2006 CMS Statistics

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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	20.4	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			
1999	39.2	33.9	5.2
2000	39.7	34.3	5.4
2001	40.1	34.5	5.6
2002	40.5	34.7	5.8
2003	41.2	35.0	6.2
2004	41.9	35.4	6.4
2005	42.4	35.8	6.7
2006	43.1	36.2	6.9

NOTES: Data for 1966-1998 are as of July. Data for 1999-2006 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding.

SOURCE: CMS, 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	43.0	42.5	40.0	39.5	3.0	0.5
Aged persons	36.2	35.6	33.9	33.4	2.2	0.5
Disabled persons	6.8	6.8	6.0	6.0	0.8	(1)

[1]Number less than 500.

NOTE: Projected average monthly enrollment during fiscal year 2006. Based on FY 2007 President's Budget.

SOURCE: CMS, Office of the Actuary.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	41,729	18,294	23,435
Aged	35,328	14,834	20,494
65-74 years	18,018	8,321	9,698
75-84 years	12,685	5,123	7,562
85 years and over	4,625	1,391	3,234
Disabled	6,401	3,460	2,941
Under 45 years	1,749	977	772
45-54 years	1,987	1,079	908
55-64 years	2,665	1,404	1,261
White	35,139	15,396	19,743
Black	4,071	1,732	2,339
All Other	2,434	1,135	1,299
Native American	157	71	86
Asian/Pacific	668	290	378
Hispanic	973	459	514
Other	636	315	321
Unknown Race	85	31	54

NOTES: Data as of July 1, 2004. 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
2000[1]	291.8	291.3	273.1
2002[1]	336.5	336.2	315.1
2003[1]	350.1	347.3	332.3
2004[1]	359.4	359.3	341.2
2005[1]	371.2	371.1	351.9

[1]Denominator File; estimated person years.

NOTES: Data prior to 2000 are as of July 1; estimated person years 2000-2005.
SOURCE: CMS, Office of Research, Development, and Information.

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	418.0
Age	
Under 35 years	27.9
35-44 years	40.3
45-64 years	161.2
65 years and over	188.6
Sex	
Male	231.3
Female	186.7
Race	
White	229.5
Other	186.7
Unknown	1.8

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2005.

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

Table 6
Medicare managed care

	Number of Plans	Enrollees (in thousands)
Total prepaid	459	6,122
Medicare Advantage	319	5,367
TEFRA Cost/Demos	33	358
Demos and/or PPOs	57	291
HCPPs Part B	16	95
PACE	34	11
Percent of total Medicare beneficiaries		14.4

NOTES: Data as of December 1, 2005. Percent of total Medicare beneficiaries based on enrollment as of July 1, 2005. Numbers may not add to totals because of rounding.

SOURCE: CMS, Center for Beneficiary Choices.

Table 7
Medicare enrollment/CMS region

	Resident population[1]	Medicare enrollees[2]	Enrollees as percent of population
	In thousands		
All regions	293,657	41,383	14.1
Boston	14,221	2,171	15.3
New York	27,966	3,979	14.2
Philadelphia	28,633	4,313	15.1
Atlanta	56,502	8,599	15.2
Chicago	51,094	7,262	14.2
Dallas	35,156	4,335	12.3
Kansas City	13,195	2,039	15.5
Denver	9,863	1,176	11.9
San Francisco	45,177	5,350	11.8
Seattle	11,851	1,559	13.2

[1]Estimated July 1, 2004 resident population.
[2]Medicare denominator enrollment file data are as of July 1, 2004.

NOTES: Resident population is a provisional estimate. The 2004 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
Social security population/projected[1]

	2010	2020	2040	2060	2080	2100
	In millions					
Total	314.7	339.3	376.9	402.1	428.2	453.6
Under 20	84.9	87.5	92.3	96.8	101.2	105.7
20-64	190.1	198.2	207.4	218.8	230.1	240.7
65 years and over	39.8	53.5	77.2	86.5	96.9	107.2

[1]As of July 1.

SOURCE: SSA, Office of the Actuary.

Table 9
Period life expectancy at age 65/trends

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1990	15.1	19.1
2000	15.9	19.0
2010[1]	16.6	19.1
2020[1]	17.3	19.7
2030[1]	17.9	20.2
2040[1]	18.4	20.8
2050[1]	19.0	21.3
2060[1]	19.5	21.9
2070[1]	20.0	22.3
2080[1]	20.5	22.8
2090[1]	21.0	23.2

[1]Preliminary.

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	60.8
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
2003	77.5	78.0	72.7
		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
2003	18.4	18.5	17.0

SOURCE: Public Health Service, Health United States, 2005.

Table 11
Medicaid and SCHIP enrollment

	Fiscal year					
	1990	1995	2000	2004	2005	2006
	Average monthly enrollment in millions					
Total	22.9	33.4	33.6	45.0	46.9	49.3
Age 65 years and over	3.1	3.7	3.7	4.5	4.6	5.2
Blind/Disabled	3.8	5.8	6.7	7.9	8.1	8.8
Children	10.7	16.5	16.2	22.1	23.1	23.9
Adults	4.9	6.7	6.9	10.5	11.0	11.4
Other Title XIX	0.5	0.6	NA	NA	NA	NA
SCHIP	NA	NA	2.1	4.3	4.3	4.4
	Unduplicated annual enrollment in millions					
Total	NA	42.5	43.3	57.6	60.1	63.2
Age 65 years and over	NA	4.4	4.3	5.2	5.4	6.1
Blind/Disabled	NA	6.5	7.5	8.8	9.0	9.7
Children	NA	21.3	20.9	28.7	30.0	31.1
Adults	NA	9.4	10.6	15.0	15.7	16.2
Other Title XIX	NA	0.9	NA	NA	NA	NA
SCHIP	NA	NA	3.3	6.8	6.8	6.9

NOTES: Territories not included in Medicaid numbers. Medicaid enrollment excludes Medicaid expansion SCHIP programs. SCHIP numbers include adults covered under waivers.

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

Table 12
Medicaid eligibles/demographics

	Fiscal year 2003 Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	55.4	100.0
Age	55.4	100.0
Under 21	29.8	53.8
21-64 years	19.5	35.3
65 years and over	5.9	10.7
Unknown	0.1	0.2
Sex	55.4	100.0
Male	22.4	40.4
Female	32.9	59.4
Unknown	0.1	0.2
Race	55.4	100.0
White, not Hispanic	24.2	43.7
Black, not Hispanic	12.9	23.3
Am. Indian/Alaskan Native	0.8	1.5
Asian	1.5	2.6
Hawaiian/Pacific Islander	0.6	1.1
Hispanic	12.1	21.8
Other	(1)	--
Unknown	3.3	6.0

[1]Less than 100,000.

NOTES: The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of rounded components. Eligible is defined as any one 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.

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

Table 13
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	290,850	55,183	19.0
Boston	14,195	2,575	18.1
New York	27,868	5,558	19.9
Philadelphia	28,446	4,054	14.3
Atlanta	55,651	11,009	19.8
Chicago	50,889	8,268	16.2
Dallas	34,699	6,551	18.9
Kansas City	13,122	2,130	16.2
Denver	9,745	1,137	11.7
San Francisco	44,525	11,778	26.5
Seattle	11,711	2,123	18.1

[1]Estimated July 1, 2003 population. [2]Persons ever enrolled in Medicaid during fiscal year 2003.

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 Research, Development, and Information; U.S. Department of Commerce, Bureau of the Census.

Table 14
Medicaid beneficiaries/State buy-ins for Medicare

	1975[1]	1980[1]	2004[2]	2005[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	6,540	6,845
Aged	2,483	2,449	4,086	4,226
Disabled	363	504	2,454	2,619
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	16.7	17.3
Aged	11.4	10.0	12.2	12.5
Disabled	18.7	18.9	44.4	45.1

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

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

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

	1990	1995	2004	2005
Total hospitals	6,522	6,376	6,117	6,180
Beds in thousands	1,105	1,056	950	947
Beds per 1,000 enrollees[1]	32.8	28.4	22.9	22.5
Short-stay	5,549	5,252	3,951	3,790
Beds in thousands	970	926	821	812
Beds per 1,000 enrollees[1]	28.8	24.9	19.8	19.3
Critical access hospitals	NA	NA	NA	1,217
Beds in thousands	---	---	---	28
Beds per 1,000 enrollees[1]	---	---	---	0.7
Other non-short-stay	973	1,124	2,166	1,173
Beds in thousands	135	130	132	107
Beds per 1,000 enrollees[1]	1.0	1.2	3.2	2.5

[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 Research, Development, and Information

Table 16
Medicare assigned claims/CMS region

	Net assignment rates		
	2003	2004	2005
All regions	98.5	98.7	98.8
Boston	99.9	99.9	([1])
New York	98.7	98.8	98.8
Philadelphia	98.8	99.0	99.2
Atlanta	98.8	98.9	99.1
Chicago	98.1	98.3	98.6
Dallas	98.6	98.7	98.8
Kansas City	98.0	98.3	98.6
Denver	97.7	97.8	98.1
San Francisco	99.2	99.3	99.3
Seattle	99.4	95.2	96.7

[1] No carriers in the Boston region.

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

Table 17
Medicare hospital and SNF/NF/ICF facility counts

Total hospitals	6,193
Short-term hospitals	3,728
Psychiatric units	1,302
Rehabilitation units	1,013
Swing bed units	582
Psychiatric	479
Long-term	391
Rehabilitation	218
Childrens	81
Religious non-medical	16
Critical access	1,280
Non-participating Hospitals	768
Emergency	418
Federal	350
All SNFs/SNF-NFs/NFs only	15,965
All skilled nursing facilities	15,030
SNFs	847
Hospital-based	413
Free-standing	434
SNF/NFs combination	14,183
Hospital-based	816
Free-standing	13,367
Title 19 only NFs	935
Hospital-based	147
Free-standing	788
All ICF-MR facilities	6,428

NOTES: The table is designed to give a "snapshot" as of the end of May 2006 of institutional providers participating in the program by type of provider (short term, long term, rehab., etc.). Numbers may differ from other reports and program memoranda.

SOURCES: CMS, CMM, CMSO, and ORDI.

Table 18
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	15,006	984	6,457
Boston	1,010	20	154
New York	1,026	2	620
Philadelphia	1,367	60	429
Atlanta	2,625	78	674
Chicago	3,271	239	1,512
Dallas	1,896	199	1,547
Kansas City	1,341	217	188
Denver	584	53	90
San Francisco	1,436	86	1,164
Seattle	449	30	79

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

NOTE: Data as of December 2005.

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

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	2004	2005
Home health agencies	2,242	2,924	7,519	8,090
Clinical Lab Improvement Act Facilities	NA	NA	189,340	196,296
End stage renal disease facilities	NA	999	4,618	4,755
Outpatient physical therapy	117	419	2,971	2,962
Portable X-ray	132	216	608	553
Rural health clinics	NA	391	3,536	3,661
Comprehensive outpatient rehabilitation facilities	NA	NA	635	634
Ambulatory surgical centers	NA	NA	4,136	4,445
Hospices	NA	NA	2,645	2,872

NOTES: Facility data for selected years 1975-1980 are as of July 1. Facility data for 2004 and 2005 are as of December 31, 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	3,790	15,006	8,090
		Percent of total	
Non-profit	60.1	27.7	26.8
Proprietary	20.2	67.3	62.0
Government	19.7	5.0	11.2

NOTES: Data as of December 31, 2005. 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	2003	2004	2005
Hospitals					
Number of PIP	2,276	3,242	657	626	671
Percent of total participating	33.8	48.3	10.9	10.8	10.9
Skilled nursing facilities					
Number of PIP	203	224	1,001	526	847
Percent of total participating	3.9	3.4	6.7	3.5	5.6
Home health agencies					
Number of PIP	481	931	44	46	59
Percent of total participating	16.0	16.0	0.1	0.1	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
Part B practitioners active in patient care/selected years

	April 2006	
	Number	Percent
All Part B Practitioners	1,048,243	100.0
Physician Specialties	644,308	61.5
Primary Care	237,661	22.7
Medical Specialties	104,129	9.9
Surgical Specialties	105,283	10.0
Emergency Medicine	34,746	3.3
Anesthesiology	37,074	3.5
Radiology	36,140	3.4
Pathology	13,500	1.3
Obstetrics/Gynecology	37,550	3.6
Psychiatry	37,928	3.6
Other and Unknown	292	0.0
Limited Licensed Practitioners	121,987	11.6
Non-physician Practitioners	281,948	26.9

NOTES: Specialty code is self-reported and may not correspond to actual board certification. Totals do not necessarily equal the sum of rounded components. Reflect unduplicated counts.

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

Table 23
Part B practitioners/CMS region

	Active practitioners (in thousands)	Practitioners per 100,000 population
All regions	1,185.6	400
Boston	91.5	643
New York	142.2	446
Philadelphia	125.3	435
Atlanta	211.7	369
Chicago	198.7	387
Dallas	113.8	319
Kansas City	59.9	451
Denver	44.6	446
San Francisco	145.3	317
Seattle	52.6	438

[1]Non-Federal physicians only. Includes physicians, limited licensed and non-physician practitioners who may practice in multiple States. Unknown provider states distributed.

NOTES: Physicians as of April 2006. Civilian population as of July 1, 2005.

SOURCES: CMS, ORDI, and the Bureau of the Census.

Table 24
Inpatient hospitals/CMS region

	Short-stay and CAH hospitals	Beds per 1,000 enrollees	Non Short-stay facilities	Beds per 1,000 enrollees
All regions	5,007	19.9	1,173	2.5
Boston	192	15.0	70	4.7
New York	342	22.0	73	2.8
Philadelphia	379	18.1	131	3.2
Atlanta	942	20.0	205	2.1
Chicago	876	21.6	185	2.2
Dallas	780	22.9	302	4.1
Kansas City	482	24.2	52	2.0
Denver	308	21.0	37	2.5
San Francisco	494	17.8	96	1.5
Seattle	212	14.7	22	1.7

NOTES: Critical Access Hospitals have been grouped with short stay. Data as of December 31, 2005. Rates based on number of hospital insurance person years during 2005.

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

Expenditures

Information about spending for health care services by Medicare, Medicaid, and in 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 2004	Fiscal year 2005
	$ in billions	
Gross domestic product (current dollars)	$11,546.0	$12,290.4
Total Federal outlays[1]	2,293.0	2,472.2
Percent of gross domestic product	19.9	20.1
Dept. of Health and Human Services[1]	543.4	581.5
Percent of Federal Budget	23.7	23.5
CMS Budget (Federal Outlays)		
Medicare benefit payments	295.4	332.2
SMI transfer to Medicaid[2]	0.2	0.2
Medicaid benefit payments	168.3	173.3
Medicaid State and local admin.	8.1	8.4
Medicaid offsets[3]	-0.2	-0.2
State Children's Health Ins. Prog.	4.6	5.1
CMS program management	2.7	3.1
Other Medicare admin. expenses[4]	1.4	1.8
State Eligibility Determinations, for Part D	0.0	0.1
Quality improvement organizations[5]	0.4	0.4
Health Care Fraud and Abuse Control	1.1	1.1
State Grants and Demonstrations[6]	0.0	0.1
User Fees and Reimbursables	0.1	0.1
Total CMS outlays (unadjusted)	482.1	526.6
Offsetting receipts[7]	-32.2	-40.8
Total net CMS outlays	449.9	485.9
Percent of Federal budget	19.6	19.7

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($168.2 million in FY 2004 and $242.3 million in FY 2005).
[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) and the qualified high risk pools under the Trade Act of 2002 (P.L. 107-210). Outlays for these programs amounted to $48 million in FY 2004 and $84 million in FY 2005.
[7]Almost entirely Medicare premiums. Also includes offsetting collections for user fee and reimbursable activities. Refunds to the trust funds also included beginning in FY 2005.

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

SOURCE: CMS, Office of Financial Management.

Table 26
Program expenditures/trends

	Total	Medicare[1]	Medicaid[2]	SCHIP[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
2004	605.6	301.5	297.5	6.6
2005	664.0	339.4	317.2	7.4

[1]Medicare amounts reflect gross outlays (i.e., not net of offsetting receipts). These amounts include outlays for benefits, administration, the Health Care Fraud and Abuse Control (HCFAC) activity, Quality Improvement Organizations (QIOs), the SMI transfer to Medicaid for Medicare Part B premium assistance for low income Medicare beneficiaries and, beginning in FY 2004, the administrative and benefit costs of the new 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 Medicare beneficiaries, nor do they include Medicare Part D compensation to States for low-income eligibility determinations in the Part D Drug Program. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays. Please note that SCHIP-related Medicaid began to be financed under Title XXI in FY 2001.

SOURCE: CMS, Office of Financial Management.

Table 27
Benefit outlays by program

	1967	1968	2004	2005
Annually		Amounts in billions		
CMS program outlays	$5.1	$8.4	$589	$642
Federal outlays	NA	6.7	468	512
Medicare[1]	3.2	5.1	295	333
HI	2.5	3.7	164	183
SMI	0.7	1.4	131	150
Transitional Assistance[4]	NA	NA	0	1
Medicaid[2]	1.9	3.3	287	302
Federal share	NA	1.6	168	173
SCHIP[3]	NA	NA	7	7
Federal share	NA	NA	5	5

[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 benefits and outlays for the Vaccines for Children program. [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. Please note that SCHIP-related Medicaid expansions began to be financed under SCHIP (Title XXI) in FY 2001. [4]The Medicare Modernization Act of 2003 (P.L. 108-173) provided funds for transitional assistance to low-income beneficiaries under the transitional Prescription Drug Card program. Outlays for this benefit began in the third quarter of FY 2004, and totalled $216 million for that fiscal year.

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

	Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$281,795	$166,969
Boston	18,216	10,047
New York	49,900	26,002
Philadelphia	26,345	15,177
Atlanta	49,666	33,048
Chicago	44,617	25,857
Dallas	28,309	19,205
Kansas City	11,535	7,361
Denver	5,958	3,778
San Francisco	37,586	20,852
Seattle	9,663	5,642

[1]Fiscal year 2004 data from Form CMS-64 --Net Expenditures Reported by the States, unadjusted by CMS. Medical assistance only. Excludes Medicaid expansions under the State Children's Health Insurance Program (SCHIP).

SOURCES: CMS, CMSO.

Table 29
Medicare benefit outlays

	Fiscal year		
	2004	2005	2006
	In billions		
HI benefit payments	$163.8	$181.0	$185.8
Aged	140.7	155.1	158.8
Disabled	23.1	25.8	27.1
SMI benefit payments	131.4	148.5	157.3
Aged	100.9	123.7	130.2
Disabled	21.5	24.8	27.1
Part D	0.2	1.1	46.5

NOTES: Based on FY 2007 President's Budget. 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 30
Medicare/type of benefit

	Fiscal year 2006 benefit payments[1] in millions	Percent distribution
Total HI[2]	$185,845	100.0
Inpatient hospital	120,984	65.1
Skilled nursing facility	17,607	9.5
Home health agency[3]	6,009	3.2
Hospice	9,246	5.0
Managed care	31,999	17.2
Total SMI[2]	157,264	100.0
Physician/other suppliers	58,739	37.4
DME	7,570	4.8
Other carrier	15,863	10.1
Outpatient hospital	20,553	13.1
Home health agency[3]	6,596	4.2
Other intermediary	13,014	8.3
Laboratory	6,648	4.2
Managed care	28,282	18.0
Total Part D	46,458	100.0

[1]Includes the effects of regulatory items and recent legislation but not proposed law. [2]Excludes QIO expenditures. [3]Distribution of home health benefits between the trust funds reflects the actual outlays as reported by the Treasury.

NOTES: Based on FY 2007 President's Budget. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, OACT and OFM

Table 31
National health care/trends

	Calendar year			
	1965	1980	2000	2004
National total in billions	$41.0	$245.9	$1,358.5	$1,877.6
Percent of GDP	5.7	9.1	13.8	16.0
Per capita amount	$205	$2,821	$4,729	$6,280
Source of funds		Percent of total		
Private	75.1	59.6	55.7	54.9
Public	24.9	40.4	44.3	45.1
Federal	11.4	27.0	30.8	32.0
State/local	13.5	13.4	13.5	13.2

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

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

Table 32
Medicaid/type of service

	Fiscal year		
	2002	2003	2004
	In billions		
Total medical assistance payments[1]	$246.3	$262.6	$281.8
	Percent of total		
Inpatient services	13.9	14.1	14.8
General hospitals	12.6	12.7	13.7
Mental hospitals	1.3	1.3	1.1
Nursing facility services	18.8	17.0	16.1
Intermediate care facility (MR) services	4.4	4.4	4.1
Community-based long term care svs.[2]	9.7	10.6	10.8
Prescribed drugs[3]	9.5	10.3	10.8
Physician services	3.6	3.7	4.1
Dental services	1.1	1.2	1.1
Outpatient hospital services	4.0	3.8	4.1
Clinic services[4]	2.9	2.8	4.1
Laboratory and radiological services	0.3	0.3	0.4
Early and periodic screening	0.4	0.4	0.4
Targeted case management services	1.0	1.1	1.0
Capitation payments (non-Medicare)	16.0	17.2	16.4
Medicare premiums	2.1	2.1	2.3
Disproportionate share hosp. payments	6.2	4.9	5.5
Other services	5.1	5.8	4.5
Adjustments[5]	0.9	0.3	0.9

[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. [5]Includes increasing and decreasing payment adjustments from prior quarters, collections, and other unallocated expenditures.

SOURCES: CMS, CMSO, and OACT.

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

	Workers Comp.	Working Aged	ESRD	Auto	Disability	Total
2003	122.2	2,146.7	206.1	273.9	1,604.1	4,593.3
2004	113.3	2,296.8	232.7	265.2	1,640.4	4,829.0
2005	101.9	2,780.9	280.8	244.6	1,920.6	5,670.5

NOTES: Fiscal year data. In millions of dollars. FYs 2003 through 2005 totals include liability amounts of $240.3, $280.6, and $325.0 million, respectively.

SOURCE: CMS, OFM.

Table 34
Medicaid/payments by eligibility status

	Fiscal year 2004 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$281.8	100.0
Age 65 years and over	65.0	23.1
Blind/disabled	114.2	40.5
Dependent children under 21 years of age	47.4	16.8
Adults in families with dependent children	33.6	11.9
DSH and other unallocated	21.6	7.6

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

SOURCE: CMS, Office of the Actuary.

Table 35
Medicare/dme/pos[1]

Category	Allowed Charges[2]	
	2002	2003
	In thousands	
Total	$8,270,229	$9,823,217
Medical/surgical supplies	1,108,461	1,238,970
Hospital beds	485,890	529,103
Oxygen and supplies	2,206,641	2,435,365
Wheelchairs	1,421,244	1,842,963
Prosthetic/orthotic devices	1,111,417	1,379,186
Drugs admin. through DME	1,082,507	1,351,581
Other DME	854,068	1,046,049

[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.

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

Table 36
National health care/type of expenditure

	National total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$1,877.6	$6,289	31.9	16.5	15.5
Health serv/suppl.	1,753.0	5,863	34.2	17.6	16.6
Personal health care	1,560.2	5,218	36.6	19.2	17.4
Hospital care	570.8	1,909	45.9	28.6	17.3
Prof. services	587.4	1,965	27.8	15.7	12.1
Phys./clinical	399.9	1,337	27.3	20.5	6.9
Nursing/home hlth.	158.4	530	61.4	20.5	40.9
Retail outlet sales	243.7	815	19.7	4.8	14.9
Admn. and pub. hlth.	192.8	645	15.2	4.9	10.3
Investment	124.6	417	--	--	--

NOTES: Data are as of calendar year 2004.

SOURCE: CMS, Office of the Actuary.

Table 37
Personal health care/payment source

	Calendar year			
	1980	1990	2000	2004
	In billions			
Total	$215.3	$607.5	$1,139.9	$1,560.2
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	60.0	61.1	57.2	55.6
Private health insurance	28.4	33.7	35.3	36.1
Out-of-pocket	27.2	22.4	16.9	15.1
Other private	4.3	5.0	5.0	4.4
Public funds	40.0	38.9	42.8	44.4
Federal	28.9	28.4	32.6	33.9
State and local	11.1	10.4	10.2	10.5

NOTE: Excludes administrative expenses, research, structures & equipment 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	2003	2004
Discharges				
Total in millions	10.5	10.5	12.7	13.0
Rate per 1,000 enrollees[1]	347	313	315	316
Days of care				
Total in millions	92	94	74	75
Rate per 1,000 enrollees[1]	3,016	2,805	1,845	1,834
Average length of stay				
All short-stay	8.7	9.0	5.9	5.8
Excluded units[2]	18.8	19.5	11.5	11.5
Total charges per day	$597	$1,060	$4,033	$4,458

[1]The population base is HI enrollment excluding HI enrollees residing in foreign countries. [2]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

	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	1,240	33	3,457	93
2001	1,545	[1]46	2,403	[1]71
2002	1,622	[1]47	2,544	[1]73
2003	1,693	[1]48	2,681	[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	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				
HI					
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
SMI					
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[1]	27,665	920	4,922	859
Boston	1,453	913	258	843
New York[2]	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[3]	2,651	889	459	795
Seattle	950	943	166	847

[1]Includes utilization for residents of outlying territories, possessions and foreign countries.
[2]Excludes residents of Puerto Rico and Virgin Islands.
[3]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[1]	317,460	336,545	350,085
Dialysis patients[2]	285,982	297,928	310,095
Outpatient	258,195	269,741	281,460
Home	27,787	28,187	28,635
Transplants performed[3]	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

[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 2003 Medicaid beneficiaries
	In thousands
Total eligibles	55,182
Number using service:	
Total beneficiaries, any service[1]	51,971
Inpatient services	
General hospitals	5,217
Mental hospitals	104
Nursing facility services[2]	1,691
Intermediate care facility (MR) services[3]	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

[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 all categories of ICF, other than "MR". [3]"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
Inpatient hospital	
Total discharges[1]	7,345
Beneficiaries discharged	5,217
Total days of care	34,743
Nursing facility	
Total days of care	493,911
Intermediate care facility/mentally retarded	
Total days of care	45,477

[1]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
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
2004[1]	2,920	1.8
2005[1]	2,850	1.6
SMI Trust Fund[3]		
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
2004	2,817	2.1
2005	2,914	1.9

[1]Includes non-expenditure transfers for Health Care Fraud and Abuse Control. [2]Includes expenses paid in fiscal years 1966 and 1967. [3]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[1]	32.8	70.2

[1]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[1]	$13,584	$14,486
Federal share[1]		
Family planning	32	31
Design, development or installation of MMIS[2]	470	382
Skilled professional medical personnel	367	374
Operation of an approved MMIS[2]	1,071	1,081
All other	5,577	6,005
Mechanized systems not approved under MMIS[2]	85	146
Total Federal Share	$7,602	8,019
Net adjusted Federal share[3]	$7,580	$8,048

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

Sources: 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

Fiscal Year	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
2004	[1]2,920	1.8
2005	[1]2,850	1.6
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
2004[1]	2,817	2.1
2005[1]	2,914	1.9

[1]Includes non-expenditure transfers for Health Care Fraud and Abuse Control. [2]Includes expenses paid in fiscal years 1966 and 1967. [2]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	23	15
Other	2	5

NOTE: Data as of May 2005.

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[1]	32.8	70.2

[1]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

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
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	Claims received
Intermediary claims received in thousands	185,442
	Percent of total
Inpatient hospital	8.3
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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	89.8	83.0
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[1]	$13,584	$14,486
Federal share[1]		
Family planning	32	31
Design, development or installation of MMIS[2]	470	382
Skilled professional medical personnel	367	374
Operation of an approved MMIS[2]	1,071	1,081
All other	5,577	6,005
Mechanized systems not approved under MMIS[2]	85	146
Total Federal Share	$7,602	8,019
Net adjusted Federal share[3]	$7,580	$8,048

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

Sources: CMS, Center for Medicaid and State Operations

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	2004	2005	2006
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Maximum taxable amount (CY 2006) None[1]

Voluntary HI Premium[2]

Monthly Premium (CY 2006): $393

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 2006): $88.50

Medicaid/financing

1. Federal contributions (ranging from 50 to 76 percent for fiscal year 2006)
2. State contributions (ranging from 24 to 50 percent for fiscal year 2006)

[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 $216 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 (1/1/06)	$952/benefit period
Regular coinsurance days (1/1/06)	$238/day for 61st thru 90th day
Lifetime reserve days (1/1/06)	$476/day (60 nonrenewable days)
SNF coinsurance days (1/1/06)	$119/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/06)	$393/month $216/month if have at least 30 quarters of coverage
Limitations:	
Inpatient psychiatric hospital days	190 nonrenewable days
Part B (effective date)	**Amount**
Deductible (1/1/06)[1]	$124 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Premium (1/1/06)	$88.50/month
Limitations:	
Outpatient treatment for mental illness	No limitations

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

SOURCE: CMS, Office of the Actuary.

Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2006

I.	Boston	FMAP
	Connecticut	50.00
	Maine	62.90
	Massachusetts	50.00
	New Hampshire	50.00
	Rhode Island	54.45
	Vermont	58.49
III.	Philadelphia	
	Delaware	50.09
	Dist. of Columbia	70.00
	Maryland	50.00
	Pennsylvania	55.05
	Virginia	50.00
	West Virginia	72.99
V.	Chicago	
	Illinois	50.00
	Indiana	62.98
	Michigan	56.59
	Minnesota	50.00
	Ohio	59.88
	Wisconsin	57.65
VII.	Kansas City	
	Iowa	63.61
	Kansas	60.41
	Missouri	61.93
	Nebraska	59.68
IX.	San Francisco	
	Arizona	66.98
	California	50.00
	Hawaii	58.81
	Nevada	54.76
	American Samoa	50.00
	Guam	50.00
	N. Mariana Islds	50.00

II.	New York	FMAP
	New Jersey	50.00
	New York	50.00
	Puerto Rico	50.00
	Virgin Islands	50.00
	Canada	--
IV.	Atlanta	
	Alabama	69.51
	Florida	58.89
	Georgia	60.60
	Kentucky	69.26
	Mississippi	76.00
	North Carolina	63.49
	South Carolina	69.32
	Tennessee	63.99
VI.	Dallas	
	Arkansas	73.77
	Louisiana	69.79
	New Mexico	71.15
	Oklahoma	67.91
	Texas	60.66
VIII.	Denver	
	Colorado	50.00
	Montana	70.54
	North Dakota	65.85
	South Dakota	65.07
	Utah	70.76
	Wyoming	54.23
X.	Seattle	
	Alaska	50.16/57.58
	Idaho	69.91
	Oregon	61.57
	Washington	50.00

SOURCE: CMS, Center for Medicaid and State Operations.