/supplier claim.

SOURCE: CMS, Center for Beneficiary Choices.

Table 36
National health care/type of expenditure

	National total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$1,424.5	$5,035	32.7	17.0	15.7
Health serv/suppl.	1,372.6	4,851	34.0	17.6	16.3
Personal health care	1,236.4	4,370	35.8	19.0	16.9
Hospital care	451.2	1,595	47.0	29.9	17.1
Prof. services	462.4	1,634	26.5	15.0	11.5
Phys./clinical	313.6	1,109	27.2	20.4	6.8
Nursing/home hlth.	132.1	467	57.2	16.2	41.0
Retail outlet sales	190.7	674	17.2	4.6	12.6
Admn. and pub. hlth.	136.1	481	17.0	5.4	11.6
Investment	52.0	184	--	--	--

NOTES: Data are as of calendar year 2001.

SOURCE: CMS, Office of the Actuary.

Table 37
Personal health care/payment source

	Calendar year			
	1970	1980	2000	2001
	In billions			
Total	$63.2	$214.6	$1,137.6	$1,236.4
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	64.8	59.7	57.0	56.6
Private health insurance	22.3	28.3	34.9	35.4
Out-of-pocket	39.7	27.1	17.1	16.6
Other private	2.8	4.3	4.9	4.6
Public funds	35.2	40.3	43.0	43.4
Federal	22.9	29.3	32.6	32.9
State and local	12.3	11.1	10.4	10.6

NOTE: Excludes administrative expenses, research, construction, and other types of spending that are not directed at patient care.

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 38
Medicare/short-stay hospital utilization

	1985	1990	2000	2001
Discharges				
Total in millions	10.5	10.5	11.8	12.2
Rate per 1,000 enrollees[1]	347	313	303	310
Days of care				
Total in millions	92	94	71	73
Rate per 1,000 enrollees[1]	3,016	2,805	1,825	1,846
Average length of stay				
All short-stay	8.7	9.0	6.0	6.0
Excluded units[2]	18.8	19.5	12.3	12.0
Total charges per day	$597	$1,060	$2,720	$3,027

[1]The population base is HI enrollment excluding HI enrollees residing in foreign countries and should be treated as preliminary. [2]Includes alcohol/drug, psychiatric, and rehabilitation units through 1990, and psychiatric and rehabilitation units for 2000 and 2001.

NOTE: Data may reflect under reporting 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.

SOURCE: CMS, Office of Information Services.

Table 39
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	1,589	51
1990	638	19	1,967	57
1995	1,240	33	3,469	102
1996	1,384	37	3,600	107
1997	1,503	[1]46	3,558	[1]108
1998	1,447	[1]45	3,062	[1]95
1999	1,390	[1]47	2,720	[1]85
2000	1,468	[1]45	2,461	[1]75

[1]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	1999	2000	2001
All short-stay hospitals	9.1	9.0	7.1	6.1	6.0	6.0
PPS hospitals	8.0	8.9	7.1	6.1	6.0	6.0
Excluded units	18.0	19.5	14.8	12.3	12.3	12.0

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 2001 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.

Table 41
Medicare persons served/trends

	Calendar year				
	1975	1980	1985	1999	2000
Aged persons served per 1,000 enrollees					
HI and/or SMI	528	638	722	921	916
HI	221	240	219	232	232
SMI	536	652	739	966	965
Disabled persons served per 1,000 enrollees					
HI and/or SMI	450	594	669	830	835
HI	219	246	228	198	196
SMI	471	634	715	936	943

NOTES: Prior to 1998, data were obtained from the Annual Person Summary Record. Beginning in 1998, utilization rates are based on persons receiving fee-for-service care and total persons not enrolled in prepaid health plans. Prior to 1997, users of hospice services were excluded.

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				
	1996	1997	1998	1999	2000
	Numbers in millions				
HI					
Aged					
FFS Enrollees	28.9	28.1	27.3	27.0	27.4
Persons served	7.2	7.1	6.7	6.3	6.4
Rate per 1,000	249	254	243	232	232
Disabled					
FFS Enrollees	4.4	4.5	4.6	4.7	4.9
Persons served	1.0	1.0	1.0	0.9	1.0
Rate per 1,000	220	218	206	198	196
SMI					
Aged					
FFS Enrollees	27.9	27.0	26.2	25.9	26.2
Persons served	26.4	25.9	25.3	25.0	25.3
Rate per 1,000	947	959	964	966	965
Disabled					
FFS Enrollees	3.9	4.0	4.1	4.2	4.3
Persons served	3.6	3.7	3.8	3.9	4.1
Rate per 1,000	920	925	925	936	943

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[1]	25,486	916	4,096	835
Boston	1,323	909	217	816
New York	2,829	886	464	784
Philadelphia	2,724	927	408	838
Atlanta	5,458	940	1,039	876
Chicago	5,110	941	708	840
Dallas	2,679	923	449	862
Kansas City	1,469	947	202	874
Denver	755	941	104	806
San Francisco	2,274	880	373	777
Seattle	843	939	130	828

[1]Includes utilization for residents of foreign countries.

NOTES: Data as of calendar year 2000 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		
	1999	2000	2001
Total enrollees[1]	270,438	290,884	317,460
Dialysis patients[2]	259,493	273,333	285,982
Outpatient	231,032	245,207	258,195
Home	28,461	28,126	27,787
Transplants performed[3]	13,483	14,311	14,628
Living donor	3,583	4,052	4,236
Cadaveric donor	8,839	8,884	8,824
Living unrelated	1,061	1,375	1,568
Average dialysis payment rate	$127	$129	$129
Hospital-based facilities	$129	$131	$131
Freestanding facilities	$125	$127	$127

[1]Medicare ESRD enrollees as of July 1.
[2]Includes Medicare and non-Medicare patients receiving dialysis as of December 31.
[3]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 2000 Medicaid beneficiaries
	In thousands
Total eligibles	44,297
Number using service:	
Total beneficiaries, any service	42,763
Inpatient services	
General hospitals	4,933
Mental hospitals	99
Nursing facility services[1]	1,703
Intermediate care facility (MR) services[2]	118
Physician services	19,104
Dental services	5,892
Other practitioner services	4,735
Outpatient hospital services	13,226
Clinic services	7,667
Laboratory and radiological services	11,396
Home health services	995
Prescribed drugs	20,517
Personal care support services	4,549
Sterilization services	137
PCCM services	5,560
Capitated payment services	21,261
Other care	9,037
Unknown	176

[1]Nursing facilities include: SNFs and all categories of ICF, other than "MR".
[2]"MR" indicates mentally retarded.

NOTE: 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 1999 units of service
	In thousands
Inpatient hospital	
Total discharges	5,452
Recipients discharged	NA
Total days of care	25,627
Nursing facility	
Total days of care	372,213
Intermediate care facility/mentally retarded	
Total days of care	47,482

NOTES: Data are derived from the MSIS 1999 State Summary Mart. For New York, the hard copy HCFA-2082 data were used. Excludes territories.

SOURCE: CMS, Center for Medicaid and State Operations.

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 47
Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
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	[1]2,350	1.8
2001	[1]2,368	1.7
2002	[1]2,464	1.7
SMI Trust Fund		
1967	[2]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
2001	1,986	2.0
2002	1,830	1.7

[1]Includes non-expenditure transfers for Health Care Fraud and Abuse Control.
[2]Includes expenses paid in fiscal years 1966 and 1967.

NOTE: Fiscal year data.

SOURCE: CMS, Office of the Actuary.

Table 48
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	26	15
Other	2	5

NOTE: Data as of May 2003.

SOURCE: CMS, Office of Financial Management.

Table 49
Medicare appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	34,739	2,410,573
Percent with increased payments[1]	28.0	61.8

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 2002.

SOURCE: CMS, Office of Financial Management.

Table 50
Medicare claims processing bottom line unit costs

	Unit cost per claim				
	1975	1980	1999	2000	2001
Intermediaries[1]	$3.84	$2.96	$0.76[3]	$0.86[3]	$0.86[3]
Carriers[2]	2.90	2.33	0.60	0.63	0.61

[1]Includes direct costs and overhead costs for bill payment, reconsiderations, and hearings lines. [2]Includes direct costs and overhead costs for the claims payment, reviews and hearings, and beneficiary/physician inquiries lines. [3]Beginning in FY 1998, inquiries and PET activities are separated from other bill payment cost for intermediaries.

NOTE: Fiscal year data.

SOURCE: CMS, Office of Financial Management.

Table 51
Medicare claims processing

	Intermediaries	Carriers
Claims processed in millions	158.6	772.0
Total PM costs in millions	$330.4	$940.8
Total MIP costs in millions	$396.7	$280.7
Claims processing costs in millions	$188.1	$615.5
Claims processing unit costs	$0.86	$0.61
Range		
High	$1.57	$1.22
Low	$0.70	$0.57

NOTES: Data for fiscal year 2001. PM= Program Management. MIP= Medicare Integrity Program.

SOURCE: CMS, Office of Financial Management.

Table 52
Medicare claims received

	Claims received
Intermediary claims received in thousands	168,568
	Percent of total
Inpatient hospital	8.9
Outpatient hospital	47.2
Home health agency	6.5
Skilled nursing facility	2.5
Other	34.8
Carrier claims received in thousands	821,993
	Percent of total
Assigned	98.4
Unassigned	1.6

NOTE: Data for calendar year 2002.

SOURCE: CMS, Office of Financial Management.

Table 53
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	722.8	12.1
Percent reduced	87.7	79.8
Total covered charges		
Amount in millions	$152,373	$1,107
Percent reduced	56.3	17.2
Amount reduced per claim	$135.31	$21.01

NOTES: Data for calendar year 2002. 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	
	2000	2001
	In thousands	
Total payments computable for Federal funding[1]	$10,577,053	$11,880,615
Federal share of current expenditures:		
Family planning	$24,045	$23,198
Design, development or installation of MMIS[2]	73,439	141,923
Skilled professional medical personnel	391,825	327,814
Operation of an approved MMIS[2]	847,718	962,534
Other financial participation	4,486,357	5,017,419
Mechanized systems not approved under MMIS[2]	68,811	82,503
Total administration	$5,892,195	$6,555,391
Net adjusted Federal share[3]	$5,732,484	$6,533,230

[1]Source: Form CMS-64. Expenditures for State and Local Administration for the Medical Assistance Program (Net Expenditures Reported--Administration). FY 2001 data are preliminary (04/2002).
[2]Medicaid Management Information System.
[3]Includes Federal share of net expenditures reported plus CMS adjustments.

Sources: CMS, Center for Medicaid and State Operations, and the Office of Financial Management.

Reference

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

Program financing

Medicare/source of income

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
   a. uninsured persons
   b. military wage credits
5. Premiums from voluntary enrollees
6. Interest on investments

*Contribution rate	2001	2002	2003
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2003) None[1]

Voluntary HI Premium[2]

Monthly Premium (CY 2003): $316

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

Part B Premium

Monthly Basic Premium (CY 2003): $58.70

Medicaid/financing

1. Federal contributions (ranging from 50 to 76.62 percent for fiscal year 2003)
2. State contributions (ranging from 23.38 to 50 percent for fiscal year 2003)

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[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 $174 is available to individuals aged 65 and over who are not otherwise entitled to hospital insurance but who have, or whose spouse has or had, at least 30 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

Medicare deductible and coinsurance amounts

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/03)	$840/benefit period
Regular coinsurance days (1/1/03)	$210/day for 61st thru 90th day
Lifetime reserve days (1/1/03)	$420/day (60 nonrenewable days)
SNF coinsurance days (1/1/03)	$105/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/03)	$316/month $174/month if have at least 30 quarters of coverage
Limitations:	
Inpatient psychiatric hospital days	190 nonrenewable days
Part B (effective date)	**Amount**
Deductible (1/1/91)[1]	$100 in reasonable charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Premium (1/1/03)	$58.70/month
Limitations:	
Outpatient treatment for mental illness	No limitations
Licensed physical therapist's services in home or office (1/1/91)	$600 (80% of maximum annual program payment of $750)

[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, influenza vaccine and its administration, and pneumococcal vaccine and its administration. In addition, federally qualified health center services are not subject to the deductible but are subject to the coinsurance.

SOURCE: CMS, Office of the Actuary.

Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2003

I.	**Boston**	**FMAP**	**II.**	**New York**	**FMAP**
	Connecticut	50		New Jersey	50
	Maine	66		New York	50
	Massachusetts	50		Puerto Rico	50
	New Hampshire	50		Virgin Islands	50
	Rhode Island	55		Canada	--
	Vermont	62			
			IV.	**Atlanta**	
III.	**Philadelphia**			Alabama	71
	Delaware	50		Florida	59
	Dist. of Columbia	70		Georgia	60
	Maryland	50		Kentucky	70
	Pennsylvania	55		Mississippi	77
	Virginia	51		North Carolina	63
	West Virginia	75		South Carolina	70
				Tennessee	65
V.	**Chicago**				
	Illinois	50	**VI.**	**Dallas**	
	Indiana	62		Arkansas	74
	Michigan	55		Louisiana	71
	Minnesota	50		New Mexico	75
	Ohio	59		Oklahoma	71
	Wisconsin	58		Texas	60
VII.	**Kansas City**		**VIII.**	**Denver**	
	Iowa	64		Colorado	50
	Kansas	60		Montana	73
	Missouri	61		North Dakota	68
	Nebraska	60		South Dakota	65
				Utah	71
IX.	**San Francisco**			Wyoming	61
	Arizona	67			
	California	50	**X.**	**Seattle**	
	Hawaii	59		Alaska	58
	Nevada	52		Idaho	71
	American Samoa	50		Oregon	60
	Guam	50		Washington	50
	N. Mariana Islands	50			

SOURCE: CMS, Center for Medicaid and State Operations.

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