Table 5.1

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2009

Type of Entitlement and Year	Discharges		Total Days of Care		
	Number in Thousands	Rate per 1,000 HI Enrollees	Number in Thousands	Rate per 1,000 HI Enrollees	Per Discharge
All Beneficiaries					
1972	6,380	302	77,198	3,656	12.1
1973	6,984	300	81,529	3,499	11.7
1974	7,629	319	87,523	3,658	11.5
1975	8,001	325	89,275	3,623	11.2
1976	8,465	334	93,480	3,693	11.0
1977	8,808	338	96,825	3,711	11.0
1978	9,216	344	99,372	3,712	10.8
1979	9,642	351	102,469	3,750	10.7
1980	10,279	366	109,175	3,890	10.6
1981	10,660	368	110,806	3,827	10.4
1982	11,109	382	113,047	3,889	10.2
1983	11,436	387	112,011	3,786	9.8
1984	10,896	363	96,485	3,217	8.9
1985	10,027	328	86,339	2,822	8.6
1986	10,044	322	86,910	2,784	8.7
1987	10,110	317	89,651	2,815	8.9
1988	10,256	316	90,873	2,804	8.9
1989 [3]	10,148	307	89,902	2,721	8.9
1990	10,522	312	92,735	2,749	8.8
1991 [4]	10,737	312	92,935	2,699	8.7
1992 [4]	10,958	312	91,990	2,616	8.4
1993 [4]	10,979	306	87,883	2,446	8.0
1994 [4]	11,282	335	84,742	2,516	7.5
1995 [4]	11,435	340	80,056	2,378	7.0
1996 [4]	11,474	345	75,660	2,272	6.6
1997 [4]	11,527	353	73,029	2,239	6.3
1998 [4]	11,355	355	70,055	2,192	6.2
1999 [4]	11,605	365	70,508	2,219	6.1
2000 [4]	11,720	363	70,330	2,175	6.0
2001 [4]	12,231	366	72,607	2,171	5.9
2002 [4]	12,607	365	74,566	2,158	5.9
2003 [4]	12,858	363	75,230	2,126	5.9
2004 [4]	12,918	359	74,606	2,072	5.8
2005 [4]	12,904	355	73,996	2,037	5.7
2006 [4]	12,384	349	70,301	1,981	5.7
2007 [4]	12,036	343	68,048	1,936	5.7
2008 [4]	11,821	338	66,591	1,904	5.6
2009 [4]	11,558	330	63,442	1,811	5.5

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2009

Total Charges		Program Payments					
Amount in Millions	Per Discharge	Amount in Millions	Per Discharge[1]	Per HI Enrollee	Per Day	Percent of Total Charges	Percent of Total Medicare Payments [2]
$7,401	$1,160	$5,576	$874	$264	$72	75.3	69.5
8,494	1,216	6,446	923	277	79	75.9	69.7
10,471	1,373	7,837	1,027	328	90	74.8	69.7
13,073	1,634	9,748	1,218	396	109	74.6	67.0
15,951	1,882	11,803	1,394	466	126	74.1	67.0
19,157	2,170	13,944	1,583	534	144	73.0	68.1
22,408	2,431	16,008	1,737	598	161	71.4	68.0
26,120	2,709	18,463	1,915	672	180	70.7	66.7
31,992	3,112	22,099	2,150	787	202	69.1	66.4
38,164	3,580	25,936	2,433	907	234	68.0	65.0
46,369	4,174	30,601	2,755	1,053	271	66.0	63.6
54,127	4,733	34,338	3,003	1,161	307	63.4	64.3
52,901	4,855	38,500	3,533	1,284	399	72.8	65.1
53,397	5,332	40,200	4,009	1,314	466	75.2	62.9
59,376	5,911	41,781	4,160	1,338	481	70.4	60.7
68,490	6,775	44,068	4,359	1,383	492	64.3	58.1
78,536	7,657	46,879	4,571	1,446	516	59.7	57.6
88,038	8,676	49,091	4,838	1,486	546	55.8	52.3
102,544	9,746	53,708	5,281	1,593	579	52.4	53.0
117,616	10,954	58,750	5,610	1,706	632	50.0	53.0
131,451	11,996	64,810	6,057	1,843	705	49.3	53.7
139,375	12,695	67,260	6,257	1,872	765	48.3	52.0
146,074	12,948	70,624	6,377	2,097	833	48.3	48.2
149,502	13,074	74,836	6,656	2,223	935	50.1	47.1
152,854	13,322	78,546	6,953	2,359	1,038	51.4	47.0
159,285	13,818	80,725	7,118	2,475	1,105	50.7	46.0
163,541	14,402	78,364	7,021	2,452	1,119	47.9	46.6
178,399	15,373	79,013	6,920	2,486	1,121	44.3	47.4
196,017	16,725	81,231	6,971	2,513	1,155	41.4	46.6
227,145	18,572	88,323	7,262	2,641	1,216	38.9	44.7
271,750	21,555	94,194	7,507	2,726	1,263	34.7	43.7
310,889	24,180	98,432	7,691	2,781	1,308	31.7	42.3
341,749	26,455	102,648	7,985	2,850	1,376	30.0	40.2
369,775	28,656	107,615	8,383	2,963	1,454	29.1	39.3
382,766	30,908	106,758	8,669	3,008	1,519	27.9	38.0
397,852	33,054	106,784	8,926	3,039	1,569	26.8	37.0
420,206	35,548	110,232	9,390	3,151	1,655	26.2	36.6
438,092	37,903	114,516	9,977	3,268	1,805	26.1	36.0

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2009

Type of Entitlement and Year	Discharges		Total Days of Care		
	Number in Thousands	Rate per 1,000 HI Enrollees	Number in Thousands	Rate per 1,000 HI Enrollees	Per Discharge
Aged Beneficiaries					
1972	6,380	302	77,198	3,656	12.1
1973	6,751	313	78,987	3,662	11.7
1974	7,033	320	80,880	3,677	11.5
1975	7,285	324	81,592	3,631	11.2
1976	7,607	332	84,438	3,684	11.1
1977	7,850	334	86,967	3,705	11.1
1978	8,133	339	88,557	3,692	10.9
1979	8,478	345	91,239	3,717	10.8
1980	9,051	361	96,772	3,855	10.7
1981	9,400	367	98,223	3,838	10.4
1982	9,817	376	100,431	3,846	10.2
1983	10,152	381	99,740	3,740	9.8
1984	9,705	358	86,062	3,174	8.9
1985	8,918	322	76,926	2,779	8.6
1986	8,917	316	77,240	2,733	8.7
1987	9,000	312	79,804	2,769	8.9
1988	9,146	312	80,938	2,761	8.8
1989 [3]	9,026	302	79,784	2,671	8.8
1990	9,351	307	82,179	2,696	8.8
1991 [4]	9,510	306	81,994	2,641	8.6
1992 [4]	9,663	306	80,818	2,559	8.4
1993 [4]	9,628	300	76,719	2,393	8.0
1994 [4]	9,802	331	73,278	2,471	7.5
1995 [4]	9,879	336	68,842	2,340	7.0
1996 [4]	9,853	341	64,610	2,237	6.6
1997 [4]	9,873	351	62,184	2,212	6.3
1998 [4]	9,683	354	59,286	2,169	6.1
1999 [4]	9,873	365	59,577	2,204	6.0
2000 [4]	9,913	361	59,002	2,152	6.0
2001 [4]	10,289	364	60,470	2,139	5.9
2002 [4]	10,510	361	61,515	2,113	5.9
2003 [4]	10,648	359	61,553	2,075	5.8
2004 [4]	10,595	353	60,436	2,016	5.7
2005 [4]	10,501	350	59,473	1,980	5.7
2006 [4]	10,042	343	56,222	1,921	5.6
2007 [4]	9,695	336	54,034	1,875	5.6
2008 [4]	9,481	331	52,694	1,841	5.6
2009 [4]	9,163	320	49,638	1,735	5.4

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2009

Total Charges		Program Payments					
Amount in Millions	Per Discharge	Amount in Millions	Per Discharge[1]	Per HI Enrollee	Per Day	Percent of Total Charges	Percent of Total Medicare Payments [2]
$7,401	$1,160	$5,576	$874	$264	$72	75.3	69.5
8,227	1,219	6,245	925	290	79	75.9	69.1
9,614	1,367	7,209	1,025	328	89	75.0	70.3
11,853	1,627	8,859	1,216	394	109	74.7	67.9
14,263	1,875	10,589	1,392	462	125	74.2	67.7
17,072	2,175	12,455	1,587	531	143	73.0	69.1
19,772	2,431	14,182	1,744	591	160	71.7	68.9
22,938	2,706	16,251	1,917	662	178	70.8	67.7
28,114	3,106	19,460	2,150	775	201	69.2	66.6
33,564	3,571	22,814	2,427	891	232	68.0	62.3
40,875	4,164	27,008	2,751	1,034	269	66.1	64.6
47,851	4,713	30,398	2,994	1,140	305	63.5	65.1
46,964	4,839	34,188	3,523	1,261	397	72.8	65.6
47,371	5,312	35,738	4,007	1,291	465	75.4	63.3
52,623	5,901	37,030	4,153	1,310	479	70.4	60.9
60,900	6,766	39,350	4,372	1,365	493	64.6	58.6
69,920	7,645	41,918	4,583	1,430	518	60.0	58.1
78,204	8,665	43,747	4,847	1,465	548	55.9	52.9
90,948	9,726	47,842	5,270	1,570	582	52.6	53.4
103,871	10,922	52,278	5,601	1,684	638	50.3	53.3
115,789	11,982	57,494	6,058	1,821	704	49.7	54.1
122,083	12,681	59,281	6,253	1,849	764	48.6	52.2
126,880	12,944	61,691	6,375	2,081	831	48.6	48.3
129,319	13,091	64,987	6,656	2,209	928	50.3	47.1
131,673	13,364	67,860	6,961	2,349	1,050	51.5	47.0
136,777	13,854	69,547	7,124	2,473	1,118	50.8	46.4
139,738	14,432	67,204	7,022	2,458	1,134	48.1	46.5
152,293	15,426	67,588	6,918	2,500	1,134	44.4	47.5
165,964	16,742	69,088	6,995	2,519	1,171	41.6	46.5
191,263	18,590	74,742	7,291	2,643	1,236	39.1	44.5
226,904	21,590	79,120	7,550	2,718	1,286	34.9	43.4
257,787	24,211	82,195	7,742	2,771	1,335	31.9	42.0
281,096	26,531	85,034	8,051	2,837	1,407	30.3	39.9
301,815	28,740	88,525	8,457	2,948	1,488	29.3	38.9
311,381	31,007	87,430	8,737	2,988	1,555	28.1	37.6
321,584	33,170	86,828	8,990	3,012	1,607	27.0	36.5
338,224	35,674	89,000	9,433	3,109	1,689	26.3	36.0
348,767	38,062	91,141	9,993	3,186	1,836	26.1	35.3

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2009

Type of Entitlement and Year	Discharges		Total Days of Care		
	Number in Thousands	Rate per 1,000 HI Enrollees	Number in Thousands	Rate per 1,000 HI Enrollees	Per Discharge
Disabled Beneficiaries					
1974 [5]	596	309	6,643	3,446	11.1
1975	716	330	7,683	3,544	10.7
1976	858	359	9,042	3,780	10.5
1977	958	366	9,858	3,764	10.3
1978	1,083	388	10,815	3,872	10.0
1979	1,164	400	11,230	3,858	10.0
1980	1,228	414	12,403	4,186	10.1
1981	1,260	420	12,583	4,196	9.9
1982	1,292	437	12,616	4,271	9.8
1983	1,284	440	12,272	4,206	9.6
1984	1,191	413	10,423	3,614	8.8
1985	1,109	381	9,413	3,238	8.5
1986	1,127	381	9,670	3,269	8.6
1987	1,109	366	9,847	3,249	8.9
1988	1,111	358	9,936	3,203	8.9
1989 [3]	1,122	354	10,118	3,191	9.0
1990	1,171	360	10,556	3,245	9.0
1991 [4]	1,227	362	10,941	3,230	8.9
1992 [4]	1,294	362	11,173	3,122	8.6
1993 [4]	1,352	350	11,165	2,891	8.3
1994 [4]	1,480	367	11,465	2,846	7.7
1995 [4]	1,556	367	11,214	2,646	7.2
1996 [4]	1,621	367	11,051	2,505	6.8
1997 [4]	1,654	368	10,845	2,411	6.6
1998 [4]	1,673	362	10,769	2,333	6.4
1999 [4]	1,732	365	10,931	2,306	6.3
2000 [4]	1,807	368	11,328	2,309	6.3
2001 [4]	1,942	376	12,137	2,347	6.2
2002 [4]	2,098	385	13,051	2,395	6.2
2003 [4]	2,210	386	13,677	2,387	6.2
2004 [4]	2,323	385	14,171	2,348	6.1
2005 [4]	2,402	382	14,523	2,311	6.0
2006 [4]	2,342	376	14,080	2,262	6.0
2007 [4]	2,341	371	14,014	2,218	6.0
2008 [4]	2,340	368	13,896	2,186	5.9
2009 [4]	2,395	372	13,804	2,145	5.8

[1]Beginning in 1990, the average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[2]Based on total Medicare program payments.

[3]Represents the only year that the Medicare Catastrophic Coverage Act of 1988 was in effect.

[4]This table was revised from earlier editions for years 1991-1998 to exclude discharges from short-stay hospitals that were paid for by Medicare managed care plans, thus yielding fee-for-service utilization only for those years. Data for years prior to 1991 were not revised. However, these managed care enrollees were included in calculating all user rates per enrollee until 1994. Beginning with 1994, Medicare managed care enrollees are excluded from all calculations.

[5]Effective July 1, 1973, Medicare coverage was extended to disabled beneficiaries under the Social Security and Railroad Retirement Programs. Coverage was also extended to persons under 65 years of age who require dialysis or a kidney transplant for end stage renal disease. Public Law 95-292 removed the under age 65 restriction for persons with end stage renal disease, effective October 1978.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. HI is hospital Insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2009

Total Charges		Program Payments					
Amount in Millions	Per Discharge	Amount in Millions	Per Discharge[1]	Per HI Enrollee	Per Day	Percent of Total Charges	Percent of Total Medicare Payments [2]
$857	$1,438	$628	$1,054	$326	$95	73.3	64.0
1,220	1,704	889	1,242	410	116	72.9	59.6
1,688	1,967	1,214	1,415	508	134	71.9	61.2
2,085	2,176	1,489	1,554	569	151	71.4	60.5
2,636	2,434	1,826	1,686	654	169	69.3	61.6
3,182	2,734	2,212	1,900	760	197	69.5	59.9
3,878	3,158	2,639	2,149	891	213	68.1	58.6
4,600	3,651	3,122	2,478	1,041	248	67.9	58.9
5,494	4,252	3,593	2,781	1,216	285	65.4	56.6
6,276	4,887	3,940	3,068	1,350	321	62.8	58.7
5,937	4,987	4,312	3,621	1,495	414	72.6	61.5
6,026	5,435	4,462	4,023	1,535	474	73.9	59.9
6,752	5,991	4,751	4,216	1,606	491	70.4	59.0
7,590	6,843	4,718	4,254	1,557	479	62.2	54.1
8,617	7,759	4,961	4,468	1,600	499	57.6	53.8
9,834	8,764	5,344	4,763	1,685	528	54.3	48.2
11,596	9,904	5,866	5,371	1,809	556	50.6	49.7
13,746	11,206	6,473	5,680	1,912	592	47.1	50.5
15,661	12,101	7,316	6,051	2,086	665	46.7	50.6
17,292	12,794	7,978	6,294	2,107	726	46.1	50.2
19,193	12,971	8,933	6,390	2,218	776	46.5	47.4
20,182	12,968	9,849	6,655	2,324	878	48.8	46.8
21,181	13,067	10,686	6,901	2,422	967	50.5	47.3
22,508	13,609	11,178	7,084	2,485	1,031	49.7	47.0
23,803	14,231	11,160	7,012	2,418	1,036	46.9	47.0
26,106	15,074	11,425	6,933	2,410	1,045	43.8	47.1
30,053	16,629	12,143	6,835	2,475	1,072	40.4	47.1
35,882	18,475	13,581	7,106	2,626	1,119	37.8	45.8
44,846	21,380	15,074	7,287	2,767	1,155	33.6	45.5
53,102	24,028	16,237	7,442	2,834	1,187	30.6	43.8
60,653	26,107	17,614	7,681	2,918	1,243	29.0	41.9
67,959	28,288	19,090	8,054	3,037	1,314	28.1	41.0
71,385	30,484	19,328	8,374	3,105	1,373	27.1	40.1
76,267	32,577	19,956	8,657	3,159	1,424	26.2	39.4
81,981	35,037	21,232	9,218	3,339	1,528	25.9	39.3
89,325	37,294	23,375	9,916	3,633	1,693	26.2	39.3

Table 5.2

Discharges, Coinsurance Days, Coinsurance Payments, and Deductible Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Selected Calendar Years 1985-2009

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	Number	Number With Coinsurance	Percent With Coinsurance	Number	Percent of TDOC	Per Discharge With Coinsurance	Amount in Thousands	Per Discharge With Coinsurance	Per Day With Coinsurance	Per HI Enrollee[1]	
All Beneficiaries											
1985	10,333,990	201,340	1.9	2,230,005	2.6	11.1	386,145	1,918	173	13	2,867,199
1987	10,109,560	186,300	1.8	2,223,675	2.5	11.9	506,323	2,718	228	16	3,818,919
1989[2]	10,147,665	9,075	0.1	140,285	0.2	15.5	39,013	4,299	278	1	3,607,489
1990	10,521,925	159,405	1.5	1,990,245	2.1	12.5	495,351	3,107	249	15	4,519,088
1991	10,887,700	208,650	1.9	2,564,295	2.7	12.3	740,119	3,547	289	21	4,938,491
1992	11,110,545	204,690	1.8	2,459,625	2.7	12.0	749,110	3,660	305	21	5,161,207
1993	11,157,860	190,640	1.7	2,230,130	2.5	11.7	678,846	3,561	304	19	5,407,178
1994	11,470,605	181,110	1.6	2,015,355	2.4	11.1	637,692	3,521	316	19	5,656,015
1995	11,680,885	164,535	1.4	1,738,950	2.1	10.6	535,923	3,257	308	16	5,880,735
1996	11,795,535	149,265	1.3	1,492,815	1.9	10.0	472,289	3,164	316	14	6,066,239
1997	11,919,085	144,780	1.2	1,400,900	1.9	9.7	454,071	3,136	324	14	6,274,527
1998	11,677,045	137,380	1.2	1,288,950	1.8	9.4	412,001	2,999	320	13	6,157,044
1999	11,604,590	137,940	1.2	1,278,785	1.8	9.3	423,526	3,070	331	13	6,077,414
2000	11,719,960	145,880	1.2	1,379,135	2.0	9.5	492,771	3,378	357	15	6,214,175
2001	12,230,660	156,340	1.3	1,454,450	2.0	9.3	530,950	3,396	365	16	6,579,229
2002	12,607,370	162,690	1.3	1,506,820	2.0	9.3	578,659	3,557	384	17	6,959,581
2003	12,857,535	168,950	1.3	1,531,665	2.0	9.1	594,767	3,520	388	17	7,299,864
2004	12,918,130	169,810	1.3	1,517,310	2.0	8.9	607,671	3,579	400	17	7,660,837
2005	12,903,875	172,875	1.3	1,521,535	2.1	8.8	645,944	3,736	425	18	7,977,547
2006	12,384,100	164,100	1.3	1,432,180	2.0	8.7	647,171	3,944	452	18	7,991,326
2007	12,036,270	163,515	1.4	1,417,390	2.1	8.7	681,073	4,165	481	19	8,069,580
2008	11,820,795	165,255	1.4	1,400,780	2.1	8.5	685,882	4,150	490	20	8,156,080
2009	11,558,205	156,050	1.4	1,271,830	2.0	8.2	647,793	4,151	509	18	8,275,870

See footnotes at end of table.

Table 5.2--Continued

Discharges, Coinsurance Days, Coinsurance Payments, and Deductible Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Selected Calendar Years 1985-2009

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	Number	Number With Coinsurance	Percent With Coinsurance	Number	Percent of TDOC	Per Discharge With Coinsurance	Amount in Thousands	Per Discharge With Coinsurance	Per Day With Coinsurance	Per HI Enrollee[1]	
Aged Beneficiaries											
1985	9,181,575	167,205	1.8	1,877,450	2.4	11.2	322,772	1,930	172	12	2,575,432
1987	9,000,415	154,295	1.7	1,868,520	2.3	12.1	419,639	2,720	225	15	3,435,293
1989[2]	9,025,585	7,825	0.1	121,505	0.2	15.5	34,131	4,362	281	1	3,254,277
1990	9,351,115	130,485	1.4	1,655,100	2.0	12.7	410,189	3,144	248	13	4,062,061
1991	9,654,955	171,485	1.8	2,134,965	2.6	12.4	602,694	3,515	282	19	4,428,249
1992	9,809,310	165,705	1.7	2,024,330	2.5	12.2	603,867	3,644	298	19	4,607,969
1993	9,797,540	151,855	1.5	1,798,310	2.3	11.8	678,846	3,544	299	21	4,805,070
1994	9,981,910	140,710	1.4	1,587,770	2.1	11.3	490,226	3,484	309	17	4,988,249
1995	10,110,745	125,305	1.2	1,348,065	1.9	10.8	407,180	3,250	302	14	5,160,234
1996	10,154,130	109,210	1.1	1,118,230	1.7	10.2	347,960	3,186	311	12	5,300,481
1997	10,238,610	105,800	1.0	1,041,835	1.6	9.8	325,899	3,080	313	12	5,469,574
1998	9,981,860	97,640	1.0	930,890	1.5	9.4	287,393	2,943	309	11	5,343,214
1999	9,872,680	97,240	1.0	921,210	1.5	9.5	296,315	3,047	322	11	5,245,762
2000	9,912,740	102,475	1.0	982,075	1.7	9.6	339,119	3,309	345	12	5,335,548
2001	10,288,530	109,450	1.1	1,025,070	1.7	9.4	359,299	3,283	351	13	5,619,671
2002	10,509,835	112,105	1.1	1,045,585	1.7	9.3	381,837	3,406	365	13	5,892,427
2003	10,647,510	113,995	1.1	1,040,375	1.7	9.1	384,424	3,372	370	13	6,142,079
2004	10,594,875	112,690	1.1	1,014,715	1.7	9.0	385,968	3,425	380	13	6,386,647
2005	10,501,475	113,530	1.1	1,005,315	1.7	8.9	402,672	3,547	401	13	6,604,040
2006	10,042,340	105,795	1.1	931,900	1.7	8.8	405,573	3,834	435	14	6,595,321
2007	9,695,130	105,270	1.1	915,155	1.7	8.7	420,183	3,991	459	15	6,620,084
2008	9,480,950	105,350	1.1	895,535	1.7	8.5	417,318	3,961	466	15	6,659,452
2009	9,163,075	96,645	1.1	798,005	1.6	8.3	390,386	4,039	489	14	6,691,266

See footnotes at end of table.

Table 5.2--Continued

Discharges, Coinsurance Days, Coinsurance Payments, and Deductible Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Selected Calendar Years 1985-2009

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	Number	Number With Coinsurance	Percent With Coinsurance	Number	Percent of TDOC	Per Discharge With Coinsurance	Amount in Thousands	Per Discharge With Coinsurance	Per Day With Coinsurance	Per HI Enrollee[1]	
Disabled Beneficiaries											
1985	1,152,415	34,135	3.0	352,555	3.7	10.3	63,373	1,857	180	22	291,768
1987	1,109,145	32,005	2.9	355,155	3.6	11.1	86,684	2,708	244	29	383,625
1989[2]	1,122,080	1,250	0.1	18,780	0.2	15.1	4,881	3,905	260	2	353,212
1990	1,170,810	28,920	2.5	335,145	3.2	11.6	85,162	2,945	254	26	457,027
1991	1,233,645	37,165	3.0	429,330	3.9	11.6	137,425	3,698	320	41	510,241
1992	1,301,235	38,985	3.0	435,295	4.0	11.2	145,243	3,726	334	41	553,238
1993	1,360,320	38,785	2.9	431,820	3.9	11.1	140,702	3,628	326	36	602,109
1994	1,488,695	40,400	2.7	427,585	3.8	11.0	147,466	3,650	345	37	667,766
1995	1,570,140	39,230	2.5	390,885	3.5	10.0	128,743	3,282	329	30	720,502
1996	1,641,405	40,055	2.4	374,585	3.4	9.4	124,329	3,104	332	29	765,758
1997	1,680,475	38,980	2.3	359,065	3.3	9.2	128,172	3,288	357	28	804,953
1998	1,695,185	39,740	2.3	358,060	3.3	9.0	124,608	3,136	348	27	813,830
1999	1,731,910	40,700	2.4	357,575	3.3	8.8	127,211	3,126	356	27	831,652
2000	1,807,220	43,405	2.4	397,060	3.5	9.1	153,652	3,540	387	31	878,628
2001	1,942,130	46,890	2.4	429,380	3.5	9.2	171,651	3,661	400	33	959,558
2002	2,097,535	50,585	2.4	461,235	3.5	9.1	196,822	3,891	427	35	1,067,155
2003	2,210,025	54,955	2.5	491,290	3.6	8.9	210,343	3,828	428	37	1,157,786
2004	2,323,255	57,120	2.5	502,595	3.5	8.8	221,703	3,881	441	37	1,274,191
2005	2,402,400	59,345	2.5	516,220	3.6	8.7	243,272	4,099	471	39	1,373,508
2006	2,341,760	58,305	2.5	500,280	3.6	8.6	241,597	4,144	483	39	1,396,005
2007	2,341,140	58,245	2.5	502,235	3.6	8.6	260,890	4,479	519	41	1,449,496
2008	2,339,845	59,905	2.6	505,245	3.6	8.4	268,564	4,483	532	42	1,496,628
2009	2,395,130	59,405	2.5	473,825	3.4	8.0	257,407	4,333	543	40	1,584,604

[1]Beginning with 1994, Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates and average payments.

[2]The general provisions of the Medicare Catastrophic Coverage Act of 1988 affecting cost sharing were only in effect for calendar year 1989. Special provisions covered hospital stays that transitioned the effective dates.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. TDOC is total days of care. HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.3

Enrollees, Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Demographic Characteristics, Type of Entitlement, and Discharge Status: Calendar Year 2009

Demographic Characteristics, Medicare Status, and Discharge Status	Discharge[1]		Total Days of Care			Program Payments			
	Number in Thousands	Rate Per 1,000 HI Enrollees[2]	Number in Thousands	Percent	Per Discharge	Amount in Millions	Percent	Per Discharge[3]	Per Day
Total	11,558	330	63,442	100.0	5.5	$114,516	100.0	$9,977	$1,805
Age									
Under 65 Years	2,343	364	13,508	21.3	5.8	22,839	19.9	9,905	1,691
65-69 Years	1,793	205	9,606	15.1	5.4	19,350	16.9	10,876	2,014
70-74 Years	1,630	252	8,572	13.5	5.3	17,023	14.9	10,505	1,986
75-79 Years	1,706	334	9,266	14.6	5.4	17,676	15.4	10,409	1,908
80-84 Years	1,752	426	9,704	15.3	5.5	17,152	15.0	9,822	1,767
85 Years or Over	2,334	556	12,784	20.2	5.5	20,477	17.9	8,797	1,602
Sex									
Male	5,105	322	28,432	44.8	5.6	54,061	47.2	10,679	1,901
Female	6,454	337	35,010	55.2	5.4	60,456	52.8	9,424	1,727
Race[4]									
White	9,435	321	50,711	79.9	5.4	91,329	79.8	9,734	1,801
Other	2,093	372	12,561	19.8	6.0	22,867	20.0	11,077	1,820
Type of Entitlement									
Aged[5]	9,163	320	49,638	78.2	5.4	91,141	79.6	9,993	1,836
Disabled[6]	2,395	372	13,804	21.8	5.8	23,375	20.4	9,916	1,693
Discharge Status									
Alive	11,171	N/A	60,388	95.2	5.4	106,786	93.2	9,627	1,768
Dead	388	N/A	3,054	4.8	7.9	7,730	6.8	20,046	2,531

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates.

[3]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[4]Excludes unknown race.

[5]Includes aged persons with end stage renal disease (ESRD).

[6]Includes disabled persons with ESRD and persons entitled to Medicare because of ESRD only.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance. NA is not available.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.4

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Area of Residence: Calendar Year 2009

Area of Residence	Discharges[1]		Total Days of Care			Program Payments		
	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
All Areas[4]	11,558,205	330	63,441,875	1,811	5.5	$114,516,481	$9,977	$3,268
United States	11,508,690	335	63,087,500	1,834	5.5	114,231,779	9,995	3,321
Northeast	2,295,810	352	13,837,030	2,124	6.0	25,111,377	11,025	3,855
Midwest	2,852,960	348	14,865,325	1,815	5.2	26,812,345	9,458	3,274
South	4,728,940	348	25,796,425	1,897	5.5	43,210,591	9,193	3,177
West	1,630,980	268	8,588,720	1,410	5.3	19,097,464	11,820	3,136
New England	622,850	320	3,370,830	1,734	5.4	6,553,742	10,591	3,371
Connecticut	155,510	338	903,530	1,964	5.8	1,812,862	11,739	3,941
Maine	61,385	267	317,625	1,379	5.2	571,729	9,346	2,483
Massachusetts	299,985	358	1,568,895	1,875	5.2	3,063,041	10,278	3,660
New Hampshire	48,880	242	262,440	1,302	5.4	495,220	10,172	2,457
Rhode Island	36,850	327	210,285	1,868	5.7	357,106	9,824	3,173
Vermont	20,240	197	108,055	1,050	5.3	253,782	12,607	2,467
Middle Atlantic	1,672,960	366	10,466,200	2,291	6.3	18,557,634	11,187	4,061
New Jersey	408,880	362	2,471,780	2,190	6.0	4,393,032	10,855	3,893
New York	747,980	363	5,118,055	2,486	6.8	9,391,678	12,671	4,561
Pennsylvania	516,100	374	2,876,365	2,082	5.6	4,772,923	9,304	3,454
East North Central	2,046,630	363	10,796,160	1,914	5.3	19,477,385	9,586	3,454
Illinois	610,485	381	3,221,480	2,009	5.3	5,770,908	9,559	3,600
Indiana	279,405	335	1,488,780	1,788	5.3	2,613,455	9,396	3,138
Michigan	461,595	383	2,508,025	2,081	5.4	4,697,495	10,238	3,899
Ohio	509,765	377	2,655,415	1,962	5.2	4,584,160	9,042	3,387
Wisconsin	185,380	287	922,460	1,429	5.0	1,811,366	9,838	2,807
West North Central	806,330	316	4,069,165	1,595	5.0	7,334,959	9,134	2,876
Iowa	120,115	271	624,565	1,407	5.2	1,079,811	9,038	2,432
Kansas	114,135	302	587,035	1,554	5.1	993,136	8,731	2,629
Minnesota	166,555	347	761,655	1,588	4.6	1,624,719	9,789	3,388
Missouri	282,445	360	1,476,890	1,884	5.2	2,490,959	8,861	3,178
Nebraska	66,920	276	341,780	1,408	5.1	630,738	9,458	2,599
North Dakota	24,110	244	116,490	1,179	4.8	214,092	8,902	2,168
South Dakota	32,050	258	160,750	1,296	5.0	301,500	9,429	2,431
South Atlantic	2,480,320	340	13,572,560	1,862	5.5	23,655,646	9,586	3,245
Delaware	43,735	319	248,730	1,812	5.7	480,161	11,003	3,499
District of Columbia	25,335	380	163,785	2,454	6.5	328,972	13,188	4,929
Florida	827,695	355	4,586,655	1,968	5.5	7,389,651	8,961	3,170
Georgia	319,430	320	1,758,275	1,759	5.5	2,982,220	9,379	2,983
Maryland	275,215	392	1,372,135	1,953	5.0	3,204,075	11,757	4,560
North Carolina	384,095	323	2,094,175	1,761	5.5	3,754,730	9,829	3,157
South Carolina	201,010	319	1,144,675	1,815	5.7	1,915,410	9,564	3,037
Virginia	299,545	317	1,613,940	1,706	5.4	2,692,379	9,033	2,846
West Virginia	104,260	363	590,190	2,056	5.7	908,044	8,756	3,164

See footnotes at end of table.

Table 5.4--Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Area of Residence: Calendar Year 2009

Area of Residence	Discharges[1]		Total Days of Care			Program Payments		
	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
East South Central	943,535	378	5,120,940	2,054	5.4	$7,811,498	$8,316	$3,133
Alabama	245,855	384	1,340,995	2,096	5.5	1,897,260	7,767	2,966
Kentucky	234,785	378	1,244,455	2,003	5.3	2,046,356	8,759	3,294
Mississippi	167,915	381	975,760	2,216	5.8	1,431,614	8,558	3,252
Tennessee	294,980	372	1,559,730	1,969	5.3	2,436,267	8,284	3,076
West South Central	1,305,085	342	7,102,925	1,862	5.4	11,743,445	9,080	3,078
Arkansas	146,710	328	795,520	1,778	5.4	1,223,673	8,392	2,735
Louisiana	190,880	370	1,068,935	2,071	5.6	1,600,718	8,459	3,101
Oklahoma	183,690	365	961,140	1,908	5.2	1,537,095	8,425	3,051
Texas	783,805	334	4,277,330	1,822	5.5	7,381,958	9,514	3,144
Mountain	523,190	266	2,576,695	1,309	4.9	5,182,950	9,974	2,633
Arizona	165,260	294	810,220	1,444	4.9	1,701,737	10,399	3,032
Colorado	106,680	272	513,620	1,307	4.8	1,038,278	9,789	2,643
Idaho	32,795	206	148,805	933	4.5	312,968	9,569	1,962
Montana	30,030	222	148,470	1,095	4.9	273,530	9,141	2,018
Nevada	69,015	291	393,100	1,660	5.7	717,948	10,482	3,032
New Mexico	57,155	255	280,235	1,248	4.9	543,858	9,581	2,423
Utah	43,650	237	198,125	1,074	4.5	410,472	9,431	2,225
Wyoming	18,605	254	84,120	1,147	4.5	184,157	9,936	2,510
Pacific	1,107,790	269	6,012,025	1,459	5.4	13,914,514	12,696	3,376
Alaska	13,615	221	70,135	1,140	5.2	195,145	14,413	3,172
California	822,155	285	4,593,985	1,592	5.6	10,748,128	13,237	3,724
Hawaii	23,335	194	157,425	1,310	6.7	291,189	12,603	2,423
Oregon	73,445	212	350,005	1,011	4.8	777,591	10,642	2,246
Washington	175,240	248	840,475	1,187	4.8	1,902,458	10,916	2,687
Outlying Areas [5]	49,515	76	354,375	547	7.2	284,702	5,817	440

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates and average payments.

[3]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[4]Includes 50 States and outlying areas.

[5]Includes Puerto Rico, Guam, Virgin Islands, residence unknown, and all other outlying areas not shown separately.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance. Reliability of estimates - the statistics presented in this table are based on sample data and, therefore, may differ from the figures that would be obtained if a complete census of the data had been taken. The sampling error, which is primarily a measure of sampling variability that occurs by chance because only a sample rather than an entire universe is surveyed, would be relatively small for national estimates and table cells based on a large sample size. The sampling error, however, for table cell below the national level and based on a relatively small sample size could possibly reflect a large sampling error and should be utilized with caution when analyzing the data for utilization and trend purposes.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.5

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Diagnoses Within Major Diagnostic Classifications (MDCs): Calendar Year 2009

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Total All Diagnoses	---	11,558,205	330	63,441,875	5.5	$114,516,481	$9,977	$1,805
Leading Diagnoses [5]	---	6,095,920	174	33,801,390	5.5	64,081,333	10,577	1,896
Infectious and Parasitic Diseases (MDC 1)	001-139	592,030	17	4,647,905	7.9	8,605,982	14,645	1,852
Septicemia	038	434,145	12	3,647,965	8.4	7,090,619	16,461	1,944
Neoplasms (MDC 2)	140-239	521,695	15	3,465,310	6.6	7,183,631	13,829	2,073
Malignant Neoplasms	140-208,230-234	452,630	13	3,115,120	6.9	6,394,902	14,187	2,053
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	62,215	2	559,245	9.0	1,097,843	17,693	1,963
Malignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	77,920	2	552,100	7.1	1,100,861	14,185	1,994
Malignant Neoplasm of Breast	174-175,198.81	23,830	1	59,370	2.5	135,953	5,745	2,290
Benign Neoplasms	210-229	48,470	1	237,220	4.9	560,556	11,614	2,363
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	482,600	14	2,235,610	4.6	3,343,001	7,006	1,495
Diabetes Mellitus	250	178,215	5	990,310	5.6	1,555,847	8,845	1,571
Volume Depletion	276.5	112,035	3	429,220	3.8	532,939	4,788	1,242
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	171,665	5	782,420	4.6	1,225,090	7,311	1,566
Mental Disorders (MDC 5)	290-319	467,805	13	4,249,150	9.1	3,071,423	6,695	723
Psychoses	290-299	401,610	11	3,850,815	9.6	2,775,670	7,050	721
Alcohol Dependence Syndrome	303	14,565	(6)	92,790	6.4	64,814	4,525	698
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	271,965	8	1,590,370	5.8	2,124,019	7,865	1,336

See footnotes at end of table.

Table 5.5--Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Diagnoses Within Major Diagnostic Classifications (MDCs): Calendar Year 2009

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Diseases of the Circulatory System (MDC 7)	390-459	2,773,075	79	13,257,725	4.8	$30,644,608	$11,112	$2,311
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	1,874,405	53	9,068,280	4.8	21,917,570	11,755	2,417
Acute Myocardial Infarction	410	274,970	8	1,491,355	5.4	3,963,122	14,462	2,657
Coronary Atherosclerosis	414.0	344,155	10	1,332,890	3.9	4,790,363	14,055	3,594
Other Ischemic Heart Disease	411-413, 414.1-414.9	30,845	1	84,405	2.7	353,239	11,578	4,185
Cardiac Dysrhythmias	427	408,990	12	1,572,995	3.8	3,399,280	8,345	2,161
Congestive Heart Failure	428.0	233,205	7	1,139,875	4.9	1,998,717	8,615	1,753
Cerebrovascular Disease	430-438	467,890	13	2,089,015	4.5	3,956,941	8,504	1,894
Diseases of the Respiratory System (MDC 8)	460-519	1,397,445	40	8,162,975	5.8	12,312,169	8,851	1,508
Acute Bronchitis and Bronchiolitis	466	29,005	1	110,545	3.8	121,611	4,216	1,100
Pneumonia	480-486	470,130	13	2,722,675	5.8	3,651,680	7,795	1,341
Asthma	493	99,345	3	465,465	4.7	569,004	5,763	1,222
Diseases of the Digestive System (MDC 9)	520-579	1,114,565	32	6,071,485	5.4	10,061,603	9,079	1,657
Appendicitis	540-543	20,505	1	98,180	4.8	199,542	9,762	2,032
Non Infectious Enteritis and Colitis	555-558	94,565	3	505,145	5.3	760,784	8,096	1,506
Diverticula of Intestine	562	117,505	3	639,470	5.4	956,585	8,165	1,496
Cholelithiasis	574	96,160	3	497,925	5.2	972,648	10,154	1,953
Diseases of the Genitourinary System (MDC 10)	580-629	687,405	20	3,249,650	4.7	4,590,509	6,715	1,413
Calculus of Kidney and Ureter	592	30,970	1	97,455	3.1	206,925	6,721	2,123

See footnotes at end of table.

Table 5.5--Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Diagnoses Within Major Diagnostic Classifications (MDCs): Calendar Year 2009

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	221,610	6	1,222,490	5.5	$1,494,435	$6,782	$1,222
Cellulitis and Abscess	681-682	178,775	5	918,470	5.1	1,081,615	6,078	1,178
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	816,785	23	3,154,665	3.9	9,492,994	11,672	3,009
Osteoarthrosis and Allied Disorders	715	402,660	11	1,375,555	3.4	4,631,130	11,524	3,367
Intervertebral Disc Disorders	722	84,625	2	291,280	3.4	1,128,634	13,419	3,875
Congenital Anomalies (MDC 14)	740-759	11,825	(6)	55,130	4.7	218,770	18,603	3,968
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	638,950	18	1,938,150	3.0	2,882,056	4,563	1,487
Injury and Poisoning (MDC 17)	800-999	1,078,725	31	6,101,960	5.7	12,778,913	11,932	2,094
Fractures, All Sites	800-829	430,325	12	2,342,715	5.4	4,598,760	10,729	1,963
Fracture of Neck of Femur	820	200,365	6	1,177,195	5.9	2,476,691	12,383	2,104
Poisoning by Drugs, Medicinal and Biological Substances	960-989	57,385	2	215,775	3.8	352,559	6,207	1,634
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V86	289,665	8	3,185,955	11.0	4,402,099	15,280	1,382

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification.* Although as many as 10 codes are reported on the HCFA Form-1450, only the principal diagnosis (first listed) has been used.

[2]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[3]Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates.

[4]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[5]Specific diagnostic categories were selected for presentation because of frequency of occurrence or because of special interest. The leading classifications were developed by the National Center for Health Statistics.

[6]Less than 1 discharge per 1,000 enrollees.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.6

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2009

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Total All Procedures	---	6,836,430	195	42,674,190	6.2	$87,320,088	$12,858	$2,046
Leading Procedures [5]	---	2,874,300	82	16,557,645	5.8	33,272,589	11,645	2,010
Operations on the Nervous System (MPC 1)	01-05	159,700	5	1,012,030	6.3	2,330,269	14,675	2,303
Spinal Tap	03.31	34,695	1	232,880	6.7	302,378	8,771	1,298
Operations on the Endocrine System (MPC 2)	06-07	24,510	1	89,600	3.7	230,160	9,435	2,569
Operations on the Eye (MPC 3)	08-16	7,300	(6)	33,370	4.6	63,217	8,756	1,894
Operations on the Ear (MPC 4)	18-20	2,305	(6)	12,835	5.6	22,667	9,985	1,766
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	26,700	1	130,635	4.9	222,500	8,431	1,703
Operations on the Respiratory System (MPC 6)	30-34	266,840	8	2,709,815	10.2	5,213,241	19,634	1,924
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	60,845	2	541,930	8.9	738,146	12,194	1,362
Operations on the Cardiovascular System (MPC 7)	35-39	1,467,755	42	9,332,025	6.4	22,728,949	15,608	2,436
Removal of Coronary Artery Obstruction	36.0	2,215	(6)	8,235	3.7	31,913	14,843	3,875
Coronary Artery Bypass Graft	36.1	82,065	2	814,585	9.9	2,700,272	33,003	3,315
Cardiac Catheterization	37.21-37.23	218,225	6	885,335	4.1	1,631,665	7,515	1,843
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	123,290	4	620,085	5.0	1,974,396	16,077	3,184
Hemodialysis	39.95	246,685	7	1,224,530	5.0	2,246,332	9,272	1,834
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	46,970	1	363,365	7.7	754,284	16,134	2,076

See footnotes at end of table.

Table 5.6--Continued

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2009

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Operations on the Digestive System (MPC 9)	42-54	1,067,680	30	7,632,620	7.1	$12,720,948	$11,977	$1,667
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	290,815	8	1,617,725	5.6	1,948,419	6,733	1,204
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	99,460	3	569,120	5.7	648,432	6,546	1,139
Partial Excision of Large Intestine	45.7	66,315	2	788,785	11.9	1,630,931	24,670	2,068
Appendectomy, Excluding Incidental	47.0	18,825	1	87,575	4.7	184,692	9,853	2,109
Cholecystectomy	51.2	98,465	3	594,925	6.0	1,209,287	12,323	2,033
Lysis of Peritoneal Adhesions	54.5	30,690	1	313,440	10.2	574,678	18,833	1,833
Operations on the Urinary System (MPC 10)	55-59	197,380	6	1,179,545	6.0	2,221,651	11,314	1,883
Cystoscopy with or Without Biopsy	57.31-57.33	11,745	(6)	83,075	7.1	95,688	8,182	1,152
Operations on the Male Genital Organs (MPC 11)[7]	60-64	70,005	4	223,270	3.2	464,719	6,680	2,081
Prostatectomy	60.2-60.6	61,425	4	176,905	2.9	376,017	6,153	2,126
Operations on the Female Genital Organs (MPC 12)[8]	65-71	87,025	5	287,755	3.3	624,936	7,216	2,172
Unilateral Oophorectomy	65.3-65.6	7,975	(6)	34,740	4.4	69,234	8,709	1,993
Hysterectomy	68.3-68.7,68.9	46,955	2	152,655	3.3	342,435	7,313	2,243
Obstetrical Procedures (MPC 13)[8]	72-75	14,650	1	46,220	3.2	58,339	4,018	1,262
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	450	(6)	1,070	2.4	1,037	2,306	970
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	6,340	(6)	24,715	3.9	34,430	5,491	1,393
Repair of Current Obstetric Laceration	75.5-75.6	1,465	(6)	3,660	2.5	3,883	2,668	1,061
Operations on the Musculoskeletal System (MPC 14)	76-84	1,098,885	31	5,520,795	5.0	14,863,779	13,573	2,692
Partial Excision of Bone	76.2-76.3,77.6-77.8	16,355	(6)	133,485	8.2	264,063	16,300	1,978
Reduction of Facial Fracture	76.7,79.0-79.3	190,165	5	1,066,415	5.6	2,218,528	11,703	2,080
Open Reduction of Fracture with Internal Fixation	79.3	133,570	4	750,670	5.6	1,580,319	11,870	2,105
Excision or Destruction of Intervertebral Disc	80.5	22,785	1	62,210	2.7	166,697	7,360	2,680
Total Hip Replacement	81.51	120,750	3	455,735	3.8	1,462,059	12,132	3,208
Total Knee Replacement	81.54	272,660	8	945,260	3.5	3,193,938	11,734	3,379

See footnotes at end of table.

Table 5.6--Continued

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2009

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Operations on the Integumentary System (MPC 15)	85-86	226,165	6	1,671,695	7.4	$2,597,006	$11,584	$1,554
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	67,330	2	651,885	9.7	1,149,170	17,221	1,763
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,700,560	49	10,997,730	6.5	16,448,702	9,750	1,496
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	93,420	3	426,120	4.6	642,596	6,926	1,508
Arteriography and Angiocardiography Using Contrast Materia	88.4-88.5	44,670	1	211,970	4.7	322,736	7,274	1,523
Diagnostic Ultrasound	88.7	148,475	4	743,285	5.0	1,027,452	6,958	1,382
Respiratory Therapy	93.9,96.7	311,545	9	2,581,210	8.3	5,125,284	16,597	1,986
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	43,330	1	301,365	7.0	573,609	13,313	1,903
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	33,475	1	201,860	6.0	380,956	11,425	1,887

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification.* Includes surgical and non-surgical procedures. Includes invalid codes not shown separately.

[2]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[3]Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates.

[4]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[5]Specific leading procedure categories were selected for presentation because of frequency of occurrences or because of special interest. The leading classifications were developed by the National Center for Health Statistics.

[6]Less than 1 discharge per 1,000 enrollees.

[7]Only the male enrollment population used to calculate discharges per 1,000 HI enrollees.

[8]Only the female enrollment population used to calculate discharges per 1,000 HI enrollees.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.7

Discharges, Total Days of Care, Total Charges and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs): Calendar Year 2009

DRG Code	Description	Discharges	Total Days of Care: Number	Total Days of Care: Per Discharge	Total Charges in Thousands	Program Payments: Amount in Thousands	Program Payments: Per Discharge[1]	Program Payments: Per Day
Total All DRGs	-----	11,558,205	63,441,875	5.5	$438,091,760	$114,516,481	$10,180	$1,805
Leading DRGs[2]	-----	6,933,280	35,874,395	5.2	209,584,651	54,593,871	8,072	1,522
039[3]	Extracranial Procedures without CC or MCC	43,490	73,130	1.7	1,132,259	231,311	5,506	3,163
057	Degenerative Nervous system Disorders without MCC	71,140	588,425	8.3	1,571,564	515,696	7,361	876
064	Intracranial Hemorrhage or Cerebral Infarction with MCC	70,935	475,500	6.7	3,074,513	829,191	11,863	1,744
065	Intracranial Hemorrhage or Cerebral Infarction with CC	103,800	497,750	4.8	2,901,969	700,166	6,852	1,407
066	Intracranial Hemorrhage or Cerebral Infarction without CC or MCC	64,750	210,945	3.3	1,355,335	292,344	4,643	1,386
069	Transient Ischemia	92,590	252,835	2.7	1,748,785	351,339	3,879	1,390
101	Seizures without MCC	55,065	185,540	3.4	1,069,282	248,158	4,613	1,337
177	Respiratory Infections & Inflammations with MCC	80,605	665,350	8.3	3,643,928	991,871	12,457	1,491
178	Respiratory Infections & Inflammations with CC	59,440	391,350	6.6	1,927,849	516,005	8,813	1,319
189	Pulmonary Edema & Respiratory Failure	94,090	520,575	5.5	2,865,168	757,637	8,221	1,455
190	Chronic Obstructive Pulmonary Disease with MCC	153,400	833,150	5.4	4,222,043	1,130,259	7,494	1,357
191	Chronic Obstructive Pulmonary Disease with CC	135,270	615,215	4.5	2,986,622	736,889	5,551	1,198
192	Chronic Obstructive Pulmonary Disease without CC or MCC	131,895	480,010	3.6	2,220,464	497,626	3,866	1,037
193	Simple Pneumonia & Pleurisy with MCC	140,375	878,300	6.3	4,614,036	1,186,119	8,595	1,350
194	Simple Pneumonia & Pleurisy with CC	180,315	869,795	4.8	4,108,035	1,009,212	5,695	1,160
195	Simple Pneumonia & Pleurisy without CC or MCC	86,925	316,695	3.6	1,422,660	320,665	3,773	1,013
208	Respiratory System Diagnosis with Ventilator Support < 96 Hours	74,795	523,010	7.0	4,222,815	1,059,875	14,499	2,026
244[3]	Permanent Cardiac Pacemaker Implant without CC or MCC	42,965	120,170	2.8	2,014,380	514,545	12,251	4,282
247[3]	Percutaneous Cardiovascular Proc with Drug-Eluting Stent without MCC	138,480	302,875	2.2	7,606,014	1,545,925	11,824	5,104
249[3]	Percutaneous Cardiovascular Proc with Non-Drug-Eluting Stent without MCC	41,555	109,365	2.6	2,070,122	403,767	10,060	3,692
252[3]	Other Vascular Procedures with MCC	45,435	362,470	8.0	3,434,151	936,860	21,060	2,585
280	Acute Myocardial Infarction, Discharged Alive with MCC	82,245	521,290	6.3	3,361,124	941,887	11,588	1,807
281	Acute Myocardial Infarction, Discharged Alive with CC	40,205	160,445	4.0	1,060,498	270,916	6,859	1,689
287	Circulatory Disorders Except AMI, with Cardiac Cath without MCC	127,165	374,590	2.9	3,766,384	721,060	5,903	1,925

See footnotes at end of table.

Table 5.7--Continued

Discharges, Total Days of Care, Total Charges and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs): Calendar Year 2009

DRG Code	Description	Discharges	Total Days of Care		Total Charges in Thousands	Program Payments		
			Number	Per Discharge		Amount in Thousands	Per Discharge[1]	Per Day
291	Heart Failure & Shock with MCC	237,020	1,443,370	6.1	$7,871,049	$2,136,630	$9,142	$1,480
292	Heart Failure & Shock with CC	186,545	824,715	4.4	4,025,724	1,079,278	5,874	1,309
293	Heart Failure & Shock without CC or MCC	115,565	376,610	3.3	1,825,572	457,089	4,023	1,214
300	Peripheral Vascular Disorders with CC	42,465	198,675	4.7	887,520	232,771	5,590	1,172
303	Atherosclerosis without MCC	50,005	120,455	2.4	723,362	152,797	3,129	1,268
308	Cardiac Arrhythmia & Conduction Disorders with MCC	73,330	364,575	5.0	2,040,771	575,985	7,965	1,580
309	Cardiac Arrhythmia & Conduction Disorders with CC	94,365	335,115	3.6	1,806,597	441,472	4,763	1,317
310	Cardiac Arrhythmia & Conduction Disorders without CC or MCC	128,735	317,955	2.5	1,792,148	370,916	2,962	1,167
312	Syncope & Collapse	165,265	478,080	2.9	2,969,976	656,028	4,052	1,372
313	Chest Pain	169,000	347,740	2.1	2,528,997	462,465	2,851	1,330
314	Other Circulatory System Diagnoses with MCC	66,550	444,625	6.7	2,797,738	774,523	12,078	1,742
329 [3]	Major Small & Large Bowel Procedures with MCC	49,985	756,025	15.1	5,996,044	1,711,377	34,919	2,264
330 [3]	Major Small & Large Bowel Procedures with CC	55,345	488,855	8.8	3,195,492	868,810	16,155	1,777
377	G.I. Hemorrhage with MCC	69,340	411,170	5.9	2,572,331	707,225	10,348	1,720
378	G.I. Hemorrhage with CC	117,895	473,845	4.0	2,706,669	671,331	5,790	1,417
379	G.I. Hemorrhage without CC or MCC	48,810	146,040	3.0	826,745	195,082	4,107	1,336
389	G.I. Obstruction with CC	46,675	218,700	4.7	1,042,000	246,018	5,414	1,125
391	Esophagitis, Gastroent & Misc Digest Disorders with MCC	63,400	313,945	5.0	1,718,267	435,237	7,031	1,386
392	Esophagitis, Gastroent & Misc Digest Disorders without MCC	230,595	773,785	3.4	4,109,807	832,577	3,722	1,076
394	Other Digestive System Diagnoses with CC	43,615	193,910	4.4	1,009,133	249,038	5,878	1,284
460 [3]	Spinal Fusion Except Cervical without MCC	62,925	238,585	3.8	5,352,418	1,380,341	23,010	5,786
470 [3]	Major Joint Replacement or Reattachment of Lower Extremity without MCC	415,470	1,501,410	3.6	19,016,484	4,709,917	11,778	3,137
481 [3]	Hip & Femur Procedures Except Major Joint with CC	75,940	413,325	5.4	3,228,863	810,385	10,786	1,961
491 [3]	Back & Neck Proc Except Spinal Fusion without CC or MCC	44,710	91,380	2.0	1,127,929	223,886	5,210	2,450
552	Medical Back Problems without MCC	72,100	279,310	3.9	1,370,140	300,790	4,309	1,077
603	Cellulitis without MCC	127,300	555,065	4.4	2,273,787	561,644	4,524	1,012
638	Diabetes with CC	46,960	185,105	3.9	897,175	224,116	4,888	1,211

See footnotes at end of table.

Table 5.7--Continued

Discharges, Total Days of Care, Total Charges and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs): Calendar Year 2009

DRG Code	Description	Discharges	Total Days of Care		Total Charges	Program Payments		
			Number	Per Discharge	in Thousands	Amount in Thousands	Per Discharge[1]	Per Day
640	Nutritional & Misc Metabolic Disorders with MCC	83,750	391,460	4.7	$2,002,521	$573,600	$6,999	$1,465
641	Nutritional & Misc Metabolic Disorders without MCC	158,465	553,510	3.5	2,515,728	595,898	3,839	1,077
682	Renal Failure with MCC	104,555	702,995	6.7	3,980,465	1,097,755	10,728	1,562
683	Renal Failure with CC	111,910	546,090	4.9	2,654,835	730,175	6,646	1,337
689	Kidney & Urinary Tract Infections with MCC	92,445	502,040	5.4	2,350,861	663,891	7,271	1,322
690	Kidney & Urinary Tract Infections without MCC	185,280	729,935	3.9	3,274,600	772,411	4,231	1,058
812	Red Blood Cell Disorders without MCC	93,690	331,755	3.5	1,731,381	401,740	4,508	1,211
853[3]	Infectious and Parasitic Diseases with O.R. Proc with MCC	43,150	657,180	15.2	5,403,308	1,573,467	37,357	2,394
871	Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours with MCC	292,020	2,038,140	7.0	12,907,620	3,393,553	11,842	1,665
872	Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours without MCC	73,680	378,705	5.1	1,855,712	470,582	6,525	1,243
885	Psychoses	316,070	3,242,445	10.3	7,087,374	2,240,215	7,401	691
897	Alcohol /Drug Abuse or Dependence without Rehabilitation Therapy without MCC	46,170	202,615	4.4	618,922	161,837	3,694	799
945	Rehabilitation with CC or MCC	175,740	2,312,020	13.2	6,946,628	2,934,425	16,939	1,269
946	Rehabilitation without CC or MCC	47,195	488,370	10.3	1,298,769	613,380	13,207	1,256
948	Signs and Symptoms without MCC	52,320	175,985	3.4	843,155	193,862	3,802	1,102
All Other DRGs	-----	4,624,925	27,567,480	6.0	228,507,108	59,922,609	13,358	2,174

[1]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.
[2]Based on frequency of occurrence in 2009.
[3]Represents surgical DRGs.

NOTES: Composition of some DRGs have changed over time. The twenty-fifth version of the DRG's underwent a major revision that effected all code definitions for all Medicare discharges occurring on or after October 1, 2007. For complete DRG description, refer to *Diagnosis Related Groups, Version 26.0 and 27.0, definitions Manual*. CC is complications and comorbidities. MCC is major complications and comorbidities. Cath is catheterization. AMI is acute myocardial infarction. G.I. is gastrointestinal. Proc is procedure. O.R. is operating room.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.8

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2009

Total Days of Care	All Services	Type of Accommodation: Routine Room and Board	Type of Accommodation: Intensive/ Coronary Care	Type of Ancillary Service: Total Ancillary	Type of Ancillary Service: Operating Room	Type of Ancillary Service: Pharmacy
			Number of Discharges			
Total	11,558,205	9,142,640	4,100,165	11,523,765	4,035,525	11,447,970
1-8 Days	9,671,620	7,557,245	3,171,990	9,643,720	3,083,360	9,581,450
9-20 Days	1,605,005	1,345,980	762,490	1,600,160	772,630	1,590,475
21-30 Days	190,535	161,960	107,470	189,650	116,455	187,650
31-40 Days	51,040	43,205	32,355	50,715	35,110	49,935
41-50 Days	19,585	16,715	12,650	19,375	13,840	18,995
51-60 Days	8,680	7,320	5,780	8,585	6,250	8,315
61-90 Days	8,365	7,230	5,425	8,250	5,755	7,975
91 Days or More	3,375	2,985	2,005	3,310	2,125	3,175
			Percent of Total Discharges [3]			
Total	100.0	79.1	35.5	99.7	34.9	99.0
1-8 Days	100.0	78.1	32.8	99.7	31.9	99.1
9-20 Days	100.0	83.9	47.5	99.7	48.1	99.1
21-30 Days	100.0	85.0	56.4	99.5	61.1	98.5
31-40 Days	100.0	84.6	63.4	99.4	68.8	97.8
41-50 Days	100.0	85.3	64.6	98.9	70.7	97.0
51-60 Days	100.0	84.3	66.6	98.9	72.0	95.8
61-90 Days	100.0	86.4	64.9	98.6	68.8	95.3
91 Days or More	100.0	88.4	59.4	98.1	63.0	94.1
			Total Charges in Thousands			
Total	$438,091,760	$64,182,739	$51,829,594	$322,181,634	$39,762,377	$58,956,466
1-8 Days	263,745,879	34,858,679	23,562,869	205,326,114	28,393,136	29,466,354
9-20 Days	117,012,351	20,069,983	17,233,870	79,708,853	8,346,547	18,610,292
21-30 Days	29,085,184	4,721,810	5,120,659	19,242,759	1,678,160	5,393,266
31-40 Days	12,075,495	1,836,332	2,377,321	7,861,855	652,054	2,346,657
41-50 Days	6,055,348	916,280	1,263,105	3,875,967	296,014	1,190,778
51-60 Days	3,313,488	511,209	706,883	2,095,398	153,948	651,490
61-90 Days	4,166,279	683,229	941,661	2,541,390	165,764	804,964
91 Days or More	2,637,733	585,214	623,222	1,529,296	76,750	492,661

See footnotes at end of table.

Table 5.8--Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2009

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
		Number of Discharges			
11,426,845	10,107,860	9,527,530	8,509,285	5,496,445	10,655,585
9,555,680	8,413,170	7,907,785	7,033,585	4,317,100	8,840,280
1,592,555	1,439,970	1,380,150	1,248,200	987,385	1,544,610
188,770	171,665	163,285	151,095	127,265	183,700
50,510	46,780	43,385	42,565	36,390	49,105
19,300	17,860	16,555	16,605	13,915	18,720
8,510	7,890	7,210	7,350	6,300	8,210
8,215	7,565	6,670	7,110	5,910	7,835
3,305	2,960	2,490	2,775	2,180	3,125
		Percent of Total Discharges [3]			
98.9	87.5	82.4	73.6	47.6	92.2
98.8	87.0	81.8	72.7	44.6	91.4
99.2	89.7	86.0	77.8	61.5	96.2
99.1	90.1	85.7	79.3	66.8	96.4
99.0	91.7	85.0	83.4	71.3	96.2
98.5	91.2	84.5	84.8	71.0	95.6
98.0	90.9	83.1	84.7	72.6	94.6
98.2	90.4	79.7	85.0	70.7	93.7
97.9	87.7	73.8	82.2	64.6	92.6
		Total Charges in Thousands			
$52,024,825	$35,485,249	$57,346,223	$22,796,981	$15,021,679	$40,787,831
31,223,980	23,960,335	42,796,617	17,972,111	5,790,362	25,723,215
14,207,922	8,398,336	10,541,028	3,871,359	5,294,192	10,439,173
3,409,471	1,747,963	2,147,983	571,921	1,796,578	2,497,413
1,400,467	660,914	834,016	192,327	834,190	941,226
695,126	304,253	398,653	81,585	457,005	452,549
374,188	158,619	211,791	41,092	249,454	254,813
455,302	171,567	259,269	44,338	349,246	290,937
258,366	83,259	156,863	22,245	250,649	188,501

Table 5.8--Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2009

Total Days of Care	All Services	Type of Accommodation: Routine Room and Board	Type of Accommodation: Intensive/ Coronary Care	Type of Ancillary Service: Total Ancillary	Type of Ancillary Service: Operating Room	Type of Ancillary Service: Pharmacy
			Percent of Total Charges [4]			
Total	100.0	14.7	11.8	73.5	9.1	13.5
1-8 Days	100.0	13.2	8.9	77.8	10.8	11.2
9-20 Days	100.0	17.2	14.7	68.1	7.1	15.9
21-30 Days	100.0	16.2	17.6	66.2	5.8	18.5
31-40 Days	100.0	15.2	19.7	65.1	5.4	19.4
41-50 Days	100.0	15.1	20.9	64.0	4.9	19.7
51-60 Days	100.0	15.4	21.3	63.2	4.6	19.7
61-90 Days	100.0	16.4	22.6	61.0	4.0	19.3
91 Days or More	100.0	22.2	23.6	58.0	2.9	18.7
			Average Total Charge Per Discharge			
Total	$37,903	$7,020	$12,641	$27,958	$9,853	$5,150
1-8 Days	27,270	4,613	7,428	21,291	9,209	3,075
9-20 Days	72,905	14,911	22,602	49,813	10,803	11,701
21-30 Days	152,650	29,154	47,647	101,465	14,410	28,741
31-40 Days	236,589	42,503	73,476	155,020	18,572	46,994
41-50 Days	309,183	54,818	99,850	200,050	21,388	62,689
51-60 Days	381,738	69,837	122,298	244,077	24,632	78,351
61-90 Days	498,061	94,499	173,578	308,047	28,804	100,936
91 Days or More	781,551	196,052	310,834	462,023	36,118	155,169

[1]Includes magnetic resonance imaging.

[2]Includes services such as physical therapy, occupational therapy, blood administration, anesthesia, ambulance, emergency room, clinic visits, etc.

[3]Does not sum to total because one person may have many services.

[4]The total for all services is equal to the sum of routine room and board, intensive or coronary care, and total ancillary services. Total ancillary services is equal to the sum of each type of ancillary service.

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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.8--Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2009

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
Percent of Total Charges [4]					
11.9	8.1	13.1	5.2	3.4	9.3
11.8	9.1	16.2	6.8	2.2	9.8
12.1	7.2	9.0	3.3	4.5	8.9
11.7	6.0	7.4	2.0	6.2	8.6
11.6	5.5	6.9	1.6	6.9	7.8
11.5	5.0	6.6	1.3	7.5	7.5
11.3	4.8	6.4	1.2	7.5	7.7
10.9	4.1	6.2	1.1	8.4	7.0
9.8	3.2	5.9	0.8	9.5	7.1
Average Total Charge Per Discharge					
$4,553	$3,511	$6,019	$2,679	$2,733	$3,828
3,268	2,848	5,412	2,555	1,341	2,910
8,921	5,832	7,638	3,102	5,362	6,758
18,062	10,182	13,155	3,785	14,117	13,595
27,727	14,128	19,224	4,518	22,924	19,168
36,017	17,035	24,081	4,913	32,843	24,175
43,970	20,104	29,375	5,591	39,596	31,037
55,423	22,679	38,871	6,236	59,094	37,133
78,174	28,128	62,997	8,016	114,977	60,321

Table 5.9

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care: Calendar Year 2009

Total Days of Care	Discharges [1]		Total Days of Care			Program Payments			
					Per	Amount		Per	
Total Days					Dis-	in		Dis-	Per
of Care	Number	Percent	Number	Percent	charge	Thousands	Percent	charge [2]	Day
Total	11,558,205	100.0	63,441,875	100.0	5.5	$114,516,481	100.0	$9,977	$1,805
1 Day	1,565,250	13.5	1,565,250	2.5	1.0	9,908,215	8.7	6,432	6,330
2 Days	1,753,555	15.2	3,507,110	5.5	2.0	10,817,758	9.4	6,206	3,085
3 Days	1,979,620	17.1	5,938,860	9.4	3.0	14,378,988	12.6	7,297	2,421
4 Days	1,446,645	12.5	5,786,580	9.1	4.0	11,544,427	10.1	8,017	1,995
5 Days	1,052,805	9.1	5,264,025	8.3	5.0	9,295,354	8.1	8,870	1,766
6 Days	794,970	6.9	4,769,820	7.5	6.0	7,738,671	6.8	9,786	1,622
7 Days	623,310	5.4	4,363,170	6.9	7.0	6,686,064	5.8	10,787	1,532
8 Days	455,465	3.9	3,643,720	5.7	8.0	5,347,539	4.7	11,813	1,468
9 Days	332,825	2.9	2,995,425	4.7	9.0	4,217,959	3.7	12,750	1,408
10 Days	260,105	2.3	2,601,050	4.1	10.0	3,539,514	3.1	13,703	1,361
11 Days	204,695	1.8	2,251,645	3.5	11.0	2,996,696	2.6	14,721	1,331
12 Days	161,805	1.4	1,941,660	3.1	12.0	2,550,972	2.2	15,872	1,314
13 Days	140,125	1.2	1,821,625	2.9	13.0	2,360,366	2.1	16,961	1,296
14 Days	128,695	1.1	1,801,730	2.8	14.0	2,295,652	2.0	17,949	1,274
15 Days	99,280	0.9	1,489,200	2.3	15.0	1,896,581	1.7	19,261	1,274
16 Days	76,895	0.7	1,230,320	1.9	16.0	1,584,862	1.4	20,763	1,288
17 Days	64,645	0.6	1,098,965	1.7	17.0	1,396,904	1.2	21,781	1,271
18 Days	52,755	0.5	949,590	1.5	18.0	1,211,499	1.1	23,167	1,276
19 Days	44,085	0.4	837,615	1.3	19.0	1,079,404	0.9	24,743	1,289
20 Days	39,095	0.3	781,900	1.2	20.0	998,224	0.9	25,751	1,277
21-30 Days	190,535	1.6	4,636,835	7.3	24.3	6,394,724	5.6	33,884	1,379
31-40 Days	51,040	0.4	1,767,860	2.8	34.6	2,698,730	2.4	53,669	1,527
41-50 Days	19,585	0.2	878,145	1.4	44.8	1,390,191	1.2	72,728	1,583
51-60 Days	8,680	0.1	476,720	0.8	54.9	757,725	0.7	89,354	1,589
61-90 Days	8,365	0.1	599,050	0.9	71.6	941,237	0.8	115,845	1,571
91 Days or More	3,375	(3)	444,005	0.7	131.6	488,222	0.4	158,771	1,100

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[3]Less than 0.05 percent.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.10

Number of Participating Short-Stay Hospitals (SSHs), Medicare Utilization and Program Payments for Beneficiaries Discharged from SSHs, by Location and Bedsize of Hospital, and by Medical School Affiliation (MSA), and Type of Control: Calendar Year 2009

Location and Bedsize of Hospital	Hospitals		Discharges[1]		Total Days of Care per Discharge	Program Payments		
	Number	Percent	Number	Percent		Amount in Thousands	Percent	Per Discharge[2]
Total All Hospitals[3]	3,549	100.0	11,514,420	100.0	5.5	$114,317,185	100.0	$9,998
1-99 Beds	1,254	35.3	1,137,825	9.9	4.6	8,196,690	7.2	7,239
100-299 Beds	1,409	39.7	4,174,220	36.3	5.2	35,932,809	31.4	8,662
300-499 Beds	549	15.5	3,176,220	27.6	5.6	32,156,929	28.1	10,193
500 Beds or More	337	9.5	3,026,155	26.3	6.0	38,030,757	33.3	12,682
Total Urban Hospitals	2,372	100.0	9,925,455	100.0	5.6	102,859,891	100.0	10,441
1-99 Beds	542	22.8	561,985	5.7	4.8	4,567,690	4.4	8,173
100-299 Beds	992	41.8	3,323,790	33.5	5.3	29,600,107	28.8	8,967
300-499 Beds	507	21.4	3,037,155	30.6	5.6	30,884,971	30.0	10,239
500 Beds or More	331	14.0	3,002,525	30.3	6.0	37,807,123	36.8	12,707
Total Rural Hospitals	1,177	100.0	1,588,965	100.0	4.9	11,457,293	100.0	7,240
1-99 Beds	712	60.5	575,840	36.2	4.5	3,629,000	31.7	6,328
100-299 Beds	417	35.4	850,430	53.5	5.0	6,332,702	55.3	7,476
300-499 Beds	42	3.6	139,065	8.8	5.4	1,271,957	11.1	9,184
500 Beds or More	6	0.5	23,630	1.5	5.3	223,634	2.0	9,474
Total All Hospitals[3]	3,549	100.0	11,514,420	100.0	5.5	114,317,185	100.0	9,998
Voluntary	2,142	60.4	8,264,725	71.8	5.5	82,847,906	72.5	10,096
Proprietary	714	20.1	1,659,005	14.4	5.4	14,991,393	13.1	9,090
Government	693	19.5	1,590,690	13.8	5.6	16,477,886	14.4	10,434
Total Teaching Hospitals[4]	1,072	100.0	5,553,240	100.0	5.8	63,600,626	100.0	11,547
Voluntary	762	71.1	4,399,435	79.2	5.7	49,743,697	78.2	11,397
Proprietary	108	10.1	410,495	7.4	5.8	4,185,292	6.6	10,268
Government	202	18.8	743,310	13.4	6.1	9,671,637	15.2	13,145
Total Non-Teaching Hospitals	2,477	100.0	5,961,180	100.0	5.2	50,716,559	100.0	8,558
Voluntary	1,380	55.7	3,865,290	64.8	5.2	33,104,209	65.3	8,619
Proprietary	606	24.5	1,248,510	20.9	5.3	10,806,100	21.3	8,703
Government	491	19.8	847,380	14.2	5.2	6,806,250	13.4	8,069

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[3]Includes discharges from short-stay hospitals in the 50 States and the District of Columbia; excludes discharges from short-stay hospitals in all outlying areas.

[4]Represents hospitals with an approved resident program.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. The Medicare SSH use and cost data presented in this table are slightly different from comparable national totals shown in other SSH tables since two different sample data files were utilized to generate the data. Numbers may not add to total due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.11

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2009

	Hospitals		Discharges		Covered Days of Care		
Type of Hospital	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals [2]	6,211	100.0	12,385,105	100.0	70,291,120	100.0	5.7
Short-Stay Hospitals	3,642	58.6	11,558,205	93.3	61,289,555	87.2	5.3
Hospitals	3,642	58.6	11,030,425	89.1	55,207,725	78.5	5.0
Psychiatric Hospital Units [3]	NA	----	307,605	2.5	3,324,160	4.7	10.8
Rehabilitation Hospital Units [3]	NA	----	220,175	1.8	2,757,670	3.9	12.5
Specialty Hospitals	2,569	41.4	826,900	6.7	9,001,565	12.8	10.9
Childrens	78	1.3	2,890	(4)	20,855	(4)	7.2
Psychiatric	507	8.2	138,620	1.1	1,913,585	2.7	13.8
Rehabilitation	227	3.7	151,710	1.2	2,042,840	2.9	13.5
Long Term	428	6.9	135,480	1.1	3,587,685	5.1	26.5
Critical Access (formerly Short-Stay)	1,312	21.1	397,850	3.2	1,424,450	2.0	3.6
Religious Non-Medical	17	0.3	350	(4)	12,150	(4)	34.7

See footnotes at end of table.

Table 5.11--Continued

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2009

	Covered Charges				Program Payments			
Type of Hospital	Amount in Thousands	Percent	Per Discharge	Per Covered Day	Amount in Thousands	Percent	Per Discharge[1]	Per Covered Day
Total All Hospitals [2]	$459,614,103	100.0	$37,110	$6,539	$125,117,350	100.0	$10,169	$1,780
Short-Stay Hospitals	434,052,540	94.4	37,554	7,082	114,516,481	91.5	9,977	1,868
Hospitals	418,507,925	91.1	37,941	7,581	108,551,063	86.8	9,841	1,966
Psychiatric Hospital Units [3]	7,164,464	1.6	23,291	2,155	2,393,851	1.9	7,896	720
Rehabilitation Hospital Units [3]	8,380,149	1.8	38,061	3,039	3,571,567	2.9	16,294	1,295
Specialty Hospitals	25,561,564	5.6	30,913	2,840	10,600,869	8.5	12,820	1,178
Childrens	200,666	(4)	69,434	9,622	56,651	(4)	19,602	2,716
Psychiatric	2,396,191	0.5	17,286	1,252	1,211,279	1.0	8,738	633
Rehabilitation	3,900,338	0.8	25,709	1,909	2,437,202	1.9	16,067	1,193
Long Term	14,826,967	3.2	109,440	4,133	4,742,340	3.8	35,005	1,322
Critical Access (formerly Short-Stay)	4,231,282	0.9	10,635	2,970	2,148,860	1.7	5,401	1,509
Religious Non-Medical	6,119	(4)	17,484	504	4,537	(4)	12,963	373

[1]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[2]Includes inpatient short-stay hospitals (SSHs) and specialty hospitals.

[3]There were an estimated 1,224 distinct-part psychiatric units and 829 rehabilitation units participating in the Medicare Program during 2009.

[4]Less than 0.05 percent.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to total due to rounding. NA is not applicable.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Table 5.12

Short-Stay Hospital (SSH) Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2009

Location and Bedsize of Hospital	Discharges	Hospital Case-Mix Index[1]	Percent of Discharges				
				With Procedures			Without
			Total	Total	Surgical	Non-Surgical	Procedure
Total All Hospitals [2]	11,514,420	1.5671	100.0	59.2	47.7	11.5	40.9
1-99 Beds	1,137,825	1.3128	100.0	45.2	34.2	11.0	54.8
100-299 Beds	4,174,220	1.4641	100.0	55.2	44.2	11.0	44.8
300-499 Beds	3,176,220	1.6081	100.0	61.4	50.3	11.1	38.6
500 Beds or More	3,026,155	1.7618	100.0	67.5	54.8	12.7	32.5
Total Urban Hospitals	9,925,455	1.6085	100.0	61.2	49.7	11.5	38.7
1-99 Beds	561,985	1.4521	100.0	54.2	43.2	11.0	45.8
100-299 Beds	3,323,790	1.4931	100.0	56.6	45.7	10.9	43.5
300-499 Beds	3,037,155	1.6115	100.0	61.5	50.4	11.1	38.5
500 Beds or More	3,002,525	1.7624	100.0	67.5	54.8	12.7	32.5
Total Rural Hospitals	1,588,965	1.3084	100.0	46.0	34.9	11.1	54.1
1-99 Beds	575,840	1.1769	100.0	36.4	25.4	11.0	63.6
100-299 Beds	850,430	1.3506	100.0	49.8	38.4	11.4	50.2
300-499 Beds	139,065	1.5322	100.0	58.2	48.6	9.6	41.8
500 Beds or More	23,630	1.6824	100.0	62.6	55.0	7.6	37.4

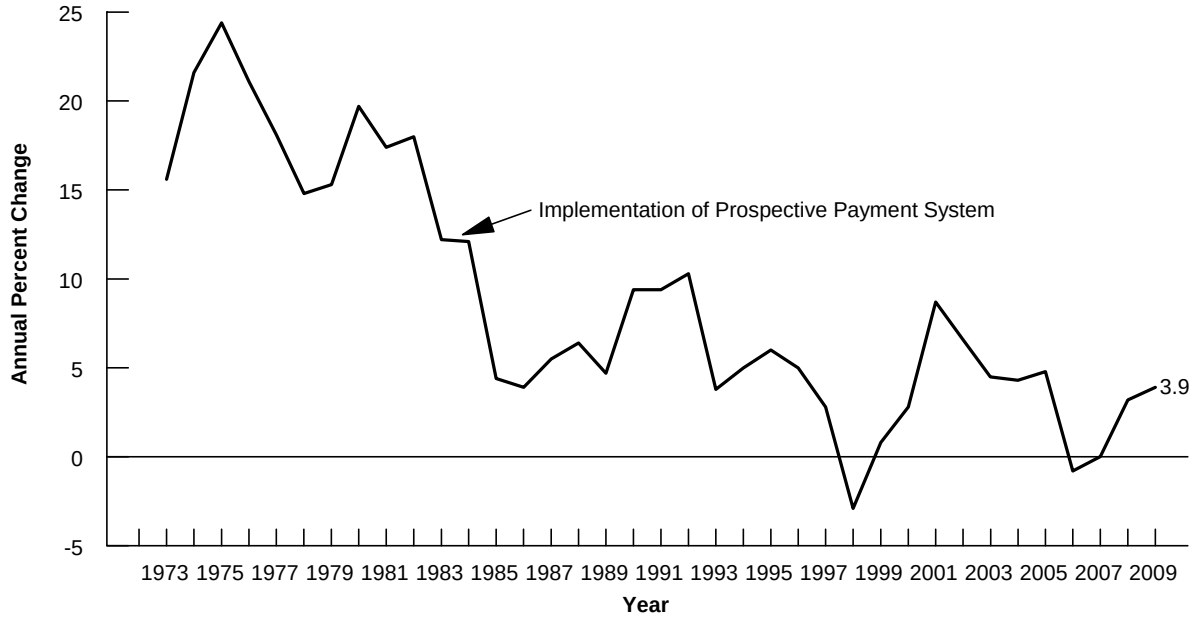
[1]For hospitals participating in the Medicare prospective payment system, the hospital case-mix index is a relative measure of the hospital's average cost per case relative to the average cost per case for all hospitals in some base or reference year. The case-mix index is presented by selected provider categories to provide a means for comparing the relative complexity, severity of illness, and costliness of the cases handled in each of these provider classifications.

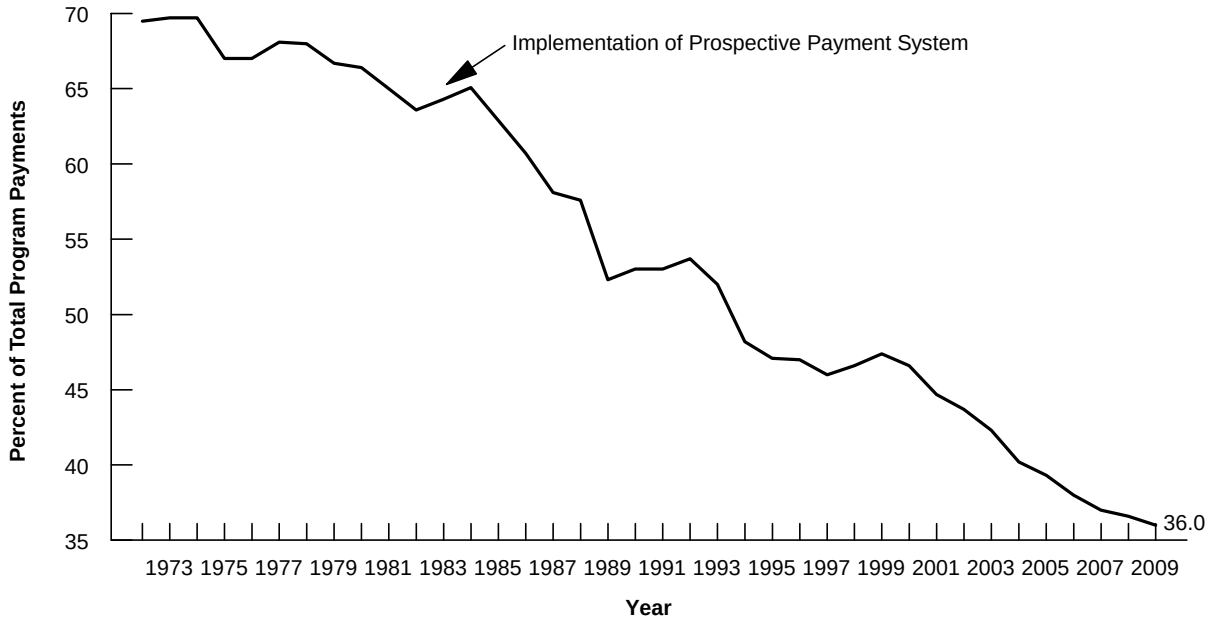
[2]Includes discharges from SSH in the 50 States and District of Columbia; excludes discharges from SSH in all outlying areas.

NOTES: The Medicare SSH use and cost data presented in this table are slightly different from comparable national totals shown in other tables in this section since two different sample data files were utilized to generate the data. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Figure 5.1
Changes in Medicare Short-Stay Hospital Program Payments: Calendar Years 1972-2009

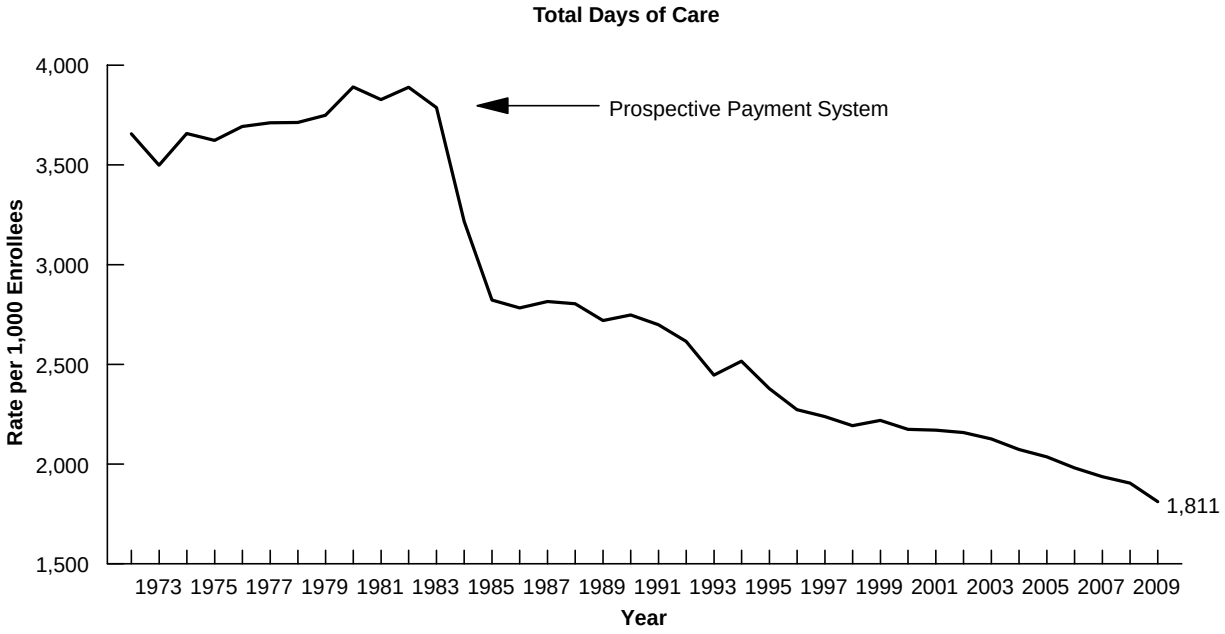


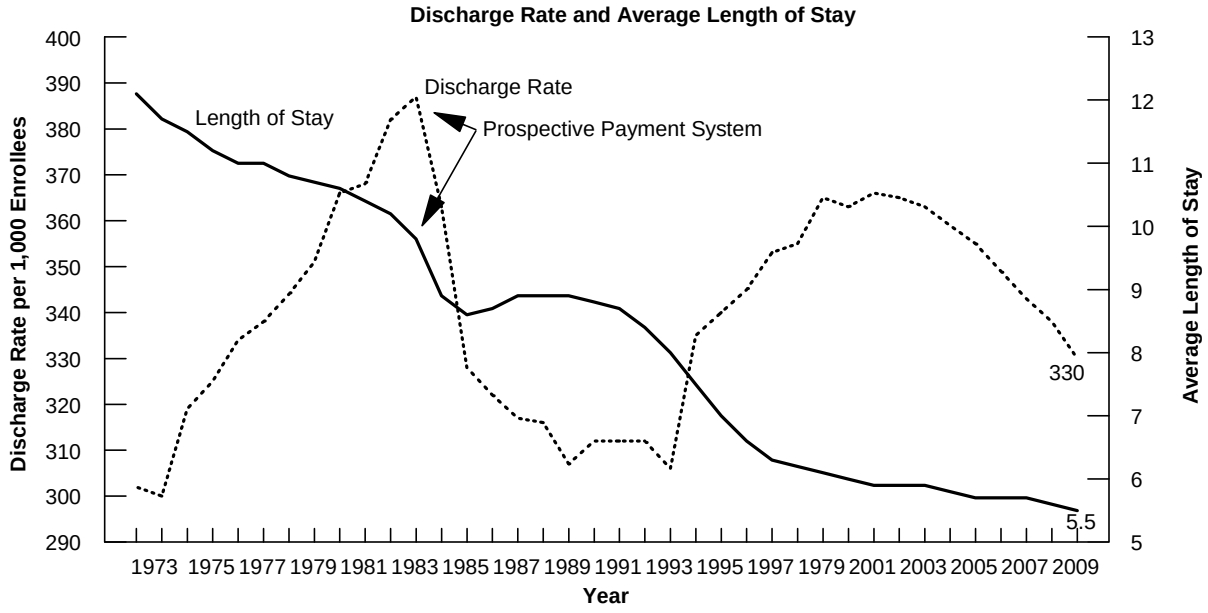


NOTE: The Medicare short-stay hospital prospective payment system was phased in by providers' fiscal years beginning on or after October 1, 1983.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Figure 5.2
Trends in Parameters of Medicare Beneficiary Stays in Short-Stay Hospitals: Calendar Years 1972-2009

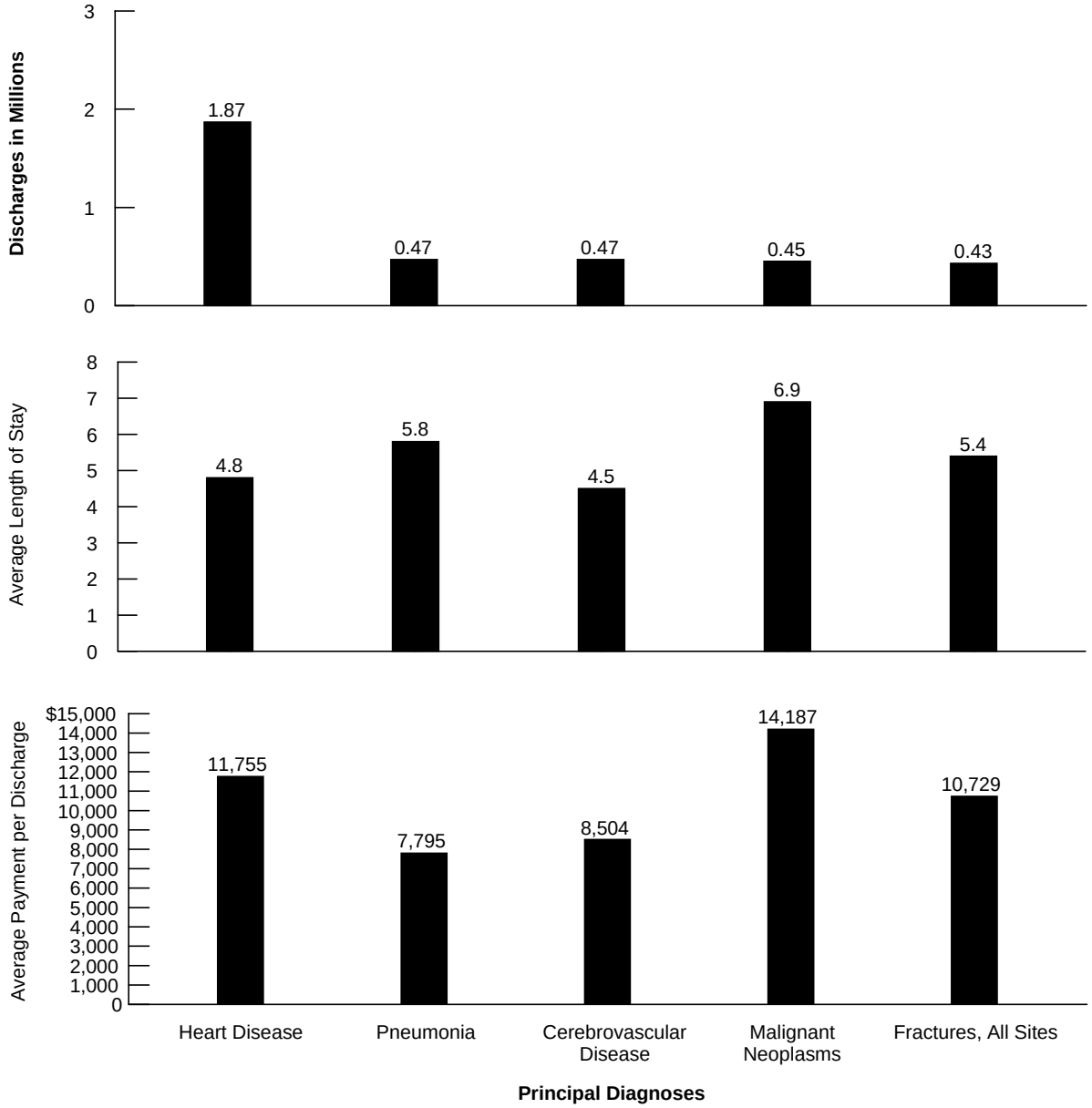




NOTES: The Medicare short-stay hospital prospective payment system was phased in by providers' fiscal years beginning on or after October 1, 1983. Beginning with 1994 data, the Medicare short-stay hospital utilization rates per 1,000 enrollees do not reflect managed care enrollment.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

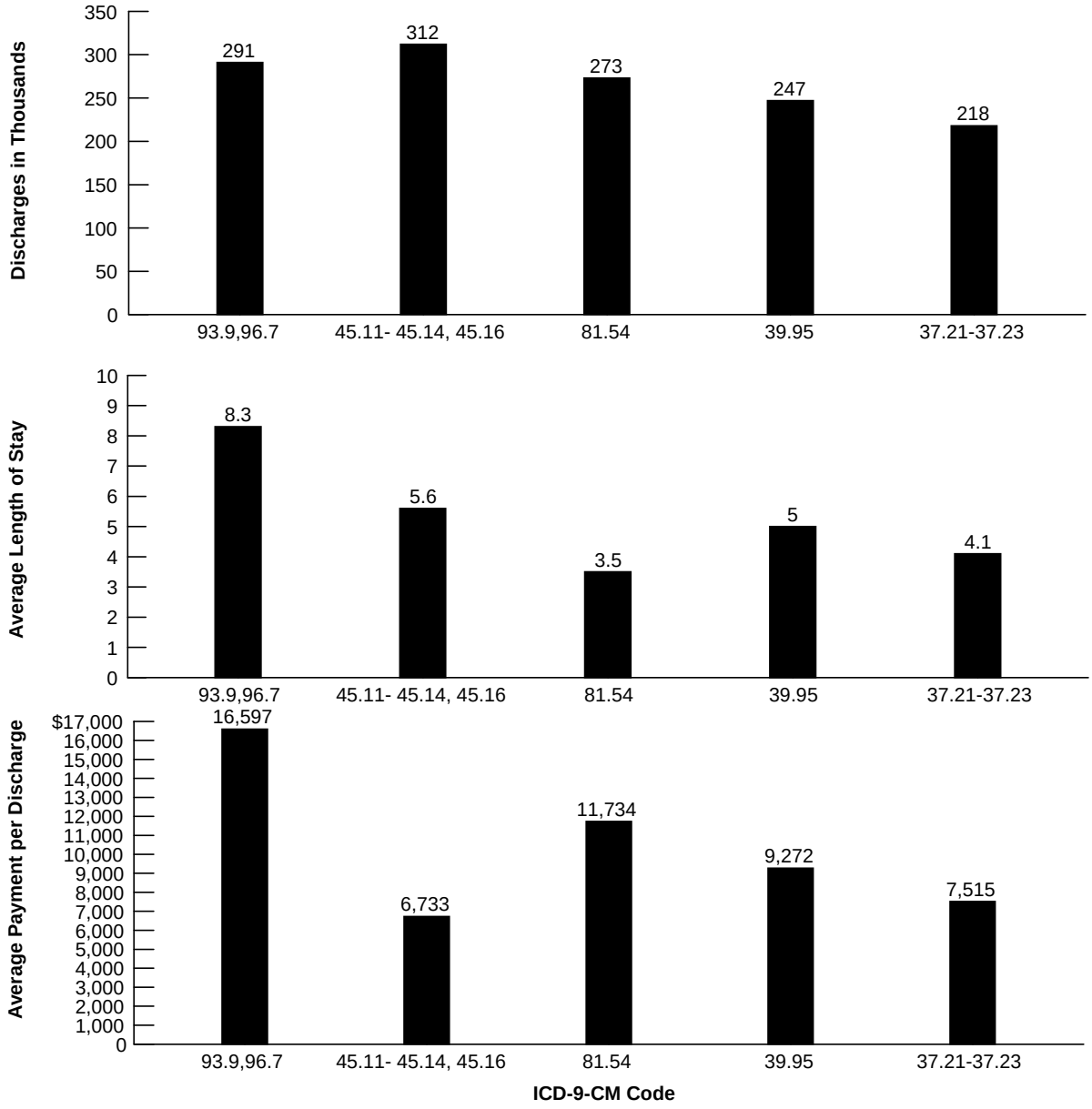
Figure 5.3
Leading Principal Diagnostic Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2009



NOTES: ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification.* ICD-9-CM codes for principle diagnoses are: heart disease, 391-392.0, 393-398, 402, 404, 410-416, and 420-429; pneumonia, 480-486; cerebrovascular disease, 430-438; malignant neoplasms, 140-208 and 230-234; and fractures, all sites, 800-829.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

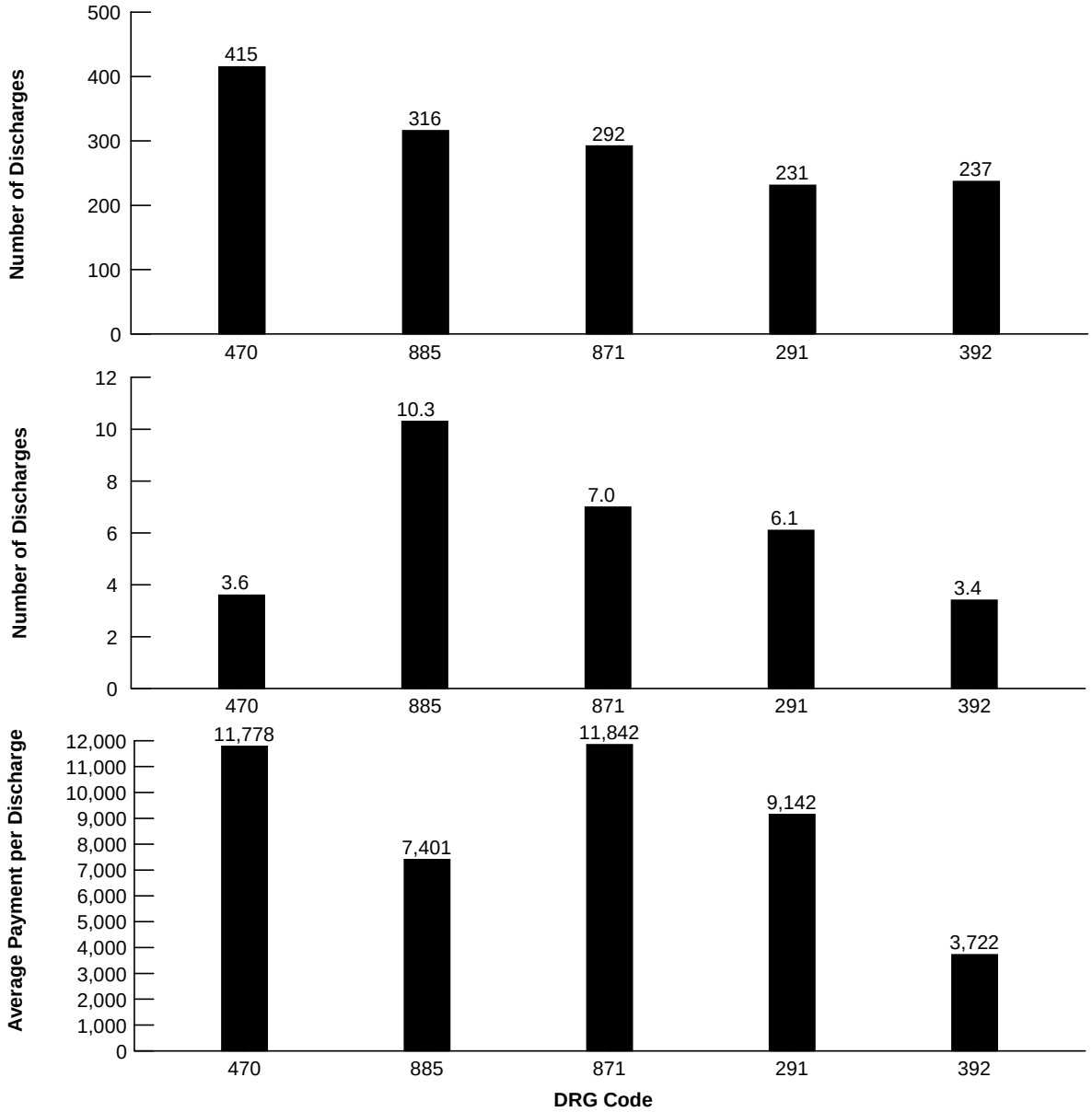
Figure 5.4
Medicare Principal Procedure Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2009



NOTES: ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification*. ICD-9-CM codes for principle procedures are: respiratory therapy, 93.9, 96.7; endoscopy of small intestine with or without biopsy, 45.11-45.14, 45.16; total knee replacement, 81.54; hemodialysis, 39.95; and cardiac catheterization, 37.21-37.23.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

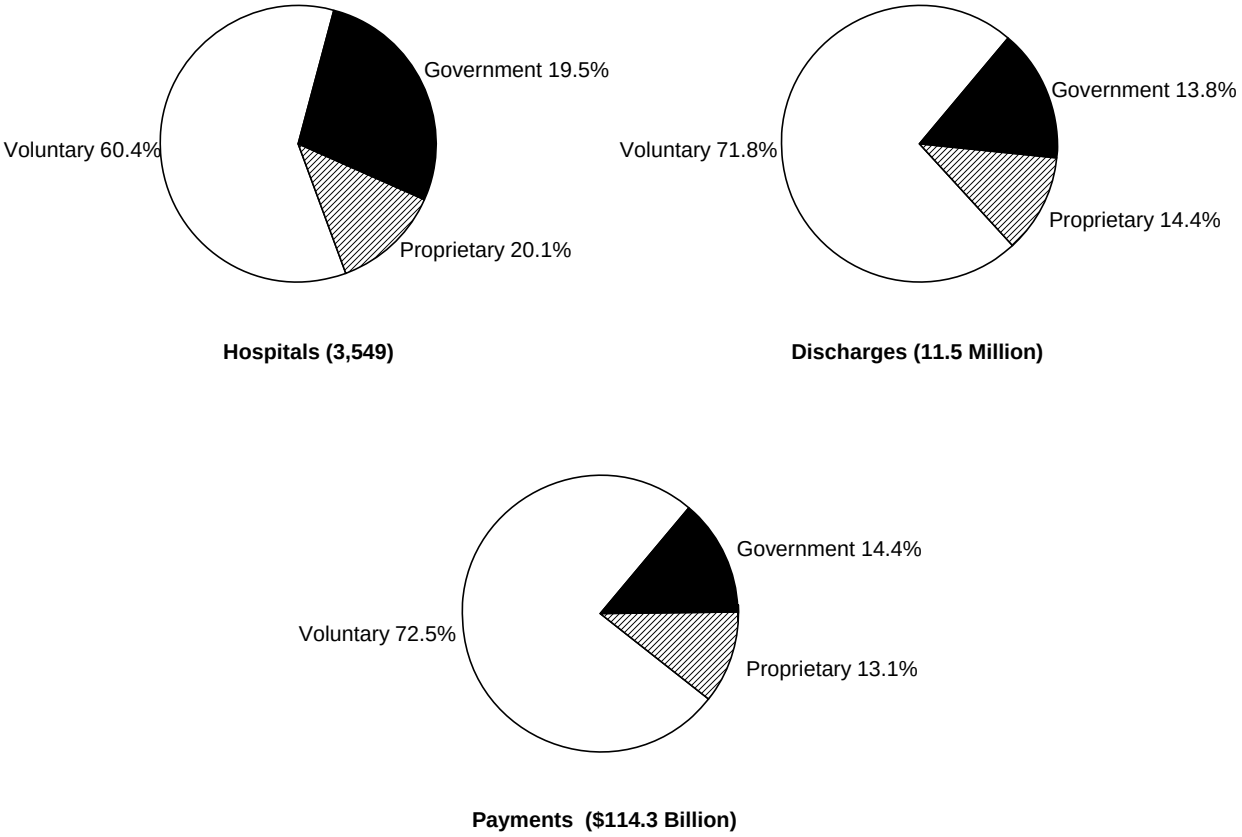
Figure 5.5
Five Most Frequent Medicare Diagnosis-Related Groups (DRGs) for Beneficiaries Discharged from Short-Stay Hospitals: Calendar Year 2009



NOTE: DRG codes are as follows: major joint replacement or reattachment of lower extremity without major complications and comorbidities (mcc), 470; psychoses, 885; septicemia or severe sepsis without mechanical ventilation 96+ hours with mcc, 871; heart failure & shock with mcc, 291; esophagitis, gastroent & misc digest disorders without mcc, 392.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

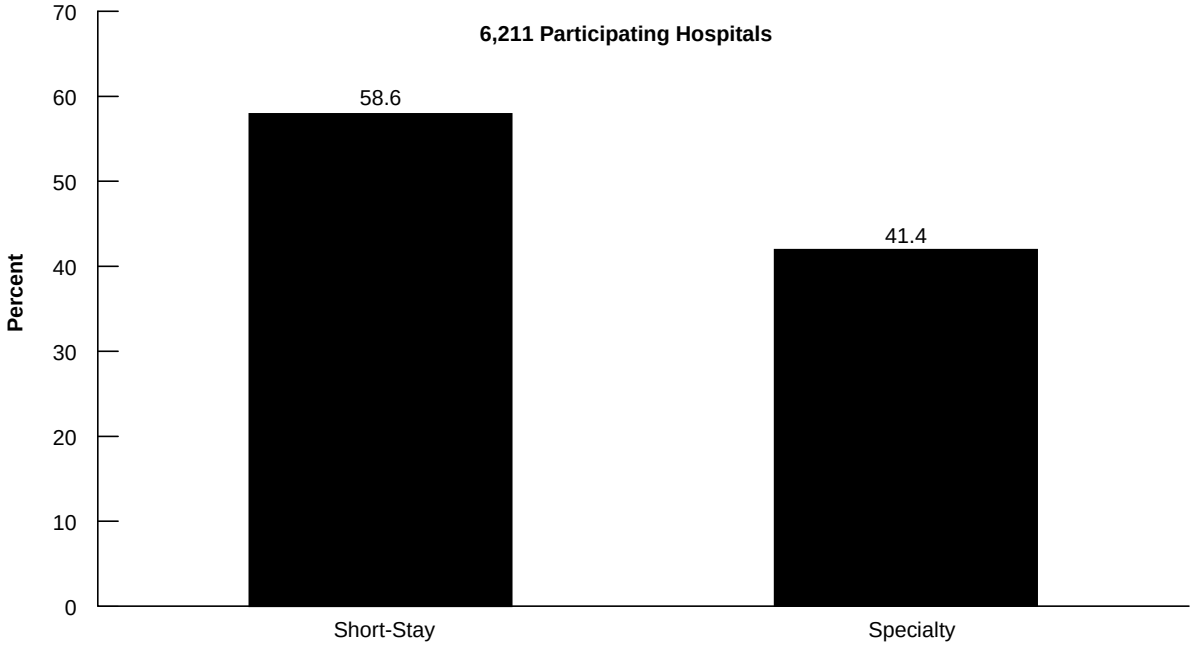
Figure 5.6
Distribution of Medicare Short-Stay Hospitals, Discharges, and Payments, by Type of Control: Calendar Year 2009

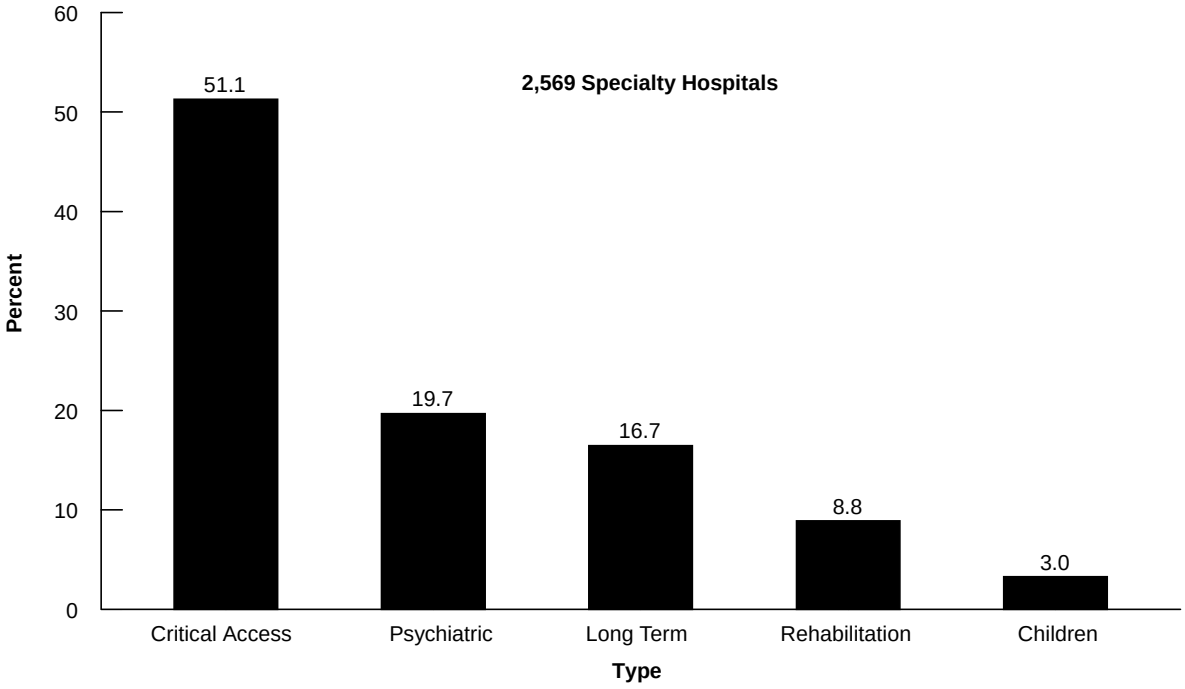


NOTE: Short-stay hospital payments excludes outlying areas.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

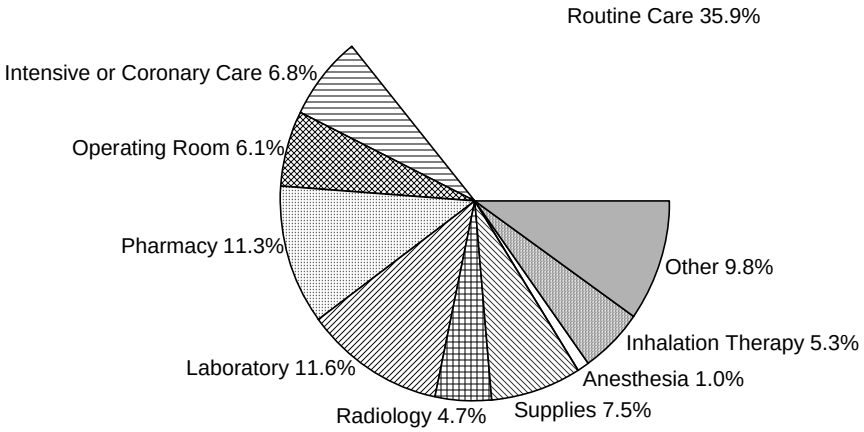
Figure 5.7
Medicare Participating Hospitals, by Type of Hospital: Calendar Year 2009





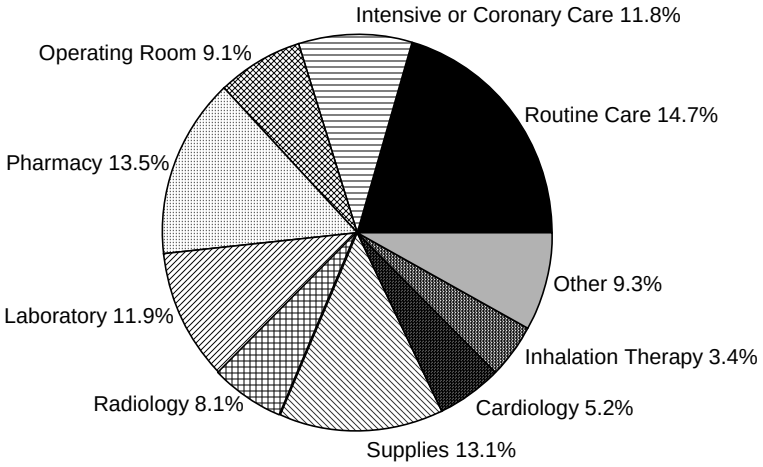
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.

Figure 5.8
Percent Distribution of Medicare Short-Stay Hospital Charges, by Type of Service: Calendar Years 1983 and 2009



1983

(Total Charges = $54.8 Billion)



2009

(Total Charges = $438.1 Billion)

NOTES: Program payment data is not available by type of service. Distribution may not add to 100 percent because of rounding. Cardiology represented less than 1 percent of total short-stay hospital charges in 1983.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.