I. BUDGET OVERVIEW

Information about the Federal, DHHS and CMS budgets.

HIGHLIGHTS

- *Medicare benefit payments are expected to increase by 7.5 percent from 2002 to 2003 and by 4.6 percent from 2003 to 2004.*

- *Federal and State Medicaid medical assistance payments are expected to increase by 10.2 percent from 2002 to 2003 and by 9.2 percent from 2003 to 2004.*

- *Program benefit payments for Medicare, Medicaid, and SCHIP combined are expected to increase by 10.4 percent from 2002 to 2003 and by 9.0 percent from 2003 to 2004.*

CMS Disbursements

Fiscal Years 2002 - 2004

	2002 Actual	2003 Current Law	2004 Current Law	2004 Proposed Law
		Dollars in millions		
CMS Budget Outlays				
Medicare Benefits	$252,207	$271,164	$283,768	$289,768
Medicare Part B Transfer to Medicaid [1]	112	118	0	55
Quality Improvement Organizations	354	346	370	370
Health Care Fraud and Abuse Control (HCFAC) [2]	963	1,075	1,075	1,075
Other Medicare Administrative Expenses [3]	1,249	1,273	1,246	1,246
CMS Program Management [4]	2,403	2,675	2,779	2,779
Medicaid Benefits [5]	140,239	155,370	169,668	173,001
State and Local Administration/Training	7,273	8,449	9,009	9,009
State Children's Health Insurance Program (SCHIP)	3,656	4,700	5,050	5,073
SCHIP Transfer to Medicaid [6]	26	-	-	-
Ticket to Work Program (P.L. 106-170)	10	20	25	25
Qualified High-Risk Pools grant programs (P.L. 107-210) [7]	0	1	23	23
Total Outlays (unadjusted)	$408,493	$445,190	$473,013	$482,424
Medicare Premiums	-25,951	-28,344	-31,853	-31,853
Offsetting Collections, Non-Federal	-60	-106	-58	-259
Reimbursables	-5	0	0	0
Total Outlays Net of Medicare Premiums and Offsetting Collections	$382,476	$416,741	$441,102	$450,312

[1] Medicare transfer to Medicaid for Medicare Part B premium assistance.

[2] Includes HCFAC outlays by CMS and other agencies.

[3] Medicare-related expenses of other agencies, e.g., Social Security Administration.

[4] Includes user fees and reimbursables.

[5] Includes not only Medicaid medical assistance payments (MAP) but also Title XIX outlays for the Vaccines for Children Program (FY 2002 - $792.2 million; FY 2003 - $1,174.2 million; FY 2004 - $1,200.1 million). The FY 2002 outlays were reduced by $137.9 million to reflect the offsetting collections. In FY 2003, the estimate is reduced by the Medicare Part B transfer to Medicaid of $117.7 million. The FY 2003 Medicaid benefits amount includes $88 million for the extension of Transitional Medical Assistance through September 2003 (P.L. 108-40).

[6] This transfer, required by section 802 of the BIPA (P.L.106-554), reimburses Title XIX for the cost of SCHIP-related Medicaid expansions in fiscal years before FY 2001.

[7] Qualified High-Risk Pools grant programs added in FY 2003.

NOTES: Fiscal year data. Totals do not necessarily equal the sum of rounded components.

SOURCES: FY 2004 Mid-Session Review; CMS/OFM

November 2003

Program Benefit Payments

Selected Fiscal Years

Fiscal Year	Total Amount	Total Annual Percent Change	Medicare [1] Amount	Medicare [1] Annual Percent Change	Medicaid [2] Amount	Medicaid [2] Annual Percent Change	SCHIP [3] Amount	SCHIP [3] Annual Percent Change
			Amount in billions					
Historical								
1980	$57.9	--	$33.9	--	$24.0	--		
1985	108.8	12.6	69.5	14.1	39.3	10.4		
1990	175.9	15.6	107.2	13.8	68.7	18.4		
1991	204.4	16.2	113.9	6.3	90.5	31.7		
1992	245.1	19.9	129.2	13.4	115.9	28.1		
1993	268.7	9.6	142.9	10.6	125.8	8.5		
1994	296.9	10.5	159.3	11.5	137.6	9.4		
1995	328.9	10.8	176.9	11.0	152.0	10.5		
1996	344.3	4.7	191.1	8.0	153.2	0.8		
1997	367.8	6.8	207.1	8.4	160.7	4.9		
1998	379.7	3.2	210.1	1.4	169.4	5.5	0.2	
1999	390.5	2.8	208.3	-0.9	180.8	6.7	1.3	655.2
2000	413.8	6.0	214.9	3.2	196.1	8.4	2.8	108.6
2001	457.8	10.6	236.6	10.1	217.4	10.9	3.8	36.6
2002	505.4	33.1	252.3	6.7	247.7	13.9	5.4	41.4
Budget								
Current law								
2003	551.0	20.4	271.3	7.5	273.0	10.2	6.7	24.4
2004	589.2	6.9	283.8	4.6	298.2	9.2	7.2	7.4

[1]Includes catastrophic benefits for HI in FY 1990. Includes SMI transfer to Medicaid. Excludes Quality Improvement Organization expenditures.

[2]Total computable benefit payments (Federal and State combined). Historical data for FYs 1980-1994 reflect total computable medical assistance payments reported by the States on line 11 of the HCFA-64 and predecessor forms. Historical data for FYs 1995-2002 include line 11 total computable medical assistance payments and outlays for the Vaccines for Children Program but do not include total computable Title XIX expenditures for the State Children's Health Insurance Program. Budget data for FYs 2003-2004 reflect current law estimates of total adjusted computable medical assistance payments and outlays for the Vaccines for Children Program.

[3]Historical data for FYs 1998-2000 include total computable expenditures (Title XIX and Title XXI) reported by the States for the State Children's Health Insurance Program (SCHIP). After FY 2000, there is no longer Title XIX funding of SCHIP. Budget data for FYs 2001-2003 reflect estimates of total computable Title XXI outlays. In FYs 2001 and 2002, the estimate does not include the SCHIP transfer to Medicaid to reimburse Title XIX for the cost of SCHIP-related Medicaid expansions in fiscal years before FY 2001.

NOTE: Percent changes based on unrounded numbers.

SOURCE: CMS/OFM

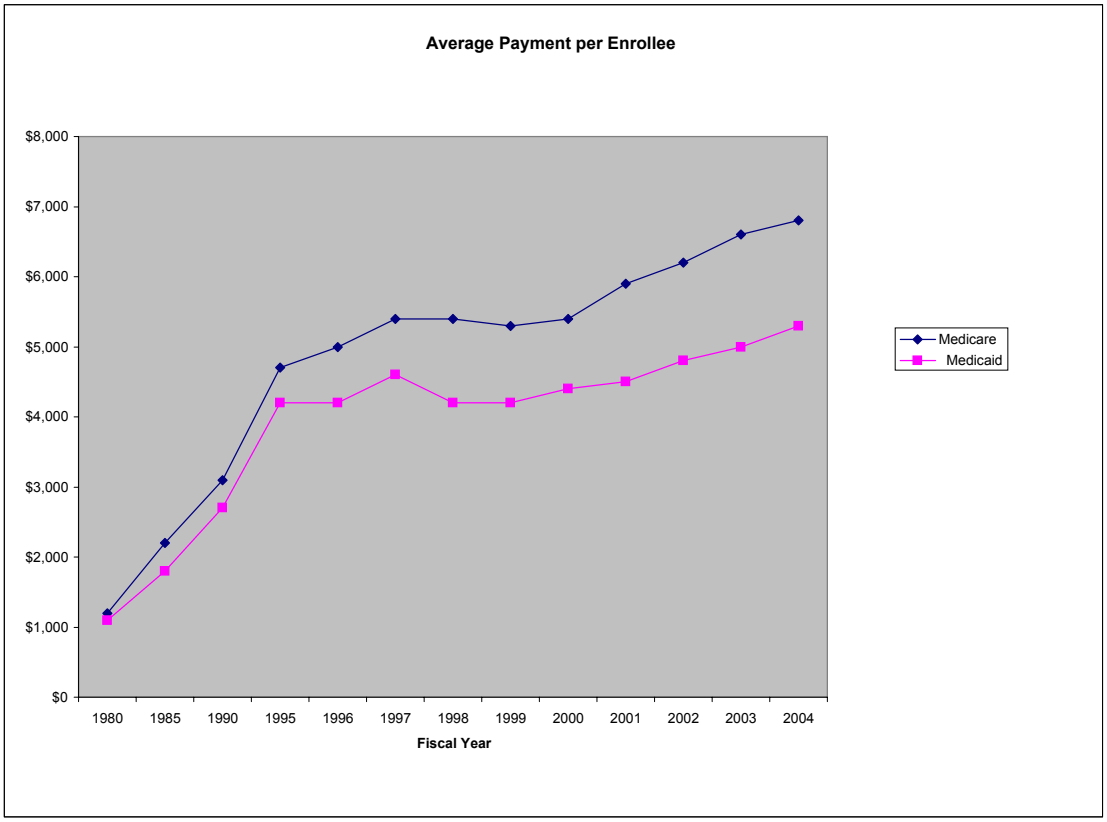
November 2003

Program Benefit Payments Per Enrollee
Selected Fiscal Years

	Medicare			Medicaid [2]			State Children's Health Insurance Program (SCHIP)	
Fiscal Year	Benefit Payments[1] (In Billions)	Enrollees (In Millions)	Average Per Enrollee	Benefit Payments (In Billions)	Beneficiaries[3] (In Millions)	Average Per Beneficiary	Medicaid Expansions[4] (In Billions)	Separate State Programs (In Billions)
1980	$33.9	28.3	$1,200	$24.0	21.6	$1,100		
1985	69.6	31.0	2,200	39.3	21.8	1,800		
1990	107.4	34.1	3,100	68.7	25.3	2,700		
1995	177.1	37.4	4,700	151.8	36.3	4,200		
1996	191.2	38.0	5,000	152.9	36.1	4,200		
1997	207.3	38.4	5,400	160.3	34.7	4,600		
1998	210.3	38.8	5,400	168.9	40.6 [6]	4,200	$0.1	$0.1
1999	208.5	39.1	5,300	180.4	42.9 [5,6]	4,200	0.6	0.7
2000	215.1	39.6	5,400	195.5	44.5 [5,6]	4,400	1.1	1.6
2001	236.8	40.0	5,900	216.2	48.4 [5,6]	4,500	1.2	2.6
2002	252.6	40.5	6,200	246.3	51.4 [5,6]	4,800	1.3	4.0
2003 [5]	271.6	41.0	6,600	264.7	53.3 [5,6]	5,000	1.8	4.9
2004 [5]	284.1	41.5	6,800	287.6	54.6 [5,6]	5,300	1.9	5.3

[1]Includes Quality Improvement Organization and SMI Medicaid transfer expenditures. [2]Excludes Medicaid expansion and separate State programs under SCHIP and payments under Vaccines for Children Program. [3]Medicaid beneficiaries are enrollees on behalf of whom at least one payment is made during the fiscal year. [4]Beginning in FY 2001, SCHIP Medicaid expansions are funded through Title XXI. See footnote 2, page 2. [5]Estimated. [6]Beginning in 1998, Medicaid beneficiaries were redefined to include eligibles on behalf of whom a capitation payment is made, which results in a large increase in the beneficiary count.

NOTES: Current law only. Consistent with data and estimates included in the FY 2004 Mid-Session Review. Medicare benefit payments reflect gross outlays, i.e., not net of offsetting receipts. Medicaid benefit payments reflect both Federal and State expenditures.



SOURCE: CMS/OACT

November 2003

Benefit Outlays by Program
Selected Fiscal Years

	1967	1968	2002	2003 [1]
		Amounts in billions		
Annually				
CMS Program Benefit Outlays	$5.1	$8.4	$505	$551
Federal Outlays	NA	6.7	396	431
Medicare	3.2	5.1	252	271
HI	2.5	3.7	144	154
SMI [2]	0.7	1.4	108	118
Medicaid [3]	1.9	3.3	248	273
Federal Share	NA	1.6	140	155
State Children's Health Insurance Program (SCHIP)	NA	NA	5	7
Federal Share	NA	NA	4	5
		In millions		In billions
Monthly				
CMS Program Benefit Outlays	$423	$702	$42	$46
Federal Outlays	NA	561	33	36
Medicare	264	427	21	23
HI	209	311	12	13
SMI [2]	55	116	9	10
Medicaid [3]	158	275	21	23
Federal Share	NA	133	12	13
State Children's Health Insurance Program	NA	NA	0.4	0.6
Federal Share	NA	NA	0.3	0.4
		In thousands		In millions
Hourly				
CMS Program Benefit Outlays	$579	$962	$58	$63
Federal Outlays	NA	768	45	49
Medicare	362	585	29	31
HI	286	426	16	18
SMI [2]	76	159	12	13
Medicaid [3]	217	377	28	31
Federal Share	NA	183	16	18
State Children's Health Insurance Program	NA	NA	0.6	0.8
Federal Share	NA	NA	0.5	0.6
			In thousands	
By Minute				
CMS Program Benefit Outlays	$10	$16	$962	$1,048
Federal Outlays	NA	13	754	821
Medicare	6	10	480	516
HI	5	7	274	292
SMI [2]	1	3	206	224
Medicaid [3]	4	6	471	519
Federal Share	NA	3	267	296
State Children's Health Insurance Program	NA	NA	10	13
Federal Share	NA	NA	7	9

[1] Estimated. [2] Includes SMI transfer to Medicaid. [3] Includes Federal outlays for the Vaccines for Children Program.

NOTES: Current law fiscal year data. Totals may not equal the sum of rounded components. For FYs 2002 and 2003 rounded annual benefit outlays used to derive monthly (12), hourly (8,760) and minutely (525,600) outlays.

SOURCE: CMS/OFM November 2003

II. EXPENDITURES

Information about proposed, current and past spending for health care by Medicare, Medicaid, CMS, the Department and the nation as a whole.

Health care spending is shown for CMS programs and national aggregates over time. Data are shown by type of service, source of funds and broad beneficiary eligibility categories.

HIGHLIGHTS

- *Medicare spending between fee-for-service (FFS) and managed care is expected to decrease between 2002 and 2004, with managed care's share of total benefit payments accounting for 13.4 percent in 2002, decreasing to 12.9 percent in 2004.*

- *Medicare FFS benefit payments for inpatient hospital care are projected to increase 7.6 percent from fiscal year 2002 to 2003. During the same period of time, FFS physician and supplier payments under Medicare are expected to increase 9.0 percent.*

- *Spending for FFS inpatient hospital services as a share of total Medicare spending decreased from 64.9 percent in 1983 to a projected 40.5 percent in 2003.*

- *The financing for home health care shifted dramatically from Part A to Part B because of the Balanced Budget Act of 1997. The benefit increased modestly under both programs in 2003, reaching $5.0 billion and $5.2 billion, respectively.*

- *Total Medicaid payments increased by 73 percent from 1985 to 1990 and by another 159.5 percent from 1990 to 2000 to reach $168.3 billion in 2000.*

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Medical care price indexes continue to increase at a faster rate than the "All Item" Consumer Price Index.

- *In recent years, changes in the CPI for all items have lagged considerably behind inpatient, outpatient, and physician services.*

- *In 2002, the CPI for all items increased by 1.5 percent, a drop from 3.2 percent in the previous year. The percent increases for inpatient, outpatient, and physician services, and prescription drugs in 2002 were 7.9, 8.7, 2.9 and 5.6, respectively, compared to 6.2, 6.8, 3.7 and 4.8 in 2001.*

- *Public funding for NHE has grown significantly from 24.9 percent in 1965 to 45.4 percent in 2002.*

- *Likewise, private funding for NHE declined from 75.1 percent in 1965 to 54.6 percent in 2002.*

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- *Likewise, private funding for NHE declined from 75.1 percent in 1965 to 54.6 percent in 2002.*

CMS Benefit Payments by Major Program Service Categories

Fiscal Year 2001

Type of Service	Total Program Payments		Medicare		Medicaid [1]	
	Amount	Percent Distribution	Amount	Percent Distribution	Amount	Percent Distribution
			Amount in millions			
Total	$452,959	100.0	$236,822	100.0	$216,137	100.0
Inpatient Hospital	138,605	30.6	93,613 [2]	39.5	44,992 [7]	20.8
Nursing Facilities	65,618	14.5	12,539	5.3	53,079 [8]	24.6
Home Health & Related	28,762	6.3	7,951	3.4	20,811 [9]	9.6
Physician & Other Practitioner	64,153	14.2	54,116 [3]	22.9	10,037 [10]	4.6
Outpatient	29,359	6.5	20,689	8.7	8,670 [11]	4.0
Clinic	6,138	1.4	[4]		6,138 [12]	2.8
Prescribed Drugs	19,772	4.4			19,772 [13]	9.1
Capitation Payments	79,686	17.6	-- 42,086 [5]	-- 17.8	37,601 [14]	17.4
Other Care	20,866	4.6	-- 5,829 [6]	-- 2.5	15,038 [15]	7.0

[1] Payments (Federal and State) from financial management reports (Form CMS-64).

[2] Includes inpatient hospital ($87,043 million) and Quality Improvement Organization ($236 million).

[3] Includes physicians, other practitioners, durable medical equipment, ambulatory surgical center facility costs, physician-administered drugs, and other Part B suppliers (total of $54,061 million) and Quality Improvement Organization ($55 million).

[4] Covered clinic services are included under outpatient.

[5] Includes Part A managed care payments ($22,837 million) and Part B managed care payments ($19,249 million).

[6] Includes hospice ($3,464 million) and clinical laboratory services furnished in a physician's office and an independent laboratory ($2,365 million).

[7] Includes Inpatient hospital payments ($29,476 million) and disproportionate share (DSH) payments ($15,516 million).

[8] Includes services in nursing facilities ($42,728 million) and intermediate care facilities for the mentally retarded ($10,351 million).

[9] Includes home health ($2,573 million), home and community-based waivers ($13,932 million), personal care services ($4,145 million), and home and community-based services for functionally disabled elderly ($162 million).

[10] Includes physician ($6,683 million), dental ($2,214 million), and other practitioner services ($1,139 million).

[11] Includes outpatient hospital ($8,003 million) and laboratory/radiological services ($667 million).

[12] Includes clinic ($5,119 million), rural health clinic ($292 million), and federally qualified health clinic services ($726 million).

[13] Includes gross prescription drug expenditures ($24,686 million) and drug rebates (-$4,914 million).

[14] Includes Medicare premiums ($4,540 million) and other capitation payments ($33,061 million).

[15] Includes early and periodic screening, diagnosis and treatment (EPSDT) ($923 million), targeted case management ($2,012 million), primary care case management ($218 million), hospice ($547 million), emergency services for undocumented immigrants ($1,074 million), miscellaneous coinsurance payments ($453 million), sterilizations ($114 million), abortions ($0.2 million), Program for All-inclusive Care of Elderly (PACE) ($14 million), community supported living arrangements ($0.1 milllion), other care services ($8,481 million), and collections net of prior adjustments ($1,201 million).

NOTE: Because of rounding, table components may not add to totals.

SOURCE: CMS/OACT

November 2003

Medicare Trust Fund Projections
Fiscal Years 2002 - 2004

	2002	2003	2004
		Amount in millions	
HI Total Disbursements [1]	$148,014	$154,344	$164,223
HI Administrative Expenses [2]	1,743	1,877	1,922
HI Benefit Payments	144,140	153,566	161,226
Aged	124,868	132,585	138,682
Disabled	19,272	20,980	22,545
HCFAC [3]	963	1,075	1,075
HI Transfer to SMI for Home Health	1,168	(2,174)	--
SMI Total Disbursements [1]	108,825	122,201	124,954
SMI Administrative Expenses [2]	1,813	2,311	2,412
SMI Benefit Payments	108,068	117,598	122,542
Aged	91,787	99,444	103,175
Disabled	16,281	18,155	19,367
SMI Transfer to Medicaid [4]	112	118	--
HI Transfer to SMI for Home Health	(1,168)	2,174	--

[1] Current law data. Totals do not necessarily equal the sum of rounded components. [2] Administrative expenses include the sum of administrative costs, research, and QIO expenditures. [3] Net Health Care Fraud and Abuse Control FY 2002 outlays reflect the U.S. Treasury's 2002 Combined Statement.

[4] SMI Transfer to Medicaid for Medicare Part B premium assistance.

NOTES: Based on FY 2004 Mid-Session Review. Benefit estimates do not reflect proposed legislation. Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS/OACT/OFM

Medicare Benefit Payments by Type of Benefit
Fiscal Years 2002 - 2004

	Benefit Payment [1]			Percent Distribution
	2002	2003	2004	2004
	Amount in millions			
Total HI [2]	$144,140	$153,566	$161,226	100.0
Inpatient Hospital	102,130	109,923	116,495	72.3
Skilled Nursing Facility	14,699	13,670	14,107	8.7
Home Health Agency	4,931 [3]	5,048	5,285	3.3
Hospice	4,516	5,870	6,258	3.9
Managed Care	17,865	19,054	19,081	11.8
Total SMI [2]	108,068	117,598	122,542	100.0
Physician/Other Suppliers	60,669	66,106	69,587	56.8
Outpatient Hospital/Other Providers	21,350	23,576	24,147	19.7
Home Health Agency	5,108 [3]	5,187	5,430	4.4
Laboratory	4,888	5,347	5,732	4.7
Managed Care	16,052	17,383	17,646	14.4

[1] Includes the effect 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 2004 Mid-Session Review. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS/OACT/OFM

November 2003

Medicaid Payments by Basis of Eligibility
Selected Fiscal Years

	Payments					Percent Distribution
	1985	1990	1995	1999	2000	2000
	Amount in millions					
Total	$37,508	$64,859	$120,141	$152,629	$168,307	100.0
Age 65 and over	14,096	21,508	36,527	42,347	44,503	26.4
Blind/Disabled	13,452	24,403	49,418	65,668	72,742	43.2
Dependent Children under Age 21	4,414	9,100	17,976	23,846	26,775	15.9
Adults in Families with Dependent Children	4,746	8,590	13,511	15,637	17,763	10.6
Unknown	798	1,051	1,499	5,131	6,525	3.9

NOTES: In 1997, the Other title XIX category was dropped and the enrollees therein were subsumed in the remaining categories. Beginning in FY 1998, payments include capitated payments as a type of service category. The large increase between 1995 and 1998 is primarily the result of this change of definition. Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS/CMSO/ORDI

Medicaid Payments by Type of Service and Basis of Eligibility
Fiscal Year 2000

	Total Payments	Inpatient Hospital Services	Long-Term Care Services [1]	Other Services
		Percent Distribution		
All Groups	100.0	14.4	27.9	57.7
Age 65 and over	26.4	1.0	16.9	8.5
Blind and Disabled	43.2	6.2	10.5	26.5
Children under Age 21	15.9	2.9	0.1	12.9
AFDC-Type Adults	10.6	2.8	0.1	7.7
Unknown	3.9	1.5	0.2	2.1

[1] Includes services in mental facilities, all nursing facilities, and home health services, and all ICF/MR.

NOTE: Totals may not equal the sum of rounded components.

SOURCE: CMS/CMSO November 2003

Medicaid Payments by Type of Service

Selected Fiscal Years

	1985	1998	1999	2000	Percent Distribution 2000
			Amount in millions		
Total	$37,508	$142,260	$152,629	$168,307	100.0
Inpatient Services	10,645	24,241	23,940	26,034	15.5
General Hospitals	9,453	21,441	22,182	24,266	14.4
Mental Hospitals	1,192	2,801	1,758	1,768	1.1
Nursing Facilities [1]	5,071	31,892	33,113	34,432	20.5
ICF Services	11,246	9,482	9,326	9,375	5.6
Mentally Retarded	4,731	9,482	9,326	9,375	5.6
All Other [1]	6,516				0.0
Physician Services	2,346	6,070	6,497	6,806	4.0
Dental Services	458	901	1,203	1,404	0.8
Other Practitioner Services	251	587	467	658	0.4
Outpatient Hospital Services	1,789	5,759	6,061	7,053	4.2
Clinic Services	714	3,921	5,778	6,174	3.7
Laboratory & Radiological Services	337	939	1,147	1,288	0.8
Home Health Services	1,120	2,702	2,898	3,119	1.9
Prescribed Drugs	2,315	13,522	16,567	20,014	11.9
Family Planning [2]	195	449			0.0
EPSDT [2]	85	1,335			0.0
Rural Health Clinics [2]	7				0.0
Home and Comm. Based Waiver Serv. [2]		6,709			0.0
Prepaid Health Care		19,296	21,115	24,413	14.5
PCCM Services	NA	134	463	165	0.1
Sterilization Services	NA		121	128	0.1
Personal Support Services	NA	8,222	10,499	11,567	6.9
Other Care	NA	4,386	12,967	14,680	8.7
Unknown	NA	1,713	469	997	0.6

NA: 928 (1985); NA (1998); NA (1999); NA (2000)

[1] Beginning in 1991, the category, nursing facilities, was created to include skilled nursing facilities and intermediate care facility services for all other than the mentally retarded. [2] Beginning in 1999, these services were reclassified as program types and the payments subsumed in the remaining types of service.

NOTES: Percent distribution based on rounded numbers. Prior to 1998, vendor payments exclude premiums and capitation amounts. Beginning in FY 1998, payments include capitated payments as a type of service category.

SOURCES: CMS/CMSO/ORDI

November 2003

National Health Care by Type of Expenditure

Calendar Year 2001

	National Total in billions	Per Capita	Percent Paid		
			Total	Medicare	Medicaid[1]
Total	$1,424.5	$5,034.9	32.7	17.0	15.7
Health Services and Supplies	1,372.6	4,851.1	34.0	17.6	16.3
Personal Health Care	1,236.4	4,370.0	35.8	19.0	16.9
Hospital Care	451.2	1,594.8	47.0	29.9	17.1
Physicians' Services	313.6	1,108.6	27.2	20.4	6.8
Nursing Home Care	98.9	349.6	59.2	11.7	47.5
Other Personal Health Care	372.6	1,317.1	23.4	6.5	16.9
Other Services and Supplies	136.1	481.1	17.0	5.4	11.6
Research and Construction	52.0	183.7	--	--	--

[1] Excludes SCHIP and Medicaid SCHIP Expansion.

NOTES: Per capita amounts based on July 1 Census resident population estimates. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS/OACT and U. S. Bureau of the Census November 2003

CMS Benefit Payments by Major Personal Health Expenditure Service Categories
Calendar Year 2001

Type of Service [1]	Total Program Payments		Medicare		Medicaid [5]	
	Amount in billions	Percent Distribution	Amount in billions	Percent Distribution	Amount in billions	Percent Distribution
Total	$443.0	100.0	$234.5	100.0	$208.5	100.0
Hospital Care	212.0	47.9	135.0	57.5	77.1	37.0
Physician and Clinical Services	85.3	19.3	63.9	27.3	21.4	10.3
Dentists' Services	3.1	0.7	0.1	0.0	3.0	1.5
Other Professional Services [2]	7.1	1.6	5.4	2.3	1.7	0.8
Home Health Care [3]	17.0	3.8	9.9	4.2	7.1	3.4
Prescription Drugs	26.5	6.0	2.4	1.0	24.1	11.6
Other Non-Durable Medical Products	1.4	0.3	1.4	0.6		
Durable Medical Equipment	4.9	1.1	4.9	2.1		
Nursing Home Care [4]	58.6	13.2	11.6	4.9	47.0	22.5
Other Personal Health Care	27.1	6.1			--	13.0
					--	--
						--

[1] Service categories used in this table are based on the National Health Accounts and differ from those used elsewhere to present program data. For example, expenditures for hospital based ICF-MR hospital based nursing homes and hospital based home health services appear as hospital care rather than nursing home care or as home health services.

[2] Other professional services include private duty nurses, chiropractors, optometrists, and other licensed health professionals.

[3] Includes non-facility based home health care and some Medicaid care delivered in homes.

[4] Freestanding nursing facilities only.

[5] Excludes Medicaid SCHIP Expansion & SCHIP.

NOTES: Payments under the Medicaid program are more commonly referred to as medical assistance payments which include vendor payments and certain premiums or per capita payments. The Federal share of total Medicaid payments was 58 percent in calendar year 2001.

SOURCE: CMS/OACT

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National Health Care Trends in Public versus Private Funding
Selected Calendar Years

Calendar Year	GDP in billions	National Health Expenditures								
		Total			Private Funds			Public Funds		
		Amount in billions	Per Capita	Percent of GDP	Amount in billions	Per Capita	Percent of Total	Amount in billions	Per Capita	Percent of Total
1965	$720	$41.0	$205	5.7	$30.8	$154	75.1	$10.2	$51	24.9
1966	789	45.1	224	5.7	31.6	156	69.9	13.6	67	30.1
1967	834	50.7	249	6.1	31.8	156	62.8	18.9	93	37.2
1970	1,040	73.1	348	7.0	45.4	216	62.2	27.6	131	37.8
1975	1,635	129.8	590	7.9	74.8	340	57.6	55.0	250	42.4
1980	2,796	245.8	1,067	8.8	140.9	612	57.3	104.8	455	42.7
1981	3,131	285.1	1,225	9.1	163.9	704	57.5	121.2	521	42.5
1982	3,259	321.0	1,366	9.8	186.7	794	58.2	134.3	571	41.8
1983	3,535	353.5	1,489	10.0	206.1	868	58.3	147.5	621	41.7
1984	3,933	390.1	1,628	9.9	229.3	957	58.8	160.8	671	41.2
1985	4,213	426.8	1,765	10.1	252.2	1,043	59.1	174.6	722	40.9
1986	4,453	457.2	1,872	10.3	266.9	1,093	58.4	190.4	780	41.6
1987	4,742	498.0	2,020	10.5	289.3	1,174	58.1	208.8	847	41.9
1988	5,108	558.1	2,243	10.9	331.7	1,333	59.4	226.4	910	40.6
1989	5,489	622.7	2,477	11.3	370.9	1,476	59.6	251.8	1,002	40.4
1990	5,803	696.0	2,738	12.0	413.5	1,627	59.4	282.5	1,111	40.6
1991	5,986	761.8	2,966	12.7	441.3	1,718	57.9	320.6	1,248	42.1
1992	6,319	827.0	3,184	13.1	468.5	1,803	56.6	358.5	1,380	43.4
1993	6,642	888.1	3,381	13.4	497.7	1,895	56.0	390.4	1,486	44.0
1994	7,054	937.2	3,534	13.3	509.8	1,922	54.4	427.3	1,611	45.6
1995	7,400	990.1	3,697	13.4	532.5	1,988	53.8	457.7	1,709	46.2
1996	7,813	1,039.4	3,847	13.3	557.5	2,063	53.6	481.9	1,784	46.4
1997	8,318	1,092.7	4,007	13.1	589.2	2,160	53.9	503.6	1,846	46.1
1998	8,781	1,150.0	4,178	13.1	628.4	2,283	54.6	521.6	1,895	45.4
1999	9,274	1,219.7	4,392	13.2	669.7	2,411	54.9	550.0	1,980	45.1
2000	9,825	1,310.0	4,672	13.3	718.7	2,563	54.9	591.3	2,109	45.1
2001	10,082	1,424.5	5,035	14.1	777.9	2,749	54.6	646.7	2,286	45.4

NOTES: These data reflect Bureau of Economic Analysis Gross Domestic Product as of October 2001. Per capita is calculated using Census resident based population estimates.

SOURCES: CMS/OACT; U.S. Bureau of the Census; and U.S. Department of Commerce, Bureau of Economic Analysis. November 2003

National Health Care Source of Funds [1]
Selected Calendar Years

	1965	1970	1975	1980	1985	1990	1995	1997	1998	1999	2000	2001
Total in billions	$41.0	$73.1	$129.8	$245.8	$426.8	$696.0	$990.1	$1,092.7	$1,150.0	$1,219.7	$1,310.0	$1,424.5
						Percent Distribution						
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private Funds	75.1	62.2	57.6	57.3	59.1	59.4	53.8	53.9	54.6	54.9	54.9	54.6
Out-of-Pocket	44.3	34.3	28.8	23.7	22.4	19.7	14.8	14.8	15.2	15.1	14.9	14.4
Private Health Insurance	24.6	21.3	23.4	27.8	30.5	33.5	33.2	32.9	33.2	33.8	34.3	34.8
Other Private	6.3	6.6	5.5	5.9	6.3	6.1	5.8	6.1	6.2	6.0	5.7	5.4
Federal Government	11.4	24.1	27.8	29.0	28.6	27.7	32.7	33.0	32.1	31.7	31.7	31.9
Medicare	--	10.5	12.6	15.2	16.8	15.8	18.6	19.2	18.3	17.5	17.1	17.0
Federal Medicaid [2]	--	3.9	5.7	5.9	5.3	6.1	8.7	8.7	8.7	8.9	9.0	9.1
Other Federal	11.4	9.7	9.5	7.9	6.5	5.7	5.4	5.1	5.1	5.3	5.6	5.8
State/Local Government	13.5	13.7	14.5	13.6	12.3	12.9	13.6	13.1	13.3	13.4	13.4	13.5
State Medicaid [2]	--	3.3	4.6	4.7	4.3	4.5	5.8	5.9	6.2	6.4	6.5	6.6
Other State/Local	13.5	10.4	9.9	8.9	8.0	8.4	7.7	7.2	7.1	7.0	7.0	6.8

[1] Includes personal health care, expenses for prepayment and administration, government public health activities, and research and medical facilities construction.

[2] 1998 and later, Includes Medicaid SCHIP Expansion and SCHIP.

NOTE: Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS/OACT

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Personal Health Care Payment Source [1]
Selected Calendar Years

	1965	1970	1975	1980	1985	1990	1995	1997	1998	1999	2000	2001
Total in billions	$34.7	$63.2	$113.0	$214.6	$372.3	$609.4	$865.7	$959.2	$1,009.4	$1,064.6	$1,137.6	$1,236.4
					Percent Distribution							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private Funds	79.6	64.8	60.2	59.7	60.6	61.0	55.3	55.5	56.6	57.0	57.0	56.6
Private Health Insurance	25.1	22.3	24.4	28.3	29.9	33.4	33.3	33.3	33.8	34.4	34.9	35.4
Out-of-Pocket	52.3	39.7	33.1	27.1	25.6	22.5	16.9	16.9	17.4	17.3	17.1	16.6
Other Private	2.2	2.8	2.7	4.3	5.1	5.0	5.1	5.4	5.4	5.3	4.9	4.6
Public Funds	20.4	35.2	39.8	40.3	39.4	39.0	44.7	44.5	43.4	43.0	43.0	43.4
Federal [2]	8.1	22.9	27.1	29.3	29.5	28.6	34.2	34.4	33.2	32.6	32.6	32.9
State and Local [2]	12.3	12.3	12.7	11.1	10.0	10.5	10.5	10.1	10.2	10.3	10.4	10.6

[1] Excludes administrative expenses, research, construction, and other types of spending that are not directed at patient care.

[2] 1998 and later, includes Medicaid SCHIP Expansion and SCHIP.

NOTE: Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS/OACT

November 2003

National Medical Care Price Indicators
(1982-1984=100)
Average Annual Index

Fiscal Year [1]	CPI: All items: Total	CPI: All items: Less Medical	CPI: All Services: Total	CPI: All Services: Less Medical	Services: Total	Services: Total	Services: CPI - Medical Care: Total	Services: Hospital and Related Services: Hospital Services	Services: Hospital and Related Services: Inpatient Services	Services: Hospital and Related Services: Outpatient Services	Services: Physicians' Services	Commodities: Total	Commodities: Prescription Drugs
Year Ending June:													
1965	31.2	31.7	26.3	27.1	24.9	22.3					24.6 [2]	45.0 [2]	48.0 [2]
1970	37.8	38.1	33.7	34.3	32.9	31.2	--				33.2	45.8	47.1
1975	51.8	52.3	46.1	46.5	45.1	44.2	--	--	--	--	45.7	51.3	49.7
Year Ending September:							--	--	--	--			
1980	80.0	80.4	75.4	75.6	73.0	72.9	66.9				74.6	73.7	70.8
1985	106.6	106.3	108.6	108.3	111.7	111.4	114.7	--		--	111.5	113.3	117.6
1990	128.7	126.9	137.2	135.0	159.2	158.9	173.4	--	--	135.1	158.0	160.2	177.5
1995	151.4	147.6	167.2	162.2	218.3	221.7	254.9	--	--	202.2	206.6	203.6	233.9
1996	155.6	151.6	172.7	167.3	226.5	230.6	266.8	--	--	212.7	214.7	208.9	240.9
1997	159.8	155.6	178.1	172.6	233.1	237.5	276.4	-- [3]	-- [3]	222.5	221.4	214.3	248.1
1998	162.4	158.0	183.1	177.3	240.1	244.8	285.2	104.1	103.2	230.9	227.6	219.7	255.4
1999	165.5	160.9	187.6	181.6	248.4	252.9	296.1	108.1	106.7	242.2	234.5	228.4	269.5
2000	170.8	166.0	193.5	187.1	258.1	263.0	312.3	114.0	112.1	259.0	242.4	236.5	282.9
2001	176.3	171.2	201.6	194.9	269.7	275.5	332.7	121.6	119.0	276.8	251.4	244.9	296.4
2002	178.9	173.4	208.1	201.0	282.2	289.0	359.5	131.6	128.4	300.8	258.7	254.4	312.9

[1] Revisions to scope, concept and methodology related to the CPI, beginning in January 1997, make comparisons with earlier periods tenuous, as the goods or services priced in 1997 and later years may differ from that priced in 1996 and earlier years. Also, shifts of the weights assigned to various goods and services have altered the composition of aggregate indexes such as "all items" and "medical care". For changes in titles of components and in definitions, see Bureau of Labor Statistics, CPI Detailed Report, January 2001.

[2] Calculated based on reported June 1964, December 1964 and June 1965 index levels.

[3] New series began in January 1997; fiscal year annual average cannot be calculated.

SOURCES: CMS/OACT and U.S. Department of Labor, Bureau of Labor Statistics

November 2003

National Medical Care Price Indicators
(1982-1984=100)
Average Annual Percent Change from Last Year Shown [1]

Fiscal Year [2]	CPI				CPI - Medical Care								
	All Items		All Services			Services						Commodities	
							Hospital and Related Services						
	Total	Less Medical	Total	Less Medical	Total	Total	Total	Hospital Services	Inpatient Services	Outpatient Services	Physicians' Services	Total	Prescription Drugs
Year Ending June:													
1965													
1970	-- 3.9	-- 3.7	-- 5.1	--4.8	--5.7	--6.9	--	--	--	--	-- 6.1	--0.4	-- -0.4
1975	6.5	6.5	6.5	6.3	6.5	7.2	--	--	--	--	6.6	2.3	1.1
Year Ending September:							--	--	--	--			
1980	8.6	8.6	9.9	9.8	9.5	9.9					9.7	7.1	7.0
1985	5.9	5.7	7.6	7.5	8.9	8.9	-- 11.4	--	--	--	8.4	9.0	10.7
1990	3.8	3.6	4.8	4.5	7.3	7.4	8.6	--	--	--	7.2	7.2	8.6
1995	3.3	3.1	4.0	3.7	6.5	6.9	8.0	--	--	--8.4	5.5	4.9	5.7
1996	2.8	2.7	3.3	3.1	3.8	4.0	4.7	--	--	5.2	3.9	2.6	3.0
1997	2.7	2.6	3.1	3.2	2.9	3.0	3.6	--	--	4.6	3.1	2.6	3.0
1998	1.6	1.5	2.8	2.7	3.0	3.1	3.2	-- [3]	-- [3]	3.8	2.8	2.5	2.9
1999	1.9	1.8	2.5	2.4	3.5	3.3	3.8	3.8	3.4	4.9	3.0	4.0	5.5
2000	3.2	3.2	3.1	3.1	3.9	4.0	5.5	5.5	5.1	6.9	3.4	3.5	5.0
2001	3.2	3.1	4.2	4.1	4.5	4.8	6.6	6.6	6.2	6.8	3.7	3.6	4.8
2002	1.5	1.3	3.2	3.1	4.6	4.9	8.1	8.2	7.9	8.7	2.9	3.9	5.6

[1] Based on average of monthly figures for given years. Percent change for 1980 year ending September is calculated as the average annual growth from year ending September 1975 to year ending September 1980.

[2] Revisions to scope, concept, and methodology related to the CPI, beginning in January 1997, make comparisons with earlier periods tenuous, as the goods or services priced in 1997 and later years may differ from that priced in 1996 and earlier years. Also, shifts of the weights assigned to various goods and services have altered the composition of aggregate indexes such as "all items" and "medical care". For changes in titles of components and in definitions, see Bureau of Labor Statistics, CPI Detailed Report, January 2001.

[3] New series begins in January 1997; fiscal year annual average percent change cannot be calculated.

SOURCES: CMS/OACT and U.S. Department of Labor, Bureau of Labor Statistics

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III. ADMINISTRATIVE/OPERATING

Information in this section concerns activities and services related to the oversight of the day-to-day operations of CMS programs. Current and trend data on trust fund operations, contractor performance and administrative costs are included.

HIGHLIGHTS

- *Medicare Hospital Insurance (HI) benefit payments grew from $2.5 billion in FY 1967 to $145.6 billion in FY 2002 (FY 2003 HI Trustees' Report). The Medicare Supplementary Medical Insurance (SMI) benefit payments increased from $0.7 billion in FY 1967 to $107.0 billion in FY 2002 (FY 2003 SMI Trustees' Report). The greatest increase to both programs occurred between 1970 and 1980, due to the addition of coverage for disabled persons beginning in 1973.*

- *Medicare total HI and SMI administrative expenses as a percent of total HI and SMI benefit payments decreased from 7.1 percent in FY 1967 to 1.7 percent in FY 2002.*

- *As of July 2003, Medicare had 28 intermediaries and 20 carriers processing claims. Between 2001 and 2002 Part A unit costs dropped slightly from $0.86 to $0.85 per claim, while Part B units costs decreased slightly over the same period, from $0.61 to $0.60.*

- *In FY 2002, covered charges on assigned claims were reduced an average of $135.31. Covered charges on unassigned claims in FY 2002 were reduced an average of $21.01.*

Medicare Operations of the HI Trust Fund

Selected Fiscal Years

		Income						Disbursements			Trust Fund	
Fiscal Year[1]	Payroll Taxes	Transfers from Railroad Retirement Account	Transfers for Uninsured Persons	Reimburse-ment for Voluntary Enrollees	Payments for Military Wage Credits	Interest and Other Income[2]	Total Income	Benefit Payments[3]	Adminis-trative Expenses[4]	Total Disburse-ments	Net Increase in Fund	Fund at End of Year
						Amount in millions						
1967	$2,689	$16	$327		$11	$46	$3,089	$2,508	$89	$2,597	$492	$1,343
1970	4,785	64	617		11	137	5,614	4,804	149	4,953	661	2,677
1975	11,291	132	481	$6	48	609	12,568	10,353	259	10,612	1,956	9,870
1980	23,244	244	697	17	141	1,072	25,415	23,790	497	24,288	1,127	14,490
1985	46,490	371	766	38	86	3,182	50,933	47,841	813	48,654	4,103[5]	21,277
1990	70,655	367	413	113	107	7,908	79,563	65,912	774	66,687	12,876	95,631
1995	98,053	396	462	998	61	14,876	114,847	113,583	1,300	114,883	-36	129,520
1996	106,934	401	419	1,107	-2,293[6]	14,565	121,135	124,088	1,229	125,317	-4,182	125,338
1997	112,725	419	481	1,279	70	13,575	128,548	136,175	1,661	137,836	-9,287	116,050
1998	121,913	419	34	1,320	67	14,449	138,203	135,487[7]	1,653	137,140	1,063	117,113
1999	134,385	430	652	1,401	71	16,075	153,015	129,463[7]	1,978	131,441	21,570	138,687
2000	137,738	465	470	1,392	2	19,614	159,681	127,934[7]	2,350	130,284	29,397	168,084
2001	151,931	470	453	1,440	-1,175[8]	17,696	171,014	139,356[7]	2,368	141,723	29,290	197,374
2002	151,575	425	442	1,525	0	25,796	179,762	145,566[7]	2,464	148,031	31,731	229,105

[1] Fiscal years 1975 and earlier consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.

[2] Other income includes recoveries of amounts reimbursed from the trust fund income that are not obligations of the trust fund, taxation of benefits, receipts from the fraud and abuse control program, and a small amount of miscellaneous income.

[3] Includes cost of Peer Review Organizations (beginning with the implementation of the Prospective Payment System on October 1, 1983), and costs of Quality Improvement Organizations beginning in 2002.

[4] Includes cost of experiments and demonstration projects and non-expenditure transfers for Health Care Fraud and Abuse Control.

[5] Includes repayment of loan principal from Old Age Survivors Insurance trust fund of $1,824 million.

[6] Includes the lump sum general revenue transfer of -$2,366 million, as provided for by section 151 of P.L. 98-21.

[7] Benefit payments plus monies transferred to the SMI trust fund for home health agency costs, as provided by P.L. 105-33.

[8] Includes the lump sum general revenue transfer of -$1,177 million, as provided for by section 151 of P.L. 98-21.

NOTE: Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS/OACT

November 2003

Medicare Operations of the SMI Trust Fund

Selected Fiscal Years

Fiscal Year [1]	Income				Disbursements			Trust Fund	
	Premiums from Participants	Government Contributions [2]	Interest and Other Income [3]	Total Income	Benefit Payments	Administrative Expenses	Total Disbursements	Net Increase in Fund	Fund at End of Year [4]
	Amount in millions								
1967	$647	$623	$15	$1,285	$664	[5]	$799		$486
1970	936	928	12	1,876	1,979	217	2,196	-321	57
1975	1,887	2,330	105	4,322	3,765	405	4,170	152	1,424
1980	2,928	6,932	415	10,275	10,144	$135 593	10,737	$486 -462	4,532
1985	5,524	17,898	1,155	24,577	21,808	922	22,730	1,847	10,646
1990	11,494 [6]	33,210 [6]	1,434 [6]	46,138 [6]	41,498	1,524 [6]	43,022 [6]	3,115 [6]	14,527 [6]
1995	19,244	36,988 [7]	1,937	58,169	63,491	1,722	65,213	-7,045	13,874 [7]
1996	18,931	61,702 [7]	1,392	82,025	67,176	1,771	68,946	13,079	26,953 [7]
1997	19,141	59,471	2,193	80,806	71,133	1,420	72,553	8,253	35,206
1998	19,427	59,919	2,608	81,955	74,837 [8]	1,435	76,272	5,683	40,889
1999	20,160	62,185	2,933	85,278	79,008 [8]	1,510	80,518	4,760	45,649
2000	20,515	65,561	3,164	89,239	87,212 [8]	1,780	88,992	247	45,896
2001	22,307	69,838	3,191	95,336	97,466 [8]	1,986	99,452	-4,116	41,780
2002	24,427	78,318	2,960	105,705	106,995 [8]	1,830	108,825	-3,121	38,659

[1] Fiscal years 1975 and earlier consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.

[2] The payments shown as being from the general fund of the Treasury include certain interest-adjustment items.

[3] Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income.

[4] The financial status of the program depends on both the total net assets and the liabilities of the program.

[5] Administrative expenses shown include those paid in fiscal years 1966 and 1967.

[6] Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

[7] General fund transfers of $6.7 billion could not be made in FY 1995 due to the absence of funding. Subsequently, a transfer was made in March 1996. Consequently, SMI government contributions are abnormally low for FY 1995 and abnormally high for FY 1996.

[8] Benefit payments less monies transferred from the HI trust fund for home health agency costs, as provided by P.L. 105-33.

NOTE: Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS/OACT

November 2003

Medicare SMI Trust Fund Income
Selected Fiscal Years

Fiscal Year	Total Income (less interest)	Premiums from Participants			Government Contributions[1,2]		
		Total	Aged	Disabled	Total	Aged	Disabled
		Amount in millions					
1967	$1,270	$647	$647	-	$623	$623	-
1970	1,863	936	936		928	928	-
1975	4,217	1,887	1,736	$151	2,330	1,711	$619
1980	9,860	2,928	2,637	291	6,932	5,608	1,324
1985	23,422	5,524	5,042	482	17,898	15,072	2,826
1990	44,704	11,494[3]	10,138	995	33,210	31,107	2,103
1995	56,232	19,244	17,126	2,117	36,988	31,146	5,842
1996	80,633	18,931	16,858	2,073	61,702	52,353	9,349
1997	78,613	19,141	16,984	2,158	59,471	51,082	8,390
1998	79,346	19,427	17,153	2,274	59,919	51,483	8,436
1999	82,345	20,160	17,722	2,438	62,185	53,653	8,532
2000	86,076	20,515	17,961	2,554	65,561	54,741	10,820
2001	92,146	22,307	19,447	2,861	69,838	57,817	12,021
2002	102,744	24,427	21,173	3,254	78,318	65,650	12,668
Percent change							
1967-2002	7,990	3,675	3,172	-	12,471	10,438	-
1975-2002	2,336	1,194	1,120	2,055	3,261	3,737	1,947
1999-2000	5	2	1	5	5	2	27
2000-2001	7	9	8	12	7	6	11
2001-2002	12	10	9	14	12	14	5

[1] Interest on delayed transfers from general funds is included.

[2] Government contributions include not only amounts to help cover program costs but adjustments to the assets to account for contingencies. Since the financing rates to determine both premium rates and government contributions are set prospectively, the financing may not be adequate to cover actual program expenditures. Consequently, trust fund assets contain contingency levels to cover the impact of a reasonable degree of variation between actual and projected expenditures. The government contributions include adjustments to maintain adequate contingency levels. Some of the adjustments increase the contingency levels when they have been depleted and in other cases decrease the levels when they are more than sufficient.

[3] Total includes the catastrophic premiums due to the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

NOTES: Totals do not necessarily equal the sum of rounded components. For more detail on fund transactions, see "Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." Legislation mandates that from January 1984 through December 1990, and January 1996 and thereafter the monthly premium for aged enrollees be kept at a constant 25 percent of expected monthly cost, i.e., one half the actuarial rate.

SOURCE: CMS/OACT November 2003

Medicare Ratio of SMI Benefit Payments to Premium Income
Selected Fiscal Years

Fiscal Year	Benefit Payments			Ratio of Benefit Payments to Premium Income		
	Total	Aged	Disabled	Total	Aged	Disabled
	Amount in Millions					
1967	$664	$664	--	1.0	1.0	--
1970	1,979	1,979	--	2.1	2.1	--
1975	3,765	3,289	$476	2.0	1.9	3.2
1980	10,144	8,497	1,647	3.5	3.2	5.7
1985	21,808	19,077	2,731	3.9	3.8	5.7
1990	41,498	36,837	4,661	3.7	3.6	4.7
1995	63,491	54,831	8,660	3.3	3.2	4.1
1996	67,176	57,816	9,360	3.5	3.4	4.5
1997	71,133	61,002	10,131	3.7	3.6	4.7
1998	75,815	65,144	10,670	3.9	3.8	4.7
1999	79,187	68,025	11,162	3.9	3.8	4.6
2000	88,918	76,450	12,468	4.3	4.3	4.9
2001	100,569	86,078	14,491	4.5	4.4	5.1
2002	108,163	91,868	16,295	4.4	4.3	5.0
Percent change						
1967-2002	16,190	13,736	--			
1975-2002	2,773	2,693	3,323			
1997-1998	7	7	5			
1998-1999	4	4	5			
1999-2000	12	12	12			
2000-2001	13	13	16			
2001-2002	8	7	12			

NOTE: For more detail on fund transactions, see "Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.'

SOURCE: CMS/OACT November 2003

Medicare Administrative Expenses
Selected Fiscal Years

Fiscal Year	Administrative Expenses: Amount in Millions	Administrative Expenses: 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
1996	1,229	1.0
1997	1,661 [1]	1.2
1998	1,653 [1]	1.2
1999	1,978 [1]	1.5
2000	2,350 [1]	1.9
2001	2,368 [1]	1.7
2002	2,464 [1]	1.7
SMI Trust Fund		
1967	135 [2]	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
1996	1,771	2.6
1997	1,420	2.0
1998	1,435	1.9
1999	1,510	1.9
2000	1,780	2.0
2001	1,986	2.0
2002	1,830	1.7

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

SOURCE: CMS/OACT November 2003

Medicare Contractors
2003

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

NOTE: Data as of July 2003.

SOURCE: CMS/OFM

Medicare Claims Processing Costs
Selected Fiscal Years

	Net Unit Cost per Claim						
	1975	1980	1985	1990	2000	2001	2002
Intermediaries [1]	$3.84	$2.96	$2.33	$1.86	$0.86 [3]	$0.86 [3]	$0.85 [3]
Carriers [2]	$2.90	$2.33	$1.88	$1.56	$0.63	$0.61	$0.60

[1] Includes direct costs and overhead costs for bill payment, reconsiderations and hearings lines.

[2] Includes direct costs and overhead costs for the claims payment, reviews and hearings, and beneficiary/physician inquiries lines.

[3] Beginning in FY 1998, inquiries and PET activities are separated from other bill payment cost for intermediaries.

SOURCE: CMS/OFM

Medicare Appeals
Fiscal Years 2001 - 2002

	2001		2002	
	Intermediary Reconsiderations	Carrier Reviews	Intermediary Reconsiderations	Carrier Reviews
Number Processed	50,143	3,722,068	34,739	3,898,383
Percent With Increased Payments	25.1	64.3	28.0	61.8

SOURCE: CMS/OFM

November 2003

Medicare Physician/Supplier Claims Charge Reductions
Selected Fiscal years 1980 - 2002

Fiscal Year	Claims Approved		Total Covered Charges		
	Number in thousands	Percent Reduced	Amount in millions	Percent Reduced	Amount Reduced per Claim
Assigned (HCFA-1490/1500)					
1980	70,937	80.0	$6,878	22.5	$21.81
1985	168,587	81.7	20,743	27.0	33.19
1986	188,075	82.5	24,108	28.4	36.43
1987	222,277	83.0	29,436	27.9	36.90
1988	264,096	85.5	36,083	29.3	39.97
1989	295,666	86.3	41,852	30.9	43.72
1990	329,061	87.6	48,711	32.6	48.22
1991	373,250	86.7	57,547	35.2	54.20
1992	406,502	87.0	66,062	39.2	63.60
1993	446,475	88.2	74,261	42.1	70.08
1994	496,264	88.1	82,855	42.5	71.03
1995	534,972	86.4	91,672	42.2	72.31
1996	544,639	87.1	96,205	44.4	78.42
1997	564,461	87.5	102,279	45.7	82.74
1998	573,077	87.6	105,682	46.5	85.91
1999	586,227	88.7	113,008	47.5	91.76
2000	612,875	88.3	124,024	47.7	96.69
2001	646,131	87.7	139,272	47.9	103.22
2002	722,826	87.7	152,373	56.3	135.31
Unassigned (HCFA-1490/1500)					
1980	66,207	83.7	$6,527	22.3	$21.96
1985	77,646	84.6	10,051	25.6	33.12
1986	84,853	84.9	10,581	26.6	33.15
1987	85,160	82.5	10,516	25.5	31.44
1988	78,484	85.7	9,351	24.7	29.47
1989	74,621	89.2	8,794	25.2	29.67
1990	75,879	90.3	8,702	25.3	28.97
1991	78,450	90.7	8,134	24.0	24.84
1992	69,522	85.4	6,671	19.8	18.95
1993	54,096	85.5	4,724	16.9	14.75
1994	42,544	86.7	3,489	16.4	13.45
1995	32,695	83.9	2,725	15.6	13.01
1996	24,390	84.5	2,071	15.6	13.22
1997	19,765	84.4	1,726	16.3	14.23
1998	16,051	82.9	1,450	16.9	15.26
1999	14,061	81.6	1,321	17.5	16.49
2000	13,128	79.4	1,301	18.1	17.85
2001	12,200	77.7	1,254	18.1	18.59
2002	11,352	79.8	1,107	17.2	21.01

NOTE: Charge reduction is the total dollar amount reduced as a result of charge determination made by a carrier.

SOURCE: CMS/OFM November 2003

Medicare Charge Determination Data for Physician/Supplier Claims
Selected Fiscal Years 1975-2002

Fiscal Year	Claims Paid or Applied to Deductible: Number in thousands	Claims Paid or Applied to Deductible: Total Covered Charges in thousands	Claims on Which Charge Reductions Were Made: Number in thousands	Claims on Which Charge Reductions Were Made: Percent of Claims Paid or Applied to Deductible	Amount of Reduction: Total in thousands	Amount of Reduction: Percent of Covered Charges	Amount of Reduction: Avg. Amount per Approved Claim
1975	75,694	$5,324,636	50,738	67.0	$863,847	16.2	$11.41
1980	145,157	13,765,039	113,707	78.3	3,063,364	22.3	21.10
1985	246,337	30,800,071	203,405	82.6	8,168,817	26.5	33.16
1986	272,969	34,692,565	227,127	83.2	9,664,309	27.9	35.40
1987	307,437	39,952,727	254,672	82.8	10,879,839	27.2	35.39
1988	342,580	45,434,338	293,027	85.5	12,867,579	28.3	37.56
1989	370,288	50,646,122	321,851	86.9	15,139,981	29.9	40.89
1990	404,939	57,413,496	356,775	88.1	18,063,716	31.5	44.61
1991	451,700	65,680,424	394,615	87.4	22,179,014	33.8	49.10
1992	476,024	72,733,350	413,095	86.8	27,170,734	37.4	57.08
1993	500,572	78,984,666	439,888	87.9	32,089,244	40.6	64.11
1994	538,808	86,344,476	473,907	88.0	35,823,544	41.5	66.49
1995	567,666	94,396,848	489,467	86.2	39,108,517	41.4	68.89
1996	569,029	98,276,302	494,764	86.9	43,035,169	43.8	75.63
1997	584,226	104,004,862	510,568	87.4	46,987,436	45.2	80.43
1998	589,128	107,132,423	515,427	87.5	49,475,682	46.2	83.98
1999	600,288	114,329,416	531,776	88.6	54,023,415	47.3	90.00
2000	626,003	125,325,545	551,784	88.1	59,491,359	47.5	95.03
2001	658,003	140,525,531	576,428	87.6	66,918,719	47.6	101.65
2002	721,854	164,157,590	637,918	88.4	82,053,460	50.0	113.67

NOTE: Data prior to July 1, 1976 exclude claims handled by the Social Security Administration's Office of Direct Reimbursement.

SOURCE: CMS/OFM

November 2003

Medicaid Administrative Expenses
Fiscal Years 2000 - 2002

	2000	2001	2002
	Amount in thousands		
Total Payments Computable for Federal Funding [1]	$10,577,053	$11,880,615	$11,931,761
Federal Share [1]			
Family Planning	$24,045	$23,198	$24,246
Design, Development or Installation of MMIS [2]	73,439	141,923	248,448
Skilled Professional Medical Personnel	391,825	327,814	370,312
Operation of an Approved MMIS [2]	847,718	962,534	1,006,146
Mechanized Systems Not Approved Under MMIS	68,811	82,503	76,930
All Other	4,486,357	5,017,419	4,875,267
Total Federal Share	$5,892,195	$6,555,391	$6,601,349
Net Adjusted Federal Share [3]	$5,732,484	$6,357,267	$6,976,026

[1] Source: Form CMS-64 (Net Expenditures Reported -- Administration).

[2] Medicaid Management Information System.

[3] Includes CMS adjustments.

SOURCE: CMS/CMSO

November 2003

IV. POPULATIONS

Information about persons covered by Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) and Medicaid.

Medicare statistics are based on persons enrolled for coverage. Medicaid recipient counts are used as a surrogate of persons eligible for coverage. Current and trend data showing demographic and eligibility category distributions are included.

HIGHLIGHTS

- *In 2002, 85 percent of the Medicare population was age 65 and over.*
- *An estimated 95 percent of the total aged population has some type of Medicare coverage.*
- *In 2002, approximately 93.0 percent of the total Medicare population was covered by both Part A and Part B.*
- *The Medicare Part A beneficiaries ages 85 and over, as a percent of all aged beneficiaries, increased from 6.2 percent in 1966 to 12.7 percent in 2002. During this same time period, the 65 to 69 year age group, as a percent of all aged beneficiaries, decreased from 34.1 percent in 1966 to 26.9 percent in 2002.*
- *The Medicare female beneficiaries enrolled in Medicare Part A, as a percent of all aged beneficiaries, increased from 57.4 percent in 1966 to 58.2 percent in 2002. During this same time period, the Medicare male beneficiaries enrolled in Medicare Part A, as a percent of all aged beneficiaries, decreased from 42.6 percent in 1966 to 41.8 percent in 2002.*
- *There has been an increase of 11.1 percent in the number of Medicare State Buy-Ins between 1999 and 2002.*

Medicare Enrollees
Selected Years

	1975	1980	1985	1990	1995	2000	2001	2002	2003	2004
					Number in millions					
HI and/or SMI										
Total	24.9	28.4	31.1	34.3	37.6	39.7	40.1	40.7	41.1	41.7
Aged	22.7	25.5	28.1	31.0	33.2	34.3	34.5	34.7	35.0	35.3
Disabled	2.2	3.0	2.9	3.3	4.4	5.4	5.6	6.0	6.1	6.4
HI										
Total	24.5	28.0	30.6	33.7	37.2	39.3	39.7	40.3	40.7	41.3
Aged	22.3	25.0	27.7	30.5	32.7	33.8	34.0	34.3	34.6	34.9
Disabled	2.2	3.0	2.9	3.3	4.4	5.4	5.6	6.0	6.1	6.4
SMI										
Total	23.7	27.3	29.9	32.6	35.6	37.3	37.7	38.0	38.5	39.0
Aged	21.8	24.6	27.2	29.6	31.7	32.6	32.7	32.9	33.1	33.4
Disabled	1.9	2.7	2.7	2.9	3.9	4.8	4.9	5.1	5.4	5.6
HI and SMI	23.4	26.8	29.4	32.1	35.2	36.9	37.2	37.6	38.1	38.6
HI Only	1.1	1.2	1.2	1.7	2.0	2.4	2.4	2.7	2.6	2.7
SMI Only	0.4	0.4	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4

NOTES: Data through 2002 are historical and may have been revised from earlier editions. Data for FY 2003 and FY 2004 represent projections.

SOURCE: CMS/OACT

November 2003

Medicare HI and/or SMI Enrollment Demographics
2002

	Total	Male	Female
All Persons	40,488,871	17,611,865	22,877,006
Aged Persons	34,668,073	14,411,865	20,256,208
65 - 74	17,758,208	8,139,843	9,618,365
75 - 84	12,464,716	4,971,089	7,493,627
85 and over	4,445,149	1,300,933	3,144,216
Disabled Persons	5,820,798	3,200,000	2,620,798
Under 45	1,679,135	958,752	720,383
45 - 54	1,798,469	993,658	804,811
55 - 64	2,343,194	1,247,590	1,095,604
White	34,275,473	14,893,674	19,381,799
Black	3,877,608	1,643,205	2,234,403
All Other	2,244,509	1,043,322	1,201,187
Native American	141,698	63,853	77,845
Asian/Pacific Islander	600,753	261,100	339,653
Hispanic	935,215	442,490	492,725
Other	566,843	275,879	290,964
Unknown Race	91,281	31,664	59,617

NOTES: Data as of July 1 based on the 100% Denominator File. Data by race are shown by the expanded categories specified by the Office of Management and Budget's Statistical Directive 15 (Federal Register, 1978). The use of the category of Other reflects CMS's use of SSA's Master Beneficiary Record which was not expanded. See Arday et al., "HCFA's Racial and Ethnic Data: Current Accuracy and Recent Improvements," HCF Review, Vol. 21, No. 4.

SOURCE: CMS/ORDI

Medicare HI and/or SMI Enrollment End Stage Renal Disease Demographics 2002

	Number of Enrollees
All Persons	379,434
Age	
Under 35	29,119
35-44	40,505
45-64	142,643
65 and over	167,167
Sex	
Male	207,235
Female	172,199
Race	
White	212,168
Non-white	166,222
Unknown	1,044

NOTES: Data reflect persons ever enrolled during the year. Based on the 2002 Denominator File.

SOURCE: CMS/ORDI November 2003

Year	All Persons	Percent Distribution of Aged Enrollees by Sex and Race							
		Male				Female			
		Total	White	Non-White	Unknown	Total	White	Non-White	Unknown
1966	100.0	42.6	38.6	3.4	0.6	57.4	50.8	4.1	2.5
1970	100.0	41.8	37.4	3.5	0.9	58.2	51.9	4.4	1.9
1975	100.0	40.8	36.2	3.6	1.0	59.2	52.8	4.7	1.7
1980	100.0	40.4	35.7	3.7	1.1	59.5	52.9	4.9	1.7
1985	100.0	40.3	35.4	3.7	1.2	59.7	52.8	5.1	1.8
1990	100.0	40.3	35.2	3.9	1.2	57.7	52.1	5.8	1.9
1995	100.0	40.7	35.9	3.8	1.0	59.3	52.2	5.8	1.4
1999	100.0	41.0	35.6	3.8	1.5	59.0	50.8	6.1	2.1
2000	100.0	41.3	36.2	5.0	0.1	58.7	51.2	7.3	0.2
2001	100.0	41.5	36.3	5.1	0.1	58.5	50.9	7.4	0.2
2002	100.0	41.7	36.4	5.3	0.1	58.3	50.6	7.6	0.2

NOTES: Data as of July. Totals do not necessarily equal the sum of rounded components. Beginning in 2000, the 100% Denominator File was used for preparing estimates of distribution by age groups and race. The detail on race available in that source allows additional breakouts of some non-white enrollees formerly classified as unknown.

SOURCES: CMS/OIS/ORDI

November 2003

Medicare HI Enrollment Demographics
Selected Years

Year	Number in thousands	Percent Distribution by Age						Median Age in Years
		Total	65-69	70-74	75-79	80-84	85+	
1966	19,082	100.0	34.1	28.7	19.8	11.2	6.2	72.6
1970	20,361	100.0	33.3	27.2	20.3	12.0	7.2	73.0
1975	22,472	100.0	33.5	26.3	19.3	12.5	8.4	73.0
1980	25,104	100.0	33.1	26.3	18.8	12.2	9.6	73.0
1985	27,683	100.0	31.9	26.3	19.2	12.3	10.3	73.3
1990	30,464	100.0	31.4	25.7	19.5	12.7	10.7	73.5
1995	32,742	100.0	28.7	26.4	19.8	13.5	11.6	74.0
1999	33,519	100.0	26.8	25.5	21.3	14.0	12.4	74.6
2000	33,841	100.0	26.9	25.1	21.3	14.2	12.6	74.6
2001	34,039	100.0	26.8	24.8	21.1	14.5	12.7	74.7
2002	34,380	100.0	26.9	24.6	21.1	15.0	12.4	74.7

Medicare State Buy-Ins for SMI
1999 - 2002

Type of Beneficiary [1]	1999	2000	2001	2002
All Persons				
Number	5,391,704	5,549,170	5,744,330	5,990,769
Percent of SMI Enrolled	14.5	14.9	15.2	15.1
Aged				
Number	3,562,777	3,632,069	3,713,670	3,832,036
Percent of SMI Enrolled	11.0	11.1	11.3	11.3
Disabled				
Number	1,828,927	1,917,101	2,030,660	2,158,731
Percent of SMI Enrolled	40.5	41.2	41.2	40.4

' Buy-ins represent beneficiaries in person-years for whom the State paid the Medicare SMI premium during the year. Percent calculated using Part B person-years.

SOURCE: CMS/ORDI November 2003

Medicaid Enrollment and Beneficiaries
Selected Fiscal Years

	1975	1980	1985	1990	1995	1999	2000	2001	2002	2003	2004
Enrollment (person-years)						Number in millions					
Total	NA	NA	NA	22.9	33.4	32.8	34.0	37.7	39.9	41.4	42.4
Aged	NA	NA	NA	3.1	3.7	3.8	3.9	4.0	4.2	4.3	4.3
Blind/Disabled	NA	NA	NA	3.8	5.8	6.6	6.8	7.2	7.5	7.8	7.9
Children	NA	NA	NA	10.7	16.5	16.3	16.7	17.5	18.4	19.1	19.6
Adults	NA	NA	NA	4.9	6.7	6.2	6.7	8.9	9.8	10.3	10.6
Other Title XIX	NA	NA	NA	0.5	0.6	NA	NA	NA	NA	NA	NA
Beneficiaries						Number in millions					
Total	22.4	21.6	21.8	25.3	36.3	42.9	44.5	48.4	51.4	53.3	54.6
Aged	3.7	3.4	3.1	3.2	4.2	4.5	4.6	4.8	4.9	5.0	5.1
Blind/Disabled	2.4	2.8	3.0	3.7	6.0	7.3	7.5	8.0	8.3	8.6	8.8
Children	9.8	9.3	9.8	11.2	17.6	21.3	22.0	23.7	25.0	25.9	26.6
Adults	4.7	4.8	5.5	6.0	7.8	9.7	10.4	12.0	13.2	13.8	14.2
Other Title XIX	1.9	1.5	1.2	1.1	0.6	NA	NA	NA	NA	NA	NA

NOTES: Beneficiaries are enrollees on behalf of whom at least one payment is made during the fiscal year. Prior to 1991, beneficiary categories do not add to total because beneficiaries could be reported in more than one category. Totals after 1990 may not add due to rounding. Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty level recipients who are not disabled. Beneficiary data for fiscal years 1975-1995 are historical data from OIS as reported by states. Enrollment and beneficiary projections for fiscal years 1999-2004 were prepared by the Office of the Actuary for the President's FY 2004 budget. FY 1998-2004 do not include the State Children's Health Insurance Program (SCHIP).

In 1997, the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories. In 1998, Medicaid beneficiaries were redefined to include enrollees on behalf of whom a capitation payment is paid. The large increase between 1995 and 1999 is primarily the result of this change of definition.

SOURCES: CMS/CMSO/OIS/OACT

November 2003

Medicaid Beneficiary Demographics
Selected Fiscal Years

	1997	1998	1999	2000
All Beneficiaries in thousands	33,579	40,096	40,264	44,638
		Percent Distribution		
Age	100.0	100.0	100.0	100.0
Under 21	51.8	51.9	51.0	55.0
21 - 64	31.5	30.3	28.9	33.6
65 and over	13.6	11.6	10.7	11.1
Unknown	3.0	6.2	9.5	0.2
Sex	100.0	100.0	100.0	100.0
Male	37.5	36.7	36.4	39.7
Female	59.4	55.8	54.1	60.1
Unknown	3.1	7.5	9.5	0.2
Race	100.0	100.0	100.0	100.0
White	46.1	41.8	41.1	43.9
Black	24.4	24.6	24.2	25.3
American Indian/Alaskan Native	1.0	0.8	1.2	1.4
Asian/Pacific Islander	2.0	2.5	2.0	2.2
Hispanic	14.8	15.8	15.7	19.8
Native Hawaiian or Other Pacific Islander	NA	NA	0.3	0.4
Unknown	11.6	14.4	15.5	6.9

NOTES: The percent distribution is based on rounded numbers. Totals do not necessarily equal the sum of rounded components. These estimates may differ from those based on Medicaid person-years of enrollment. Beginning in FY 1998, Medicaid recipients were renamed beneficiaries and were redefined to include those eligibles for whom a capitated payment was made.

SOURCES: CMS/CMSO/OIS November 2003

Life Expectancy at Birth and at Age 65 by Race and Sex: United States
Selected Calendar Years

Calendar Year	All Races			White			Black		
	Both Sexes	Male	Female	Both Sexes	Male	Female	Both Sexes	Male	Female
				At Birth					
1950	68.2	65.6	71.1	69.1	66.5	72.2	60.7	58.9	62.7
1980	73.7	70.0	77.4	74.4	70.7	78.1	68.1	63.8	72.5
1985	74.7	71.1	78.2	75.3	71.8	78.7	69.3	65.0	73.4
1990	75.4	71.8	78.8	76.1	72.7	79.4	69.1	64.5	73.6
1995	75.8	72.5	78.9	76.5	73.4	79.6	69.6	65.2	73.9
1996	76.1	73.1	79.1	76.8	73.9	79.7	70.2	66.1	74.2
1997	76.5	73.6	79.4	77.1	74.3	79.9	71.1	67.2	74.7
1998	76.7	73.8	79.5	77.3	74.5	80.0	71.3	67.6	74.8
1999	76.7	73.9	79.4	77.3	74.6	79.9	71.4	67.8	74.7
2000	77.0	74.3	79.7	77.6	74.9	80.1	71.9	68.3	75.2
2001 [1]	77.2	74.4	79.8	77.7	75.0	80.2	72.2	68.6	75.5
				At Age 65					
1950	13.9	12.8	15.0	NA	12.8	15.1	13.9	12.9	14.9
1980	16.4	14.1	18.3	16.5	14.2	18.4	15.1	13.0	16.8
1985	16.7	14.5	18.5	16.8	14.5	18.7	15.2	13.0	16.9
1990	17.2	15.1	18.9	17.3	15.2	19.1	15.4	13.2	17.2
1995	17.4	15.6	18.9	17.6	15.7	19.1	15.6	13.6	17.1
1996	17.5	15.7	19.0	17.6	15.8	19.1	15.8	13.9	17.2
1997	17.7	15.9	19.2	17.8	16.0	19.3	16.1	14.2	17.6
1998	17.8	16.0	19.2	17.8	16.1	19.3	16.1	14.3	17.4
1999	17.7	16.1	19.1	17.8	16.1	19.2	16.0	14.3	17.3
2000	18.0	16.2	19.3	18.0	16.3	19.4	16.2	14.2	17.7
2001 [1]	18.1	16.4	19.4	18.2	16.5	19.5	16.4	14.4	17.9

[1] Preliminary data for 2001.

SOURCE: Public Health Service, Health United States, 2003

November 2003

Life Expectancy at Age 65
Based on U.S. Life Table Functions

Calendar Year	Male	Female
	Number in years	
1965	12.9	16.3
1970	13.1	17.1
1975	13.7	18.0
1980	14.0	18.4
1985	14.4	18.6
1990	15.0	19.0
1991	15.1	19.1
1992	15.2	19.2
1993	15.1	19.0
1994	15.3	19.0
1995	15.3	19.0
1996	15.4	19.0
1997	15.5	19.1
1998	15.6	19.0
1999	15.7	18.9
2000 [1]	15.8	18.9
2005 [2]	16.1	19.0
2010 [2]	16.4	19.3
2015 [2]	16.7	19.6
2020 [2]	17.0	19.9
2025 [2]	17.3	20.2
2030 [2]	17.7	20.5
2035 [2]	18.0	20.8
2040 [2]	18.3	21.1
2045 [2]	18.5	21.4
2050 [2]	18.8	21.7
2055 [2]	19.1	21.9
2060 [2]	19.4	22.2
2065 [2]	19.6	22.5
2070 [2]	19.9	22.7
2075 [2]	20.2	23.0

[1] Preliminary or estimated.

[2] Projected.

NOTE: The life expectancy is the average number of years of life remaining to a person if he were to experience the age-specific mortality rates for the tabulated year throughout the remainder of his life.

SOURCE: SSA/OACT November 2003

V. UTILIZATION

Information about the use of health care services.

Current and trend data measuring health care use including: (1) persons served; (2) units of service, e.g., discharges, days of care; and (3) dimension of the services rendered, e.g. length of stay, charges per day. Utilization data are distributed for program coverage categories and type of service.

HIGHLIGHTS

- *The number of aged Medicare enrollees who received a covered service increased from 528 per 1,000 in 1975 to 918 per 1,000 enrollees in 2001.*

- *The number of disabled Medicare enrollees receiving services per 1,000 enrollees increased from 450 to 843 during the same period.*

- *The total number of all outpatient visits in the United States and the adjusted expense per patient day has increased steadily since 1983.*

- *The Medicare average length of stay for all short-stay and excluded units has been dropping for the past several years.*

- *The Medicare persons served rate per 1,000 enrollees for skilled nursing facilities has grown five-fold from 1982 to 2001. The rate of persons served by home health agencies grew dramatically (over 2 1/2 times) from 1982 through 1997 and has since declined.*

Medicare Short-Stay Hospital Utilization
Selected Fiscal Years

	1990	1998	1999	2000	2001	2002
Discharges						
Total in millions	10.5	11.9	11.7	11.8	12.2	12.5
Rate per 1,000 Enrollees [1]	313	319	310	303	310	314
Days of Care						
Total in millions	94	74	71	71	73	74
Rate per 1,000 Enrollees [1]	2,805	1,972	1,897	1,825	1,846	1,860
Average Length of Stay						
All short-stay	9.0	6.2	6.1	6.0	6.0	5.9
Excluded Units [2]	19.5	12.9	12.6	12.3	12.0	11.7
Total Charges per Day	$1,060	$2,332	$2,496	$2,720	$3,027	$3,506

[1] The population base is HI enrollment excluding HI enrollees residing in foreign countries and should be treated as preliminary.

[2] Includes alcohol/drug, psychiatric, and rehabilitation units through 1990, and psychiatric and rehabilitation units from 1997 through 2002.

NOTES: Data may reflect under reporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; and no-pay Medicare secondary payer bills. Average length of stay is shown in days. The data for 1990 through 2002 are based on 100 percent MEDPAR. Data may differ from other sources or from the same source with different update cycle.

SOURCE: CMS/OIS

November 2003

Medicare Short-Stay Hospital Days per Person by Days of Care
Calendar Year 2001

Total Days of Care	Persons Using Number of Days	Percent Distribution	Cumulative Percent Distribution	Total Days Used	Percent Distribution	Days Per Person
TOTAL	7,193,920	100.0	---	72,606,870	100.0	10.1
1 day	733,855	10.2	10.2	733,855	1.0	1.0
2 days	766,990	10.7	20.9	1,533,980	2.1	2.0
3 days	789,390	11.0	31.8	2,368,170	3.3	3.0
4 days	679,080	9.4	41.3	2,716,320	3.7	4.0
5 days	536,225	7.5	48.7	2,681,125	3.7	5.0
6 days	439,710	6.1	54.8	2,638,260	3.6	6.0
7 days	375,940	5.2	60.1	2,631,580	3.6	7.0
8 days	308,340	4.3	64.4	2,466,720	3.4	8.0
9 days	255,680	3.6	67.9	2,301,120	3.2	9.0
10 days	220,010	3.1	71.0	2,200,100	3.0	10.0
11 days	191,950	2.7	73.6	2,111,450	2.9	11.0
12 days	166,960	2.3	76.0	2,003,520	2.8	12.0
13 days	148,770	2.1	78.0	1,934,010	2.7	13.0
14 days	138,165	1.9	79.9	1,934,310	2.7	14.0
15 days	121,235	1.7	81.6	1,818,525	2.5	15.0
16 days	105,940	1.5	83.1	1,695,040	2.3	16.0
17 days	95,445	1.3	84.4	1,622,565	2.2	17.0
18 days	85,500	1.2	85.6	1,539,000	2.1	18.0
19 days	76,185	1.1	86.7	1,447,515	2.0	19.0
20 days	70,240	1.0	87.7	1,404,800	1.9	20.0
21-30 days	446,470	6.2	93.9	11,070,390	15.2	24.8
31-40 days	200,470	2.8	96.6	6,997,655	9.6	34.9
41-50 days	101,800	1.4	98.1	4,578,630	6.3	45.0
51-60 days	55,035	0.8	98.8	3,029,910	4.2	55.1
61-90 days	61,950	0.9	99.7	4,457,240	6.1	71.9
91 days or more	22,585	0.3	100.0	2,691,080	3.7	119.2

NOTES: These data reflect total individual hospital days during the calendar year. A beneficiary may have multiple hospital stays. Days from all stays are combined. Calendar year data are derived from 2001 MEDPAR stay file. This file includes stays recorded in CMS central office through June 2002. Totals do not necessarily equal the sum of rounded components. Data may differ from other sources or from the same source with different update cycle.

SOURCE: CMS/ORDI November 2003

Medicare Short-Stay Hospital Discharges by Length of Stay
Calendar Year 2001

Total Length of Stay	Discharges (aged and disabled) Number	Percent Distribution	Cumulative Percent Distribution	Total Days of Care Number	Percent Distribution	Cumulative Percent Distribution
TOTAL	12,230,660	100.0	--	72,606,870	100.0	--
1 day	1,653,965	13.5	13.5	1,653,965	2.3	2.3
2 days	1,707,475	14.0	27.5	3,414,950	4.7	7.0
3 days	1,781,920	14.6	42.1	5,345,760	7.4	14.3
4 days	1,510,440	12.3	54.4	6,041,760	8.3	22.7
5 days	1,143,920	9.4	63.8	5,719,600	7.9	30.5
6 days	888,180	7.3	71.0	5,329,080	7.3	37.9
7 days	720,865	5.9	76.9	5,046,055	6.9	44.8
8 days	532,400	4.4	81.3	4,259,200	5.9	50.7
9 days	388,910	3.2	84.4	3,500,190	4.8	55.5
10 days	308,895	2.5	87.0	3,088,950	4.3	59.8
11 days	245,495	2.0	89.0	2,700,445	3.7	63.5
12 days	194,620	1.6	90.6	2,335,440	3.2	66.7
13 days	166,420	1.4	91.9	2,163,460	3.0	69.7
14 days	152,815	1.2	93.2	2,139,410	2.9	72.6
15 days	120,215	1.0	94.2	1,803,225	2.5	75.1
16 days	91,430	0.7	94.9	1,462,880	2.0	77.1
17 days	75,950	0.6	95.5	1,291,150	1.8	78.9
18 days	63,840	0.5	96.1	1,149,120	1.6	80.5
19 days	54,120	0.4	96.5	1,028,280	1.4	81.9
20 days	48,790	0.4	96.9	975,800	1.3	83.3
21-30 days	246,975	2.0	98.9	6,022,800	8.3	91.5
31-40 days	71,625	0.6	99.5	2,479,715	3.4	95.0
41-50 days	29,690	0.2	99.7	1,329,135	1.8	96.8
51-60 days	13,365	0.1	99.9	734,050	1.0	97.8
61-90 days	13,400	0.1	100.0	962,690	1.3	99.1
91 days or more	4,940	0.0	100.0	629,760	0.9	100.0

NOTES: These data reflect individual stays. A beneficiary may use more than one stay and each is counted separately. Calendar year data are derived from the 2001 MEDPAR stay file. This file includes stays recorded in CMS central office through June 2002. Totals do not necessarily equal the sum of rounded components. Data may differ from other sources or from the same source with different update cycle.

SOURCE: CMS/ORDI November 2003

Medicare Short-Stay Hospital DRGs Ranked by Discharges

Fiscal Year 2001

Rank	DRG No.	DRG Relative Weight	Discharges[1] Number	Discharges[1] Percent	Average Length of Stay	Average Charges Per Discharge	Total Payments[2] (in thousands)	Total Medicare Payments (in thousands)	Beneficiary Payments[3] (in thousands)	Average Payments[4] Total	Average Payments[4] Medicare	Average Payments[4] Beneficiary
			12,192,174	100.0	6.0	18,019	$94,012,882	$86,949,363	$7,063,519	$7,221	$6,667	$554
			Dischar									
1	127	1.0135	686,830	5.6	5.3	12,467	3,603,784	3,258,989	344,795	5,045	4,546	499
2	089	1.0638	506,410	4.2	5.9	12,745	2,698,699	2,403,574	295,126	5,494	4,883	612
3	088	0.9314	399,849	3.3	5.1	10,934	1,829,334	1,604,216	225,118	4,431	3,873	558
4	209	2.0902	373,905	3.1	5.0	24,864	3,797,007	3,538,489	258,518	9,204	8,572	632
5	116	2.4225	368,837	3.0	3.6	28,851	4,534,966	4,317,271	217,695	10,964	10,440	524
6	014	1.2205	324,461	2.7	5.9	14,821	1,988,095	1,786,815	201,279	5,832	5,219	612
7	430	0.7659	323,840	2.7	11.0	13,651	2,063,591	1,863,347	200,245	6,124	5,530	595
8	462	1.2426	280,502	2.3	12.5	19,313	2,670,174	2,611,264	58,909	9,216	9,009	206
9	182	0.7922	263,115	2.2	4.4	9,748	1,052,786	908,098	144,688	3,568	3,060	508
10	296	0.8594	253,599	2.1	5.1	10,642	1,144,615	1,017,637	126,978	4,733	4,202	530
11	143	0.5403	252,329	2.1	2.1	6,676	690,693	532,888	157,805	4,152	3,677	475
12	174	0.9981	248,967	2.0	4.8	12,316	1,277,125	1,137,843	139,282	2,176	1,666	510
13	138	0.8288	204,852	1.7	4.0	10,168	867,051	752,577	114,474	3,868	3,340	528
14	320	0.8625	195,006	1.6	5.3	10,750	875,799	766,417	109,382	4,199	3,658	541
15	416	1.5287	182,551	1.5	7.5	20,058	1,521,465	1,419,259	102,205	7,954	7,392	562
16	121	1.6191	168,331	1.4	6.3	18,952	1,328,266	1,238,997	89,269	8,394	7,861	533
17	079	1.6471	167,416	1.4	8.5	20,179	1,437,822	1,349,403	88,419	7,010	6,917	519
18	132	0.6703	153,664	1.3	3.0	7,891	504,555	424,515	80,040	3,109	2,608	501
19	015	0.7486	153,329	1.3	3.5	9,185	573,649	475,595	98,054	3,420	2,817	603
20	124	1.4152	138,328	1.1	4.4	17,799	995,290	917,917	77,373	6,692	6,161	532
21	148	3.4317	130,662	1.1	12.3	42,826	2,511,942	2,426,954	84,988	18,537	17,893	644
22	210	1.8074	122,481	1.0	6.9	22,295	1,110,702	1,032,861	77,841	8,682	8,052	630
23	316	1.3444	117,726	1.0	6.6	17,097	875,244	817,671	57,573	11,806	11,308	497
24	478	2.3372	110,211	0.9	7.4	30,731	1,448,624	1,387,693	60,931	19,858	19,239	619
25	475	3.6949	104,740	0.9	11.2	46,665	2,188,472	2,121,352	67,120	6,882	6,705	177

[1] Based on the stay records for 100% of Medicare aged and disabled beneficiaries as recorded in the MEDPAR file.

[2] Total payments represent total hospital revenue for Medicare enrollee utilization, including Medicare payments and beneficiary obligations. Excluded bills for no-pay, at-risk managed care utilization and no-pay Medicare secondary payer bills.

[3] Beneficiary payments are the responsibility of the beneficiary or other third party payer.

[4] Average payments are calculated using actual dollar amount, not rounded data as shown.

SOURCE: CMS/OIS

November 2003

Medicare Ranking for all Short-Stay Hospital
Fiscal Year 2001 versus 2000

2001 FY Rank	2000[1]	DRG Number	Descriptions
1	1	127	Heart Failure and Shock
2	2	089	Simple Pneumonia and Pleurisy, Age over 17 with Complicating Conditions
3	3	088	Chronic Obstructive Pulmonary Disease
4	4	209	Major Joint and Limb Reattachment Procedures
5	5	116	Oth perm cardiac pacemaker implant or aicd lead or generator proc
6	6	014	Specific Cerebrovascular Disorders Except Transient Ischemic Attack
7	7	430	Psychoses
8	8	462	Rehabilitation
9	9	182	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders, Age over 17 with Complicating Conditions
10	11	296	Nutritional and Miscellaneous Metabolic Disorders, Age over 17 with Complicating Conditions
11	12	143	Chest Pain
12	10	174	Gastrointestinal Hemorrhage with Complicating Conditions
13	13	138	Cardiac Arrhythmia and Conduction Disorders, with Complicating Conditions
14	14	320	Kidney and Urinary Tract Infections, Age over 17 with Complicating Conditions
15	15	416	Septicemia, Age over 17
16	17	121	Circulatory Disorders with Acute Myocardial Infarction, with Cardiovascular Complications, Discharged Alive
17	16	079	Respiratory Infections and Inflammations, Age over 17 with Complicating Conditions
18	18	132	Atherosclerosis with Complicating Conditions
19	19	015	Transient Ischemic Attack and Precerebral Occlusions
20	20	124	Circulatory Disorders excluding Acute Myocardial Infarction, with Cardiovascular Catheter with Complex Diagnosis
21	21	148	Major small and large bowel procedures with cc
22	22	210	Hip and Femur Procedures except Major Joint, Age over 17 with Complicating Conditions
23	25	316	Renal Failure
24	23	478	Other Vascular Procedures with Complicating Conditions
25	24	475	Respiratory system diagnosis with ventilator support

[1]Ranked by Discharges

SOURCE: CMS/OIS

November 2003

Calendar Year 2002

Medicare Leading Part B Procedure Codes Based on Allowed Charges

Procedure Code		Allowed Charges	Percent of Allowed Charges[1]
All Procedure Codes[2] (Levels I, II, and III)		$83,399,058,271	100.0
Leading Procedure Codes[3] (Level I only)		38,508,412,766	46.2
99213	Office/outpatient visit, est	5,135,909,899	6.2
99214	Office/outpatient visit, est	3,374,687,464	4.0
99232	Subsequent hospital care	2,439,627,530	2.9
66984	Cataract surg w/iol, 1 stage	2,020,055,245	2.4
99233	Subsequent hospital care	1,103,828,725	1.3
99212	Office/outpatient visit, est	992,799,175	1.2
88305	Tissue exam by pathologist	823,574,116	1.0
99223	Initial hospital care	773,825,023	0.9
99231	Subsequent hospital care	754,566,852	0.9
92014	Eye exam & treatment	740,852,726	0.9
99285	Emergency dept visit	740,027,676	0.9
99244	Office consultation	732,774,369	0.9
78465	Heart image (3d), multiple	708,643,047	0.8
99215	Office/outpatient visit, est	684,729,538	0.8
99254	Initial inpatient consult	673,635,373	0.8
93307	Echo exam of heart	603,149,408	0.7
90921	ESRD related services, month	540,802,671	0.6
99284	Emergency dept visit	492,134,457	0.6
97110	Therapeutic exercises	486,199,885	0.6
99243	Office consultation	473,541,460	0.6
99255	Initial inpatient consult	471,032,245	0.6
99312	Nursing fac care, subseq	463,148,503	0.6
99291	Critical care, first hour	448,933,130	0.5
99238	Hospital discharge day	417,207,776	0.5
99203	Office/outpatient visit, new	415,505,718	0.5

Medicare Leading Part B Procedure Codes Based on Allowed Charges (continued)

Calendar Year 2002

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
92012	Eye exam established pat	390,720,583	0.5
99222	Initial hospital care	378,406,679	0.5
99245	Office consultation	373,237,844	0.4
99204	Office/outpatient visit, new	371,364,372	0.4
90806	Psytx, off, 45-50 min	368,294,082	0.4
45378	Diagnostic colonoscopy	347,733,934	0.4
70553	Mri brain w/o&w dye	333,649,737	0.4
27447	Total knee arthroplasty	300,343,123	0.4
99253	Initial inpatient consult	297,960,606	0.4
98941	Chiropractic manipulation	297,305,864	0.4
99283	Emergency dept visit	295,402,782	0.4
93325	Doppler color flow add-on	276,148,257	0.3
76092	Mammogram, screening	274,257,424	0.3
71020	Chest x-ray	272,646,517	0.3
93000	Electrocardiogram, complete	271,240,550	0.3
45385	Lesion removal colonoscopy	270,247,820	0.3
93320	Doppler echo exam, heart	265,674,391	0.3
66821	After cataract laser surgery	255,897,932	0.3
17000	Destroy benign/premlg lesion	253,307,625	0.3
43239	Upper GI endoscopy, biopsy	250,263,546	0.3
92980	Insert intracoronary stent	240,294,372	0.3
77427	Radiation tx management, x5	236,172,618	0.3
93510	Left heart catheterization	229,401,226	0.3
80061	Lipid panel	228,619,508	0.3
90862	Medication management	228,461,192	0.3
33533	CABG, arterial, single	228,402,806	0.3
72148	Mri lumbar spine w/o dye	227,710,995	0.3
93880	Extracranial study	226,477,543	0.3
84443	Assay thyroid stim hormone	223,164,591	0.3
99211	Office/outpatient visit, est	221,179,928	0.3
92004	Eye exam, new patient	220,169,479	0.3
11721	Debride nail, 6 or more	218,294,303	0.3
20610	Drain/inject, joint/bursa	213,397,608	0.3

Medicare Leading Part B Procedure Codes Based on Allowed Charges (continued)
Calendar Year 2002

Procedure Code	Description	Allowed Charges	Percent of Allowed Charges[1]
99311	Nursing fac care, subseq	211,057,433	0.3
17003	Destroy lesions, 2-14	197,261,378	0.2
80053	Comprehen metabolic panel	194,865,256	0.2
76075	Dexa, axial skeleton study	193,387,505	0.2
99313	Nursing fac care, subseq	189,528,593	0.2
98940	Chiropractic manipulation	187,905,863	0.2
93015	Cardiovascular stress test	179,759,402	0.2
74160	Ct abdomen w/dye	177,912,842	0.2
72193	Ct pelvis w/dye	177,079,140	0.2
99205	Office/outpatient visit, new	175,952,987	0.2
99202	Office/outpatient visit, new	174,058,439	0.2
14200	Anesth, lens surgery	172,518,064	0.2
71010	Chest x-ray	172,391,616	0.2
70450	Ct head/brain w/o dye	172,049,065	0.2
52000	Cystoscopy	168,374,042	0.2
45380	Colonoscopy and biopsy	167,269,293	0.2

[1] Allowed charges for leading Level I procedure codes are shown as a percent of all physician and supplier allowed charges (Levels I, II, and III) submitted to Part B carriers.

[2] The total number of procedure codes (Levels I, II and III) is 11,261.

[3] Allowed charges were aggregated by procedure code and include both the physician and ASC allowed charges. The above listed 74 procedure codes (out of a total of 8,031 Level I codes) account for approximately 46% of all allowed charges.

SOURCE: CMS/OIS November 2003

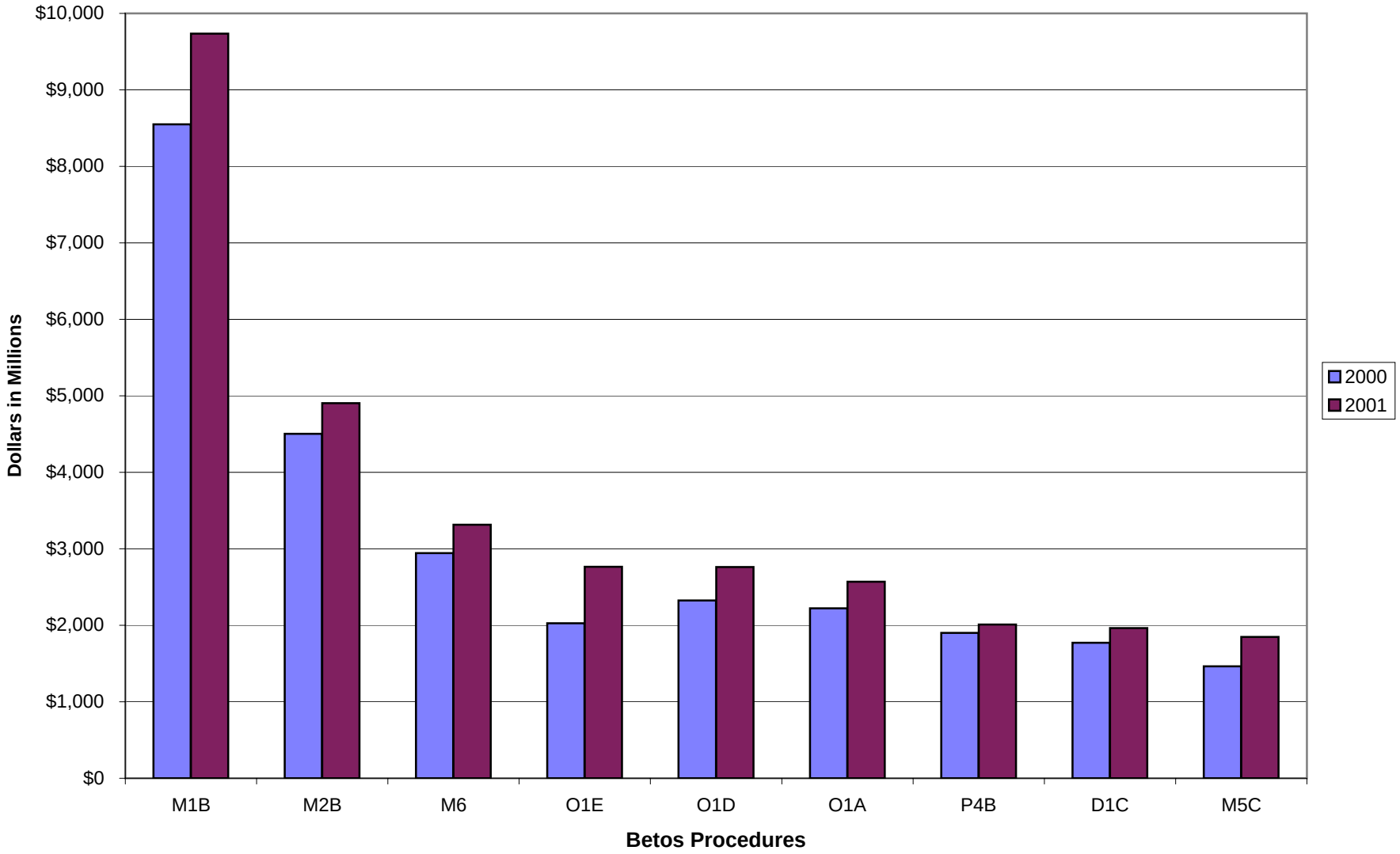
Leading Medicare Physician and Supplier BETOS Procedures Based on Allowed Charges Calendar Years 2000 and 2001

Betos Code	Description	Medicare Allowed Charges 2000	2001
M1B	Office Visits - Established	$8,548,562,453	$9,736,079,591
M2B	Hospital Visit - Subsequent	4,502,138,903	4,902,921,054
M6	Consultations	2,944,063,178	3,314,346,197
01E	Other Drugs	2,026,307,436	2,765,739,546
O1D	Chemotherapy	2,322,767,817	2,763,102,313
O1A	Ambulance	2,221,895,701	2,567,573,485
P4B	Eye Procedure - Cataract/Removal Lens Insertion	1,901,684,180	2,009,967,157
D1C	Oxygen and Supplies	1,773,277,946	1,964,082,934
M5C	Specialist - Ophthalmology	1,462,799,020	1,847,504,784

NOTE: BETOS is the Berenson/Eggers Type of Service classification system, a joint Urban Institute/Centers for Medicare & Medicaid Services effort.

SOURCE: CMS/OIS

Betos Allowed Charges



SOURCE: CMS/OIS

November 2003

Medicare Persons Served by Type of Coverage
Selected Calendar Years

	1975	1980	1985	1995	2000	2001
Aged Persons Served						
per 1,000 Enrollees	528	638	722	826	916	918
HI and/or SMI	221	240	219	218	232	233
HI	536	652	739	858	965	968
SMI						
Disabled Persons Served						
per 1,000 Enrollees	450	594	669	759	835	843
HI and/or SMI	219	246	228	212	196	199
HI	471	634	715	837	943	952
SMI						

NOTES: Prior to 1998, utilization rates per 1,000 enrollees came from the Annual Person Summary 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.

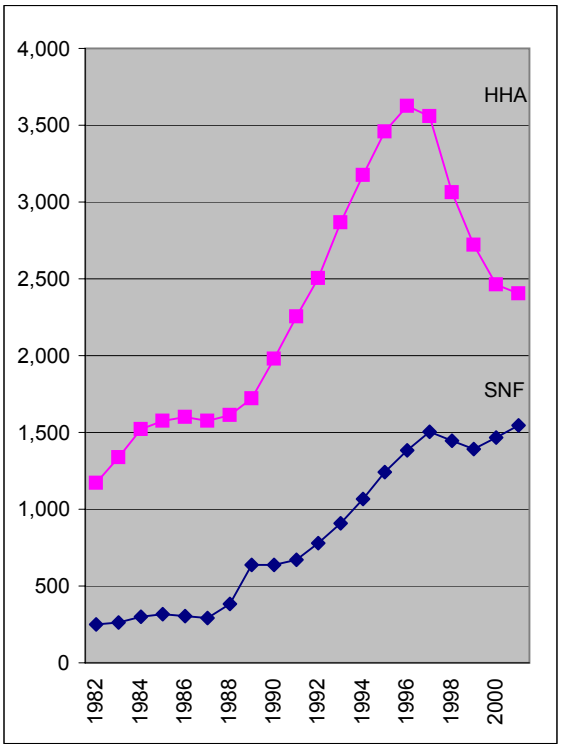
SOURCES: CMS/OIS/ORDI

Medicare Use of Selected Types of Long-Term Care
Calendar Years 1982 - 2001

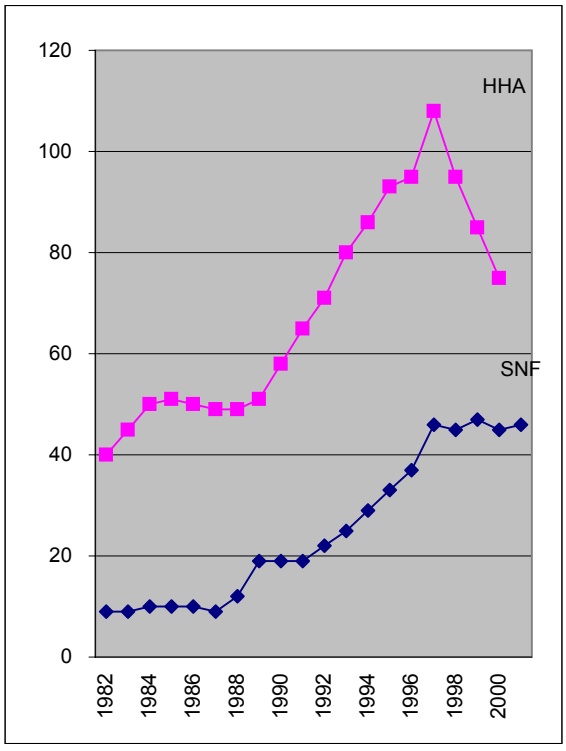
Calendar Year	Skilled Nursing Facilities		Home Health Agencies	
	Persons Served in thousands	Rate Per 1,000 Enrollees	Persons Served in thousands	Rate Per 1,000 Enrollees
1982	252	9	1,172	40
1983	264	9	1,338	45
1984	299	10	1,522	50
1985	315	10	1,576	51
1986	304	10	1,601	50
1987	293	9	1,575	49
1988	384	12	1,613	49
1989	636	19	1,721	51
1990	638	19	1,978	58
1991	670	19	2,255	65
1992	779	22	2,504	71
1993	908	25	2,867	80
1994	1,068	29	3,176	86
1995	1,240	33	3,457	93
1996	1,384	37	3,627	95
1997	1,503	46 [1]	3,558	108 [1]
1998	1,447	45 [1]	3,062	95 [1]
1999	1,390	47 [1]	2,720	85 [1]
2000	1,468	45 [1]	2,461	75 [1]
2001	1,545	46 [1]	2,403	71 [1]

[1] Excludes managed care enrollees in rate.

Persons Served in Thousands



Rates Per 1,000 Enrollees



SOURCES: CMS/ORDI

November 2003

End Stage Renal Disease Care Provided by Medicare Approved Facilities Selected Calendar Years

	1990	1998	1999	2000	2001
Dialysis Patients	129,800	245,710	259,493	273,333	285,982
Outpatient	107,160	216,310	231,032	245,207	258,195
Home	22,640	29,400	28,461	28,126	27,787
Dialysis Patient Eligibility Status					
Medicare	113,127	207,218	216,232	227,238	227,238
Medicare Application Pending	9,582	14,512	16,279	18,763	18,763
Non-Medicare	7,091	23,980	26,982	27,332	27,332
Transplant Patients	9,779	13,272	13,483	14,311	14,628
Transplant Patient Eligibility Status					
Medicare	8,340	10,241	9,900	10,260	10,669
Medicare Application Pending	633	1,105	1,183	1,540	1,777
Non-Medicare	806	1,918	2,395	2,500	2,162
Transplant Procedures	9,796	13,272	13,483	14,311	14,628
Living Related Donor	2,001	3,453	3,583	4,052	4,236
Living Unrelated Donor	90	1,067	1,061	1,375	1,568
Cadaveric Donor	7,705	8,752	8,839	8,884	8,824
Medicare Approved ESRD Facilities	2,072	3,586	3,917	4,153	4,163
Dialysis (Hospital and Non-Hospital)	1,799	3,307	3,637	3,869	3,994
Transplant and Dialysis	169	148	145	146	135
Transplant Only	53	87	92	96	105
Inpatient Care Only	51	44	43	42	34
Average Dialysis Payment Rate	$127	$127	$127	$129	$129
Hospital Based	129	129	129	131	131
Independents	125	125	125	127	127

SOURCES: CMS/OCSQ/CMM November 2003

Home Health Agency - Medicare National Summary

Calendar Year	Total Patients	Total Reimbursement	Total Visits	Average Reimbursement Per Patient	Average Visits Per Patient
2000	2,479,629	$7,352,198,941	90,729,921	$2,965	37
2001	2,425,688	8,636,629,198	73,697,665	3,560	30
2002	2,550,343	9,640,624,039	78,102,658	3,780	31

NOTE: Data include Puerto Rico, Virgin Islands, and unknown.

Hospice - Medicare National State Summary

Calendar Year	Total Patients	Total Reimbursement	Total Covered Days	Average Reimbursement Per Patient	Average Days Per Patient
2000	534,261	$2,926,546,746	25,814,389	$5,478	48
2001	594,436	3,690,388,745	30,555,548	6,208	51
2002	661,462	4,540,386,929	37,333,045	6,864	56

NOTE: Data include Puerto Rico.

Skilled Nursing Facilities Non Swing Bed - Medicare National Summary

Calendar Year	Total Discharges	Total Reimbursement	Total Covered Days	Average Reimbursement Per Discharge	Average Days Per Discharge
2000	1,438,690	$10,420,208,068	44,103,335	$7,243	31
2001	1,520,272	12,691,872,771	47,775,760	8,348	31
2002	1,601,049	13,998,617,587	52,787,085	8,743	33

NOTES: Data include Puerto Rico, Virgin Islands, and unknown. Data does not include swing bed units.

Outpatient - Medicare National Summary

Calendar Year	Total Patients	Total Charges	Total Payments	Average Charge Per Patient	Average Payment Per Patient
2000	21,039,207	$52,631,299,474	$16,893,178,592	$2,502	$803
2001	22,153,102	75,153,892,284	20,232,524,712	3,392	913
2002	23,001,276	97,319,821,467	23,234,195,040	4,231	1,010

NOTE: Data include Puerto Rico, Virgin Islands, and unknown.

SOURCES: CMS/OIS/HCIS November 2003

Medicaid Recipients by Type of Service
Fiscal Years 1998 - 2000

	1998	1999	2000
Total	40,096	39,962	42,763
Inpatient Services			
General Hospitals	4,270	4,492	4,933
Mental Hospitals	135	97	99
Nursing Facilities Services [1]	1,646	1,612	1,703
ICF Services			
Mentally Retarded	126	122	118
Physician Services	18,553	18,296	19,104
Dental Services	4,965	5,616	5,892
Other Practitioner Services	4,342	3,964	4,735
Outpatient Hospital Services	12,158	12,355	13,226
Clinic Services	5,281	6,719	7,667
Laboratory & Radiological	9,381	10,132	11,396
Home Health Services	1,225	811	995
Personal Care Support Services	3,108	4,071	4,549
Prescribed Drugs	19,338	19,819	20,517
Family Planning Services/Sterilization	1,963	133	137
Rural Health Clinics	NA	NA	NA
Early and Periodic Screening	6,175	NA	NA
Home & Community Based Waiver Services	467	NA	NA
Prepaid Health Care	19,670	20,510	21,261
PCCM Services	4,066	3,890	5,560
Other Care	6,975	8,489	9,037
Unknown	NA	136	176

[1] Nursing facilities services recipients include individuals other than the mentally retarded receiving "all other" intermediate care facility services.

SOURCES: CMS/CMSO/ORDI

November 2003

National Community Hospital Utilization
1973 - 2001

Year	Admissions in millions	Inpatient Days in millions	Average Stay in days	Outpatient Visits in millions	Adjusted Expenses per Inpatient Day
1973	31.7	248	7.8	173	$102
1974	32.9	255	7.8	189	114
1975	33.4	258	7.7	191	134
1976	34.0	261	7.7	201	153
1977	34.3	261	7.6	199	174
1978	34.5	262	7.6	202	194
1979	35.1	265	7.6	199	217
1980	36.1	273	7.6	202	245
1981	36.4	278	7.6	203	284
1982	36.4	278	7.6	248	327
1983	36.2	273	7.6	210	369
1984	35.2	257	7.3	212	411
1985	33.4	237	7.1	219	460
1986	32.4	229	7.1	232	501
1987	31.6	227	7.2	246	539
1988	31.5	227	7.2	269	586
1989	31.1	225	7.2	286	637
1990	31.2	226	7.2	301	687
1991	31.1	223	7.2	322	752
1992	31.0	221	7.1	349	820
1993	30.7	216	7.0	367	881
1994	30.7	207	6.7	383	931
1995	30.9	200	6.5	414	968
1996	31.1	194	6.2	440	1,006
1997	31.6	193	6.1	450	1,033
1998	31.8	191	6.0	474	1,067
1999	32.4	192	5.9	495	1,103
2000	33.0	192	5.8	521	1,149
2001	33.8	194	5.7	538	1,217

SOURCE: American Hospital Association November 2003

VI. PROVIDERS/SUPPLIERS

Information in this section concerns institutions, agencies or professionals who provide health care services and furnish health care equipment or supplies. Medicare and Medicaid providers are combined in this section since Medicare providers are deemed certified for the Medicaid program. Additional information on providers of services are contained in STATE DATA (Section VII).

HIGHLIGHTS

- *From 1980 to the beginning of 2003, the number of inpatient hospital facilities decreased 11.1 percent from 6,777 to 6,024. Beds per 1,000 enrollees dropped from 46.7 in 1980 to 23.9 in 2003. During this same period, the number of psychiatric hospitals increased from 408 to 487, but their beds per 1,000 enrollees dropped from 5.3 to 1.5.*

- *Skilled nursing facilities have nearly tripled from 5,052 in 1980 to 14,838 in 2003. Home health agencies have more than doubled from 2,924 in 1980 to 6,928 in 2003.*

- *The number of ambulatory surgical centers increased tenfold from 336 in 1985 to 3,567 in 2003. During this same period the number of hospices increased from 164 to 2,323.*

- *By January 2003, 176,947 facilities had registered under the Clinical Lab Improvement Act which became effective 10/1/92.*

- *End-Stage Renal Disease facilities have quadrupled from 999 in 1980 to 4,309 in 2003.*

- *The percent of Medicare assigned claims (51.9 percent in 1975) continues to increase, from 98.1 percent in 2001 to 98.3 percent in 2002.*

- *As of January 2002, enrollment in the Medicare participating physician program was 89.3 percent. By January 2003, the enrollment was 91.5 percent.*

- *As of March 1985, Medicare had 154 HMO/CMP plans with 1.1 million enrollees. By August 2003, there were 270 managed care plans with 5.3 million enrollees.*

Medicare Hospital Status
June 2003

Total Hospitals	6,051
Hospitals under any Hospital Prospective Payment System (PPS) [1]	4,537
Short-Term Hospitals under Inpatient PPS (IPPS)	995
--Regional Referral Centers	195
--Sole Community Hospitals	512
--Sole Community/Regional Referral Center	85
--Medicare Dependent Hospitals	162
--Indian Health Service Hospitals	41
--Not Receiving Special Consideration	3,113
Long-Term Hospital under Long-Term Care Hospital PPS (LTCH PPS)	213
Rehabilitation Hospital under Inpatient Rehabilitation Facility PPS (IRF PPS)	216
Hospitals Currently Exempt or Not Yet Transitioned in to PPS (as of 6/30/03)	1,514
Psychiatric	480
Religious Non-Medical	15
Childrens	81
Long-Term Facility (not yet transitioned in to LTCH PPS)	86
Critical Access (formerly Short-Term)	788
Short-Term Hospitals in MD, VI, AS, GU, and NMI (Exempt from IPPS)	53
Cancer Hospitals (Short-Term Hospitals Exempt from IPPS)	11
Total Hospital Units (PPS and Non-PPS)	2,394
Psychiatric	1,410
Rehabilitation	984

[1] Total number of hospitals subject to PPS regardless of actual submitted inpatient hospital claims during the fiscal year.

NOTES: This table is designed to give a "snapshot" as of the end of June 2003 of hospitals participating in the program by the type of provider (short term, long term, rehab, etc.) and by their payment status (PPS, waived from PPS, not yet transitioned in to PPS, etc.). Status determined for hospitals listed as active and participating in Medicare on the June 2003 Provider of Service (POS) File. PPS and Special Consideration Status under PPS determined using provider lists from CMM and the Provider Specific File which may reflect cumulative history as opposed to current status. Numbers may differ from other reports and program memoranda.

SOURCES: CMS/CMM/CMSO/ORDI November 2003

Medicare Inpatient Hospitals
Selected Years

	1980	1985	1990	2002	2003
Total Hospitals	6,777	6,707	6,520	6,002	6,024
Beds in thousands	1,150	1,144	1,105	969	958
Beds per 1,000 Enrollees [1]	46.7	42.5	37.0	24.5	23.9
Short-Stay	6,104	6,034	5,549	4,429	4,231
Beds in thousands	991	1,027	970	844	835
Beds per 1,000 Enrollees [1]	40.2	38.2	32.5	21.3	20.8
Psychiatric	408	474	674	494	487
Beds in thousands	131	95	99	67	61
Beds per 1,000 Enrollees [1]	5.3	3.5	3.3	1.7	1.5
Other Long-Stay	265	199	297	1,079	1,306
Beds in thousands	28	22	35	58	62
Beds per 1,000 Enrollees [1]	1.1	0.8	1.2	1.5	1.6

[1] Based on number of HI enrollees.

NOTES: Facility data for selected years 1980-1990 are as of July 1. Facility data for 2002 and 2003 are as of December 31, 2001 and December 31, 2002, respectively, and represent essentially those facilities eligible to participate the start of the calendar year. Facilities certified for Medicare are deemed to meet Medicaid standards.

'SOURCES: CMS/ORDI/OIS

Other Medicare Providers and Suppliers
Selected Years

	1980	1985	1990	2002	2003
Skilled Nursing Facilities	5,052	6,451	8,937	14,755	14,838
Beds in thousands	436	NA	509	1,050	1,261
Home Health Agencies	2,924	5,679	5,730	6,813	6,928
Clinical Lab Improvement Act Facilities	NA	NA	NA	173,807	176,947
End Stage Renal Disease Facilities	999	1,393	1,937	4,113	4,309
Outpatient Physical Therapy	419	854	1,195	2,836	2,961
Portable X-Ray	216	308	443	644	641
Rural Health Clinics	391	428	551	3,283	3,306
Comprehensive Outpatient Rehabilitation Facilities	NA	72	186	524	587
Ambulatory Surgical Centers	NA	336	1,197	3,371	3,597
Hospices	NA	164	825	2,275	2,323

NOTES: Facility data for selected years 1980-1990 are as of July 1. Facility data for 2002 and 2003 are as of December 31, 2001 and December 31, 2002, respectively, and represent essentially those facilities eligible to participate the start of the calendar year. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCES: CMS/ORDI/OIS November 2003

Selected Medicare Facilities by Type of Control
2003

	Short Stay Hospitals	Skilled Nursing Facilities	Home Health Agencies
All Facilities	4,231	14,838	6,928
	Percent Distribution		
Voluntary	60.6	28.2	34.2
Proprietary	15.6	66.7	51.2
Government	23.8	5.1	14.6

NOTES: Data as of December 31, 2002. Facilities certified for Medicare are deemed to meet Medicaid standards. Percent distribution may not add to 100 percent due to rounding.

SOURCES: CMS/ORDI/OIS

Medicare PIP Facilities
Selected Years

	1975	1980	1985	1990	1999	2000	2001	2002
Hospitals								
Number of PIP	1,524	2,276	3,242	1,352	915	869	754	687
Percent of Total Participating	22.5	33.8	48.3	20.6	15.3	14.4	12.5	11.4
Skilled Nursing Facilities								
Number of PIP	161	203	224	774	1,387	1,236	1,161	862
Percent of Total Participating	4.1	3.9	3.4	7.3	9.3	8.3	7.9	5.8
Home Health Agencies								
Number of PIP	86	481	931	1,211	1,122	1,038	42	40
Percent of Total Participating	3.8	16.0	16.0	21.0	14.3	14.4	0.1	0.1

NOTES: Data from 1985 to date are as of September; prior years 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 (P.L. 99-509) eliminates PIP for many PPS hospitals when the servicing intermediary meets specified processing time standards.

SOURCE: CMS/OFM November 2003

Participation Status	Number of Physicians [1]	Participation Status			
		January 2003	January 2002	January 2001	January 2000
Participating	846,423	91.5%	89.3%	88.7%	88.3%
Billing Medicare	925,508				

Medicare Participating Physician Program

[1] Includes M.D.s, D.O.s, limited license practitioners, and non-physician practitioners.

NOTES: The participating physician program was originally enacted as a part of the 1984 Deficit Reduction Act (DEFRA). Congress provided additional incentives through the 1986 Omnibus Budget Reconciliation Act (OBRA). CMS wrote to physicians to explain the benefits of participation beginning January 1, 1989. Participation counts reflect physicians who are participating in at least one practice setting. For example, a physician who is participating in private practice but not in his group practice is counted as participating.

SOURCE: CMS/OFM

Medicare Assigned Claims
Selected Fiscal Years

Fiscal Year	Net Assignment Rate [1]
1975	51.9
1980	51.4
1985	67.7
1990	80.9
1991	82.5
1992	85.4
1993	89.2
1994	92.1
1995	94.2
1996	95.6
1997	96.5
1998	97.2
1999	97.5
2000	97.8
2001	98.1
2002	98.3

[1] The net assignment rate is the percentage of assigned claims to total assigned/unassigned claims received. If a physician or supplier agrees to accept assignment, he or she agrees not to charge more than the Medicare approved fee for a particular service.

SOURCE: CMS/OFM November 2003

Participation Rates as Percentage of Physicians, by Specialty
Selected Periods

	Apr. 1990 Dec. 1990	Jan. 1995 Dec. 1995	Jan. 1998 Dec. 1998	Jan. 1999 Dec. 1999	Jan. 2000 Dec. 2000	Jan. 2001 Dec. 2001	Jan.2002 Dec. 2002	Jan.2003 Dec. 2003
	Percent of Physicians Participating							
Physicians (M.D.s and D.O.s):								
General practice	39.7	59.9	71.1	73.7	80.2	79.0	80.2	84.3
General surgery	55.8	80.2	89.3	90.4	93.3	92.5	92.8	95.6
Otology, laryngology, rhinology	45.2	77.1	87.7	88.7	91.8	91.3	91.7	93.9
Anesthesiology	30.8	73.9	85.9	88.9	93.7	92.3	92.3	95.5
Cardiovascular disease	60.6	84.9	91.5	92.9	95.8	94.4	94.3	96.4
Dermatology	53.4	79.3	87.2	88.0	90.8	90.1	90.1	92.4
Family practice	47.2	74.5	85.9	86.9	90.8	90.3	90.8	93.2
Internal medicine	48.8	73.8	84.8	86.8	90.7	88.7	88.8	92.2
Neurology	53.1	78.9	87.1	88.4	92.1	89.9	89.1	93.3
Obstetrics-gynecology	48.8	72.5	81.3	82.9	86.8	86.3	86.5	88.8
Ophthalmology	55.6	81.2	89.8	90.9	93.3	92.8	93.3	95.1
Orthopedic surgery	53.7	82.6	90.4	90.6	93.8	93.1	92.4	95.5
Pathology	53.4	78.9	86.6	89.8	93.6	92.2	92.0	95.4
Psychiatry	41.6	58.7	70.4	73.9	79.1	79.6	80.4	83.0
Radiology	55.6	82.8	88.3	91.6	95.3	91.9	91.6	95.7
Urology	49.6	83.0	90.6	91.5	94.6	93.8	93.6	96.0
Nephrology	66.5	87.0	91.3	93.0	95.1	93.6	93.6	95.5
Clinic or other group practice - not GPPP	68.7	79.4	90.1	89.2	91.6	92.7	93.5	93.4
Limited license practitioners (LLP):								
Chiropractor	26.2	42.6	54.3	56.3	59.4	63.0	64.4	65.2
Podiatry-surgical chiropody	54.0	79.2	87.9	88.4	90.7	91.6	92.1	92.3
Optometrist	54.0	66.9	74.7	76.0	78.4	80.0	80.6	82.4

NOTE: Effective with the October 1, 1985 election period, carriers were instructed to count individuals only once, even if practicing in multiple settings.

SOURCE: CMS/OFM

November 2003

Medicare Benefit and Premium Summary
Medicare+Choice Coordinated Care Plans
Contract Year 2003

Specific Benefits	Percent of Plans Offering Benefits: In Standard Package	Percent of Plans Offering Benefits: For an Additional Premium
Vision Exams	86.6	1.3
Hearing Exams	66.4	0.2
Prescription Drugs	67.3	3.1
Eyewear	60.1	4.5
Hearing Aids	35.6	0.9
Chiropractic	0.0	6.7
Podiatry	0.0	3.1
Preventive Dental	29.0	11.1
Comprehensive Dental	9.4	9.1
Point of Service	0.0	2.0
Inpatient Hospital greater than FFS Medicare	86.2	0.0
SNF greater than FFS Medicare	0.9	0.4
Worldwide Coverage (Emergency/Urgent Care)	83.1	0.0
Physical Exams	91.8	0.0
Health Education/Wellness	73.1	0.0

Median PCP Copayment (Physician Office Visit)	$10.00
Median Generic Drug Copayment	$10.00
Median Brand Name Drug Copayment	$30.00

Premium [1] Distribution (Percent of Packages)

Range	Percent
$0.00	34.3
$0.01 - $20.00	2.2
$20.01 - $40.00	14.5
$40.01 - $60.00	10.5
$60.01 - $80.00	15.8
$80.01 - $100.00	11.4
More than $100.00	11.4
Median Plan Premium 2002	$40.00

[1] The premium is the monthly payment made by the beneficiary to the health insurance organization.

SOURCE: CMS/CBC November 2003

Medicare Contracts with Prepaid Organizations

Type of Contract	Number of Contracts	Number of Enrollees	Payment FY 2003 to date in millions
Total Prepaid Organizations	270	5,304,299	$33,281.7
Medicare+Choice Programs	150	4,622,154	30,284.2
TEFRA Cost (Cost 1, Cost 2, Cost C)	30	335,114	874.4
Demonstrations and/or PPOs	54	218,319	1,811.3
HCPPs Part B (Health Care Prepayment Plans)	15	102,215	152.9
PFFS	4	23,555	123.9
PACE	17	2,942	35.0

NOTES: The Balanced Budget Act of 1997 changed the requirements regarding effective dates of coverage. As a result, the numbers do not include beneficiaries who changed enrollment status in the latter part of each month. Therefore, the total number of enrollees is understated. This understatement will continue for all future months until the report modifications have been completed. As of August 1, 2003.

SOURCE: CMS/CBC November 2003

Medicare Summary of Monthly Risk Contracts

Date	Number of Contracts	Total Enrollees	Monthly Payment in millions
2000			
January	348	6,831,637	3,307
February	346	6,848,119	3,292
March	346	6,853,392	3,276
April	345	6,865,504	3,328
May	343	6,856,197	3,307
June	343	6,866,435	3,292
July	345	6,872,270	3,395
August	343	6,873,845	3,339
September	344	6,868,985	3,365
October	343	6,860,037	3,327
November	343	6,847,912	3,351
December	343	6,826,877	3,334
2001			
January	247	6,153,976	3,085
February	247	6,199,297	3,151
March	250	6,225,458	3,246
April	250	6,225,282	3,209
May	249	6,185,684	3,194
June	250	6,179,262	3,199
July	250	6,179,980	3,208
August	250	6,173,178	3,238
September	251	6,159,822	3,247
October	251	6,144,528	3,191
November	252	6,106,141	3,165
December	253	6,061,252	3,142
2002			
January	224	5,575,853	3,046
February	224	5,587,200	3,089
March	225	5,575,175	3,047
April	225	5,561,679	3,068
May	224	5,541,519	3,033
June	224	5,532,808	3,040
July	224	5,525,427	3,040
August	227	5,522,252	3,061
September	229	5,518,569	3,061
October	229	5,516,293	3,052
November	240	5,501,326	3,034
December	240	5,494,284	3,053

SOURCE: CMS/CBC November 2003

Medicare Summary of Risk and Cost Contracts by Category

Type of Contract	Number of Contracts	Percent	Number of Enrollees	Percent
HCPP Contracts				
Model				
Group	10	67	69,252	68
Union	2	13	19,329	19
Employer Group	1	7	4,221	4
IPA	1	7	2,913	3
Other	1	6	6,500	6
Ownership				
Profit	1	7	2,913	3
Nonprofit	13	93	92,802	97
Cost Contracts [1]				
Model				
IPA	11	37	193,828	58
Group	16	53	134,859	40
Staff	3	10	6,427	2
Ownership				
Profit	7	23	46,789	14
Nonprofit	23	77	288,325	86
CCP Contracts [1]				
Model				
IPA	76	54	2,550,229	56
Group	55	39	1,505,259	33
Staff	11	7	471,292	11
Ownership				
Profit	96	67	2,598,494	57
NonProfit	48	33	1,958,431	43
PACE Contracts				
Model				
Group	10	100	1,302	100
Ownership				
Profit	8	50	1,227	44
NonProfit	8	50	1,590	56
PFFS Contracts				
Model				
Group	2	100	2,005	100
Ownership				
Profit	3	100	21,863	100

[1] Does not include cost enrollees remaining in risk plans.

NOTES: Data as of August 2003. IPA is the Individual Practice Association.

SOURCE: CMS/CBC November 2003

Active Physicians

Year	Total	Type of Physician		Active Physicians per 10,000 Population
		Doctors of Medicine	Doctors of Osteopathy	
1970	323,525	310,929	12,596	15.7
1971	334,978	322,228	12,750	16.1
1972	346,179	333,259	12,920	16.5
1973	NA	NA	13,191	NA
1974	364,232	350,609	13,623	17.0
1975	380,402	366,425	13,977	17.6
1976	393,151	378,572	14,579	18.0
1977	397,113	381,969	15,144	18.0
1978	417,314	401,364	15,590	18.7
1979	434,095	417,266	16,829	19.2
1980	435,165	435,545	17,620	19.8
1981	463,330	444,899	18,431	20.1
1982	482,195	462,947	19,248	20.7
1983	499,679	479,440	20,239	21.3
1984	NA	NA	21,295	NA
1985	533,573	511,090	22,483	22.3
1986	543,247	519,393	23,854	22.5
1987	559,777	534,692	25,085	23.0
1988	575,626	549,160	26,466	23.4
1989	587,751	559,988	27,763	23.7
1990	601,612	572,660	28,952	24.0
1991	624,797	594,697	30,100	24.6
1992	636,891	605,685	31,206	24.8
1993	652,240	619,751	32,489	24.9
1994	666,200	632,121	34,079	25.2
1995	681,742	646,022	35,720	25.5
1996	701,249	663,943	37,306	26.0
1997	723,537	684,605	38,932	27.0
1998	747,784	707,032	40,752	27.5
1999	763,519	720,855	42,664	27.9
2000	782,280	737,504	44,776	27.8
2001	793,091	751,689	41,402	27.8

NOTES: The AMA changed the methodology for calculating active MDs. Active MDs now include All Not Classified MDs, and excludes physicians whose addresses are unknown.

SOURCES: National Centers for Health Statistics, based on data from the American Medical Association, American Association of Colleges of Osteopathic Medicine and the Bureau of the Census

November 2003

Active Federal and Non-Federal Physicians By CMS Region 2001

CMS Region	Total	Type of Physician: Doctors of Medicine	Type of Physician: Doctors of Osteopathy	Active Physicians per 100,000 Population [1]
Total	793,091	751,689	41,402	278
Boston	53,134	51,737	1,397	378
New York	104,586	99,528	5,058	379
Philadelphia	93,638	87,323	6,315	334
Atlanta	128,843	123,942	4,901	238
Chicago	134,039	123,474	10,565	266
Dallas	75,622	71,429	4,193	223
Kansas City	31,457	28,329	3,128	242
Denver	22,278	21,250	1,028	234
San Francisco	109,629	105,920	3,709	254
Seattle	28,221	27,113	1,108	247
U.S. Possessions [2]	11,644	11,644	--	NA
Foreign and Unknown [3]	--	--	--	NA

[1] Rate for Total (All Areas) based on U.S. Resident population as of July 1, 2001.

[2] Possessions include Puerto Rico, Virgin Islands, and Pacific Islands.

[3] Includes osteopathic physicians in military service, U.S. Public Health Service and foreign countries.

SOURCES: National Centers for Health Statistics, based on data from the American Medical Association, American Asociation of Colleges of Osteopathic Medicine, and the Bureau of the Census

November 2003

Medicare Part B Practitioners by Major Category
February 2004

Major Category	Number	Percent
All Part B Practitioners	906,422	100.0
Physician Specialties (PHYSSTAT=1)	586,411	64.7
Primary Care	213,468	23.6
Medical Specialties	93,685	10.3
Surgical Specialties	99,509	11.0
Emergency Medicine	30,171	3.3
Anesthesiology	33,960	3.7
Radiology	33,463	3.7
Pathology	12,471	1.4
Obstetrics/Gynecology	34,884	3.8
Psychiatry	34,618	3.8
Other and Unknown	182	0.0
Limited Licensed Practitioners (PHYSSTAT=2)	108,964	12.0
Non-physician Practitioners (PHYSSTAT=3)	211,047	23.3

NOTES: PHYSSTAT refers to the name of the variable in the Unique Physician Identification Number (UPIN) database that is used to group practitioners by his or her medical credentials. Specialty code is self-reported and may not correspond to actual board certification. Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS/OFM's and CMM's Unique Physician Identification Number database/classification by ORDI

Physician Income and Expenses by Specialty
1998

	Mean Net Income [1]	Mean Total Expenses	Expenses						
			Total	Non-Physician Payroll	Office	Medical Supplies	Professional Liability Expenses	Medical Equipment	Other
	in thousands		Percent Distribution						
All Physicians	$194.4	$261.9	100.0	35.9	24.0	9.4	6.4	4.3	20.0
Specialty									
General/Family Practice	142.5	263.0	100.0	41.7	22.9	11.0	4.1	3.9	16.4
Internal Medicine	182.1	259.7	100.0	38.1	22.9	12.2	6.4	4.0	16.5
Surgery	268.2	325.8	100.0	37.4	35.3	11.0	7.0	4.3	16.4
Pediatrics	139.6	187.3	100.0	32.3	28.8	13.9	5.5	2.3	17.2
Obstetrics/Gynecology	214.4	375.9	100.0	35.6	32.9	6.5	9.5	4.3	15.5

[1] After expenses, before taxes.

NOTES: The data for categories "Mean Net Income" and "Mean Total Expenses" are in thousands. Totals do not necessarily equal the sum of rounded components.

SOURCE: American Medical Association, Socioeconomic Characteristics of Medical Practice, 2000. November 2003

Physician Income and Expenses
1986 - 1998

Year	Mean Net Income [1]	Mean Total Expenses	Expenses						
			Total	Non-Physician Payroll	Office	Medical Supplier	Professional Liability Expenses	Medical Equipment	Other
	in thousands		Percent Distribution						
1986	$119.5	$118.4	100.0	32.8	24.1	11.1	10.8	5.9	15.3
1987	132.3	123.7	100.0	34.4	24.3	10.9	12.1	5.3	13.1
1988	144.7	140.8	100.0	34.4	24.1	10.3	11.3	4.9	15.0
1989	155.8	148.4	100.0	35.5	22.4	11.5	10.4	5.1	15.0
1990	164.3	150.0	100.0	36.3	22.5	11.0	9.7	5.1	15.5
1991	170.6	168.4	100.0	36.4	23.3	10.9	8.8	5.3	15.3
1992	177.4	179.0	100.0	36.9	23.7	9.0	7.5	4.1	18.7
1993	189.3	182.2	100.0	38.3	23.5	9.1	7.9	4.8	16.3
1994	182.4	183.1	100.0	38.9	26.0	10.5	8.2	4.6	11.7
1995	195.5	201.6	100.0	36.0	28.3	10.1	7.4	5.1	13.0
1996	199.0	217.6	100.0	34.8	23.8	9.3	6.5	3.9	21.8
1997	199.6	228.6	100.0	36.8	25.9	9.5	6.2	3.3	18.3
1998	194.4	261.9	100.0	35.9	24.0	9.4	6.4	4.3	20.0

[1] After expenses, before taxes.

NOTES: The data for categories "Mean Net Income" and "Mean Total Expenses" are in thousands. Totals do not necessarily equal the sum of rounded components.

SOURCE: American Medical Association, Socioeconomic Characteristics of Medical Practice, 2000.

November 2003

Medicare Physician and Other Practitioner Registry by Specialty
February 2004

Specialty [1]	April 2003 Number	April 2003 Percent
All Medical Specialties	**586,411**	**64.7**
General and Family Practice	**96,754**	**10.7**
General Practice	19,941	2.2
Family Practice	76,437	8.4
Preventive Medicine [2]	376	0.0
Medical	**183,784**	**20.3**
Allergy/Immunology	3,165	0.3
Cardiology	20,173	2.2
Dermatology	9,234	1.0
Gastroenterology	9,713	1.1
Internal Medicine	91,825	10.1
Neurology	11,264	1.2
Pulmonary Disease	7,136	0.8
Physical Med and Rehab	6,373	0.7
Geriatrics	1,066	0.1
Nephrology	5,166	0.6
Infectious Disease	3,323	0.4
Endocrinology [2]	3,152	0.3
Rheumatology [2]	3,023	0.3
Clinic multispec W/O GPP	111	0.0
Periph. Vascular Disease [2]	117	0.0
Critical Care Intensivists [2]	1,023	0.1
Hematology [2]	601	0.1
Hematology/Oncology [2]	5,253	0.6
Medical Oncology [2]	2,066	0.2
Surgical	**102,805**	**11.3**
General Surgery	24,191	2.7
Otolaryngology (ENT)	8,977	1.0
Neurosurgery	4,337	0.5
Ophthalmology	17,641	1.9
Orthopedic Surgery	21,507	2.4
Plastic/reconstructive Surgery	5,302	0.6
Colorectal Surgery (proctology)	859	0.1
Thoracic Surgery	2,659	0.3
Urology	9,399	1.0

Medicare Physician and Other Practitioner Registry by Specialty
February 2004
continued

Specialty [1]	April 2003 Number	April 2003 Percent
Hand Surgery	570	0.1
Vascular Surgery [2]	1,773	0.2
Cardiac Surgery [2]	1,565	0.2
Maxillofacial Surgery [2]	270	0.0
Surgical Oncology [2]	477	0.1
Radiation Oncology [2]	3,278	0.4
Emergency Medicine [2]	**30,171**	**3.3**
Pediatrics	**25,265**	**2.8**
Other and Unknown	**110,060**	**12.1**
Obstetrics-Gynecology	34,419	3.8
Pathology	12,471	1.4
Psychiatry	34,483	3.8
Radiology	28,687	3.2
Limited Licensed Practitioners (PHYSSTAT=2)	**107,521**	**11.9**
Optometry	29,465	3.3
Oral Surgery/Dentists only	10,651	1.2
Podiatry	14,929	1.6
Chiropractor	52,476	5.8
Non-Physician Practitioners (PHYSSTAT=3)	**34,605**	**3.8**
Anesthesiology	33,960	3.7
Osteopathic Manipulative Therapy	645	0.1
Nuclear Medicine	687	0.1
Certified Nurse Midwife	2,633	0.3
CRNA, Anesthesia Assistant	26,217	2.9
Ambulatory Surgical Center (formerly Misc)	67	0.0
Nurse Practitioner	36,153	4.0
Psychologist/billing independently	1,325	0.1
Audiologist/billing independently	3,955	0.4
Physical Therpist	24,479	2.7
Occupational Therapist	3,631	0.4
Addiction Medicine [2]	123	0.0
Clinical Social Worker	42,091	4.6
Neuropsychiatry [2]	135	0.0
Certified Clinical Nurse	2,672	0.3
Interventional Radiology [2]	811	0.1
Physician Assistant	27,700	3.1
Gynecology Oncology [3]	465	0.1
Clinical Psychology	33,562	3.7
Unknown Physician Specialty	102	0.0
Miscellaneous Specialties		0.0
Totals	**906,422**	**100.0**

NOTES: Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS/CMS/ORDI November 2003

VII. STATE DATA

State distributions are included for Medicare and Medicaid expenditures, populations, utilization and providers. In addition, State distributions are included for national experience on utilization and providers of services. New in this section are several tables showing number of patients and reimbursement for hospice, home health and skilled nursing facility services.

HIGHLIGHTS

- *Medicare enrollees comprise 13.7 percent of the United States' resident population. State enrollees range from a low of 7.1 percent of Alaska's resident population to a high of 19.0 percent of West Virginia's resident population.*

- *Medicaid enrollees (as measured by eligibles or ever enrolled) comprise 15.7 percent of the United States' resident population. State enrollees range from a low of 7.9 percent of Nevada's resident population to a high of 26.9 percent of Tennessee's resident population.*

- *Long-stay hospital beds per 1,000 HI enrollees range from a low of 1.0 in Oregon to a high of 13.9 in the District of Columbia. This contrasts with the national average of 3.1.*

- *The percentage of Medicare Part B participating physicians and other practitioners range from a high of 97.3 percent in Michigan and North Dakota to a low of 77.2 percent in Rhode Island.*

- *Under fee-for-service, aged persons served per 1,000 enrollees (U.S.) range from a low of 777 in the District of Columbia to essentially all aged enrollees in Oregon. This contrasts with the national average of 918 persons served per 1,000 enrollees.*

- *The average reimbursement per patient for Medicare home health agency services (U.S.) range from a high of $5,362 in Louisiana to a low of $2,255 in North Dakota. This contrasts with the national average reimbursement per patient of $3,560.*

- *The average reimbursement per discharge for Medicare skilled nursing facility non-swing bed services (U.S.) range from a high of $15,109 in New York to a low of $5,093 in Montana. This contrasts with the national average of $8,348 per discharge.*

Medicare Estimated Benefit Payments by State
Fiscal Year 2001

	yments
All Areas	$236,492,551,946
United States	234,970,769,877
Alabama	4,270,957,179
Alaska	169,288,393
Arizona	3,322,292,384
Arkansas	2,420,405,701
California	24,858,719,236
Colorado	2,698,488,436
Connecticut	3,117,051,627
Delaware	500,000,394
District of Columbia	792,265,128
Florida	21,580,487,727
Georgia	4,397,177,577
Hawaii	717,997,990
Idaho	741,440,673
Illinois	8,001,946,687
Indiana	4,999,249,587
Iowa	1,632,031,674
Kansas	2,141,311,524
Kentucky	3,640,056,994
Louisiana	4,902,925,823
Maine	875,798,371
Maryland	4,611,431,715
Massachusetts	5,963,041,223
Michigan	7,012,604,450
Minnesota	3,136,906,920
Mississippi	2,140,390,706
Missouri	$4,755,401,621
Montana	663,415,658
Nebraska	1,366,977,351
Nevada	1,272,773,858
New Hampshire	714,188,267
New Jersey	6,885,641,611
New Mexico	879,539,933
New York	20,436,629,972
North Carolina	6,797,677,203
North Dakota	562,654,098
Ohio	10,685,163,793
Oklahoma	2,343,402,917
Oregon	2,181,557,489
Pennsylvania	15,141,847,286
Rhode Island	1,146,888,423
South Carolina	3,356,574,015
South Dakota	622,091,698
Tennessee	5,545,548,969
Texas	16,336,060,639
Utah	1,077,334,102
Vermont	361,871,329
Virginia	3,897,031,283
Washington	3,209,405,506
West Virginia	1,822,038,805
Wisconsin	3,961,454,618
Wyoming	281,638,648
Puerto Rico	1,454,822,599
All Other Areas	66,959,470

Benefit Pa

Benefit Pa

NOTES: Benefit payments for all areas represent actual Department of Treasury (DOT) disbursements on a paid basis by location of provider or plan, not residence of beneficiary. Distribution of benefit payments by State is based on a methodology which considered actual payments to health maintenance organizations and estimated payments for other providers of Medicare services.
Estimated payments were determined by applying the relative weight of each State's share of total fee-for-service provider payments for fiscal year 2001 to the DOT disbursements net of Managed Care payments.

SOURCES: CMS/OFM/OIS

November 2003

Medicaid Medical Assistance Payments
Fiscal Year 2002

	Total Payments Computable For Federal Funding	Net Expenditures Reported Federal Share		Total Payments Computable For Federal Funding	Net Expenditures Reported Federal Share
	Amount in thousands				
TOTAL	$246,283,943	$140,041,579	Missouri	5,360,608	3,280,561
			Montana	571,456	421,899
Alabama	3,093,271	2,184,680	Nebraska	1,339,132	800,204
Alaska	685,773	441,180	Nevada	808,198	407,108
American Samoa	11,209	5,804	New Hampshire	1,016,095	508,912
Arizona	3,541,599	2,376,801			
Arkansas	2,237,818	1,630,195	New Jersey	7,745,878	3,881,053
California	26,890,541	13,939,975	New Mexico	1,776,812	1,313,098
			New York	36,295,107	18,180,862
Colorado	2,323,069	1,167,104	North Carolina	6,723,599	4,161,694
Connecticut	3,456,339	1,742,046	North Dakota	461,402	325,016
Delaware	634,046	318,201			
District of Columbia	1,021,773	715,695	N. Mariana Islands	11,745	6,073
Florida	9,871,508	5,586,227	Ohio	9,658,041	5,686,522
			Oklahoma	2,260,404	1,609,587
Georgia	6,241,211	3,684,680	Oregon	2,571,561	1,535,724
Guam	11,158	5,779	Pennsylvania	12,130,925	6,641,322
Hawaii	740,007	417,393			
Idaho	773,535	550,619	Puerto Rico	541,495	270,748
Illinois	8,809,060	4,424,297	Rhode Island	1,358,501	713,450
Indiana	4,448,318	2,765,176	South Carolina	3,292,901	2,291,550
			South Dakota	549,884	373,705
Iowa	2,575,146	1,620,509	Tennessee	5,787,079	3,689,247
Kansas	1,836,717	1,106,550			
Kentucky	3,763,204	2,634,564	Texas	13,523,486	8,158,615
Louisiana	4,885,972	3,441,288	Utah	984,161	691,467
Maine	1,430,109	954,013	Vermont	660,732	417,784
			Virginia	3,812,166	1,970,078
Maryland	3,613,476	1,819,847	Virgin Islands	10,715	5,371
Massachusetts	8,063,005	4,045,127			
Michigan	7,562,053	4,267,978	Washington	5,168,512	2,620,485
Minnesota	4,414,511	2,218,157	West Virginia	1,584,166	1,192,038
Mississippi	2,877,014	2,191,340	Wisconsin	4,193,175	2,461,670
			Wyoming	274,565	170,511

NOTES: Source Form CMS-64 -- Net Expenditures Reported. Excludes: Administration, Medicaid SCHIP expansions and CMS adjustments.

SOURCE: CMS/CMSO

November 2003

Mean Medicaid Outlays by Basis of Eligibility
2000

	Total	Aged	Disabled	Child	Adult
United States	$3,936	$11,929	$10,559	$1,358	$2,030
Alabama	3,860	10,504	4,860	788	1,978
Alaska	4,876	12,833	16,754	2,665	3,630
Arizona	3,100	11,616	9,082	1,246	2,444
Arkansas	3,086	8,620	7,065	1,278	1,071
California	2,155	6,269	8,532	1,108	1,006
Colorado	4,747	12,679	12,257	1,820	2,266
Connecticut	6,762	23,813	20,406	1,705	1,981
Delaware	4,584	15,968	14,877	1,698	2,661
District of Columbia	5,715	19,993	16,535	2,008	2,474
Florida	3,114	9,763	8,467	1,072	1,680
Georgia	2,774	8,799	6,587	1,053	2,343
Hawaii	2,626	8,774	6,587	1,514	1,519
Idaho	4,530	14,213	13,560	1,205	2,810
Illinois	5,150	13,185	13,790	1,505	2,482
Indiana	4,224	15,079	13,424	1,344	2,149
Iowa	4,707	14,605	11,282	1,424	2,028
Kansas	4,670	14,375	13,003	1,153	2,080
Kentucky	3,780	10,891	7,334	1,594	2,270
Louisiana	3,456	8,183	8,506	952	2,477
Maine	6,820	13,297	15,075	3,030	2,907
Maryland	5,396	15,360	15,577	2,052	4,026
Massachusetts	5,153	17,502	12,073	1,513	1,893
Michigan	3,611	11,685	5,658	893	1,777
Minnesota	5,857	18,475	17,988	1,833	2,113
Mississippi	2,987	8,069	6,287	969	2,539
Missouri	3,673	12,149	10,308	1,398	1,344
Montana	4,173	13,832	10,303	1,930	2,624
Nebraska	4,185	13,727	12,247	1,513	2,017
Nevada	3,733	8,850	9,839	1,595	2,402
New Hampshire	6,712	19,475	20,083	2,350	2,562
New Jersey	5,724	15,913	13,499	1,567	5,591
New Mexico	3,325	9,797	10,306	1,461	1,940
New York	7,646	22,139	20,400	2,142	4,059
North Carolina	3,996	9,845	10,256	1,173	2,611
North Dakota	5,852	16,391	17,490	1,474	2,038
Ohio	5,434	18,936	13,097	1,324	2,246
Oklahoma	3,163	8,285	8,980	1,195	1,264
Oregon	3,135	10,161	8,693	1,503	2,084
Pennsylvania	4,266	13,518	7,640	1,617	2,055
Rhode Island	5,982	18,920	17,745	1,469	1,877
South Carolina	3,900	8,125	8,678	1,369	1,483
South Dakota	3,935	11,227	11,183	1,314	2,129
Tennessee	2,226	977	5,015	1,288	2,157
Texas	3,487	9,210	10,930	1,287	2,421
Utah	4,277	10,490	13,000	1,493	1,851
Vermont	3,451	7,431	11,049	1,775	1,431
Virginia	3,960	9,318	9,699	1,240	2,232
Washington	2,717	9,735	6,986	1,075	2,733
West Virginia	4,154	12,891	7,389	1,288	1,874
Wisconsin	5,039	16,330	12,361	1,191	1,422
Wyoming	4,609	14,451	14,045	1,362	2,560

NOTE: Other and unknown basis of eligibility not shown separately.

SOURCES: CMS/CMSO/ORDI

November 2003

Mean Medicaid Outlays by Basis of Eligibility
2000

	Total	Aged	Disabled	Child	Adult
United States	$3,936	$11,929	$10,559	$1,358	$2,030
Alabama	3,860	10,504	4,860	788	1,978
Alaska	4,876	12,833	16,754	2,665	3,630
Arizona	3,100	11,616	9,082	1,246	2,444
Arkansas	3,086	8,620	7,065	1,278	1,071
California	2,155	6,269	8,532	1,108	1,006
Colorado	4,747	12,679	12,257	1,820	2,266
Connecticut	6,762	23,813	20,406	1,705	1,981
Delaware	4,584	15,968	14,877	1,698	2,661
District of Columbia	5,715	19,993	16,535	2,008	2,474
Florida	3,114	9,763	8,467	1,072	1,680
Georgia	2,774	8,799	6,587	1,053	2,343
Hawaii	2,626	8,774	6,587	1,514	1,519
Idaho	4,530	14,213	13,560	1,205	2,810
Illinois	5,150	13,185	13,790	1,505	2,482
Indiana	4,224	15,079	13,424	1,344	2,149
Iowa	4,707	14,605	11,282	1,424	2,028
Kansas	4,670	14,375	13,003	1,153	2,080
Kentucky	3,780	10,891	7,334	1,594	2,270
Louisiana	3,456	8,183	8,506	952	2,477
Maine	6,820	13,297	15,075	3,030	2,907
Maryland	5,396	15,360	15,577	2,052	4,026
Massachusetts	5,153	17,502	12,073	1,513	1,893
Michigan	3,611	11,685	5,658	893	1,777
Minnesota	5,857	18,475	17,988	1,833	2,113
Mississippi	2,987	8,069	6,287	969	2,539
Missouri	3,673	12,149	10,308	1,398	1,344
Montana	4,173	13,832	10,303	1,930	2,624
Nebraska	4,185	13,727	12,247	1,513	2,017
Nevada	3,733	8,850	9,839	1,595	2,402
New Hampshire	6,712	19,475	20,083	2,350	2,562
New Jersey	5,724	15,913	13,499	1,567	5,591
New Mexico	3,325	9,797	10,306	1,461	1,940
New York	7,646	22,139	20,400	2,142	4,059
North Carolina	3,996	9,845	10,256	1,173	2,611
North Dakota	5,852	16,391	17,490	1,474	2,038
Ohio	5,434	18,936	13,097	1,324	2,246
Oklahoma	3,163	8,285	8,980	1,195	1,264
Oregon	3,135	10,161	8,693	1,503	2,084
Pennsylvania	4,266	13,518	7,640	1,617	2,055
Rhode Island	5,982	18,920	17,745	1,469	1,877
South Carolina	3,900	8,125	8,678	1,369	1,483
South Dakota	3,935	11,227	11,183	1,314	2,129
Tennessee	2,226	977	5,015	1,288	2,157
Texas	3,487	9,210	10,930	1,287	2,421
Utah	4,277	10,490	13,000	1,493	1,851
Vermont	3,451	7,431	11,049	1,775	1,431
Virginia	3,960	9,318	9,699	1,240	2,232
Washington	2,717	9,735	6,986	1,075	2,733
West Virginia	4,154	12,891	7,389	1,288	1,874
Wisconsin	5,039	16,330	12,361	1,191	1,422
Wyoming	4,609	14,451	14,045	1,362	2,560

NOTE: Other and unknown basis of eligibility not shown separately.

SOURCES: CMS/CMSO/ORDI

November 2003

Medicare Enrollment by State
2002

	Enrollees		Enrollees
All Areas [1]	40,488,871	Missouri	874,014
		Montana	140,236
United States [2]	39,582,287	Nebraska	255,678
		Nevada	264,257
Alabama	706,136	New Hampshire	176,054
Alaska	45,615		
Arizona	714,179	New Jersey	1,208,991
Arkansas	445,983	New Mexico	244,178
California	3,998,983	New York	2,731,061
		North Carolina	1,181,900
Colorado	483,563	North Dakota	102,985
Connecticut	517,148		
Delaware	116,952	Ohio	1,710,854
District of Columbia	73,520	Oklahoma	515,025
Florida	2,894,202	Oregon	505,866
		Pennsylvania	2,098,754
Georgia	954,759	Rhode Island	171,833
Hawaii	171,438		
Idaho	173,451	South Carolina	594,269
Illinois	1,640,907	South Dakota	120,750
Indiana	865,293	Tennessee	857,332
		Texas	2,341,711
Iowa	479,042	Utah	215,456
Kansas	391,459		
Kentucky	637,478	Vermont	91,366
Louisiana	611,518	Virginia	928,155
Maine	223,292	Washington	760,122
		West Virginia	342,829
Maryland	663,301	Wisconsin	793,959
Massachusetts	959,845	Wyoming	67,276
Michigan	1,423,221		
Minnesota	666,707	Puerto Rico	560,725
Mississippi	429,384		

[1] Includes U.S. and enrollees residing in outlying territories, foreign countries and those with unknown state of residence.

[2] Includes enrollees residing in 50 states and the District of Columbia.

NOTE: Data based on Denominator Tables as of March 2003.

SOURCE: CMS/ORDI

November 2003

Medicare Enrollment as a Percent of Resident Population by State
2002

	Resident Population in thousands	Medicare Enrollees in thousands	Enrollees as Percent of Population		Resident Population in thousands	Medicare Enrollees in thousands	Enrollees as Percent of Population
All Areas	NA	40,489 [1]		Missouri	5,673	874	15.4
				Montana	909	140	15.4
United States	288,369	39,582 [2]	NA 13.7	Nebraska	1,729	256	14.8
				Nevada	2,173	264	12.1
Alabama	4,487	706	15.7	New Hampshire	1,275	176	13.8
Alaska	644	46	7.1				
Arizona	5,456	714	13.1	New Jersey	8,590	1,209	14.1
Arkansas	2,710	446	16.5	New Mexico	1,855	244	13.2
California	35,116	3,999	11.4	New York	19,158	2,731	14.3
				North Carolina	8,320	1,182	14.2
Colorado	4,507	484	10.7	North Dakota	634	103	16.2
Connecticut	3,461	517	14.9				
Delaware	807	117	14.5	Ohio	11,421	1,711	15.0
District of Columbia	571	74	13.0	Oklahoma	3,494	515	14.7
Florida	16,713	2,894	17.3	Oregon	3,522	506	14.4
				Pennslyvania	12,335	2,099	17.0
Georgia	8,560	955	11.2	Rhode Island	1,070	172	16.1
Hawaii	1,245	171	13.7				
Idaho	1,341	173	12.9	South Carolina	4,107	594	14.5
Illinois	12,601	1,641	13.0	South Dakota	761	121	15.9
Indiana	6,159	865	14.0	Tennessee	5,797	857	14.8
				Texas	21,780	2,342	10.8
Iowa	2,937	479	16.3	Utah	2,316	215	9.3
Kansas	2,716	391	14.4				
Kentucky	4,093	637	15.6	Vermont	617	91	14.7
Louisiana	4,483	612	13.7	Virginia	7,294	928	12.7
Maine	1,294	223	17.2	Washington	6,069	760	12.5
				West Virginia	1,802	343	19.0
Maryland	5,458	663	12.1	Wisconsin	5,441	794	14.6
Massachusetts	6,428	960	14.9	Wyoming	499	67	13.4
Michigan	10,050	1,423	14.2				
Minnesota	5,020	667	13.3	Puerto Rico	NA	561	
Mississippi	2,872	429	14.9				

[1] Includes the United States, its Territories and Possessions, residents of foreign countries and residence unknown. NA

[2] Includes enrollees residing in the 50 States and the District of Columbia.

NOTES: Resident population is a provisional estimate. The 2002 resident population data for Outlying Areas, Puerto Rico, and the Virgin Islands are not available. Medicare Denominator enrollment data as of March 2003. Detail may not add to total due to rounding.

SOURCES: CMS/ORDI and Bureau of the Census November 2003

Medicaid Eligibles by State
Fiscal Year 2000

	Resident Population in thousands	Medicaid Eligibles in thousands	Eligibles as Percent of Population
All Reporting Medicaid Jurisdictions	NA		
United States	282,224	NA 44,297	NA 15.7
Alabama	4,452	666	15.0
Alaska	628	109	17.4
Arizona [1]	5,167	683	13.2
Arkansas	2,679	504	18.8
California	34,010	8,064	23.7
Colorado	4,327	378	8.7
Connecticut	3,412	418	12.3
Delaware	787	124	15.8
District of Columbia	572	151	26.4
Florida	16,051	2,238	13.9
Georgia	8,234	1,239	15.0
Hawaii	1,213	203	16.7
Idaho	1,300	151	11.6
Illinois	12,441	1,736	14.0
Indiana	6,092	756	12.4
Iowa	2,929	316	10.8
Kansas	2,693	268	10.0
Kentucky	4,049	724	17.9
Louisiana	4,470	827	18.5
Maine	1,277	214	16.8
Maryland	5,312	722	13.6
Massachusetts	6,362	1,104	17.4
Michigan	9,956	1,361	13.7
Minnesota	4,934	597	12.1
Mississippi	2,849	596	20.9
Missouri	5,605	991	17.7
Montana	903	97	10.7
Nebraska	1,713	238	13.9
Nevada	2,019	159	7.9
New Hampshire	1,240	110	8.9
New Jersey	8,433	856	10.2
New Mexico	1,822	398	21.8
New York	19,000	3,401	17.9
North Carolina	8,082	1,228	15.2
North Dakota	641	62	9.7
Ohio	11,364	1,420	12.5
Oklahoma	3,454	585	16.9
Oregon	3,431	561	16.4
Pennsylvania	12,286	1,768	14.4
Rhode Island	1,051	182	17.3
South Carolina	4,024	775	19.3
South Dakota	756	99	13.1
Tennessee	5,703	1,535	26.9
Texas	20,955	2,707	12.9
Utah	2,243	204	9.1
Vermont	610	148	24.3
Virginia	7,106	681	9.6
Washington	5,912	917	15.5
West Virginia	1,807	354	19.6
Wisconsin	5,374	619	11.5
Wyoming	494	52	10.5
Puerto Rico	NA		
Virgin Islands	NA		

[1] Arizona operates a medical assistance program under a Section 1115 Demonstration project.

NA NA NA

NOTES: Resident population is a provisional estimate as of July 1, 2000. The 2000 resident population data for Puerto Rico and Virgin Islands are not available. Medicaid eligibles represent those ever enrolled in Medicaid at any time during the year.

SOURCES: CMS/CMSO/ORDI and Bureau of the Census

November 2003

Medicare State Buy-Ins for Part A and Part B
June 2003

State	Part A QMBs	Part B Buy-Ins	Part B QMBs[1]	Part B SLMBs[1]	Part B QI-1s[1]	Part B MAOs[1]	State	Part A QMBs	Part B Buy-Ins	Part B QMBs[1]	Part B SLMBs[1]	Part B QI-1s[1]	Part B MAOs[1]
Total	376,746	6,127,590	2,698,703	553,851	138,684	388,230	Missouri	687	99,005	68,065	14,364	1,791	
							Montana	391	13,904	9,204	2,257	389	---
Alabama	2,114	162,698	46,293	23,554	10,971	4,192	Nebraska		22,879	12,227	2,003		--- 11
Alaska	689	9,947	7,312	114			Nevada	1,476	24,410	14,419	3,957	1,100	1,414
Arizona	796	90,531	43,615	10,358	6,533	14,788	New Hampshire	30	10,059	1,384	5,785		734
Arkansas	2,554	86,300	25,406	9,276	3,010	5,991	New Jersey	7,661	155,541	94,747	18,410	7,577	14,600
California	134,436	945,548	334,241	29,345	4,987	164,447	New Mexico	331	44,519	10,994	3,579	1,084	5,809
Colorado	373	58,886	10,226			3,529	New York	344	429,937	175,127	8,964	10,570	
Connecticut	2,666	64,727	44,413	9,139	5,468		North Carolina	10,836	239,944	63,622	4,410	9,116	771
Delaware	319	15,146	3,257	1,711	378	---	North Dakota		6,560	2,008	822	271	
District of Columbia	706	11,968	311	1,537		---	Ohio	5,171	190,806	58,227	21,296	8,939	11,067
Florida	44,091	390,171	178,177	38,834	15,724	33,237	Oklahoma	3,453	71,299	56,056	10,757	3,403	
Georgia	3,204	194,959	53,032	24,311	9,834	19,558	Oregon	67	68,504	37,108	10,625		1,989
Hawaii	4,031	22,911	19,081	905	247	1,912	Pennsylvania	16,066	229,534	127,100	38,649	---	
Idaho	524	21,222	11,768	2,144	673	4,495	Rhode Island	398	25,087	809		---	
Illinois	2,357	175,151	118,877	20,867	8,107		South Carolina	1,317	119,491	76,308	11,699		10,632
Indiana	1,712	101,992	62,733	16,664	2,767	16,820	South Dakota	717	14,195	4,501	2,030	534	---
Iowa	953	56,833	35,634	8,751	1,661	9,042	Tennessee	5,253	203,181	93,116	12,846		---
Kansas	625	44,500	17,993	3,563	787	956	Texas	46,143	408,108	120,312	55,968	---	
Kentucky	2,710	126,770	34,872	15,372	4,465		Utah	84	18,426	11,970	2,412	---	2,900
Louisana	3,735	126,890	74,054	15,869	5,996	250	Vermont	101	15,061	3,962	2,809	---	13
Maine	16	42,307	19,458	5,886			Virginia	3,315	120,167	40,552	9,897	2,555	10,436
Maryland	8,594	73,929	59,226	5,031	1,664	7,491	Washington	4,846	105,473	75,379	7,233	2,318	7,534
Massachusetts	18,764	167,599	140,622	18,583	2,785	11	West Virginia	3,034	49,961	40,819	6,807	1,797	
Michigan	14,030	158,118	51,748	19,195	271	871	Wisconsin	3,844	77,906	22,011	9,770	584	---
Minnesota	5,875	74,801	13,775	3,160			Wyoming	147	7,465	2,844	880	325	859
Mississippi	5,156	131,373	69,708	1,450	---	31,862	Outlying Areas		891				

[1] Included in Part B Buy-In column.

NOTES: "---" equals ten or fewer observations. Qualified Medicare Beneficiaries (QMBs) and Specified Low-income Medicare Beneficiaries (SLMBs), Qualified Individuals (QI-1s), and Medical Assistance Only (MAOs) are persons with limited resources. In addition to Medicare premiums, the Medicaid program may cover the cost of deductibles, coinsurance, and certain non-Medicare covered services which Medicare beneficiaries normally pay out of their own pockets.

SOURCE: CMS/OIS

November 2003

Medicare Persons Served by State
Calendar Year 2001

	Aged		Disabled			Aged		Disabled	
	Persons Served in thousands	Served per 1,000 Enrollees	Persons Served in thousands	Served per 1,000 Enrollees		Persons Served in thousands	Served per 1,000 Enrollees	Persons Served in thousands	Served per 1,000 Enrollees
All Areas	26,326	918	4,358	843	Missouri	576	934	105	856
					Montana	111	935	16	849
United States	26,001	929	4,262	850	Nebraska	206	946	25	897
					Nevada	126	859	21	785
Alabama	483	937	111	873	New Hampshire	133	912	18	788
Alaska	30	850	6	808					
Arizona	360	919	53	779	New Jersey	847	909	110	835
Arkansas	314	934	69	874	New Mexico	152	893	27	834
California	1,797	881	312	784	New York	1,731	916	283	818
					North Carolina	859	945	177	892
Colorado	261	964	45	803	North Dakota	87	949	9	857
Connecticut	358	924	50	871					
Delaware	92	941	13	818	Ohio	1,175	944	175	840
District of					Oklahoma	364	936	61	874
Columbia	47	777	8	784	Oregon	276	1,019	45	841
Florida	1,829	952	241	877	Pennsylvania	1,266	926	171	815
					Rhode Island	84	910	16	760
Georgia	677	927	150	880					
Hawaii	97	972	12	846	South Carolina	441	937	100	917
Idaho	131	981	19	935	South Dakota	96	926	12	888
Illinois	1,184	918	159	854	Tennessee	607	933	132	862
Indiana	670	952	100	847	Texas	1,621	918	241	867
					Utah	169	941	21	842
Iowa	399	983	47	904					
Kansas	301	960	37	874	Vermont	71	920	12	882
Kentucky	439	945	117	874	Virginia	696	920	118	864
Louisiana	385	915	86	874	Washington	458	907	72	806
Maine	169	925	31	840	West Virginia	245	987	59	884
					Wisconsin	616	954	78	872
Maryland	497	891	66	857	Wyoming	53	939	7	867
Massachusetts	549	896	102	817					
Michigan	1,076	951	171	866	Puerto Rico	293		92	
Minnesota	496	985	63	863	Other Outlying Areas	7		1	---
Mississippi	303	937	84	898	Unknown & Foreign	24	---	3	---

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[1] Less than 500.

NOTES: Persons served represents persons receiving a reimbursed service under fee-for-service at any time during the year. The denominator used to calculate the rate served per 1,000 enrollees is the July 1, 2001 HI and/or SMI fee-for-service population. The rates may exceed 1,000 for a variety of reasons, including areas with rapidly changing fee-for-service/managed care distributions.

SOURCE: CMS/ORDI

November 2003

National Community Hospital Care by State
2001 Annual Survey

	Admissions in thousands	Average Stay in Days	Outpatient Visits in thousands		Admissions in thousands	Average Stay in Days	Outpatient Visits in thousands
United States	33,814	5.7	538,480	Missouri	801	5.3	14,199
				Montana	103	10.2	2,648
Alabama	685	5.2	7,786	Nebraska	207	8.8	3,430
Alaska	49	6.2	1,388	Nevada	208	4.9	2,126
Arizona	563	4.5	5,072	New Hampshire	116	5.5	2,930
Arkansas	371	5.5	4,494				
California	3,333	5.4	48,548	New Jersey	1,084	5.7	18,445
				New Mexico	164	4.6	3,409
Colorado	414	5.1	6,913	New York	2,411	7.9	45,646
Connecticut	360	6.1	6,489	North Carolina	973	6.1	13,431
Delaware	83	6.0	1,485	North Dakota	92	8.6	1,859
District of Columbia	132	6.8	1,419	Ohio	1,439	5.2	28,377
Florida	2,207	5.2	20,771	Oklahoma	435	5.4	4,570
				Oregon	335	4.3	7,658
Georgia	904	6.1	12,015	Pennsylvania	1,809	5.7	32,063
Hawaii	108	8.1	3,168	Rhode Island	121	5.3	2,151
Idaho	123	5.6	2,640				
Illinois	1,559	5.3	25,270	South Carolina	505	5.8	7,629
Indiana	718	5.5	14,393	South Dakota	104	10.1	1,828
				Tennessee	751	5.5	9,537
Iowa	371	6.7	9,399	Texas	2,461	5.1	31,454
Kansas	322	6.8	5,394	Utah	203	4.4	4,418
Kentucky	595	5.6	8,677				
Louisiana	683	5.5	10,060	Vermont	55	7.4	1,292
Maine	149	6.0	3,513	Virginia	744	5.7	9,749
				Washington	523	4.8	9,433
Maryland	608	4.9	6,266	West Virginia	297	6.1	5,762
Massachusetts	767	5.7	18,778	Wisconsin	579	6.0	11,029
Michigan	1,122	5.4	25,984	Wyoming	48	8.0	818
Minnesota	586	7.0	8,566				
Mississippi	436	6.9	4,102				

SOURCE: American Hospital Association's 2003 Hospital Statistics.

November 2003

Medicare Hospice Utilization by State
Calendar Year 2001

	Total Patients	Total Reimbursement	Total Covered Days	Total Covered Hours	Total Covered Procedures	Average Reimbursement Per Patient	Average Days Per Patient
Total	594,436	$3,690,388,745	30,555,548	2,291,673	535,075	$6,208	51
Alabama	13,111	108,496,688	1,084,255	35,881	1,428	8,275	83
Alaska	47	310,045	2,430	-	-	6,597	52
Arizona	17,614	116,603,922	888,804	21,162	23,088	6,620	50
Arkansas	5,830	37,593,532	370,851	5,312	1,803	6,448	64
California	54,104	331,044,777	2,437,209	151,144	33,751	6,119	45
Colorado	9,865	55,982,267	442,209	1,091	3,672	5,675	45
Connecticut	5,919	38,031,788	215,912	2,893	8,460	6,425	36
Delaware	1,671	9,321,668	79,771	-	72	5,578	48
District of Columbia	643	3,953,237	28,029	-	296	6,148	44
Florida	63,444	449,961,096	3,312,577	1,263,859	157,802	7,092	52
Georgia	16,015	101,648,959	869,507	6,866	4,308	6,347	54
Hawaii	1,448	9,222,318	60,228	-	32	6,369	42
Idaho	2,021	11,346,762	107,362	9,273	221	5,614	53
Illinois	25,786	147,553,225	1,186,355	99,708	9,985	5,722	46
Indiana	11,658	69,930,739	617,979	2,698	13,186	5,999	53
Iowa	7,511	40,476,441	371,909	1,621	4,164	5,389	50
Kansas	4,825	25,897,707	244,331	877	3,251	5,367	51
Kentucky	8,945	55,946,153	502,559	9,277	12,087	6,254	56
Louisiana	8,419	50,368,628	461,080	8,848	4,380	5,983	55
Maine	1,285	7,255,236	67,995	68	130	5,646	53
Maryland	8,748	44,340,327	348,388	250	6,926	5,069	40
Massachusetts	11,070	58,107,526	435,858	3,181	557	5,249	39
Michigan	25,366	145,003,945	1,187,987	9,457	7,766	5,716	47
Minnesota	8,473	51,413,930	425,164	16,112	4,343	6,068	50
Mississippi	6,778	65,333,842	638,956	38,549	10,640	9,639	94
Missouri	15,097	78,542,003	768,174	3,403	826	5,202	51
Montana	1,515	9,085,996	84,278	151	246	5,997	56
Nebraska	3,440	17,217,128	162,672	259	289	5,005	47
Nevada	4,418	26,965,614	177,044	79	8,535	6,104	40

Medicare Hospice Utilization by State
Calendar Year 2001
(continued)

	Total Patients	Total Reimbursement	Total Covered Days	Total Covered Hours	Total Covered Procedures	Average Reimbursement Per Patient	Average Days Per Patient
New Hampshire	1,832	$10,475,665	82,590	424	246	$5,718	45
New Jersey	14,319	82,608,015	631,407	66	4,473	5,769	44
New Mexico	4,073	28,982,103	269,876	630	1,734	7,116	66
New York	23,915	152,122,689	1,053,302	15,214	21,169	6,361	44
North Carolina	15,219	98,229,772	854,267	7,010	56,494	6,454	56
North Dakota	1,202	5,107,207	49,900	4,646	222	4,249	42
Ohio	30,909	169,848,806	1,391,259	82,229	28,493	5,495	45
Oklahoma	12,068	97,396,562	988,541	15,850	2,092	8,071	82
Oregon	9,938	53,623,861	451,704	4,649	1,071	5,396	45
Pennsylvania	30,110	164,060,623	1,335,657	28,254	11,850	5,449	44
Puerto Rico	4,670	24,762,826	324,171	948	14,963	5,303	69
Rhode Island	2,047	9,280,510	67,443	-	1,351	4,534	33
South Carolina	7,279	46,632,735	432,691	1,221	1,412	6,406	59
South Dakota	1,008	4,953,137	49,297	58	226	4,914	49
Tennessee	8,910	52,373,942	451,492	11,691	9,372	5,878	51
Texas	43,930	289,729,584	2,517,075	386,533	43,633	6,595	57
Utah	3,895	24,791,981	210,665	433	955	6,365	54
Vermont	846	3,917,836	35,161	1,131	25	4,631	42
Virginia	10,585	64,513,675	558,298	1,233	4,384	6,095	53
Washington	10,789	59,647,498	472,844	9,282	1,728	5,529	44
West Virginia	3,665	21,413,317	195,050	15,416	2,004	5,843	53
Wisconsin	10,128	56,054,810	525,835	12,681	4,932	5,535	52
Wyoming	478	2,899,718	27,077	46	-	6,066	57

NOTES: Provider based data are derived from bills for services performed in 2001 and recorded in CMS central records as of June 2002. These interim payment amounts may differ from final cost report adjusted payment amounts. Patient counts are unique to the State and therefore do not add to the total. Data have been screened for privacy.

SOURCES: CMS/OIS/HCIS

November 2003

Medicare Inpatient Hospitals by State
2003

	Short-Stay Hospitals	Beds per 1,000 Enrollees	Long-Stay Hospitals[1]	Beds per 1,000 Enrollees		Short-Stay Hospitals	Beds per 1,000 Enrollees	Long-Stay Hospitals[1]	Beds per 1,000 Enrollees
All Areas	4,231	20.8	1,793	3.1	Missouri	101	25.7	37	2.7
United States	4,173	21.1	1,787	3.1	Montana	31	16.8	34	4.2
					Nebraska	27	17.9	68	9.8
Alabama	102	26.3	19	2.1	Nevada	24	16.7	18	3.1
Alaska	17	28.6	7	5.4	New Hampshire	22	15.9	8	3.2
Arizona	61	15.6	22	1.5	New Jersey	80	23.0	27	3.4
Arkansas	65	20.2	38	4.8	New Mexico	38	18.5	15	2.7
California	371	19.9	76	1.5	New York	207	25.6	50	3.8
Colorado	48	19.1	28	4.1	North Carolina	108	19.8	26	2.8
Connecticut	32	16.1	14	4.0	North Dakota	17	22.9	33	9.0
Delaware	5	16.2	6	3.7	Ohio	151	24.9	60	2.9
Dist. of Columbia	7	49.0	7	13.9	Oklahoma	100	25.4	46	3.4
Florida	176	17.0	53	1.3	Oregon	48	14.9	14	1.0
Georgia	122	23.0	54	3.7	Pennsylvania	180	16.6	68	3.8
Hawaii	17	13.3	10	2.7	Rhode Island	11	17.1	4	5.1
Idaho	21	13.6	24	3.0	South Carolina	61	19.2	15	2.1
Illinois	167	27.2	49	2.1	South Dakota	36	22.0	30	5.5
Indiana	99	21.7	53	2.9	Tennessee	114	26.6	34	2.4
Iowa	72	22.0	49	3.1	Texas	332	20.8	153	3.7
Kansas	88	24.1	64	5.1	Utah	39	19.9	10	4.2
Kentucky	82	23.8	34	3.6	Vermont	11	22.6	5	3.1
Louisiana	111	30.4	82	6.8	Virginia	86	20.7	31	3.2
Maine	30	16.1	12	2.6	Washington	66	15.4	34	3.2
Maryland	48	20.1	19	5.0	West Virginia	43	24.8	23	3.1
Massachusetts	71	13.9	46	6.8	Wisconsin	97	21.6	45	3.2
Michigan	131	19.2	44	2.5	Wyoming	21	20.0	7	2.2
Minnesota	89	20.9	59	4.2					
Mississippi	90	28.6	16	1.4	Puerto Rico	53	17.1	6	2.1
					Other Outlying Areas	5	0.8	0	0.0

[1] Includes long term, religious nonmedical healthcare institutions, psychiatric, rehabilitation, childrens', and critical access hospitals.

NOTES: Facility data as of end of December 2002. Beds per 1,000 enrollees based on HI enrollment data as of July 1, 2002.

SOURCE: CMS/ORDI

November 2003

Medicare Skilled Nursing Facilities and Certified Beds by State
2002

	Facilities	Beds		Facilities	Beds
All Areas	14,838	1,260,625			
United States	14,829	1,260,265	Missouri	464	27,751
			Montana	101	7,078
Alabama	224	20,501	Nebraska	175	11,552
Alaska	15	519	Nevada	42	4,840
Arizona	133	9,971	New Hampshire	68	5,580
Arkansas	191	13,517			
California	1,263	92,582	New Jersey	359	43,803
			New Mexico	71	3,090
Colorado	200	15,331	New York	672	121,907
Connecticut	244	30,119	North Carolina	413	35,062
Delaware	37	3,324	North Dakota	84	6,618
District of Columbia	20	2,017			
Florida	695	63,331	Ohio	916	72,997
			Oklahoma	238	16,972
Georgia	332	30,096	Oregon	122	8,290
Hawaii	41	3,447	Pennsylvania	739	67,255
Idaho	79	5,824	Rhode Island	97	7,896
Illinois	676	44,530			
Indiana	498	36,640	South Carolina	176	13,593
			South Dakota	90	6,252
Iowa	336	22,644	Tennessee	302	18,163
Kansas	256	15,234	Texas	977	75,228
Kentucky	303	21,385	Utah	79	5,705
Louisiana	266	26,486			
Maine	121	7,248	Vermont	43	3,227
			Virginia	240	16,121
Maryland	233	20,360	Washington	256	18,157
Massachusetts	483	46,705	West Virginia	119	8,271
Michigan	388	33,844	Wisconsin	361	36,258
Minnesota	404	37,202	Wyoming	33	2,729
Mississippi	154	13,013			
			U.S. Territories and Possessions	9	360

NOTE: Data as of December.

SOURCE: CMS/ORDI

November 2003

Nursing Facilities Certified for Medicaid Only and Other Medicaid Long-Term Care Facilities by State

2002

	Nursing Facilities Title 19 Only	Institutions for Mentally Retarded		Nursing Facilities Title 19 Only	Institutions for Mentally Retarded
United States	1,878	6,749	Missouri	76	19
			Montana	1	2
Alabama	5	8	Nebraska	55	4
Alaska	0	0	Nevada	2	19
Arizona	1	13	New Hampshire	15	1
Arkansas	56	41			
California	87	1,085	New Jersey	0	9
			New Mexico	11	44
Colorado	24	3	New York	2	750
Connecticut	8	120	North Carolina	2	331
Delaware	5	2	North Dakota	0	66
District of Columbia	1	131			
Florida	8	107	Ohio	79	469
			Oklahoma	136	59
Georgia	30	13	Oregon	23	1
Hawaii	4	20	Pennsylvania	19	242
Idaho	3	65	Rhode Island	0	15
Illinois	178	315			
Indiana	50	573	South Carolina	0	136
			South Dakota	22	1
Iowa	127	128	Tennessee	37	83
Kansas	119	38	Texas	161	904
Kentucky	0	14	Utah	11	14
Louisiana	55	473			
Maine	0	25	Vermont	1	2
			Virginia	39	20
Maryland	13	5	Washington	11	15
Massachusetts	16	7	West Virginia	18	62
Michigan	44	1	Wisconsin	46	39
Minnesota	21	240	Wyoming	6	2
Mississippi	50	13			

NOTE: Data as of December.

SOURCE: CMS/ORDI

November 2003

Community Hospitals by State

2001 Annual Survey

	Hospitals	Beds	Beds per 1,000 Resident Population		Hospitals	Beds	Beds per 1,000 Resident Population
United States	4,908	825,966	2.9	Missouri	117	19,257	3.4
				Montana	53	4,463	4.9
Alabama	107	16,627	3.7	Nebraska	84	8,324	4.9
Alaska	19	1,442	2.3	Nevada	24	4,099	1.9
Arizona	61	10,732	2.0	New Hampshire	28	2,853	2.3
Arkansas	83	9,535	3.5				
California	384	73,291	2.1	New Jersey	78	24,580	2.9
				New Mexico	35	3,584	2.0
Colorado	66	9,442	2.1	New York	212	67,296	3.5
Connecticut	35	8,041	2.3	North Carolina	111	23,755	2.9
Delaware	5	1,853	2.3	North Dakota	40	3,717	5.9
District of Columbia	10	3,372	5.9				
Florida	202	51,762	3.2	Ohio	166	33,310	2.9
				Oklahoma	108	11,207	3.2
Georgia	147	24,113	2.9	Oregon	60	6,660	1.9
Hawaii	23	3,235	2.6	Pennsylvania	205	42,131	3.4
Idaho	40	3,439	2.6	Rhode Island	11	2,449	2.3
Illinois	192	36,834	3.0				
Indiana	110	19,036	3.1	South Carolina	62	11,282	2.8
				South Dakota	50	4,465	5.9
Iowa	116	11,538	3.9	Tennessee	123	20,600	3.6
Kansas	133	11,211	4.2	Texas	411	56,354	2.6
Kentucky	103	15,001	3.7	Utah	42	4,437	2.0
Louisiana	125	17,975	4.0				
Maine	37	3,844	3.0	Vermont	14	1,694	2.8
				Virginia	87	16,775	2.3
Maryland	49	11,234	2.1	Washington	84	11,382	1.9
Massachusetts	80	16,504	2.6	West Virginia	57	7,906	4.4
Michigan	145	25,630	2.6	Wisconsin	121	15,597	2.9
Minnesota	133	16,508	3.3	Wyoming	24	1,920	3.9
Mississippi	96	13,670	4.8				

NOTE: Includes total hospital and nursing unit beds.

SOURCE: American Hospital Associations' 2003 Hospital Statistics.

November 2003

Medicare Part B Participating Physicians and Other Practitioners by State
Selected Years

	January 1999	January 2000	January 2001	January 2002	January 2003
Alabama	94.5	95.5	96.0	96.1	96.4
Alaska	81.4	82.9	83.7	86.1	87.2
Arizona	89.7	90.3	88.5	90.6	91.1
Arkansas	83.1	94.6	95.1	95.5	95.9
California	81.0	85.5	78.5	78.6	89.5
Colorado	84.6	87.4	88.4	89.5	90.0
Connecticut	88.7	89.3	89.9	90.5	93.4
Delaware	84.1	85.2	86.9	92.0	92.4
District of Columbia	81.0	84.1	85.2	90.8	91.3
Florida	77.6	90.1	92.1	92.9	92.5
Georgia	83.3	89.4	89.5	90.8	90.4
Hawaii	85.6	90.3	91.0	94.3	94.7
Idaho	75.6	77.6	79.4	80.8	84.0
Illinois	84.2	90.9	92.4	92.6	93.4
Indiana	79.0	83.2	85.1	85.5	87.4
Iowa	91.1	93.2	94.0	94.2	94.6
Kansas	94.7	94.2	94.4	94.6	95.4
Kentucky	92.3	93.8	93.3	93.7	94.0
Louisiana	73.5	91.7	92.1	92.3	92.4
Maine	93.8	94.3	93.6	93.7	94.8
Maryland	91.7	93.4	94.2	94.1	94.3
Massachusetts	94.0	94.9	91.7	92.1	96.0
Michigan	87.7	95.3	96.6	96.9	97.3
Minnesota	78.1	79.3	79.9	80.4	80.6
Mississippi	82.6	83.5	84.6	85.6	86.1
Missouri	89.2	87.9	90.0	95.6	94.0
Montana	84.7	86.6	88.6	89.9	90.9
Nebraska	92.4	92.7	93.2	93.8	94.6
Nevada	93.3	94.1	91.2	96.2	95.6
New Hampshire	92.2	93.1	90.8	91.1	94.0
New Jersey	80.1	82.8	84.5	87.4	88.9
New Mexico	89.3	89.9	91.1	92.6	93.3
New York	75.3	80.3	81.0	81.2	82.3
North Carolina	88.3	89.6	90.0	91.1	91.9
North Dakota	94.3	95.5	96.3	97.2	97.3
Ohio	93.2	93.9	94.2	95.5	95.7
Oklahoma	89.9	91.7	92.5	93.9	94.4
Oregon	89.8	90.7	91.2	92.8	93.4
Pennsylvania	83.5	85.5	94.3	95.8	96.4
Rhode Island	71.7	72.5	74.1	75.6	77.2
South Carolina	90.0	91.4	91.5	92.1	92.8
South Dakota	85.7	86.7	87.7	89.3	90.6
Tennessee	90.9	91.2	91.3	92.2	92.6
Texas	83.3	85.4	86.5	88.0	89.4
Utah	94.1	94.6	95.1	96.2	97.0
Vermont	91.8	92.9	94.8	94.9	93.8
Virginia	87.2	87.3	87.6	88.6	93.7
Washington	91.7	92.9	93.8	96.2	95.8
West Virginia	92.1	93.5	94.2	94.8	94.8
Wisconsin	89.4	90.9	92.7	94.5	95.0
Wyoming	86.4	87.1	87.3	87.7	88.0

NOTE: Other practitioners includes limited license practitioners and non-physician practitioners.

SOURCE: CMS/OFM November 2003

Physician Assignment Rates as a Percent of Allowed Charges by State
Fiscal Year 2002

CMS Region/State	Assignment Rate	CMS Region/State	Assignment Rate
National	99.4		
Alabama	99.8	Montana	99.0
Alaska	99.2	Nebraska	97.9
Arizona	96.1	Nevada	99.9
Arkansas	99.8	New Hampshire	99.5
California	99.4	New Jersey	98.6
Colorado	98.7	New Mexico	99.1
Connecticut	99.2	New York	98.9
Delaware	99.5	North Carolina	99.3
District of Columbia	98.9	North Dakota	99.5
Florida	99.6	Ohio	99.9
Georgia	99.5	Oklahoma	99.3
Hawaii	99.5	Oregon	98.8
Idaho	94.9	Pennsylvania	99.9
Illinois	99.2	Rhode Island	100.0
Indiana	99.5	South Carolina	99.6
Iowa	99.4	South Dakota	94.9
Kansas	99.6	Tennessee	99.7
Kentucky	99.6	Texas	99.4
Louisiana	99.7	Utah	99.7
Maine	99.8	Vermont	99.7
Maryland	99.4	Virginia	99.7
Massachusetts	99.9	Washington	99.3
Michigan	99.7	West Virginia	99.8
Minnesota	96.7	Wisconsin	99.6
Mississippi	99.7	Wyoming	95.6
Missouri	99.4		

SOURCE: CMS/OFM November 2003

Medicare Physicians and Other Medical Professionals by State [1]
2003

State	Number	Percent of Total	State	Number	Percent of Total
Total	914,303 [2]	100.0	Mississippi	6,289	0.7
			Montana	3,367	0.4
Alabama	10,389	1.1	North Carolina	25,715	2.8
Alaska	2,161	0.2	North Dakota	2,875	0.3
Arizona	14,289	1.6	Nebraska	5,809	0.6
Arkansas	8,762	1.0			
California	90,222	9.9	New Hampshire	5,853	0.6
			New Jersey	32,038	3.5
			New Mexico	4,951	0.5
Colorado	14,835	1.6	Nevada	4,925	0.5
Connecticut	10,064	1.1	New York	74,194	8.1
Delaware	2,689	0.3			
District Columbia	4,546	0.5	Ohio	37,111	4.1
Florida	51,245	5.6	Oklahoma	8,445	0.9
			Oregon	11,834	1.3
Georgia	22,944	2.5	Pennsylvania	45,990	5.0
Hawaii [3]	4,540	0.5	Puerto Rico [4]	6,891	0.8
Iowa	10,402	1.1			
Idaho	3,687	0.4	Rhode Island	3,430	0.4
Illinois	35,555	3.9	South Carolina	11,577	1.3
			South Dakota	2,709	0.3
Indiana	17,543	1.9	Tennessee	19,309	2.1
Kansas	8,971	1.0	Texas	52,595	5.8
Kentucky	12,473	1.4			
Lousiana	15,668	1.7	Utah	6,566	0.7
Massachusetts	37,314	4.1	Virginia	17,204	1.9
			Vermont	3,029	0.3
Maryland	21,154	2.3	Washington	21,302	2.3
Maine	6,350	0.7	Wisconsin	19,198	2.1
Michigan	32,264	3.5			
Minnesota	15,872	1.7	West Virginia	5,914	0.6
Missouri	19,600	2.1	Wyoming	1,635	0.2

[1] Medicare physicians and other medical professionals include active medical doctors, limited licensed practitioners, and non-physicians.

[2] Total includes unknown. [3] Guam included in Hawaii. [4] Virgin Islands included in Puerto Rico.

NOTES: Percent total does not necessarily equal sum of rounded components. Data as of April 2003.

SOURCES: CMS/ORDI/CBC (Medicare Physician Registry) November 2003

VIII. FINANCING

Selected reference material including contribution rates, taxable earning ceilings, cost-sharing provisions and Medicaid Federal matching percentages.

HIGHLIGHTS

- *The Omnibus Budget 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.*
- *The Medicare Part A inpatient hospital deductible increased from $40 in 1966 to $840 in 2003.*
- *The Medicare Part B coinsurance has remained at 20 percent since the beginning of the program. The annual Part B deductible increased from $50 beginning July 1966 to $100 beginning January 1991.*
- *The Medicare Part B premiums increased from $3 per month in 1966 to $58.70 per month in 2003.*

Financing of Medicare Programs

Source of Income	
HI Trust Fund	
1. Payroll taxes *	
2. Transfers from railroad retirement account	
3. General revenue for	
a. uninsured persons	
b. military wage credits	
4. Premiums from voluntary enrollees	
5. Interest on investments	
* Contribution rate	
Employees and employers, each	1.45%
Self-employed	2.90%
Maximum taxable amount (CY 2003)	none [1]
Voluntary HI Premium [2]	
Monthly Premium (2003):	$316
SMI Trust Fund	
1. Premiums paid by or on behalf of enrollees	
2. General revenue	
3. Interest on investments	
Part B Premium	
Monthly Basic Premium (2003):	$58.70

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

SOURCE: CMS/OACT November 2003

Financing of Medicaid Programs

Fiscal Year 2003

Federal Contributions	Percent
1. Medical Vendor Payments[1]	50-83
2. Family Planning Services	90
3. Administrative Costs	50
4. Development of Management Information Systems[2]	90
5. Operation of Management Information Systems	75
6. Skilled Nursing Facility, Inspectors	75
7. Intermediate Care Facility for the Mentally Retarded, Inspectors	
a. Salaries, Fringe Benefits, Travel & Training	75
b. All Other Costs	50
8. Skilled Professional Medical Personnel	75
9. State Medicaid Fraud and Abuse Units	75
10. PRO Performance Review	75
11. Systematic Alien Verification for Entitlements System	100
12. Preadmission Screening and Annual Resident Review	75
13. Indian Health Services	100
14. TANF Allocation Enhanced Administrative Match[3]	75-90

[1] Range reflects floor to ceiling percentages available under statute in any fiscal year. The ceiling for Medicaid State Children's Health Insurance Program payments under sections 1905(u)(2) and 1905(u)(3) is 85 percent.

[2] After approval of an application for 90% rate by CMS.

[3] Special transitional enhanced match for certain administrative expenditures attributable to the costs of Medicaid eligibility determinations with the advent of the Temporary Assistance to Needy Families (TANF) program (section 1931).

SOURCE: CMS/CMSO November 2003

Medicare Cost Sharing and Premium Amounts for Hospital Insurance [1]

		Inpatient Hospital			SNF [3]	
		Deductible (IHD)	Daily Coinsurance		Daily	
		Covers first 60 days	61st through 90th days (1/4 x IHD)	LTR [2] after 90 days (1/2 x IHD)	Coinsurance after 20 days (1/8 x IHD)	Hospital Insurance Monthly Premium [4]
		Beginning in January unless noted				
July	1966	$40	$10	[5]	[5]	
	1970	52	13	26	6.50	
	1980	180	45	(90	(22.50	78 [6 7]
	1985	400	100	200	50.00	-- 174 [8]
	1990	592	148	296	74.00	-- 175 [9]
	1995	716	179	358	89.50	261 [10]
	1996	736	184	368	92.00	289 [10]
	1997	760	190	380	95.00	311 [10]
	1998	764	191	382	95.50	309 [10]
	1999	768	192	384	96.00	309 [10]
	2000	776	194	388	97.00	301 [10]
	2001	792	198	396	99.00	300 [10]
	2002	812	203	406	101.50	319 [10]
	2003	840	210	420	105.00	316 [10]

[1] Hospital Insurance covers all expenses in "benefit period" except deductible and coinsurances shown below.
[2] LTR is lifetime reserve.
[3] SNF is skilled nursing facility.
[4] Premium paid for voluntary participation of individuals aged 65 or older not otherwise entitled to hospital insurance and of certain disabled individuals who have exhausted other entitlement.
[5] Benefit not provided.
[6] Beginning in July for years 1973 through 1982.
[7] Set to 33/76 times the IHD, rounded to the nearest dollar, for years 1973 through 1988.
[8] Beginning in January for 1984 and succeeding years.
[9] Set at the estimated actuarial value of incurred benefits and administrative expenses for hospital insurance entitled aged beneficiaries, rounded to the nearest dollar, for 1989 and succeeding years.
[10] For 1994 and later, a reduced premium is available to individuals aged 65 or older 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. For 2003, the reduced premium is $174.

SOURCE: CMS/OACT

November 2003

Medicare Cost Sharing and Premium Amounts for Supplementary Medical Insurance

			Monthly Premiums		
				Government Amounts	
	Annual Deductible	Coinsurance	For Enrollee (aged and disabled)[1]	Aged	Disabled
		Beginning July unless otherwise noted			
1966	$50	20%	$3.00	$3.00	--
1970	50 [2] [3]	20% [3]	4.00	4.00	--
1975	60 [4]	20% [5]	6.70	6.70	29.30
1980	60	20%	8.70	18.10	41.30
1985	75 [6] [7] [8]	20%	15.50 [9]	46.50 [9]	89.90 [9]
1990	75	20%	28.60	85.80	59.60
1995	100 [10]	20%	46.10	100.10	165.50
1996	100	20%	42.50	127.30	167.70
1997	100	20%	43.80	131.40	177.00
1998	100	20%	43.80	132.00	150.40
1999	100	20%	45.50	139.10	160.50
2000	100	20%	45.50	138.30	196.70
2001	100	20%	50.00	152.00	214.40
2002	100	20%	54.00	164.60	192.20
2003	100	20%	58.70	178.70	223.30

[1] Beginning July 1973 for the disabled.
[2] Beginning in January for 1967 and succeeding years.
[3] Professional inpatient services of pathologists and radiologists not subject to deductible or coinsurance for the period April 1968 - December 1980.
[4] Deductible was $60 for the years 1973 - 1981.
[5] Home health services are not subject to coinsurance, beginning July 1972.
[6] Home health services are not subject to deductible, beginning 1981.
[7] Professional inpatient services of pathologists and radiologists not subject to deductible and coinsurance only when physician accepts assignment for the period January 1981 - September 1982 and are subject to deductible and coinsurance for October 1982 and later.
[8] Deductible was $75 for the years 1982 - 1990.
[9] Beginning in January for 1984 and succeeding years.
[10] Deductible is $100 for the years 1991 and later.

SOURCE: CMS/OACT

November 2003

Medicare Annual Maximum Taxable Earnings and HI Contribution Rates
Calendar Years 1966 - 2003

Calendar Year	Annual Maximum Taxable Earnings	Contribution Rate [1]	
		Employees and employers, each	Self-employed
1966	$6,600	0.35	0.35
1967	6,600	0.50	0.50
1968	7,800	0.60	0.60
1969	7,800	0.60	0.60
1970	7,800	0.60	0.60
1971	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
1988	45,000	1.45	2.90
1989	48,000	1.45	2.90
1990	51,300	1.45	2.90
1991	125,000	1.45	2.90
1992	130,200	1.45	2.90
1993	135,000	1.45	2.90
1994 and later	none [2]	1.45	2.90

[1] Percent of taxable earnings.

[2] The Omnibus Budget Reconciliation Act of 1993 eliminated the Annual Maximum Taxable Earnings amount for 1994 and later. For those years, the contribution rate is applied to all earnings in covered employment.

SOURCE: CMS/OACT November 2003

Title XIX
Federal Medical Assistance Percentages
Fiscal Years 2001 - 2004

	2001	2002	2003	2003 TFMAP[1]	2004	2004 TFMAP[1]		2001	2002	2003	2003 TFMAP[1]	2004	2004 TFMAP[1]
Alabama	69.99	70.45	70.60	73.55	70.75	73.70	Missouri	61.03	61.06	61.23	64.18	61.47	64.42
Alaska[2]	60.13	57.38	58.27	61.22	58.39	61.34	Montana	73.04	72.83	72.96	75.91	72.85	75.91
Arizona	65.77	64.98	67.25	70.20	67.26	70.21	Nebraska	60.38	59.55	59.52	62.50	59.89	62.84
Arkansas	73.02	72.64	74.28	77.23	74.67	77.62	Nevada	50.36	50.00	52.39	55.34	54.93	57.88
California	51.25	51.40	50.00	54.35	50.00	52.95	New Hampshire	50.00	50.00	50.00	52.95	50.00	52.95
Colorado	50.00	50.00	50.00	52.95	50.00	52.95	New Jersey	50.00	50.00	50.00	52.95	50.00	52.95
Connecticut	50.00	50.00	50.00	52.95	50.00	52.95	New Mexico	73.80	73.04	74.56	77.51	74.85	77.80
Delaware	50.00	50.00	50.00	52.95	50.00	52.95	New York	50.00	50.00	50.00	52.95	50.00	52.95
District of Columbia[3]	70.00	70.00	70.00	72.95	70.00	72.95	North Carolina	62.47	61.46	62.56	65.51	62.85	65.80
Florida	56.62	56.43	58.83	61.78	58.93	61.88	North Dakota	69.99	69.87	68.36	72.82	68.31	71.31
Georgia	59.67	59.00	59.60	62.55	59.58	62.55	Ohio	59.03	58.78	58.83	61.78	59.23	62.18
Hawaii	53.85	56.34	58.77	61.72	58.90	61.85	Oklahoma	71.24	70.43	70.56	73.51	70.24	73.51
Idaho	70.76	71.02	70.96	73.97	70.46	73.91	Oregon	60.00	59.20	60.16	63.11	60.81	63.76
Illinois	50.00	50.00	50.00	52.95	50.00	52.95	Pennsylvania	53.62	54.65	54.69	57.64	54.76	57.71
Indiana	62.04	62.04	61.97	64.99	62.32	65.27	Rhode Island	53.79	52.45	55.40	58.35	56.03	58.98
Iowa	62.67	62.86	63.50	66.45	63.93	66.88	South Carolina	70.44	69.34	69.81	72.76	69.86	72.81
Kansas	59.85	60.20	60.15	63.15	60.82	63.77	South Dakota	68.31	65.93	65.29	68.88	65.67	68.62
Kentucky	70.39	69.94	69.89	72.89	70.09	73.04	Tennessee	63.79	63.64	64.59	67.54	64.40	67.54
Louisiana	70.53	70.30	71.28	74.23	71.63	74.58	Texas	60.57	60.17	59.99	63.12	60.22	63.17
Maine	66.12	66.58	66.22	69.53	66.01	69.17	Utah	71.44	70.00	71.24	74.19	71.72	74.67
Maryland	50.00	50.00	50.00	52.95	50.00	52.95	Vermont	62.40	63.06	62.41	66.01	61.34	65.36
Massachusetts	50.00	50.00	50.00	52.95	50.00	52.95	Virginia	51.85	51.45	50.53	54.40	50.00	53.48
Michigan	56.18	56.36	55.42	59.31	55.89	58.84	Washington	50.70	50.37	50.00	53.32	50.00	52.95
Minnesota	51.11	50.00	50.00	52.95	50.00	52.95	West Virginia	75.34	75.27	75.04	78.22	75.19	78.14
Mississippi	76.82	76.09	76.62	79.57	77.08	80.03	Wisconsin	59.29	58.57	58.43	61.52	58.41	61.38
							Wyoming	64.60	61.97	61.32	64.92	59.77	64.27
							Territories[4]	50.00	50.00	50.00	52.95	50.00	52.95

[1] Temporary FMAPs established by Section 401 of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27) available for certain expenditures for the last two quarters of Federal FY 2003 and the first three quarters of Federal FY 2004.

[2] Per Section 706 of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554).

[3] Per Section 4725 of the Balanced Budget Act of 1997 (P.L. 105-33).

[4] Includes American Samoa, Guam, N. Mariana Islands, Puerto Rico and Virgin Islands. Subject to Federal share limit.

SOURCE: CMS/CMSO

November 2003

Geographical Jurisdictions of CMS Regional Office
Federal Medical Assistance Percentages
and Enhanced Federal Medical Assistance Percentages
Fiscal Year 2004

	Region	FMAP	TFMAP[1]	EFMAP[2]
I.	**Boston**			
	Connecticut	50.00	52.95	65.00
	Maine	66.01	69.17	76.21
	Massachusetts	50.00	52.95	65.00
	New Hampshire	50.00	52.95	65.00
	Rhode Island	56.03	58.98	69.22
	Vermont	61.34	65.36	72.94
III.	**Philadelphia**			
	Delaware	50.00	52.95	65.00
	District of Columbia	70.00	72.95	79.00
	Maryland	50.00	52.95	65.00
	Pennsylvania	54.76	57.71	68.33
	Virginia	50.00	53.48	65.00
	West Virginia	75.19	78.14	82.53
V.	**Chicago**			
	Illinois	50.00	52.95	65.00
	Indiana	62.32	65.27	73.62
	Michigan	55.89	58.84	69.12
	Minnesota	50.00	52.95	65.00
	Ohio	59.23	62.18	71.46
	Wisconsin	58.41	61.38	70.89
VII.	**Kansas City**			
	Iowa	63.93	66.88	74.75
	Kansas	60.82	63.77	72.57
	Missouri	61.47	64.42	73.03
	Nebraska	59.89	62.84	71.92
IX.	**San Francisco**			
	Arizona	67.26	70.21	77.08
	California	50.00	52.95	65.00
	Hawaii	58.90	61.85	71.23
	Nevada	54.93	57.88	68.45
	American Samoa	50.00	52.95	65.00
	Guam	50.00	52.95	65.00
	N. Mariana Islands	50.00	52.95	65.00
II.	**New York**			
	New Jersey	50.00	52.95	65.00
	New York	50.00	52.95	65.00
	Puerto Rico	50.00	52.95	65.00
	Virgin Islands	50.00	52.95	65.00
IV.	**Atlanta**			
	Alabama	70.75	73.70	79.53
	Florida	58.93	61.88	71.25
	Georgia	59.58	62.55	71.71
	Kentucky	70.09	73.04	79.06
	Mississippi	77.08	80.03	83.96
	North Carolina	62.85	65.80	74.00
	South Carolina	69.86	72.81	78.90
	Tennessee	64.40	67.54	75.08
VI.	**Dallas**			
	Arkansas	74.67	77.62	82.27
	Louisiana	71.63	74.58	80.14
	New Mexico	74.85	77.80	82.40
	Oklahoma	70.24	73.51	79.17
	Texas	60.22	63.17	72.15
VIII.	**Denver**			
	Colorado	50.00	52.95	65.00
	Montana	72.85	75.91	81.00
	North Dakota	68.31	71.31	77.82
	South Dakota	65.67	68.62	75.97
	Utah	71.72	74.67	80.20
	Wyoming	59.77	64.27	71.84
X.	**Seattle**			
	Alaska	58.39	61.34	70.87
	Idaho	70.46	73.91	79.32
	Oregon	60.81	63.76	72.57
	Washington	50.00	52.95	65.00

[1] Temporary FMAPs established by Section 401 (P.L. 108-27) available for certain expenditures for the first three quarters of Federal FY 2004.

[2] The "Enhanced Federal Medical Assistance Percentages" are for use in the State Children's Health Insurance Program (Title XXI), and Medicaid State Children's Health Insurance Program expansions under sections 1905(u)(2) and (u)(3).

SOURCE: CMS/CMSO November 2003