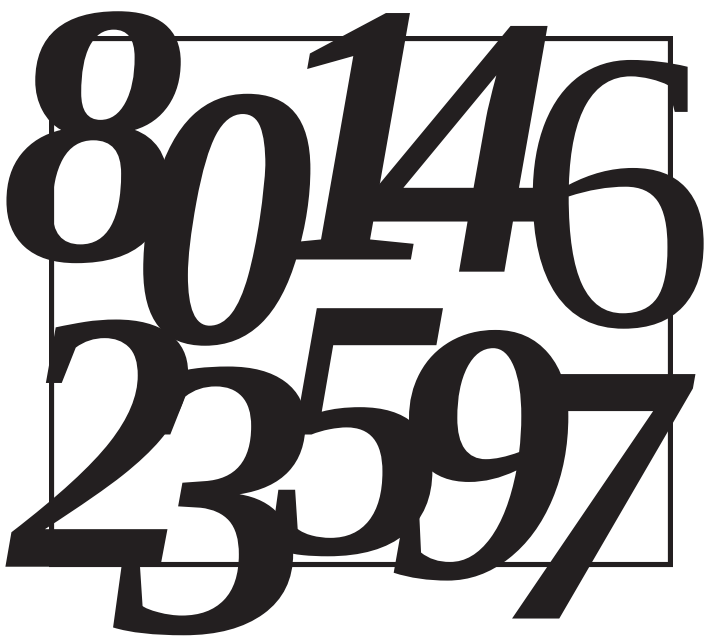
# *2007 CMS Statistics*

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HEALTH AND HUMAN SERVICES

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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:

**Glossary of Acronyms for Data Source Attribution**

| | |
|---|---|
| CMM | Center for Medicare Management |
| CMS | Centers for Medicare & Medicaid Services |
| CMSO | Center for Medicaid and State Operations |
| HCFA | Health Care Financing Administration |
| OACT | Office of the Actuary |
| OFM | Office of Financial Management |
| ORDI | Office of Research, Development, and Information |
| SSA | Social Security Administration |

# *Highlights*

**Growth in CMS programs and health expenditures**

**Populations**

- Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 43.9 million in 2007, a 130 percent increase.
- On average, the number of Medicaid monthly enrollees in 2007 is estimated to be about 48.1 million, the largest group being children (23.5 million or 48.9 percent).
- In 2004, about 20.0 percent of the population was at some point enrolled in the Medicaid program.
- Medicare enrollees with end-stage renal disease increased from 66.7 thousand in 1980 to 432.8 thousand in 2006, an increase of 549 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 7.1 million beneficiaries in 2006, an increase of about 154 percent.

- About 7.3 million persons on average were dually eligible for both Medicare and Medicaid in FY 2004.

**Providers/Suppliers**

- The number of inpatient hospital facilities decreased from 6,770 in December 1975 to 6,177 in December 2006. Total inpatient hospital beds have dropped from 46.5 beds per 1,000 enrolled in 1975 to 21.8 in 2006, a decrease of 53 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 about 803,000. (NOTE: This includes a reclassification of some short-stay hospitals as critical access hospitals. There were about 29,000 critical access hospital beds in 2006.)
- 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 remains currently at this level.
- The number of participating home health agencies has fluctuated considerably over the years, almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed. The number decreased sharply but has since stabilized, reaching 8,618 in 2006.

**Expenditures**

- National health expenditures (NHE) were $1,987.7 billion in 2005, comprising 16.0 percent of the gross domestic product (GDP). Comparably, NHE amounted to $1,858.9 billion, or 15.9 percent of the GDP in 2004.

- In 2006, total net Federal outlays for CMS programs were $517.3 billion, 19.5 percent of the Federal budget.

- Medicare skilled nursing facility benefit payments increased slightly from $17.6 billion in 2005 to about $21.0 billion in 2007.

- Medicare home health agency benefit payments increased slightly between 2006 and 2007 from $12.6 billion to $14.2 billion.

- National health expenditures per person were $205 in 1965 and grew steadily to reach $6,697 by 2005.

**Utilization of Medicare and Medicaid services**

- Between 1990 and 2005, the number of short-stay hospital discharges increased from 10.5 million to 13.0 million, an increase of 24 percent.

- The short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.7 days in 2005, a decrease of 37 percent. Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 11.5 days in 2005, a decrease of 41 percent.

- About 33.0 million persons received a reimbursed

service under Medicare fee-for-service during 2005. Comparably, almost 56 million persons used Medicaid services or had a premium paid on their behalf in 2004.

- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 923 per 1,000 enrolled in 2004.

- 7.7 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2005.

- 32.7 million persons received reimbursable fee-for-service physician services under Medicare during 2005. 23.9 million persons received reimbursable physician services under Medicaid during 2004.

- 24.4 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2005. During 2004, 15.9 million persons received Medicaid reimbursable outpatient hospital services.

- Nearly 1.8 million persons received care in SNFs covered by Medicare during 2005. 1.7 million persons received care in nursing facilities, which include SNFs and all other nursing facilities other than mentally retarded, covered by Medicaid during 2004.

- Nearly 28.0 million persons received prescribed drugs under Medicaid during 2004

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# *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 | 6.5 |
| 2005 | 42.6 | 35.8 | 6.8 |
| 2006 | 43.2 | 36.3 | 7.0 |
| 2007 | 43.9 | 36.8 | 7.1 |

NOTES: Represents those enrolled in HI (Part A) and/or SMI (Part B and Part D) of Medicare. Data for 1966-1995 are as of July. Data for 1999-2007 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on FY 2008 President's Budget.

SOURCE: CMS, Office of the Actuary.

**Table 2**
**Medicare enrollment/coverage**

| | HI and/or SMI | HI | SMI | | HI and SMI | HI only | SMI only |
|---|---|---|---|---|---|---|---|
| | | | Part B | Part D | | | |
| | | | In millions | | | | |
| All persons | 43.8 | 43.4 | 40.6 | 30.4 | 40.2 | 3.1 | 0.4 |
| Aged persons | 36.7 | 36.3 | 34.4 | -- | 34.0 | 2.3 | 0.4 |
| Disabled persons | 7.1 | 7.1 | 6.3 | -- | 6.3 | 0.8 | ([1]) |

[1]Number less than 500.

NOTE: Projected average monthly enrollment during fiscal year 2007. Aged/disabled split of Part D not available. Based on FY 2008 President's Budget.

SOURCE: CMS, Office of the Actuary.

**Table 3**
**Medicare enrollment/demographics**

| | Total | Male | Female |
|---|---|---|---|
| | | In thousands | |
| All persons | 43,339 | 19,140 | 24,198 |
| Aged | 36,317 | 15,395 | 20,922 |
| 65-74 years | 18,596 | 8,631 | 9,965 |
| 75-84 years | 12,769 | 5,230 | 7,539 |
| 85 years and over | 4,951 | 1,534 | 3,417 |
| Disabled | 7,022 | 3,745 | 3,277 |
| Under 45 years | 1,798 | 985 | 813 |
| 45-54 years | 2,192 | 1,171 | 1,021 |
| 55-64 years | 3,032 | 1,590 | 1,442 |
| White | 36,235 | 16,007 | 20,228 |
| Black | 4,320 | 1,841 | 2,479 |
| All Other | 2,708 | 1,265 | 1,443 |
| Native American | 180 | 81 | 99 |
| Asian/Pacific | 760 | 329 | 431 |
| Hispanic | 1,046 | 490 | 556 |
| Other | 722 | 365 | 357 |
| Unknown Race | 76 | 28 | 48 |

NOTES: Data as of July 1, 2006. 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 |
| 2003[1] | 350.1 | 347.3 | 332.3 |
| 2004[1] | 359.4 | 359.3 | 341.2 |
| 2005[1] | 371.2 | 371.1 | 351.9 |
| 2006[1] | 432.8 | 385.2 | 365.0 |

[1]Denominator File; estimated person years.

NOTES: Data prior to 2000 are as of July 1; estimated person years 2000-2006.
SOURCE: CMS, Office of Research, Development, and Information.

**Table 5**
**Medicare enrollment/end stage renal disease demographics**

| | Number of enrollees (in thousands) |
|---|---|
| All persons | 432.8 |
| Age | |
| Under 35 years | 27.7 |
| 35-44 years | 41.3 |
| 45-64 years | 169.1 |
| 65 years and over | 194.7 |
| Sex | |
| Male | 241.1 |
| Female | 191.7 |
| Race | |
| White | 236.4 |
| Other | 194.4 |
| Unknown | 2.1 |

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2006.

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

**Table 6**
**Medicare advantage, cost, PACE, demo & prescription drug**

| | Number of Contracts | MA only | Drug Plan | Total |
|---|---|---|---|---|
| | | (Enrollees in thousands) | | |
| Total prepaid[1] | 604 | 1,376 | 7,132 | 8,509 |
| Local CCPs | 410 | 419 | 5,706 | 6,125 |
| PFFS | 47 | 571 | 914 | 1,484 |
| Demos | 38 | 2 | 212 | 214 |
| 1876 Cost | 27 | 147 | 160 | 307 |
| 1833 Cost (HCPP) | 13 | 78 | -- | 78 |
| PACE | 37 | -- | 13 | 13 |
| Other plans[2] | 32 | 159 | 128 | 287 |
| Total PDPs[1] | 101 | -- | 16,926 | 16,926 |
| Total | 705 | 1,376 | 24,058 | 25,435 |

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

NOTE: Data as of April 7, 2007.

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 | 296,410 | 42,356 | 14.3 |
| Boston | 14,240 | 2,224 | 15.6 |
| New York | 27,973 | 4,047 | 14.5 |
| Philadelphia | 28,809 | 4,449 | 15.4 |
| Atlanta | 57,416 | 9,025 | 15.7 |
| Chicago | 51,289 | 7,478 | 14.6 |
| Dallas | 35,639 | 4,565 | 12.8 |
| Kansas City | 13,270 | 2,095 | 15.8 |
| Denver | 9,993 | 1,241 | 12.4 |
| San Francisco | 45,761 | 5,582 | 12.2 |
| Seattle | 12,022 | 1,654 | 13.8 |

[1]Estimated July 1, 2005 resident population.
[2]Medicare denominator enrollment file data are as of July 1, 2006.

NOTES: Resident population is a provisional estimate. The 2005 resident population data for Outlying Areas, Puerto Rico, and the Virgin Islands are not available. Numbers may not add to totals because of rounding.

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 |
| 2100[1] | 21.4 | 23.7 |

[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 |
| 1990 | 75.4 | 76.1 | 69.1 |
| 1995 | 75.8 | 76.5 | 69.6 |
| 2000 | 77.0 | 77.6 | 71.9 |
| 2004 | 77.8 | 78.3 | 73.1 |
| | | At Age 65 | |
| 1950 | 13.9 | NA | 13.9 |
| 1980 | 16.4 | 16.5 | 15.1 |
| 1990 | 17.2 | 17.3 | 15.4 |
| 1995 | 17.4 | 17.6 | 15.6 |
| 2000 | 18.0 | 18.0 | 16.2 |
| 2004 | 18.7 | 18.7 | 17.1 |

SOURCE: Public Health Service, Health United States, 2006.

**Table 11**
**Medicaid and SCHIP enrollment**

| | Fiscal year | | | | | |
|---|---|---|---|---|---|---|
| | 1990 | 1995 | 2000 | 2005 | 2006 | 2007 |
| | Average monthly enrollment in millions | | | | | |
| Total | 22.9 | 33.4 | 33.6 | 45.4 | 46.9 | 48.1 |
| Age 65 years and over | 3.1 | 3.7 | 3.7 | 4.6 | 4.9 | 5.0 |
| Blind/Disabled | 3.8 | 5.8 | 6.7 | 8.0 | 8.3 | 8.5 |
| Children | 10.7 | 16.5 | 16.2 | 22.2 | 22.9 | 23.5 |
| Adults | 4.9 | 6.7 | 6.9 | 10.5 | 10.8 | 11.1 |
| Other Title XIX | 0.5 | 0.6 | NA | NA | NA | NA |
| SCHIP | NA | NA | 2.1 | 4.3 | 4.4 | 4.2 |
| | Unduplicated annual enrollment in millions | | | | | |
| Total | NA | 42.5 | 43.3 | 57.4 | 59.4 | 60.9 |
| Age 65 years and over | NA | 4.4 | 4.3 | 5.6 | 5.6 | 6.0 |
| Blind/Disabled | NA | 6.5 | 7.5 | 8.9 | 9.3 | 9.5 |
| Children | NA | 21.3 | 20.9 | 27.7 | 28.5 | 29.2 |
| Adults | NA | 9.4 | 10.6 | 15.3 | 15.8 | 16.2 |
| Other Title XIX | NA | 0.9 | NA | NA | NA | NA |
| SCHIP | NA | NA | 3.3 | 6.8 | 6.9 | 6.7 |

NOTES: Some totals for 1990 and later years may not equal the sum of categories because of 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. Medicaid enrollment excludes Medicaid expansion SCHIP programs. SCHIP numbers include adults covered under waivers. Projections for fiscal years 2005-2007 were prepared by the Office of the Actuary for the President's 2008 Budget.

In 1997, the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories. Medicaid data after 2000 exclude enrollees in outlying territories and possessions. Some totals for territories not included in Medicaid numbers.

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

**Table 12**
**Medicaid eligibles/demographics**

| | Fiscal year 2004 Medicaid eligibles | Percent distribution |
|---|---|---|
| | In millions | |
| Total eligibles | 58.2 | 100.0 |
| Age | 58.2 | 100.0 |
| Under 21 | 31.4 | 54.0 |
| 21-64 years | 20.7 | 35.6 |
| 65 years and over | 6.0 | 10.3 |
| Unknown | 0.1 | 0.2 |
| Sex | 58.2 | 100.0 |
| Male | 23.6 | 40.5 |
| Female | 34.5 | 59.3 |
| Unknown | 0.1 | 0.2 |
| Race | 58.2 | 100.0 |
| White, not Hispanic | 25.4 | 43.6 |
| Black, not Hispanic | 13.4 | 23.0 |
| Am. Indian/Alaskan Native | 0.8 | 1.4 |
| Asian | 1.5 | 2.6 |
| Hawaiian/Pacific Islander | 0.5 | 0.9 |
| Hispanic | 12.8 | 22.0 |
| Other | ([1]) | -- |
| Unknown | 3.6 | 6.2 |

[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 | 293,638 | 58,161 | 19.8 |
| Boston | 14,242 | 2,485 | 17.4 |
| New York | 27,968 | 5,878 | 21.0 |
| Philadelphia | 28,622 | 4,257 | 14.9 |
| Atlanta | 56,464 | 11,886 | 21.1 |
| Chicago | 51,084 | 8,721 | 17.1 |
| Dallas | 35,185 | 6,886 | 19.6 |
| Kansas City | 13,192 | 2,210 | 16.8 |
| Denver | 9,858 | 1,210 | 12.3 |
| San Francisco | 45,178 | 12,494 | 27.7 |
| Seattle | 11,847 | 2,134 | 18.0 |

[1]Estimated July 1, 2004 population. [2]Persons ever enrolled in Medicaid during fiscal year 2004.

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] | 2005[2] | 2006[2] |
|---|---|---|---|---|
| Type of Beneficiary | | In thousands | | |
| All buy-ins | 2,846 | 2,954 | 6,845 | 7,115 |
| Aged | 2,483 | 2,449 | 4,226 | 4,353 |
| Disabled | 363 | 504 | 2,619 | 2,763 |
| | | Percent of SMI enrollees | | |
| All buy-ins | 12.0 | 10.9 | 17.3 | 17.6 |
| Aged | 11.4 | 10.0 | 12.5 | 12.7 |
| Disabled | 18.7 | 18.9 | 45.1 | 45.6 |

[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 | 2005 | 2006 |
|---|---|---|---|---|
| Total hospitals | 6,522 | 6,376 | 6,180 | 6,177 |
| Beds in thousands | 1,105 | 1,056 | 947 | 939 |
| Beds per 1,000 enrollees[1] | 32.8 | 28.4 | 22.5 | 21.8 |
| Short-stay | 5,549 | 5,252 | 3,790 | 3,702 |
| Beds in thousands | 970 | 926 | 812 | 803 |
| Beds per 1,000 enrollees[1] | 28.8 | 24.9 | 19.3 | 18.7 |
| Critical access hospitals | NA | NA | 1,217 | 1,284 |
| Beds in thousands | --- | --- | 28 | 29 |
| Beds per 1,000 enrollees[1] | --- | --- | 0.7 | 0.7 |
| Other non-short-stay | 973 | 1,124 | 1,173 | 1,191 |
| Beds in thousands | 135 | 130 | 107 | 107 |
| Beds per 1,000 enrollees[1] | 1.0 | 1.2 | 2.5 | 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 | | |
|---|---|---|---|
| | 2004 | 2005 | 2006 |
| All regions | 98.7 | 98.8 | 99.0 |
| Boston | 99.9 | ([1]) | ([1]) |
| New York | 98.8 | 98.8 | 98.8 |
| Philadelphia | 99.0 | 99.2 | 99.4 |
| Atlanta | 98.3 | 98.6 | 99.1 |
| Chicago | 98.3 | 98.6 | 98.7 |
| Dallas | 98.7 | 98.8 | 99.1 |
| Kansas City | 98.3 | 98.6 | 98.8 |
| Denver | 97.8 | 98.1 | 98.3 |
| San Francisco | 99.3 | 99.3 | 99.3 |
| Seattle | 95.2 | 96.7 | 97.2 |

[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 participating hospitals | 6,176 |
| Short-term hospitals | 3,708 |
| Psychiatric units | 1,284 |
| Rehabilitation units | 998 |
| Swing bed units | 573 |
| Psychiatric | 480 |
| Long-term | 391 |
| Rehabilitation | 217 |
| Childrens | 81 |
| Religious non-medical | 16 |
| Critical access | 1,283 |
| Non-participating Hospitals | 768 |
| Emergency | 418 |
| Federal | 350 |
| All SNFs/SNF-NFs/NFs only | 15,890 |
| All skilled nursing facilities | 15,042 |
| SNFs | 836 |
| Hospital-based | 389 |
| Free-standing | 447 |
| SNF/NFs combination | 14,206 |
| Hospital-based | 804 |
| Free-standing | 13,402 |
| Title 19 only NFs | 848 |
| Hospital-based | 143 |
| Free-standing | 705 |
| All ICF-MR facilities | 6,456 |

NOTES: The table is designed to give a "snapshot" as of the end of April 2007 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] | 15,028 | 877 | 6,454 |
| Boston | 1,003 | 18 | 154 |
| New York | 1,014 | 2 | 603 |
| Philadelphia | 1,366 | 56 | 433 |
| Atlanta | 2,620 | 73 | 658 |
| Chicago | 3,287 | 207 | 1,517 |
| Dallas | 1,919 | 160 | 1,563 |
| Kansas City | 1,352 | 197 | 189 |
| Denver | 582 | 51 | 89 |
| San Francisco | 1,428 | 83 | 1,168 |
| Seattle | 447 | 30 | 80 |

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

NOTE: Data as of December 2006.

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

**Table 19**
**Other Medicare providers and suppliers/trends**

| | 1975 | 1980 | 2005 | 2006 |
|---|---|---|---|---|
| Home health agencies | 2,242 | 2,924 | 8,090 | 8,618 |
| Independent and Clinical Lab Improvement Act Facilities | NA | NA | 196,296 | 199,817 |
| End stage renal disease facilities | NA | 999 | 4,755 | 4,892 |
| Outpatient physical therapy and/or speech patholgy | 117 | 419 | 2,962 | 3,009 |
| Portable X-ray | 132 | 216 | 553 | 549 |
| Rural health clinics | NA | 391 | 3,661 | 3,723 |
| Comprehensive outpatient rehabilitation facilities | NA | NA | 634 | 589 |
| Ambulatory surgical centers | NA | NA | 4,445 | 4,707 |
| Hospices | NA | NA | 2,872 | 3,071 |

NOTES: Facility data for selected years 1975 and 1980 are as of July 1. Facility data for 2005 and 2006 are as of December 31.

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 | 3,702 | 15,028 | 8,618 |
| | | Percent of total | |
| Non-profit | 59.7 | 27.4 | 24.6 |
| Proprietary | 20.6 | 67.6 | 65.2 |
| Government | 19.7 | 5.0 | 10.2 |

NOTES: Data as of December 31, 2006. 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 | 2005 | 2006 |
|---|---|---|---|---|---|
| Hospitals | | | | | |
| Number of PIP | 2,276 | 3,242 | 657 | 671 | 639 |
| Percent of total participating | 33.8 | 48.3 | 10.9 | 10.9 | 10.3 |
| Skilled nursing facilities | | | | | |
| Number of PIP | 203 | 224 | 1,001 | 847 | 837 |
| Percent of total participating | 3.9 | 3.4 | 6.7 | 5.6 | 5.6 |
| Home health agencies | | | | | |
| Number of PIP | 481 | 931 | 44 | 59 | 90 |
| Percent of total participating | 16.0 | 16.0 | 0.1 | 0.1 | 1.0 |

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**

| | March 2007 | |
|---|---|---|
| | Number | Percent |
| All Part B Practitioners | 1,075,571 | 100.0 |
| Physician Specialties | 660,819 | 61.4 |
| Primary Care | 243,687 | 22.7 |
| Medical Specialties | 107,528 | 10.0 |
| Surgical Specialties | 107,283 | 10.0 |
| Emergency Medicine | 36,118 | 3.4 |
| Anesthesiology | 38,046 | 3.5 |
| Radiology | 37,225 | 3.5 |
| Pathology | 13,859 | 1.3 |
| Obstetrics/Gynecology | 38,258 | 3.6 |
| Psychiatry | 38,526 | 3.6 |
| Other and Unknown | 289 | 0.0 |
| Limited Licensed Practitioners | 124,640 | 11.6 |
| Non-physician Practitioners | 290,112 | 27.0 |

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 | Practitioners per 100,000 population |
|---|---|---|
| All regions | [1]1,226,327 | 414 |
| Boston | 95,316 | 669 |
| New York | 145,680 | 457 |
| Philadelphia | 130,492 | 453 |
| Atlanta | 218,627 | 381 |
| Chicago | 208,189 | 406 |
| Dallas | 116,451 | 327 |
| Kansas City | 61,934 | 467 |
| Denver | 45,527 | 456 |
| San Francisco | 149,235 | 326 |
| Seattle | 54,876 | 456 |

[1]Non-Federal physicians only. Includes limited licensed, non-physician practitioners. Unduplicated count (may include practitioners practicing in multiple sites or States). Unknown provider States distributed. NOTES: Physicians as of March 2007. Civilian population as of July 1, 2005. Resident population for outlying areas and the Virgin Islands are not available.

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 | 4,986 | 19.4 | 1,191 | 2.5 |
| Boston | 193 | 14.8 | 70 | 4.7 |
| New York | 337 | 21.4 | 75 | 2.8 |
| Philadelphia | 376 | 17.0 | 129 | 3.0 |
| Atlanta | 941 | 19.6 | 205 | 2.0 |
| Chicago | 875 | 20.9 | 187 | 2.1 |
| Dallas | 774 | 22.1 | 310 | 4.0 |
| Kansas City | 470 | 23.5 | 54 | 2.0 |
| Denver | 309 | 20.4 | 38 | 2.7 |
| San Francisco | 500 | 17.6 | 101 | 1.5 |
| Seattle | 211 | 14.1 | 22 | 1.6 |

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2006. Rates based on number of hospital insurance enrollees as of July 1, 2006.

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 2005 | Fiscal year 2006 |
|---|---|---|
| | $ in billions | |
| Gross domestic product (current dollars) | $12,290.4 | $13,061.1 |
| Total Federal outlays[1] | 2,472.2 | 2,655.4 |
| Percent of gross domestic product | 20.1 | 20.3 |
| Dept. of Health and Human Services[1] | 581.5 | 614.3 |
| Percent of Federal Budget | 23.5 | 23.1 |
| CMS Budget (Federal Outlays) | | |
| Medicare benefit payments | 333.2 | 375.2 |
| SMI transfer to Medicaid[2] | 0.2 | 0.3 |
| Medicaid benefit payments | 173.3 | 171.5 |
| Medicaid State and local admin. | 8.4 | 9.1 |
| Medicaid offsets[3] | -0.2 | -0.3 |
| State Children's Health Ins. Prog. | 5.1 | 5.5 |
| CMS program management | 3.1 | 3.3 |
| Other Medicare admin. expenses[4] | 1.8 | 1.9 |
| State Eligibility Determinations, for Part D | 0.1 | 0.0 |
| Quality improvement organizations[5] | 0.4 | 0.4 |
| Health Care Fraud and Abuse Control | 1.1 | 1.1 |
| State Grants and Demonstrations[6] | 0.1 | 1.3 |
| User Fees and Reimbursables | 0.1 | 0.2 |
| Total CMS outlays (unadjusted) | 526.6 | 569.4 |
| Offsetting receipts[7] | -40.8 | -52.1 |
| Total net CMS outlays | 485.9 | 517.3 |
| Percent of Federal budget | 19.7 | 19.5 |

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($242.3 million in FY 2005 and $264.2 million in FY 2006).
[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 $84 million in FY 2005. The significant FY 2006 increase primarily reflects Katrina hurricane relief outlays.
[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 |
| 2005 | 664.0 | 339.4 | 317.2 | 7.4 |
| 2006 | 707.5 | 381.8 | 316.7 | 9.0 |

[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, since 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 | 2005 | 2006 |
|---|---|---|---|---|
| Annually | | Amounts in billions | | |
| CMS program outlays | $5.1 | $8.4 | $642 | $684 |
| Federal outlays | NA | 6.7 | 512 | 552 |
| Medicare[1] | 3.2 | 5.1 | 333 | 375 |
| HI | 2.5 | 3.7 | 183 | 184 |
| SMI | 0.7 | 1.4 | 150 | 159 |
| Transitional Assistance[2] | NA | NA | 1 | 0 |
| Presciption (Part D) | NA | NA | NA | 32 |
| Medicaid[3] | 1.9 | 3.3 | 302 | 300 |
| Federal share | NA | 1.6 | 173 | 171 |
| SCHIP[4] | NA | NA | 7 | 9 |
| 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 transitional Prescription Drug Card program, begun in the the third quarter of FY 2004 under the Medicare Modernization Act of 2003 (P.L. 108-173), was terminated in FY 2006 as it was replaced by Medicare Part D. Its FY 2006 benefit outlays totalled $229 million. [3]The Medicaid amounts include total computable outlays (Federal and State shares) for benefits and outlays for the Vaccines for Children program. [4]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.

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 | $300,724 | $172,071 |
| Boston | 19,602 | 10,323 |
| New York | 51,292 | 25,703 |
| Philadelphia | 29,632 | 16,272 |
| Atlanta | 52,455 | 33,881 |
| Chicago | 46,526 | 26,109 |
| Dallas | 30,464 | 20,118 |
| Kansas City | 12,251 | 7,545 |
| Denver | 6,356 | 3,883 |
| San Francisco | 41,642 | 22,257 |
| Seattle | 10,504 | 5,980 |

[1]Fiscal year 2005 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 | | |
|---|---|---|---|
| | 2005 | 2006 | 2007 |
| | In billions | | |
| HI benefit payments | $181.0 | $181.5 | $202.5 |
| Aged | 155.1 | 154.4 | 171.8 |
| Disabled | 25.9 | 27.1 | 30.7 |
| SMI benefit payments | 148.4 | 158.0 | 173.9 |
| Aged | 123.7 | 131.3 | 144.4 |
| Disabled | 24.7 | 26.8 | 29.5 |
| Part D | 1.1 | 34.6 | 54.2 |

NOTES: Based on FY 2008 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 2007 benefit payments[1] in millions | Percent distribution |
|---|---|---|
| Total HI[2] | $202,545 | 100.0 |
| Inpatient hospital | 125,510 | 62.0 |
| Skilled nursing facility | 20,965 | 10.4 |
| Home health agency[3] | 6,442 | 3.2 |
| Hospice | 9,694 | 4.8 |
| Managed care | 39,934 | 19.7 |
| Total SMI[2] | 173,895 | 100.0 |
| Physician/other suppliers | 59,503 | 34.2 |
| DME | 8,563 | 4.9 |
| Other carrier | 16,809 | 9.7 |
| Outpatient hospital | 23,626 | 13.6 |
| Home health agency[3] | 7,709 | 4.4 |
| Other intermediary | 14,141 | 8.1 |
| Laboratory | 7,135 | 4.1 |
| Managed care | 36,409 | 20.9 |
| Total Part D | 49,174 | 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 2008 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 | 2005 |
| National total in billions | $41.0 | $253.9 | $1,353.3 | $1,987.7 |
| Percent of GDP | 5.7 | 9.1 | 13.8 | 16.0 |
| Per capita amount | $205 | $1,102 | $4,790 | $6,697 |
| Source of funds | | Percent of total | | |
| Private | 75.1 | 58.1 | 55.9 | 54.6 |
| Public | 24.9 | 41.9 | 44.1 | 45.4 |
| Federal | 11.4 | 28.2 | 30.9 | 32.4 |
| State/local | 13.5 | 13.7 | 13.2 | 13.0 |

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 | | |
|---|---|---|---|
| | 2003 | 2004 | 2005 |
| | In billions | | |
| Total medical assistance payments[1] | $262.6 | $281.8 | $300.7 |
| | Percent of total | | |
| Inpatient services | 14.1 | 14.8 | 14.5 |
| General hospitals | 12.7 | 13.7 | 13.6 |
| Mental hospitals | 1.3 | 1.1 | 0.9 |
| Nursing facility services | 17.0 | 16.1 | 15.7 |
| Intermediate care facility (MR) services | 4.4 | 4.1 | 4.0 |
| Community-based long term care svs.[2] | 10.6 | 10.8 | 11.2 |
| Prescribed drugs[3] | 10.3 | 10.8 | 10.3 |
| Physician services | 3.7 | 4.1 | 4.1 |
| Dental services | 1.2 | 1.1 | 1.2 |
| Outpatient hospital services | 3.8 | 4.1 | 4.1 |
| Clinic services[4] | 2.8 | 2.8 | 3.0 |
| Laboratory and radiological services | 0.3 | 0.4 | 0.4 |
| Early and periodic screening | 0.4 | 0.4 | 0.4 |
| Targeted case management services | 1.1 | 1.0 | 0.9 |
| Capitation payments (non-Medicare) | 17.2 | 16.4 | 16.8 |
| Medicare premiums | 2.1 | 2.3 | 2.6 |
| Disproportionate share hosp. payments | 4.9 | 5.5 | 5.2 |
| Other services | 5.8 | 4.5 | 4.8 |
| Adjustments[5] | 0.3 | 0.9 | 0.8 |

[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 |
|---|---|---|---|---|---|---|
| 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 |
| 2006 | 93.1 | 2,980.6 | 298.6 | 243.7 | 2,033.7 | 6,088.6 |

NOTES: Fiscal year data. In millions of dollars. FYs 2004 through 2006 totals include liability amounts of $280.6, $325.0, and $410.3 million, respectively.

SOURCE: CMS, OFM.

**Table 34**
**Medicaid/payments by eligibility status**

| | Fiscal year 2005 Medical assistance payments | Percent distribution |
|---|---|---|
| | In billions | |
| Total[1] | $300.7 | 100.0 |
| Age 65 years and over | 69.8 | 23.2 |
| Blind/disabled | 125.7 | 41.8 |
| Dependent children under 21 years of age | 50.9 | 16.9 |
| Adults in families with dependent children | 35.2 | 11.7 |
| DSH and other unallocated | 19.2 | 6.4 |

[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] | |
|---|---|---|
| | 2004 | 2005 |
| | In thousands | |
| Total | $10,095,221 | $10,205,304 |
| Medical/surgical supplies | 137,162 | 176,943 |
| Hospital beds | 370,434 | 319,279 |
| Oxygen and supplies | 2,669,003 | 2,679,455 |
| Wheelchairs | 1,434,402 | 1,554,703 |
| Prosthetic/orthotic devices | 1,729,111 | 1,605,247 |
| Drugs admin. through DME | 1,308,947 | 799,140 |
| Other DME | 2,446,163 | 3,070,537 |

[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.

NOTE: Over time, the composition of BETOS categories has changed with the re-assignment of selected procedures, services and supplies.

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 | $1,987.7 | $6,697 | 32.9 | 17.2 | 15.6 |
| Health serv/suppl. | 1,860.9 | 6,270 | 35.1 | 18.4 | 16.7 |
| Personal health care | 1,661.4 | 5,598 | 37.4 | 19.9 | 17.4 |
| Hospital care | 611.6 | 2,061 | 46.8 | 29.5 | 17.3 |
| Prof. services | 621.7 | 2,095 | 22.3 | 16.3 | 6.1 |
| Phys./clinical | 421.2 | 1,419 | 28.3 | 21.2 | 7.1 |
| Nursing/home hlth. | 169.3 | 570 | 53.5 | 21.9 | 31.6 |
| Retail outlet sales | 258.8 | 872 | 16.0 | 1.5 | 14.4 |
| Admn. and pub. hlth. | 199.5 | 672 | 16.2 | 5.3 | 10.9 |
| Investment | 126.8 | 427 | -- | -- | -- |

NOTES: Data are as of calendar year 2005.

SOURCE: CMS, Office of the Actuary.

**Table 37**
**Personal health care/payment source**

| | Calendar year | | | |
|---|---|---|---|---|
| | 1980 | 1990 | 2000 | 2005 |
| | In billions | | | |
| Total | $215.3 | $607.5 | $1,139.9 | $1,661.4 |
| | Percent | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |
| Private funds | 60.0 | 61.1 | 57.3 | 55.0 |
| Private health insurance | 28.4 | 33.7 | 35.4 | 35.9 |
| Out-of-pocket | 27.2 | 22.4 | 16.9 | 15.0 |
| Other private | 4.3 | 5.0 | 5.0 | 4.1 |
| Public funds | 40.0 | 38.9 | 42.7 | 45.0 |
| Federal | 28.9 | 28.4 | 32.5 | 34.2 |
| State and local | 11.1 | 10.4 | 10.2 | 10.7 |

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 | 2004 | 2005 |
|---|---|---|---|---|
| Discharges | | | | |
| Total in millions | 10.5 | 10.5 | 13.0 | 13.0 |
| Rate per 1,000 enrollees[1] | 347 | 320 | 364 | 361 |
| Days of care | | | | |
| Total in millions | 92 | 94 | 75 | 75 |
| Rate per 1,000 enrollees[1] | 3,016 | 2,866 | 2,110 | 2,073 |
| Average length of stay | | | | |
| All short-stay | 8.7 | 9.0 | 5.8 | 5.7 |
| Excluded units[2] | 18.8 | 19.5 | 11.5 | 11.5 |
| Total charges per day | $597 | $1,060 | $4,458 | $4,882 |

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

NOTES: Data may reflect underreporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; no-pay Medicare secondary payer bills; and for certain years, discharges where the beneficiary received services out of State. The data for 1990 through 2005 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 | 1,233 | 37 | 3,468 | 103 |
| 2000 | 1,468 | [1]45 | 2,634 | [1]84 |
| 2002 | 1,622 | [1]47 | 2,672 | [1]79 |
| 2004 | 1,752 | [1]49 | 2,966 | [1]85 |
| 2005 | 1,847 | [1]51 | 3,122 | [1]85 |

[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 | 2004 | 2005 |
| All short-stay hospitals | 9.1 | 9.0 | 7.1 | 6.0 | 5.8 | 5.7 |
| PPS hospitals | 8.0 | 8.9 | 7.1 | 6.0 | 5.8 | 5.7 |
| Excluded units | 18.0 | 19.5 | 14.8 | 12.3 | 11.5 | 11.6 |

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 2005 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 | 1985 | 1995 | 2000 | 2004 | 2005 |
| Aged persons served per 1,000 enrollees | | | | | | |
| HI and/or SMI | 528 | 722 | 826 | 916 | 919 | 923 |
| HI | 221 | 219 | 218 | 232 | 231 | 234 |
| SMI | 536 | 739 | 858 | 965 | 972 | 979 |
| Disabled persons served per 1,000 enrollees | | | | | | |
| HI and/or SMI | 450 | 669 | 759 | 835 | 856 | 865 |
| HI | 219 | 228 | 212 | 196 | 203 | 205 |
| SMI | 471 | 715 | 837 | 943 | 965 | 977 |

NOTES: Prior to 2000, data were obtained from the Annual Person Summary Record and were not yet modified to exclude persons enrolled in managed care. Beginning in 2000, 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 | | | | |
|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 |
| | Numbers in millions | | | | |
| HI | | | | | |
| Aged | | | | | |
| FFS Enrollees | 28.3 | 29.1 | 29.7 | 30.0 | 30.0 |
| Persons served | 6.7 | 6.3 | 6.9 | 6.9 | 7.0 |
| Rate per 1,000 | 233 | 232 | 231 | 231 | 234 |
| Disabled | | | | | |
| FFS Enrollees | 5.2 | 5.4 | 5.7 | 6.0 | 6.3 |
| Persons served | 1.0 | 1.1 | 1.2 | 1.2 | 1.3 |
| Rate per 1,000 | 199 | 202 | 203 | 203 | 205 |
| SMI | | | | | |
| Aged | | | | | |
| FFS Enrollees | 27.0 | 27.8 | 28.3 | 28.4 | 28.4 |
| Persons served | 26.1 | 26.9 | 27.4 | 27.6 | 27.8 |
| Rate per 1,000 | 968 | 968 | 970 | 972 | 979 |
| Disabled | | | | | |
| FFS Enrollees | 4.5 | 4.8 | 5.0 | 5.3 | 5.5 |
| Persons served | 4.3 | 4.6 | 4.9 | 5.1 | 5.4 |
| Rate per 1,000 | 952 | 963 | 969 | 965 | 977 |

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] | 28,071 | 923 | 5,436 | 865 |
| Boston | 1,465 | 914 | 285 | 843 |
| New York[2] | 2,581 | 913 | 451 | 845 |
| Philadelphia | 2,909 | 929 | 538 | 851 |
| Atlanta | 6,085 | 951 | 1,390 | 902 |
| Chicago | 5,475 | 956 | 935 | 878 |
| Dallas | 3,121 | 931 | 628 | 893 |
| Kansas City | 1,524 | 954 | 273 | 910 |
| Denver | 853 | 954 | 133 | 869 |
| San Francisco[3] | 2,764 | 884 | 525 | 805 |
| Seattle | 994 | 939 | 188 | 843 |

[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 2005 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 | | |
|---|---|---|---|
| | 2002 | 2003 | 2004 |
| Total enrollees[1] | 336,545 | 350,085 | 358,193 |
| Dialysis patients[2] | 297,928 | 310,095 | 320,404 |
| Outpatient | 269,741 | 281,460 | 292,084 |
| Home | 28,187 | 28, 635 | 28,320 |
| Transplants performed[3] | 14,714 | 15,589 | 16,568 |
| Living related donor | 4,044 | 4,217 | 4,200 |
| Cadaveric donor | 9,026 | 9,402 | 10,062 |
| Living unrelated donor | 1,644 | 1,970 | 2,306 |
| 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 2004 Medicaid beneficiaries |
|---|---|
| | In thousands |
| Total eligibles | 58,161 |
| Number using service: | |
| Total beneficiaries, any service[1] | 55,553 |
| Inpatient services | |
| General hospitals | 5,420 |
| Mental hospitals | 117 |
| Nursing facility services[2] | 1,718 |
| Intermediate care facility (MR) services[3] | 114 |
| Physician services | 23,949 |
| Dental services | 9,015 |
| Other practitioner services | 5,920 |
| Outpatient hospital services | 15,943 |
| Clinic services | 11,113 |
| Laboratory and radiological services | 16,033 |
| Home health services | 1,148 |
| Prescribed drugs | 27,970 |
| Personal care support services | 851 |
| Sterilization services | 174 |
| PCCM capitation | 8,548 |
| HMO capitation | 23,587 |
| PHP capitation | 16,995 |
| Targeted case management | 2,478 |
| Other services, unspecified | 10,343 |
| Additional service categories | 7,458 |
| Unknown | 82 |

[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: 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 2004 units of service |
|---|---|
| | In thousands |
| Inpatient hospital | |
| Total discharges | 8,126 |
| Beneficiaries discharged | 5,420 |
| Total days of care | 35,461 |
| Nursing facility | |
| Total days of care | 454,709 |
| Intermediate care facility/mentally retarded | |
| Total days of care | 45,938 |

NOTES: Data are derived from the MSIS 2004 State Summary Mart. Excludes territories.

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

# *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 |
| 1980 | 497 | 2.1 |
| 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 |
| 2006[1] | 3,086 | 1.7 |
| SMI Trust Fund[2] | | |
| 1967 | [3]135 | 20.3 |
| 1970 | 217 | 11.0 |
| 1980 | 593 | 5.8 |
| 1990 | 1,524 | 3.7 |
| 1995 | 1,722 | 2.7 |
| 2000 | 1,780 | 2.0 |
| 2004 | 2,664 | 2.0 |
| 2005 | 2,348 | 1.6 |
| 2006 | 3,108 | 1.6 |

[1]Includes non-expenditure transfers for Health Care Fraud and Abuse Control. [2]Starting in FY 2004 includes the transactions of the Part D account. [3]Includes expenses paid in fiscal years 1966 and 1967.

SOURCE: CMS, Office of the Actuary.

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

| | Intermediaries | Carriers |
|---|---|---|
| Blue Cross/Blue Shield | 23 | 16 |
| Other | 2 | 3 |

NOTES: Data as of FY 2006. Numbers do not include MACs or DMACs.

SOURCE: CMS, Office of Financial Management.

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

| | Intermediary reconsiderations | Carrier reviews |
|---|---|---|
| Number processed | 22,953 | 2,312,580 |
| Percent with increased payments[1] | N/A | 70.1 |

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 2006.

SOURCE: CMS, Office of Financial Management.

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

| | 2000 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|
| | in thousands | | | | | |
| Claims total | 720.5 | 822.0 | 860.7 | 922.2 | 951.6 | 944.9 |
| Claims assigned | 705.7 | 808.6 | 847.8 | 909.9 | 940.7 | 935.1 |
| Claims unassigned | 15.3 | 13.3 | 12.9 | 12.3 | 10.9 | 9.8 |
| Percent assigned | 97.9 | 98.4 | 98.5 | 98.7 | 98.9 | 99.0 |

NOTE: Fiscal year data. Historical data revised from earlier year editions.

SOURCE: CMS, Office of Financial Management

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

| | Intermediaries | Carriers |
|---|---|---|
| Claims processed in millions | 185.0 | 971.0 |
| Total PM costs in millions | $433.2 | $1,261.4 |
| Total MIP costs in millions | $531.8 | $279.0 |
| Claims processing costs in millions | $290.4 | $889.6 |
| Claims processing unit costs | $0.82 | $0.50 |
| Range | | |
| High | $1.74 | $1.09 |
| Low | $0.52 | $0.34 |

NOTES: Data for fiscal year 2006. 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 millions | 185.7 |
| | Percent of total |
| Inpatient hospital | 8.2 |
| Outpatient hospital | 56.3 |
| Home health agency | 7.1 |
| Skilled nursing facility | 2.8 |
| Other | 25.7 |
| Carrier claims received in millions | 944.1 |
| | Percent of total |
| Assigned | 99.0 |
| Unassigned | 1.0 |

NOTE: Data for calendar year 2006.

SOURCE: CMS, Office of Financial Management.

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

| | Assigned | Unassigned |
|---|---|---|
| Claims approved | | |
| Number in millions | 912.8 | 10.9 |
| Percent reduced | 87.4 | 82.3 |
| Total covered charges | | |
| Amount in millions | $246,608 | $894 |
| Percent reduced | 52.6 | 17.5 |
| Amount reduced per claim | $152.63 | $18.46 |

NOTES: Data for calendar year 2006. 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 | |
|---|---|---|
| | 2005 | 2006 |
| | In millions | |
| Total payments computable for Federal funding[1] | $15,146 | $16,032 |
| Federal share[1] | | |
| Family planning | 33 | 28 |
| Design, development or installation of MMIS[2] | 244 | 223 |
| Skilled professional medical personnel | 447 | 415 |
| Operation of an approved MMIS[2] | 1,164 | 1,208 |
| All other | 6,339 | 6,772 |
| Mechanized systems not approved under MMIS[2] | 81 | 93 |
| Total Federal Share | $8,308 | $8,739 |
| Net adjusted Federal share[3] | $8,256 | $8,733 |

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

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

# *Reference*

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

**Program financing, cost sharing and limitations**

**Medicare/source of income**

**Medicare Part A**

Hospital Insurance trust fund:

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

| *Contribution rate | 2005 | 2006 | 2007 |
|---|---|---|---|
| | | Percent | |
| Employees and employers, each | 1.45 | 1.45 | 1.45 |
| Self-employed | 2.90 | 2.90 | 2.90 |
| Maximum taxable amount (CY 2007) | | None[1] | |
| Voluntary HI monthly premium[2] | | $410.00 | |

| Part A (effective date) | Amount |
|---|---|
| Inpatient hospital deductible (1/1/07) | $992/benefit period |
| Regular coinsurance days (1/1/07) | $248/day for 61st thru 90th day |
| Lifetime reserve days (1/1/07) | $496/day (60 non-renewable days) |
| SNF coinsurance days (1/1/07) | $124/day after 20th day |
| Blood deductible | first 3 pints/benefit period |
| Voluntary hospital insurance premium (1/1/07) | $410/month; $226/mo. with at least 30 quarters of coverage |
| **Limitations:** | |
| Inpatient psychiatric hospitals | 190 nonrenewable days |

[1]The Omnibus Reconciliation Act of 1993 eliminated the Annual Maximum Taxable Earnings amounts for 1994 and later. For these years, the contribution rate is applied to all earnings in covered employment. [2]Premium paid for voluntary participation of individuals aged 65 and over not otherwise entitled to hospital insurance and certain disabled individuals who have exhausted other entitlement. A reduced premium of $226 is available to individuals aged 65 and over who are not otherwise entitled to hospital insurance but who have, or whose spouse has or had, at least 30 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

**Program financing, cost sharing and limitations**

**Medicare Part B**

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

| **Part B (effective date)** | **Amount** |
|---|---|
| Deductible (1/1/07) | $131 in allowed charges/year |
| Blood deductible | first 3 pints/calendar year |
| Coinsurance[1] | 20 percent of allowed charges |
| Monthly standard premium (1/1/07) | $93.50/month |
| **Limitations:** | |
| Outpatient treatment for 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

### Medicare Part B (continued)

Listed below are the 2007 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

| Beneficiaries who file an individual tax return with income: | Beneficiaries who file a joint tax return with income: | Income-related monthly adjustment amount | Total monthly premium amount |
|---|---|---|---|
| Less than or equal to $80,000 | Less than or equal to $160,000 | $0.00 | $93.50 |
| Greater than $80,000 and less than or equal to $100,000 | Greater than $160,000 and less than or equal to $200,000 | $12.30 | $105.80 |
| Greater than $100,000 and less than or equal to $150,000 | Greater than $200,000 and less than or equal to $300,000 | $30.90 | $124.40 |
| Greater than $150,000 and less than or equal to $200,000 | Greater than $300,000 and less than or equal to $400,000 | $49.40 | $142.90 |
| Greater than $200,000 | Greater than $400,000 | $67.90 | $161.40 |

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

| Married beneficiaries who lived with their spouse and filed a separate tax return | Income-related monthly adjustment amount | Total monthly premium amount |
|---|---|---|
| Less than or equal to $80,000 | $0.00 | $93.50 |
| Greater than $80,000 and less than or equal to $120,000 | $49.40 | $142.90 |
| Greater than $120,000 | $67.90 | $161.40 |

SOURCE: CMS, Office of the Actuary.

## Program financing, cost sharing and limitations

**Medicare Part D Standard Benefits**

| | |
|---|---|
| Deductible (1/1/2007) | $265 in charges/year |
| Initial coverage limit (1/1/2007) | $2,400 in charges/year |
| Out-of-pocket threshold (1/1/2007) | $3,850 in charges/year |
| Base beneficiary premium (1/1/2007)[1] | $27.35/month |

**Medicaid financing**

1. Federal contributions (ranging from 50 to 76 percent for fiscal year 2007)
2. State contributions (ranging from 26 to 50 percent for fiscal year 2007)

[1]The base beneficiary premium was calculated based on a national average plan bid. The actual premiums that a beneficiary pay varies according to the plan in which the beneficiary is enrolled. For 2007, the average premium rate paid by beneficiaries is estimated to be about $22.

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

SOURCE: CMS, Office of the Actuary.

**Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2007**

| I. | Boston | FMAP | II. | New York | FMAP |
|---|---|---|---|---|---|
| | Connecticut | 50.00 | | New Jersey | 50.00 |
| | Maine | 63.27 | | New York | 50.00 |
| | Massachusetts | 50.00 | | Puerto Rico | 50.00 |
| | New Hampshire | 50.00 | | Virgin Islands | 50.00 |
| | Rhode Island | 52.35 | | Canada | -- |
| | Vermont | 58.93 | | | |
| | | | IV. | Atlanta | |
| III. | Philadelphia | | | Alabama | 68.85 |
| | Delaware | 50.00 | | Florida | 58.76 |
| | Dist. of Columbia | 70.00 | | Georgia | 61.97 |
| | Maryland | 50.00 | | Kentucky | 69.58 |
| | Pennsylvania | 54.39 | | Mississippi | 75.89 |
| | Virginia | 50.00 | | North Carolina | 64.52 |
| | West Virginia | 72.82 | | South Carolina | 69.54 |
| | | | | Tennessee | 63.65 |
| V. | Chicago | | | | |
| | Illinois | 50.00 | VI. | Dallas | |
| | Indiana | 62.61 | | Arkansas | 73.37 |
| | Michigan | 56.38 | | Louisiana | 69.69 |
| | Minnesota | 50.00 | | New Mexico | 71.93 |
| | Ohio | 59.66 | | Oklahoma | 68.14 |
| | Wisconsin | 57.47 | | Texas | 60.78 |
| VII. | Kansas City | | VIII. | Denver | |
| | Iowa | 61.98 | | Colorado | 50.00 |
| | Kansas | 60.25 | | Montana | 69.11 |
| | Missouri | 61.60 | | North Dakota | 64.72 |
| | Nebraska | 57.93 | | South Dakota | 62.92 |
| | | | | Utah | 70.14 |
| IX. | San Francisco | | | Wyoming | 52.91 |
| | Arizona | 66.47 | | | |
| | California | 50.00 | X. | Seattle | |
| | Hawaii | 57.55 | | Alaska | 51.07 |
| | Nevada | 53.93 | | Idaho | 70.36 |
| | American Samoa | 50.00 | | Oregon | 61.07 |
| | Guam | 50.00 | | Washington | 50.12 |
| | N. Mariana Islds | 50.00 | | | |

Source: CMS, Center for Medicare and State Operations.

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