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 1972-2010

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
2010 [4]	12,341	347	66,680	1,874	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 1972-2010

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
495,513	40,152	116,852	9,588	3,285	1,752	23.6	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 1972-2010

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
2010 [4]	9,775	338	52,082	1,799	5.3

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 1972-2010

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
394,074	40,314	92,450	9,554	3,193	1,775	23.5	34.5

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 1972-2010

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
2010 [4]	2,566	388	14,598	2,206	5.7

[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 Center for Strategic Planning.

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 1972-2010

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
101,440	39,536	24,402	9,719	3,687	1,672	24.1	38.5

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 1985-2010

	Discharges			Coinsurance Days			Coinsurance Payments				
Type of Entitlement and Year	Number	Number With Coin-surance	Percent With Coin-surance	Number	Percent of TDOC	Per Discharge With Coin-surance	Amount in Thousands	Per Discharge With Coin-surance	Per Day With Coin-surance	Per HI Enrollee[1]	Deductible Payments in Thousands
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
2010	12,340,835	152,765	1.2	1,239,980	1.9	8.1	657,591	4,305	530	18	8,538,230

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 1985-2010

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	Number	Number With Coin-surance	Percent With Coin-surance	Number	Percent of TDOC	Per Discharge With Coin-surance	Amount in Thousands	Per Discharge With Coin-surance	Per Day With Coin-surance	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
2010	9,775,060	91,610	0.9	756,215	1.5	8.3	380,981	4,159	504	13	6,873,079

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 1985-2010

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	Number	Number With Coin-surance	Percent With Coin-surance	Number	Percent of TDOC	Per Discharge With Coin-surance	Amount in Thousands	Per Discharge With Coin-surance	Per Day With Coin-surance	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
2010	2,565,775	61,155	2.4	483,765	3.3	7.9	276,610	4,523	572	42	1,665,151

[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 Center for Strategic Planning.

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 2010

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	12,341	347	66,680	100.0	5.4	$116,852	100.0	$9,588	$1,752
Age									
Under 65 Years	2,513	380	14,288	21.4	5.7	23,833	20.4	9,691	1,668
65-69 Years	1,945	217	10,318	15.5	5.3	19,931	17.1	10,379	1,932
70-74 Years	1,767	271	9,193	13.8	5.2	17,492	15.0	10,016	1,903
75-79 Years	1,801	354	9,606	14.4	5.3	17,579	15.0	9,860	1,830
80-84 Years	1,830	447	9,952	14.9	5.4	17,068	14.6	9,414	1,715
85 Years or Over	2,484	579	13,323	20.0	5.4	20,949	17.9	8,498	1,572
Sex									
Male	5,492	340	30,164	45.2	5.5	55,391	47.4	10,225	1,836
Female	6,849	353	36,516	54.8	5.3	61,461	52.6	9,079	1,683
Race[4]									
White	10,010	337	52,953	79.4	5.3	92,892	79.5	9,385	1,754
Other	2,296	396	13,545	20.3	5.9	23,618	20.2	10,472	1,744
Type of Entitlement									
Aged[5]	9,775	338	52,082	78.1	5.3	92,450	79.1	9,554	1,775
Disabled[6]	2,566	388	14,598	21.9	5.7	24,402	20.9	9,719	1,672
Discharge Status									
Alive	11,942	n/a	63,633	95.4	5.3	109,455	93.7	9,283	1,720
Dead	399	n/a	3,047	4.6	7.6	7,397	6.3	18,697	2,428

[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 Center for Strategic Planning.

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 2010

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 Dis- charge	Amount in Thousands	Per Dis- charge[3]	Per HI Enrollee[2]
All Areas[4]	12,340,835	347	66,680,030	1,874	5.4	$116,852,409	$9,588	$3,285
United States	12,284,510	352	66,275,255	1,897	5.4	116,558,944	9,608	3,336
Northeast	2,514,410	382	14,930,300	2,266	5.9	25,493,609	10,297	3,869
Midwest	3,024,450	364	15,527,115	1,868	5.1	27,369,024	9,155	3,293
South	4,918,175	357	26,473,980	1,920	5.4	43,970,463	9,033	3,188
West	1,827,475	293	9,343,860	1,497	5.1	19,725,848	10,968	3,160
New England	661,465	335	3,523,025	1,783	5.3	6,721,080	10,273	3,402
Connecticut	165,520	359	931,950	2,024	5.6	1,749,223	10,687	3,798
Maine	59,695	259	302,915	1,316	5.1	560,261	9,458	2,433
Massachusetts	322,725	377	1,667,335	1,948	5.2	3,232,388	10,133	3,777
New Hampshire	49,645	242	257,140	1,251	5.2	500,856	10,165	2,437
Rhode Island	42,740	364	252,530	2,152	5.9	398,337	9,453	3,394
Vermont	21,140	199	111,155	1,049	5.3	280,014	13,391	2,642
Middle Atlantic	1,852,945	402	11,407,275	2,472	6.2	18,772,529	10,306	4,068
New Jersey	423,905	371	2,501,995	2,188	5.9	4,427,211	10,565	3,871
New York	828,675	402	5,559,965	2,700	6.7	9,358,190	11,478	4,544
Pennsylvania	600,365	425	3,345,315	2,370	5.6	4,987,128	8,494	3,534
East North Central	2,184,505	379	11,318,115	1,965	5.2	19,845,591	9,196	3,445
Illinois	624,800	382	3,225,295	1,971	5.2	5,821,547	9,449	3,557
Indiana	291,055	346	1,509,600	1,794	5.2	2,607,929	9,037	3,100
Michigan	539,100	391	2,880,385	2,088	5.3	5,249,883	9,828	3,805
Ohio	536,080	426	2,736,625	2,173	5.1	4,339,817	8,229	3,445
Wisconsin	193,470	301	966,210	1,501	5.0	1,826,415	9,518	2,837
West North Central	839,945	329	4,209,000	1,650	5.0	7,523,433	9,051	2,950
Iowa	123,715	276	632,025	1,410	5.1	1,087,128	8,872	2,426
Kansas	116,305	303	594,200	1,547	5.1	1,024,304	8,896	2,667
Minnesota	178,610	391	819,730	1,793	4.6	1,704,060	9,641	3,726
Missouri	292,685	370	1,518,485	1,920	5.2	2,503,651	8,647	3,166
Nebraska	71,475	292	362,025	1,477	5.1	665,399	9,393	2,714
North Dakota	24,650	247	120,360	1,208	4.9	229,995	9,434	2,309
South Dakota	32,505	259	162,175	1,294	5.0	308,895	9,635	2,464
South Atlantic	2,588,625	351	13,950,765	1,892	5.4	24,117,041	9,398	3,271
Delaware	44,690	312	258,035	1,803	5.8	496,471	11,167	3,469
District of Columbia	26,585	388	161,780	2,363	6.1	325,339	12,556	4,752
Florida	878,690	374	4,792,105	2,039	5.5	7,527,249	8,633	3,203
Georgia	322,870	336	1,751,075	1,824	5.4	2,951,001	9,228	3,074
Maryland	273,955	381	1,363,590	1,897	5.0	3,231,204	11,916	4,496
North Carolina	407,405	333	2,164,550	1,769	5.3	3,893,911	9,654	3,182
South Carolina	213,040	330	1,196,740	1,854	5.6	1,987,028	9,403	3,079
Virginia	309,110	319	1,637,810	1,691	5.3	2,759,469	8,994	2,850
West Virginia	112,280	381	625,080	2,122	5.6	945,370	8,483	3,210

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 2010

	Discharges[1]		Total Days of Care			Program Payments		
Area of Residence	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Dis-charge	Amount in Thousands	Per Dis-charge[3]	Per HI Enrollee[2]
East South Central	963,640	381	5,186,810	2,049	5.4	$7,786,714	$8,149	$3,076
Alabama	253,420	385	1,347,760	2,046	5.3	1,910,245	7,608	2,900
Kentucky	241,895	385	1,266,310	2,014	5.2	2,044,960	8,525	3,252
Mississippi	171,515	382	991,710	2,210	5.8	1,448,510	8,517	3,229
Tennessee	296,810	373	1,581,030	1,988	5.3	2,382,999	8,092	2,996
West South Central	1,365,910	351	7,336,405	1,887	5.4	12,066,708	8,964	3,104
Arkansas	152,555	335	796,765	1,752	5.2	1,220,475	8,056	2,684
Louisiana	201,110	386	1,125,075	2,158	5.6	1,637,434	8,255	3,141
Oklahoma	191,485	374	999,735	1,955	5.2	1,599,516	8,438	3,127
Texas	820,760	342	4,414,830	1,839	5.4	7,609,283	9,433	3,170
Mountain	580,410	286	2,807,855	1,382	4.8	5,406,084	9,449	2,661
Arizona	190,090	324	917,640	1,566	4.8	1,803,854	9,680	3,078
Colorado	119,065	293	561,715	1,380	4.7	1,070,536	9,052	2,630
Idaho	34,810	214	154,870	952	4.4	318,622	9,213	1,958
Montana	31,240	225	147,350	1,063	4.7	283,979	9,244	2,048
Nevada	78,520	317	429,715	1,736	5.5	752,101	9,725	3,038
New Mexico	61,660	268	305,510	1,327	5.0	561,743	9,216	2,441
Utah	47,455	256	209,630	1,133	4.4	416,811	8,925	2,253
Wyoming	17,570	236	81,425	1,092	4.6	198,438	11,517	2,661
Pacific	1,247,065	296	6,536,005	1,552	5.2	14,319,765	11,677	3,400
Alaska	14,650	226	76,440	1,178	5.2	212,259	14,792	3,272
California	934,155	318	5,017,440	1,706	5.4	11,046,507	12,052	3,755
Hawaii	26,115	218	172,760	1,439	6.6	309,384	12,022	2,577
Oregon	87,580	244	405,700	1,131	4.6	838,918	9,687	2,339
Washington	184,565	254	863,665	1,189	4.7	1,912,697	10,449	2,633
Outlying Areas [5]	56,325	89	404,775	636	7.2	293,464	5,274	461

[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 Center for Strategic Planning.

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 2010

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	---	12,340,835	347	66,680,030	5.4	$116,852,409	$9,588	$1,752
Leading Diagnoses [5]	---	6,500,225	183	35,685,255	5.5	65,410,787	10,172	1,833
Infectious and Parasitic Diseases (MDC 1)	001-139	680,465	19	5,248,705	7.7	9,401,663	13,944	1,791
Septicemia	038	511,650	14	4,191,100	8.2	7,844,456	15,467	1,872
Neoplasms (MDC 2)	140-239	548,065	15	3,632,040	6.6	7,242,758	13,321	1,994
Malignant Neoplasms	140-208,230-234	473,025	13	3,246,035	6.9	6,427,279	13,696	1,980
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	64,305	2	567,415	8.8	1,062,393	16,631	1,872
Malignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	80,365	2	561,865	7.0	1,077,641	13,491	1,918
Malignant Neoplasm of Breast	174-175,198.81	24,195	1	62,715	2.6	136,488	5,723	2,176
Benign Neoplasms	210-229	50,585	1	244,785	4.8	556,292	11,077	2,273
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	509,655	14	2,340,195	4.6	3,450,001	6,885	1,474
Diabetes Mellitus	250	193,795	5	1,060,850	5.5	1,605,951	8,423	1,514
Volume Depletion	276.5	99,255	3	366,850	3.7	456,870	4,668	1,245
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	185,095	5	818,190	4.4	1,232,145	6,854	1,506
Mental Disorders (MDC 5)	290-319	489,610	14	4,381,470	8.9	3,213,176	6,767	733
Psychoses	290-299	420,105	12	3,972,115	9.5	2,894,894	7,115	729
Alcohol Dependence Syndrome	303	15,980	(6)	93,300	5.8	72,958	4,648	782
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	294,395	8	1,690,935	5.7	2,236,596	7,709	1,323

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 2010

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2]		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Diseases of the Circulatory System (MDC 7)	390-459	2,906,110	82	13,810,520	4.8	$30,280,760	$10,536	$2,193
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	1,950,085	55	9,432,985	4.8	21,499,231	11,132	2,279
Acute Myocardial Infarction	410	297,425	8	1,581,230	5.3	3,993,099	13,499	2,525
Coronary Atherosclerosis	414.0	331,370	9	1,288,220	3.9	4,361,793	13,398	3,386
Other Ischemic Heart Disease	411-413, 414.1-414.9	29,840	1	85,785	2.9	308,644	10,512	3,598
Cardiac Dysrhythmias	427	431,770	12	1,650,780	3.8	3,357,274	7,836	2,034
Congestive Heart Failure	428.0	197,235	6	938,000	4.8	1,619,986	8,315	1,727
Cerebrovascular Disease	430-438	504,485	14	2,218,910	4.4	4,041,585	8,117	1,821
Diseases of the Respiratory System (MDC 8)	460-519	1,444,460	41	8,245,315	5.7	12,114,565	8,455	1,469
Acute Bronchitis and Bronchocolitis	466	28,635	1	107,790	3.8	115,358	4,068	1,070
Pneumonia	480-486	490,635	14	2,808,920	5.7	3,695,199	7,581	1,316
Asthma	493	101,120	3	459,030	4.5	542,777	5,423	1,182
Diseases of the Digestive System (MDC 9)	520-579	1,210,555	34	6,479,320	5.4	10,325,500	8,611	1,594
Appendicitis	540-543	22,550	1	107,545	4.8	203,551	9,107	1,893
Non Infectious Enteritis and Colitis	555-558	106,295	3	552,600	5.2	799,233	7,602	1,446
Diverticula of Intestine	562	127,370	4	666,765	5.2	950,007	7,505	1,425
Cholelithiasis	574	101,485	3	515,425	5.1	951,834	9,490	1,847
Diseases of the Genitourinary System (MDC 10)	580-629	749,630	21	3,488,950	4.7	4,708,272	6,351	1,349
Calculus of Kidney and Ureter	592	35,955	1	112,520	3.1	224,555	6,351	1,996

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 2010

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	243,030	7	1,307,725	5.4	$1,580,703	$6,568	$1,209
Cellulitis and Abscess	681-682	198,550	6	999,315	5.0	1,162,355	5,908	1,163
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	891,600	25	3,353,275	3.8	10,245,516	11,588	3,055
Osteoarthrosis and Allied Disorders	715	449,635	13	1,488,730	3.3	5,044,288	11,262	3,388
Intervertebral Disc Disorders	722	90,055	3	310,270	3.4	1,204,279	13,522	3,881
Congenital Anomalies (MDC 14)	740-759	13,115	(6)	62,390	4.8	243,468	18,714	3,902
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	687,035	19	2,047,490	3.0	2,966,543	4,424	1,449
Injury and Poisoning (MDC 17)	800-999	1,179,090	33	6,565,590	5.6	13,195,239	11,319	2,010
Fractures, All Sites	800-829	463,485	13	2,483,485	5.4	4,728,253	10,287	1,904
Fracture of Neck of Femur	820	212,630	6	1,228,445	5.8	2,527,697	11,958	2,058
Poisoning by Drugs, Medicinal and Biological Substances	960-989	65,490	2	245,930	3.8	389,584	6,023	1,584
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V89	287,860	8	3,132,185	10.9	4,320,385	15,374	1,379

[1]ICD-9-CM is *International Classification of Diseases, 10th Revision, Clinical Modification.* Although as many as 25 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 Center for Strategic Planning.

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 2010

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2]		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Total All Procedures	---	7,333,205	206	45,158,660	6.2	$88,994,782	$12,271	$1,971
Leading Procedures [5]	---	3,083,940	87	17,506,715	5.7	33,738,882	11,044	1,927
Operations on the Nervous System (MPC 1)	01-05	173,265	5	1,086,505	6.3	2,414,502	14,050	2,222
Spinal Tap	03.31	38,615	1	258,720	6.7	320,794	8,364	1,240
Operations on the Endocrine System (MPC 2)	06-07	25,550	1	90,655	3.5	227,750	8,986	2,512
Operations on the Eye (MPC 3)	08-16	8,145	(6)	34,255	4.2	65,447	8,166	1,911
Operations on the Ear (MPC 4)	18-20	2,490	(6)	13,360	5.4	22,933	9,341	1,717
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	28,085	1	138,550	4.9	226,598	8,231	1,635
Operations on the Respiratory System (MPC 6)	30-34	285,560	8	2,832,860	9.9	5,180,573	18,294	1,829
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	62,285	2	540,805	8.7	693,890	11,239	1,283
Operations on the Cardiovascular System (MPC 7)	35-39	1,547,595	44	9,823,205	6.3	22,675,690	14,828	2,308
Removal of Coronary Artery Obstruction	36.0	2,125	(6)	8,030	3.8	32,284	15,596	4,020
Coronary Artery Bypass Graft	36.1	83,565	2	806,975	9.7	2,512,322	30,216	3,113
Cardiac Catheterization	37.21-37.23	232,855	7	946,510	4.1	1,663,449	7,198	1,757
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	122,865	3	622,855	5.1	1,867,225	15,333	2,998
Hemodialysis	39.95	262,640	7	1,310,120	5.0	2,324,316	9,053	1,774
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	50,270	1	389,095	7.7	781,146	15,736	2,008

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 2010

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	1,132,260	32	7,956,115	7.0	$12,790,460	$11,401	$1,608
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	305,605	9	1,658,865	5.4	1,947,898	6,428	1,174
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	100,350	3	557,750	5.6	617,069	6,199	1,106
Partial Excision of Large Intestine	45.7	66,300	2	760,135	11.5	1,522,118	23,108	2,002
Appendectomy, Excluding Incidental	47.0	20,325	1	92,545	4.6	182,496	9,055	1,972
Cholecystectomy	51.2	103,935	3	627,875	6.0	1,212,856	11,803	1,932
Lysis of Peritoneal Adhesions	54.5	32,320	1	325,920	10.1	577,546	18,009	1,772
Operations on the Urinary System (MPC 10)	55-59	215,985	6	1,275,255	5.9	2,302,244	10,779	1,805
Cystoscopy with or Without Biopsy	57.31-57.33	12,065	(6)	84,700	7.0	98,636	8,268	1,165
Operations on the Male Genital Organs (MPC 11)[7]	60-64	71,640	4	235,540	3.3	461,271	6,505	1,958
Prostatectomy	60.2-60.6	61,925	4	183,070	3.0	370,536	6,039	2,024
Operations on the Female Genital Organs (MPC 12)[8]	65-71	89,655	5	290,650	3.2	633,005	7,157	2,178
Unilateral Oophorectomy	65.3-65.6	15,175	1	61,030	4.0	120,849	8,030	1,980
Hysterectomy	68.3-68.7,68.9	42,705	2	129,030	3.0	300,535	7,086	2,329
Obstetrical Procedures (MPC 13)[8]	72-75	15,160	1	52,630	3.5	67,441	4,478	1,281
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	390	(6)	900	2.3	956	2,452	1,063
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	13,400	1	58,415	4.4	80,938	6,081	1,386
Repair of Current Obstetric Laceration	75.5-75.6	1,475	(6)	3,590	2.4	4,284	2,924	1,193
Operations on the Musculoskeletal System (MPC 14)	76-84	1,203,035	34	5,914,085	4.9	15,845,311	13,252	2,679
Partial Excision of Bone	76.2-76.3,77.6-77.8	19,310	1	161,440	8.4	294,687	15,481	1,825
Reduction of Facial Fracture	76.7,79.0-79.3	203,300	6	1,111,470	5.5	2,245,422	11,126	2,020
Open Reduction of Fracture with Internal Fixation	79.3	140,865	4	765,370	5.4	1,569,081	11,222	2,050
Excision or Destruction of Intervertebral Disc	80.5	22,160	1	59,775	2.7	158,596	7,215	2,653
Total Hip Replacement	81.51	134,150	4	481,890	3.6	1,562,956	11,688	3,243
Total Knee Replacement	81.54	303,820	9	1,026,955	3.4	3,466,203	11,455	3,375

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 2010

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2]		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Operations on the Integumentary System (MPC 15)	85-86	236,595	7	1,665,680	7.0	$2,522,390	$10,810	$1,514
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	80,860	2	751,450	9.3	1,167,266	14,602	1,553
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,856,745	52	11,815,760	6.4	17,051,134	9,308	1,443
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	95,555	3	427,585	4.5	626,490	6,628	1,465
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	46,590	1	213,655	4.6	320,119	6,955	1,498
Diagnostic Ultrasound	88.7	168,335	5	824,560	4.9	1,084,605	6,504	1,315
Respiratory Therapy	93.9,96.7	356,855	10	2,919,810	8.2	5,489,434	15,554	1,880
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	42,995	1	295,805	6.9	521,029	12,235	1,761
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	35,655	1	222,620	6.2	390,269	11,065	1,753

[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 Center for Strategic Planning.

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 2010

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
Total All DRGs	----	12,340,835	66,680,030	5.4	$495,513,491	$116,852,408	$9,782	$1,752
Leading DRGs[2]	----	7,407,895	37,923,190	5.1	234,831,189	55,839,863	7,774	1,472
039[3]	Extracranial Procedures without CC/MCC	44,210	73,755	1.7	1,255,720	222,980	5,236	3,023
057	Degenerative Nervous System Disorders without MCC	70,700	582,005	8.2	1,672,704	504,286	7,379	866
064	Intracranial Hemorrhage Or Cerebral Infarction with MCC	78,205	517,715	6.6	3,585,112	874,882	11,355	1,690
065	Intracranial Hemorrhage Or Cerebral Infarction with CC	114,145	521,820	4.6	3,319,650	728,365	6,494	1,396
066	Intracranial Hemorrhage Or Cerebral Infarction without CC/MCC	69,805	217,265	3.1	1,544,769	293,335	4,318	1,350
069	Transient Ischemia	98,135	263,795	2.7	1,990,062	352,245	3,769	1,335
101	Seizures without MCC	58,840	195,895	3.3	1,231,878	256,772	4,480	1,311
177	Respiratory Infections & Inflammations with MCC	82,925	689,985	8.3	4,103,944	1,016,560	12,460	1,473
178	Respiratory Infections & Inflammations with CC	61,085	390,495	6.4	2,085,595	520,678	8,674	1,333
189	Pulmonary Edema & Respiratory Failure	99,435	527,825	5.3	3,117,061	761,564	7,829	1,443
190	Chronic Obstructive Pulmonary Disease with MCC	162,195	851,370	5.2	4,648,263	1,092,763	6,882	1,284
191	Chronic Obstructive Pulmonary Disease with CC	146,285	640,615	4.4	3,384,975	757,847	5,305	1,183
192	Chronic Obstructive Pulmonary Disease without CC/MCC	131,300	453,740	3.5	2,270,296	473,764	3,721	1,044
193	Simple Pneumonia & Pleurisy with MCC	151,520	944,455	6.2	5,381,359	1,255,297	8,446	1,329
194	Simple Pneumonia & Pleurisy with CC	186,305	875,195	4.7	4,472,045	1,007,728	5,523	1,151
195	Simple Pneumonia & Pleurisy without CC/MCC	86,640	306,035	3.5	1,484,899	302,462	3,568	988

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 2010

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
208	Respiratory System Diagnosis with Ventilator Support <96 Hours	77,395	537,560	6.9	4,602,797	1,069,603	14,163	1,990
247[3]	Perc Cardiovasc Proc with Drug-Eluting Stent without MCC	138,965	313,825	2.3	8,073,909	1,444,651	11,082	4,603
252[3]	Other Vascular Procedures with MCC	47,125	369,655	7.8	3,734,556	938,064	20,462	2,538
280	Acute Myocardial Infarction, Discharged Alive with MCC	83,180	521,995	6.3	3,551,166	880,886	10,743	1,688
281	Acute Myocardial Infarction, Discharged Alive with CC	45,465	179,125	3.9	1,287,909	284,403	6,372	1,588
287	Circulatory Disorders Except Ami, with Card Cath without MCC	133,635	398,535	3.0	4,227,448	742,785	5,771	1,864
291	Heart Failure & Shock with MCC	242,525	1,467,940	6.1	8,558,442	2,114,677	8,889	1,441
292	Heart Failure & Shock with CC	206,065	911,030	4.4	4,770,154	1,137,841	5,632	1,249
293	Heart Failure & Shock without CC/MCC	111,360	354,510	3.2	1,855,402	406,965	3,744	1,148
300	Peripheral Vascular Disorders with CC	45,655	209,795	4.6	1,037,173	241,918	5,411	1,153
303	Atherosclerosis without MCC	47,195	111,025	2.4	719,539	139,589	3,034	1,257
308	Cardiac Arrhythmia & Conduction Disorders with MCC	79,615	396,155	5.0	2,353,042	571991	7,341	1,444
309	Cardiac Arrhythmia & Conduction Disorders with CC	103,060	357,225	3.5	2,045,794	456,691	4,531	1,278
310	Cardiac Arrhythmia & Conduction Disorders without CC/MCC	132,805	317,830	2.4	1,917,595	354,170	2,749	1,114
312	Syncope & Collapse	176,325	502,695	2.9	3,343,564	655,325	3,884	1,304
313	Chest Pain	177,700	356,220	2.0	2,764,180	464,920	2,773	1,305
314	Other Circulatory System Diagnoses with MCC	69,290	460,050	6.6	3,089,729	766,473	11,570	1,666
329[3]	Major Small & Large Bowel Procedures with MCC	51,160	764,720	14.9	6,537,368	1,663,970	33,269	2,176
330[3]	Major Small & Large Bowel Procedures with CC	59,345	517,320	8.7	3,714,726	872779	15,176	1,687
377	G.I. Hemorrhage with MCC	70,685	417,720	5.9	2,823,609	706415	10,161	1,691
378	G.I. Hemorrhage with CC	132,930	525,800	4.0	3,254,457	721689	5,536	1,373

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 2010

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
379	G.I. Hemorrhage without CC/MCC	48,820	142,615	2.9	$860,948	$178,233	$3,750	$1,250
389	G.I. Obstruction with CC	52,225	238,065	4.6	1,212,956	265,505	5,205	1,115
390	G.I. Obstruction without CC/MCC	43,010	140,925	3.3	713,520	133,228	3,200	945
391	Esophagitis, Gastroent & Misc Digest Disorders with MCC	72,470	354,960	4.9	2,071,311	477,402	6,845	1,345
392	Esophagitis, Gastroent & Misc Digest Disorders without MCC	265,715	888,650	3.3	5,049,851	954,034	3,721	1,074
394	Other Digestive System Diagnoses with CC	47,555	208,755	4.4	1,180,147	263,452	5,699	1,262
460[3]	Spinal Fusion Except Cervical without MCC	72,340	269,560	3.7	6,464,273	1,561,160	22,622	5,792
470[3]	Major Joint Replacement Or Reattachment Of Lower Extremity without MCC	461,530	1,618,550	3.5	22,077,384	5,098,435	11,534	3,150
481[3]	Hip & Femur Procedures Except Major Joint with CC	81,465	434,180	5.3	3,710,531	834,907	10,385	1,923
491[3]	Back & Neck Proc Exc Spinal Fusion without CC/MCC	45,670	94,410	2.1	1,254,871	224,765	5,144	2,381
552	Medical Back Problems without MCC	77,995	297,340	3.8	1,591,795	314,943	4,272	1,059
603	Cellulitis without MCC	143,445	618,010	4.3	2,704,315	621031	4,458	1,005
638	Diabetes with CC	52,930	207,935	3.9	1,078,573	244,110	4,748	1,174
640	Nutritional & Misc Metabolic Disorders with MCC	89,475	408,285	4.6	2,293,764	593,648	6,852	1,454
641	Nutritional & Misc Metabolic Disorders without MCC	156,150	531,220	3.4	2,627,373	573,437	3,768	1,079
682	Renal Failure with MCC	109,465	724,940	6.6	4,293,544	1,093,693	10,265	1,509
683	Renal Failure with CC	127,210	605,005	4.8	3,123,023	735,762	5,936	1,216
689	Kidney & Urinary Tract Infections with MCC	97,060	524,615	5.4	2,639,999	670,662	7,028	1,278
690	Kidney & Urinary Tract Infections without MCC	206,740	802,770	3.9	3,891,388	852633	4,199	1,062
812	Red Blood Cell Disorders without MCC	102,055	356,330	3.5	2,015,560	433070	4,479	1,215

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 2010

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
853[3]	Infectious & Parasitic Diseases with O.R. Procedure with MCC	48,835	730,180	15.0	6,549,662	1,700,487	35,804	2,329
871	Septicemia Or Severe Sepsis without Mv 96+ Hours with MCC	338,255	2,348,435	6.9	15,901,664	3,847,976	11,603	1,639
872	Septicemia Or Severe Sepsis without Mv 96+ Hours without MCC	94,525	470,240	5.0	2,485,159	582,126	6,294	1,238
884	Organic Disturbances & Mental Retardation	43,505	398,170	9.2	1,050,524	327,437	7,728	822
885	Psychoses	328,720	3,319,210	10.1	7,738,843	2,325,007	7,472	700
897	Alcohol/Drug Abuse Or Dependence without Rehabilitation Therapy without MCC	49,555	216,585	4.4	705,331	177,142	3,768	818
945	Rehabilitation with CC/MCC	173,865	2,272,765	13.1	7,380,722	2,899,481	17,369	1,276
946	Rehabilitation without CC/MCC	44,365	460,480	10.4	1,324,118	581,786	13,603	1,263
948	Signs & Symptoms without MCC	59,735	197,310	3.3	1,029,117	216,943	3,741	1,100
All Other DRGs	----	4,932,940	28,756,840	5.8	260,682,301	61,012,544	12,810	2,122

[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 2010.
[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 Center for Strategic Planning.

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 2010

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	12,340,835	9,671,935	4,481,455	12,243,385	4,310,625	12,165,085
1-8 Days	10,384,355	8,041,750	3,496,565	10,300,945	3,312,930	10,236,580
9-20 Days	1,665,985	1,385,335	811,705	1,654,925	812,120	1,644,980
21-30 Days	196,595	165,200	112,960	195,050	121,030	192,940
31-40 Days	53,145	44,695	33,990	52,540	36,410	51,755
41-50 Days	20,275	17,335	13,010	19,875	14,135	19,455
51-60 Days	8,870	7,470	5,910	8,710	6,280	8,480
61-90 Days	8,355	7,260	5,440	8,195	5,705	7,905
91 Days or More	3,255	2,890	1,875	3,145	2,015	2,990
			Percent of Total Discharges [3]			
Total	100.0	78.4	36.3	99.2	34.9	98.6
1-8 Days	100.0	77.4	33.7	99.2	31.9	98.6
9-20 Days	100.0	83.2	48.7	99.3	48.7	98.7
21-30 Days	100.0	84.0	57.5	99.2	61.6	98.1
31-40 Days	100.0	84.1	64.0	98.9	68.5	97.4
41-50 Days	100.0	85.5	64.2	98.0	69.7	96.0
51-60 Days	100.0	84.2	66.6	98.2	70.8	95.6
61-90 Days	100.0	86.9	65.1	98.1	68.3	94.6
91 Days or More	100.0	88.8	57.6	96.6	61.9	91.9
			Total Charges in Thousands			
Total	$495,513,491	$72,411,519	$60,108,137	$363,046,110	$46,385,392	$64,755,429
1-8 Days	302,427,497	39,966,653	27,999,530	234,463,172	33,420,532	33,000,947
9-20 Days	130,297,452	22,246,994	19,846,622	88,204,188	9,538,711	20,170,087
21-30 Days	32,326,171	5,211,438	5,905,316	21,209,461	1,930,280	5,784,287
31-40 Days	13,301,393	2,004,414	2,670,732	8,626,258	705,017	2,509,361
41-50 Days	6,651,988	1,068,352	1,335,511	4,248,129	344,055	1,316,272
51-60 Days	3,645,019	565,113	809,001	2,270,905	166,141	708,282
61-90 Days	4,163,120	735,697	928,300	2,499,123	190,455	781,491
91 Days or More	2,700,848	612,855	613,122	1,524,871	90,198	484,698

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 2010

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
		Number of Discharges			
12,152,430	10,757,035	9,987,770	9,049,625	5,824,140	11,386,145
10,217,905	9,002,945	8,323,655	7,515,380	4,603,405	9,510,425
1,648,300	1,492,215	1,418,835	1,299,780	1,022,620	1,597,555
194,155	177,075	167,050	156,190	131,820	189,000
52,330	48,195	45,110	44,245	37,765	50,755
19,770	18,190	16,815	16,800	14,310	19,180
8,685	8,050	7,390	7,550	6,400	8,425
8,145	7,550	6,515	7,000	5,660	7,825
3,140	2,815	2,400	2,680	2,160	2,980
		Percent of Total Discharges [3]			
98.5	87.2	80.9	73.3	47.2	92.3
98.4	86.7	80.2	72.4	44.3	91.6
98.9	89.6	85.2	78.0	61.4	95.9
98.8	90.1	85.0	79.4	67.1	96.1
98.5	90.7	84.9	83.3	71.1	95.5
97.5	89.7	82.9	82.9	70.6	94.6
97.9	90.8	83.3	85.1	72.2	95.0
97.5	90.4	78.0	83.8	67.7	93.7
96.5	86.5	73.7	82.3	66.4	91.6
		Total Charges in Thousands			
$58,698,431	$40,123,492	$63,793,627	$25,339,822	$16,953,759	$46,996,156
35,700,638	27,385,205	47,915,989	20,070,714	6,719,148	30,249,995
15,803,370	9,305,968	11,491,942	4,202,710	5,990,937	11,700,460
3,781,085	1,953,779	2,369,565	647,486	1,983,981	2,758,995
1,559,473	727,269	942,321	214,715	943,464	1,024,634
762,356	334,539	435,913	88,380	463,437	503,172
400,751	167,850	230,522	49,316	277,458	270,581
436,804	166,842	254,139	44,313	337,746	287,329
253,949	82,036	153,231	22,184	237,585	200,986

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 2010

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	14.6	12.1	73.3	9.4	13.1
1-8 Days	100.0	13.2	9.3	77.5	11.1	10.9
9-20 Days	100.0	17.1	15.2	67.7	7.3	15.5
21-30 Days	100.0	16.1	18.3	65.6	6.0	17.9
31-40 Days	100.0	15.1	20.1	64.9	5.3	18.9
41-50 Days	100.0	16.1	20.1	63.9	5.2	19.8
51-60 Days	100.0	15.5	22.2	62.3	4.6	19.4
61-90 Days	100.0	17.7	22.3	60.0	4.6	18.8
91 Days or More	100.0	22.7	22.7	56.5	3.3	17.9
			Average Total Charge Per Discharge			
Total	$40,152	$7,487	$13,413	$29,652	$10,761	$5,323
1-8 Days	29,123	4,970	8,008	22,761	10,088	3,224
9-20 Days	78,210	16,059	24,451	53,298	11,745	12,262
21-30 Days	164,430	31,546	52,278	108,739	15,949	29,980
31-40 Days	250,285	44,847	78,574	164,185	19,363	48,485
41-50 Days	328,088	61,630	102,653	213,742	24,341	67,657
51-60 Days	410,938	75,651	136,887	260,724	26,456	83,524
61-90 Days	498,279	101,336	170,644	304,957	33,384	98,860
91 Days or More	829,754	212,061	326,998	484,856	44,764	162,107

[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 Center for Strategic Planning.

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 2010

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
Percent of Total Charges [4]					
11.8	8.1	12.9	5.1	3.4	9.5
11.8	9.1	15.8	6.6	2.2	10.0
12.1	7.1	8.8	3.2	4.6	9.0
11.7	6.0	7.3	2.0	6.1	8.5
11.7	5.5	7.1	1.6	7.1	7.7
11.5	5.0	6.6	1.3	7.0	7.6
11.0	4.6	6.3	1.4	7.6	7.4
10.5	4.0	6.1	1.1	8.1	6.9
9.4	3.0	5.7	0.8	8.8	7.4
Average Total Charge Per Discharge					
$4,830	$3,730	$6,387	$2,800	$2,911	$4,127
3,494	3,042	5,757	2,671	1,460	3,181
9,588	6,236	8,100	3,233	5,858	7,324
19,475	11,034	14,185	4,146	15,051	14,598
29,801	15,090	20,889	4,853	24,983	20,188
38,561	18,391	25,924	5,261	32,386	26,234
46,143	20,851	31,194	6,532	43,353	32,117
53,629	22,098	39,008	6,331	59,673	36,719
80,876	29,143	63,847	8,278	109,993	67,445

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 2010

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	12,340,835	100.0	66,680,030	100.0	5.4	$116,852,409	100.0	$9,588	$1,752
1 Day	1,704,770	13.8	1,704,770	2.6	1.0	10,008,739	8.6	6,071	5,871
2 Days	1,919,755	15.6	3,839,510	5.8	2.0	11,503,197	9.8	6,054	2,996
3 Days	2,141,255	17.4	6,423,765	9.6	3.0	15,329,011	13.1	7,210	2,386
4 Days	1,538,930	12.5	6,155,720	9.2	4.0	11,964,562	10.2	7,832	1,944
5 Days	1,108,345	9.0	5,541,725	8.3	5.0	9,493,921	8.1	8,630	1,713
6 Days	836,140	6.8	5,016,840	7.5	6.0	7,923,417	6.8	9,557	1,579
7 Days	657,520	5.3	4,602,640	6.9	7.0	6,850,540	5.9	10,509	1,488
8 Days	477,640	3.9	3,821,120	5.7	8.0	5,427,347	4.6	11,468	1,420
9 Days	345,420	2.8	3,108,780	4.7	9.0	4,230,468	3.6	12,363	1,361
10 Days	270,375	2.2	2,703,750	4.1	10.0	3,554,745	3.0	13,292	1,315
11 Days	214,190	1.7	2,356,090	3.5	11.0	3,056,354	2.6	14,419	1,297
12 Days	169,245	1.4	2,030,940	3.0	12.0	2,567,122	2.2	15,356	1,264
13 Days	146,130	1.2	1,899,690	2.8	13.0	2,377,630	2.0	16,475	1,252
14 Days	133,985	1.1	1,875,790	2.8	14.0	2,274,091	1.9	17,173	1,212
15 Days	102,860	0.8	1,542,900	2.3	15.0	1,894,983	1.6	18,692	1,228
16 Days	77,520	0.6	1,240,320	1.9	16.0	1,507,462	1.3	19,767	1,215
17 Days	64,910	0.5	1,103,470	1.7	17.0	1,356,538	1.2	21,208	1,229
18 Days	54,360	0.4	978,480	1.5	18.0	1,198,004	1.0	22,334	1,224
19 Days	45,385	0.4	862,315	1.3	19.0	1,052,263	0.9	23,543	1,220
20 Days	41,605	0.3	832,100	1.2	20.0	1,025,185	0.9	25,044	1,232
21-30 Days	196,595	1.6	4,779,355	7.2	24.3	6,253,556	5.4	32,427	1,308
31-40 Days	53,145	0.4	1,840,480	2.8	34.6	2,659,509	2.3	51,347	1,445
41-50 Days	20,275	0.2	909,015	1.4	44.8	1,330,759	1.1	67,414	1,464
51-60 Days	8,870	0.1	486,895	0.7	54.9	723,629	0.6	84,734	1,486
61-90 Days	8,355	0.1	600,360	0.9	71.9	855,697	0.7	107,567	1,425
91 Days or More	3,255	(3)	423,210	0.6	130.0	433,679	0.4	145,286	1,025

[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 Center for Strategic Planning.

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 2010

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]	3,510	100.0	12,290,165	100.0	5.4	$116,642,883	100.0	$9,611
1-99 Beds	1,222	34.8	1,091,320	8.9	4.5	7,933,506	6.8	7,353
100-299 Beds	1,393	39.7	4,326,125	35.2	5.1	36,272,074	31.1	8,492
300-499 Beds	554	15.8	3,448,510	28.1	5.5	32,879,527	28.2	9,649
500 Beds or More	341	9.7	3,424,210	27.9	5.9	39,557,776	33.9	11,706
Total Urban Hospitals	2,362	100.0	10,719,625	100.0	5.5	105,160,964	100.0	9,938
1-99 Beds	537	22.7	540,805	5.0	4.6	4,404,747	4.2	8,256
100-299 Beds	981	41.5	3,482,525	32.5	5.2	29,920,610	28.5	8,707
300-499 Beds	509	21.5	3,297,450	30.8	5.5	31,507,716	30.0	9,672
500 Beds or More	335	14.2	3,398,845	31.7	5.9	39,327,891	37.4	11,725
Total Rural Hospitals	1,148	100.0	1,570,540	100.0	4.8	11,481,919	100.0	7,382
1-99 Beds	685	59.7	550,515	35.1	4.5	3,528,759	30.7	6,470
100-299 Beds	412	35.9	843,600	53.7	4.9	6,351,464	55.3	7,609
300-499 Beds	45	3.9	151,060	9.6	5.2	1,371,811	11.9	9,145
500 Beds or More	6	0.5	25,365	1.6	5.5	229,885	2.0	9,130
Total All Hospitals[3]	3,510	100.0	12,290,165	100.0	5.4	116,642,883	100.0	9,611
Voluntary	2,107	60.0	8,903,615	72.4	5.4	84,990,198	72.9	9,666
Proprietary	738	21.0	1,748,915	14.2	5.3	15,077,946	12.9	8,728
Government	665	18.9	1,637,635	13.3	5.5	16,574,738	14.2	10,252
Total Teaching Hospitals[4]	1,075	100.0	6,126,450	100.0	5.7	64,851,966	100.0	10,717
Voluntary	758	70.5	4,882,830	79.7	5.6	50,967,402	78.6	10,562
Proprietary	120	11.2	470,570	7.7	5.6	4,238,114	6.5	9,103
Government	197	18.3	773,050	12.6	5.9	9,646,449	14.9	12,685
Total Non-Teaching Hospitals	2,435	100.0	6,163,715	100.0	5.1	51,790,917	100.0	8,510
Voluntary	1,349	55.4	4,020,785	65.2	5.1	34,022,796	65.7	8,576
Proprietary	618	25.4	1,278,345	20.7	5.2	10,839,832	20.9	8,589
Government	468	19.2	864,585	14.0	5.1	6,928,289	13.4	8,092

[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 Center for Strategic Planning.

Table 5.11

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2010

	Hospitals		Discharges		Covered Days of Care		
Type of Hospital	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals [2]	6,204	100.0	13,173,380	100.0	73,467,945	100.0	5.6
Short-Stay Hospitals	3,593	57.9	12,340,835	93.7	64,212,045	87.4	5.2
Hospitals	3,593	57.9	11,816,505	89.7	58,346,825	79.4	4.9
Psychiatric Hospital Units [3]	NA	----	310,275	2.4	3,261,900	4.4	10.5
Rehabilitation Hospital Units [3]	NA	----	214,055	1.6	2,603,320	3.5	12.2
Specialty Hospitals	2,611	42.1	832,545	6.3	9,255,900	12.6	11.1
Childrens	77	1.2	2,865	(4)	20,160	(4)	7.0
Psychiatric	515	8.3	147,895	1.1	2,027,690	2.8	13.7
Rehabilitation	237	3.8	155,815	1.2	2,081,370	2.8	13.4
Long Term	440	7.1	140,365	1.1	3,748,985	5.1	26.7
Critical Access (formerly Short-Stay)	1,325	21.4	385,215	2.9	1,367,085	1.9	3.5
Religious Non-Medical	17	0.3	390	(4)	10,610	(4)	27.2

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 2010

Type of Hospital	Covered Charges				Program Payments			
	Amount in Thousands	Percent	Per Discharge	Per Covered Day	Amount in Thousands	Percent	Per Discharge[1]	Per Covered Day
Total All Hospitals [2]	$517,261,466	100.0	$39,266	$7,041	$128,040,209	100.0	$9,835	$1,743
Short-Stay Hospitals	489,606,799	94.7	39,674	7,625	116,852,409	91.3	9,588	1,820
Hospitals	473,567,433	91.6	40,077	8,116	110,972,211	86.7	9,502	1,902
Psychiatric Hospital Units [3]	7,463,569	1.4	24,055	2,288	2,399,265	1.9	7,988	736
Rehabilitation Hospital Units [3]	8,575,797	1.7	40,064	3,294	3,480,932	2.7	16,713	1,337
Specialty Hospitals	27,654,668	5.3	33,217	2,988	11,187,801	8.7	13,447	1,209
Childrens	204,793	(4)	71,481	10,158	54,600	(4)	19,091	2,708
Psychiatric	2,627,760	0.5	17,768	1,296	1,319,626	1.0	8,923	651
Rehabilitation	4,169,947	0.8	26,762	2,003	2,562,534	2.0	16,473	1,231
Long Term	16,241,019	3.1	115,706	4,332	5,004,567	3.9	35,725	1,335
Critical Access (formerly Short-Stay)	4,405,071	0.9	11,435	3,222	2,242,452	1.8	5,821	1,640
Religious Non-Medical	6,077	(4)	15,583	573	4,021	(4)	10,310	379

[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 1,193 distinct-part psychiatric units and 804 rehabilitation units participating in the Medicare Program during 2010.

[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 Center for Strategic Planning.

Table 5.12

Short-Stay Hospital (SSH) Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2010

Location and Bedsize of Hospital	Discharges	Hospital Case-Mix Index[1]	Percent of Discharges				
				With Procedures			Without Procedure
			Total	Total	Surgical	Non-Surgical	
Total All Hospitals [2]	12,290,165	1.5777	100.0	59.4	47.7	11.7	40.6
1-99 Beds	1,091,320	1.3267	100.0	45.9	34.8	11.1	54.1
100-299 Beds	4,326,125	1.4713	100.0	55.2	44.2	11.0	44.8
300-499 Beds	3,448,510	1.6064	100.0	61.2	49.6	11.6	38.8
500 Beds or More	3,424,210	1.7631	100.0	67.1	54.3	12.8	32.9
Total Urban Hospitals	10,719,625	1.6155	100.0	61.3	49.5	11.7	38.7
1-99 Beds	540,805	1.4700	100.0	54.5	43.8	10.8	45.5
100-299 Beds	3,482,525	1.4987	100.0	56.4	45.6	10.8	43.6
300-499 Beds	3,297,450	1.6096	100.0	61.4	49.7	11.7	38.6
500 Beds or More	3,398,845	1.7640	100.0	67.2	54.4	12.8	32.8
Total Rural Hospitals	1,570,540	1.3197	100.0	46.6	35.4	11.2	53.4
1-99 Beds	550,515	1.1859	100.0	37.5	26.0	11.5	62.5
100-299 Beds	843,600	1.3582	100.0	50.3	38.8	11.5	49.7
300-499 Beds	151,060	1.5367	100.0	56.9	47.8	9.2	43.1
500 Beds or More	25,365	1.6474	100.0	59.9	51.9	8.0	40.1

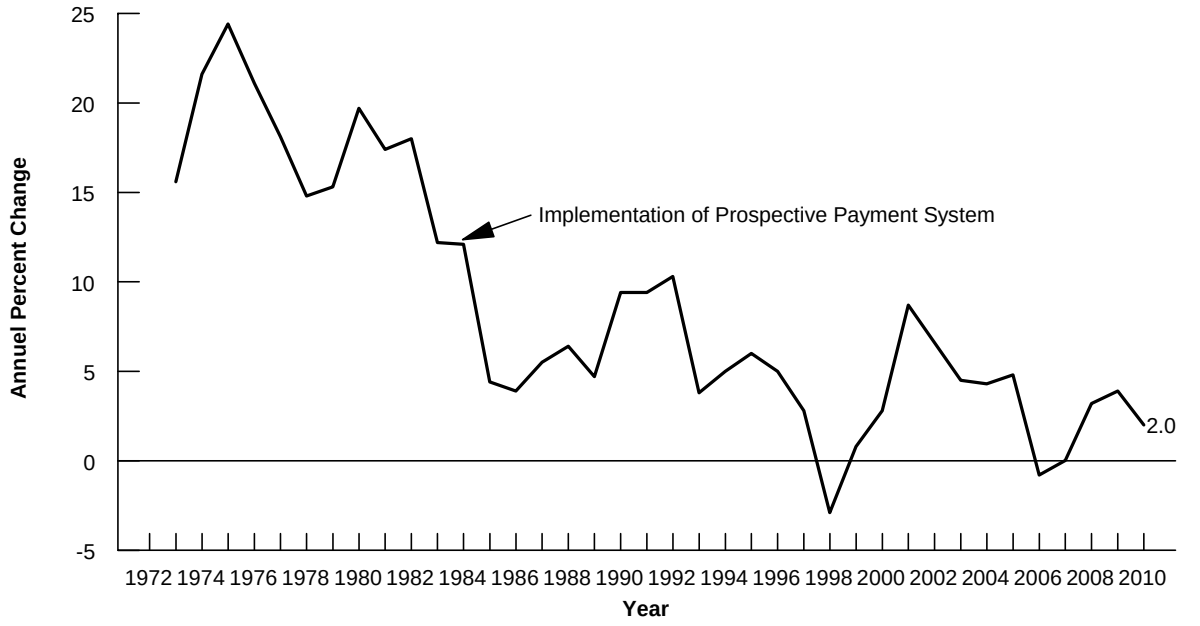
[1]For hospitals participating in the Medicare prospective payment system, the hospital case-mix index is a relative measure of the hospital's average cost per case relative to the average cost per case for all hospitals in some base or reference year. The case-mix index is presented by selected provider 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.

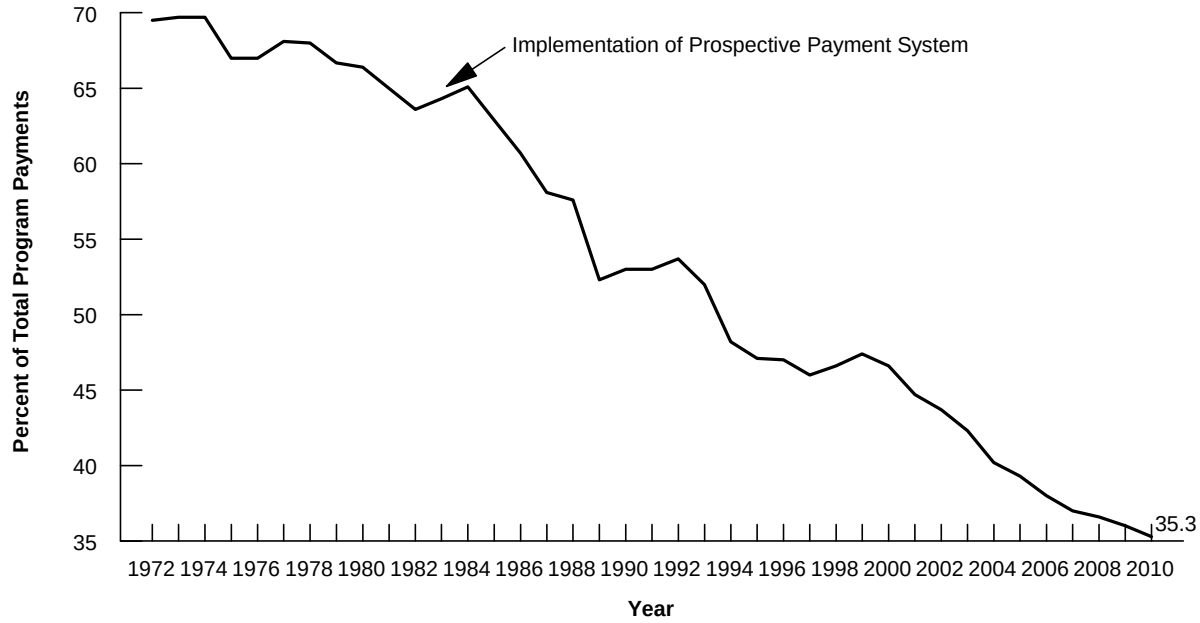
[2]Includes discharges from SSH in the 50 States and District of Columbia; excludes discharges from SSH in all outlying areas.

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 Center for Strategic Planning.

Figure 5.1
Changes in Medicare Short-Stay Hospital Program Payments: Calendar Years 1972-2010

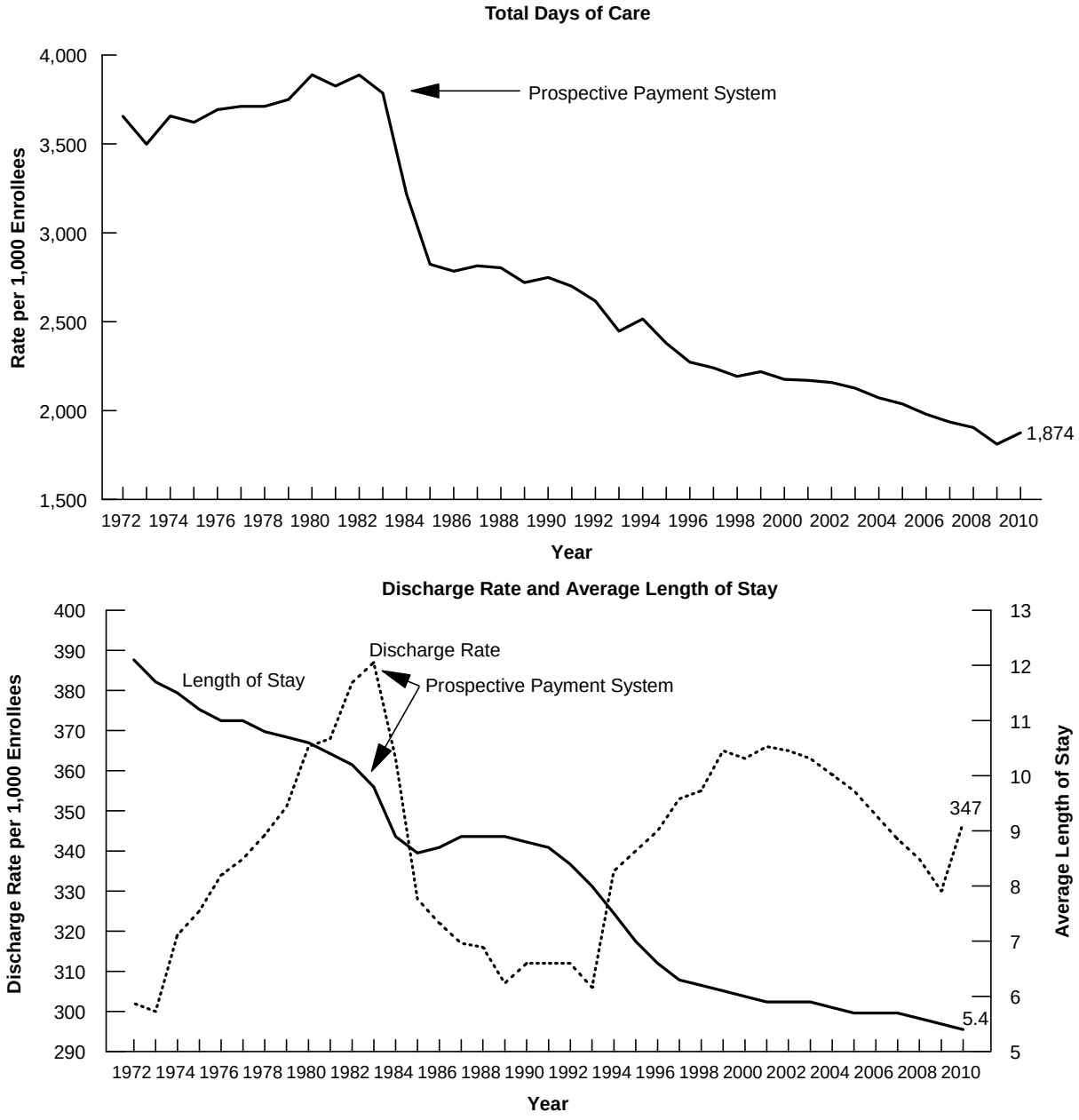




NOTE: The Medicare short-stay hospital prospective payment system was phased in by providers' fiscal years beginning on or after October 1, 1983.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Center for Strategic Planning. See Table 5.1.

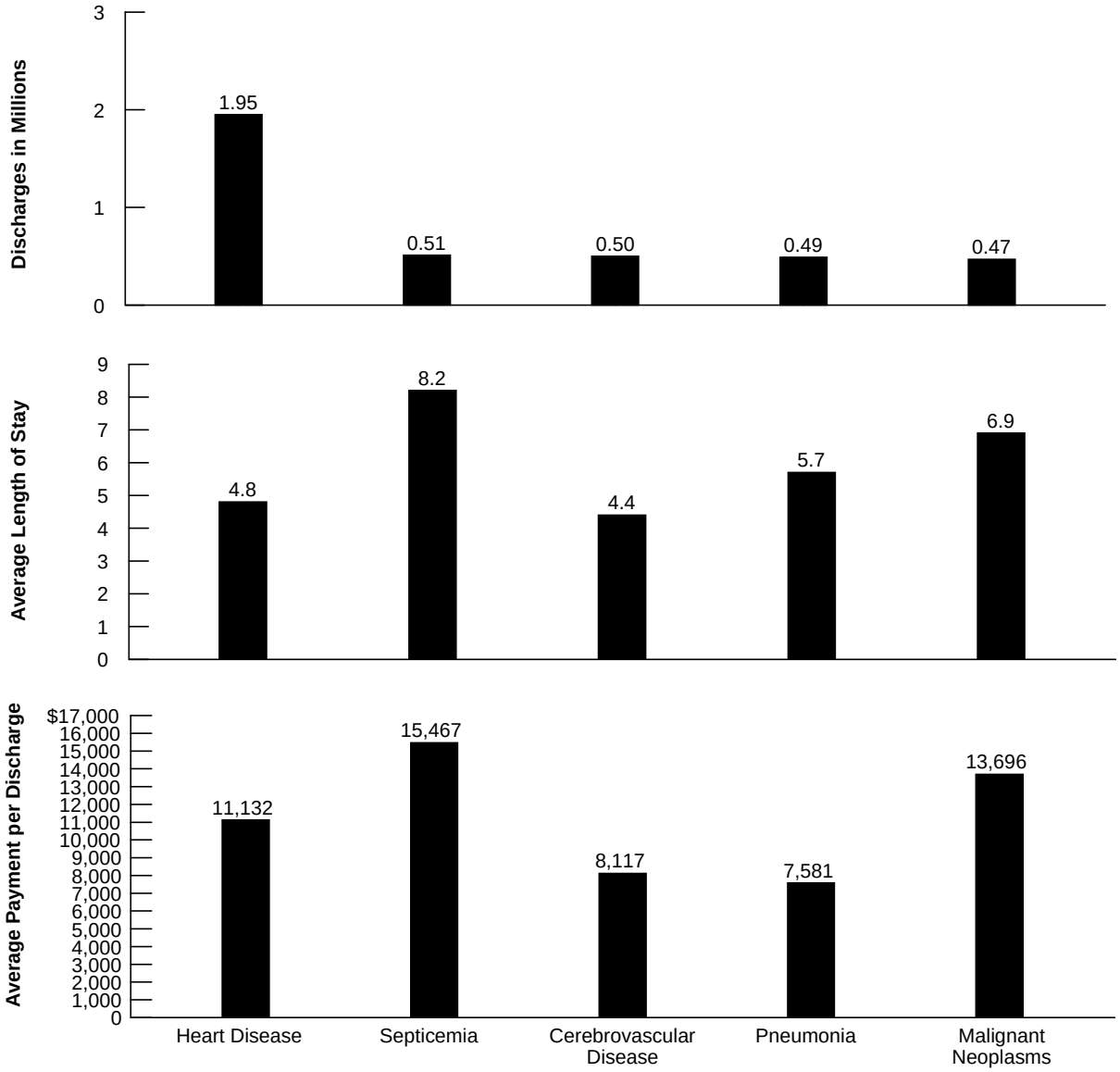
Figure 5.2
Trends in Parameters of Medicare Beneficiary Stays in Short-Stay Hospitals: Calendar Years 1972-2010



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 Center for Strategic Planning. See Table 5.1.

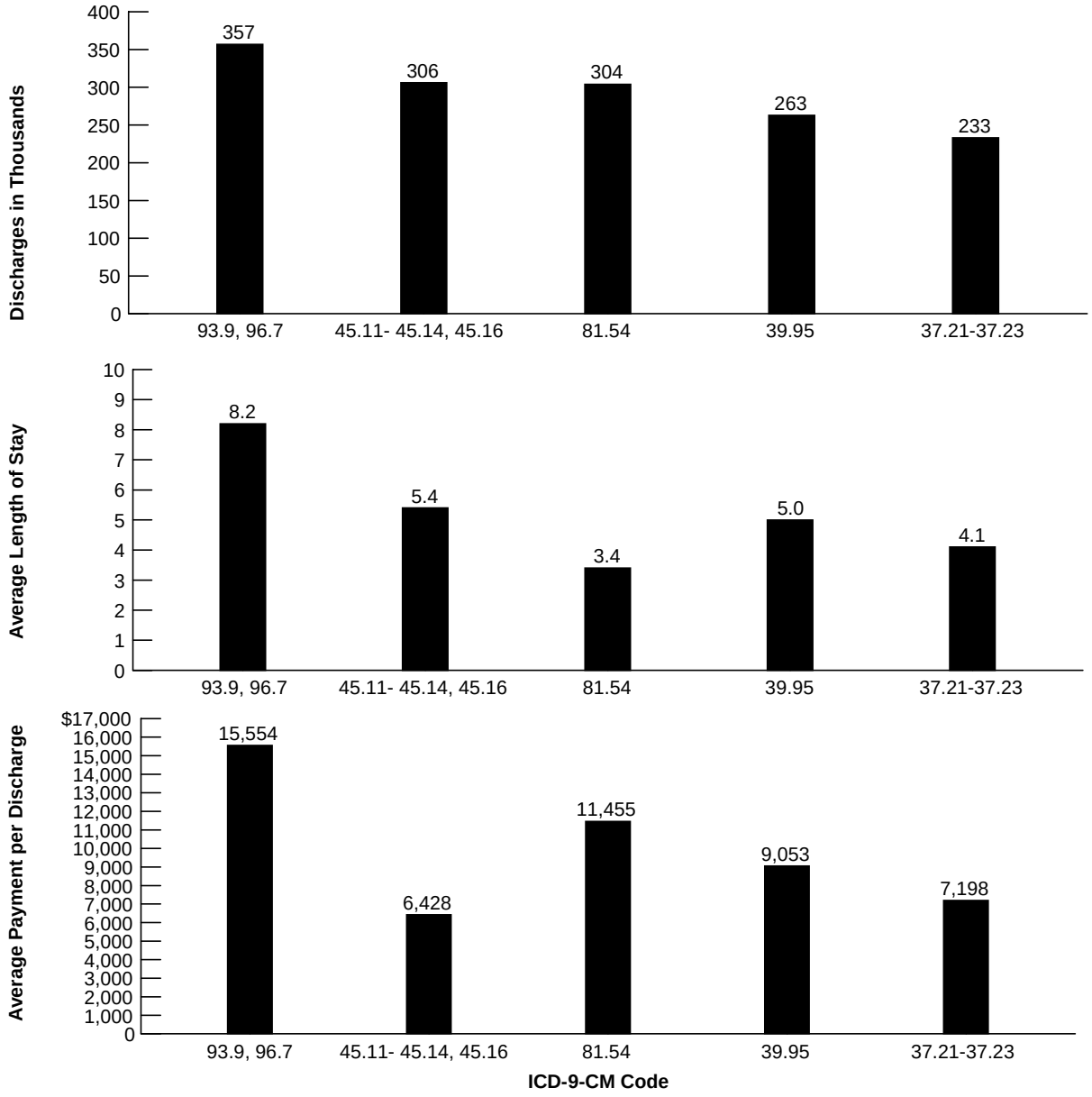
Figure 5.3
Leading Principal Diagnostic Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2010



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 septicemia, 038.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Center for Strategic Planning. See Table 5.5.

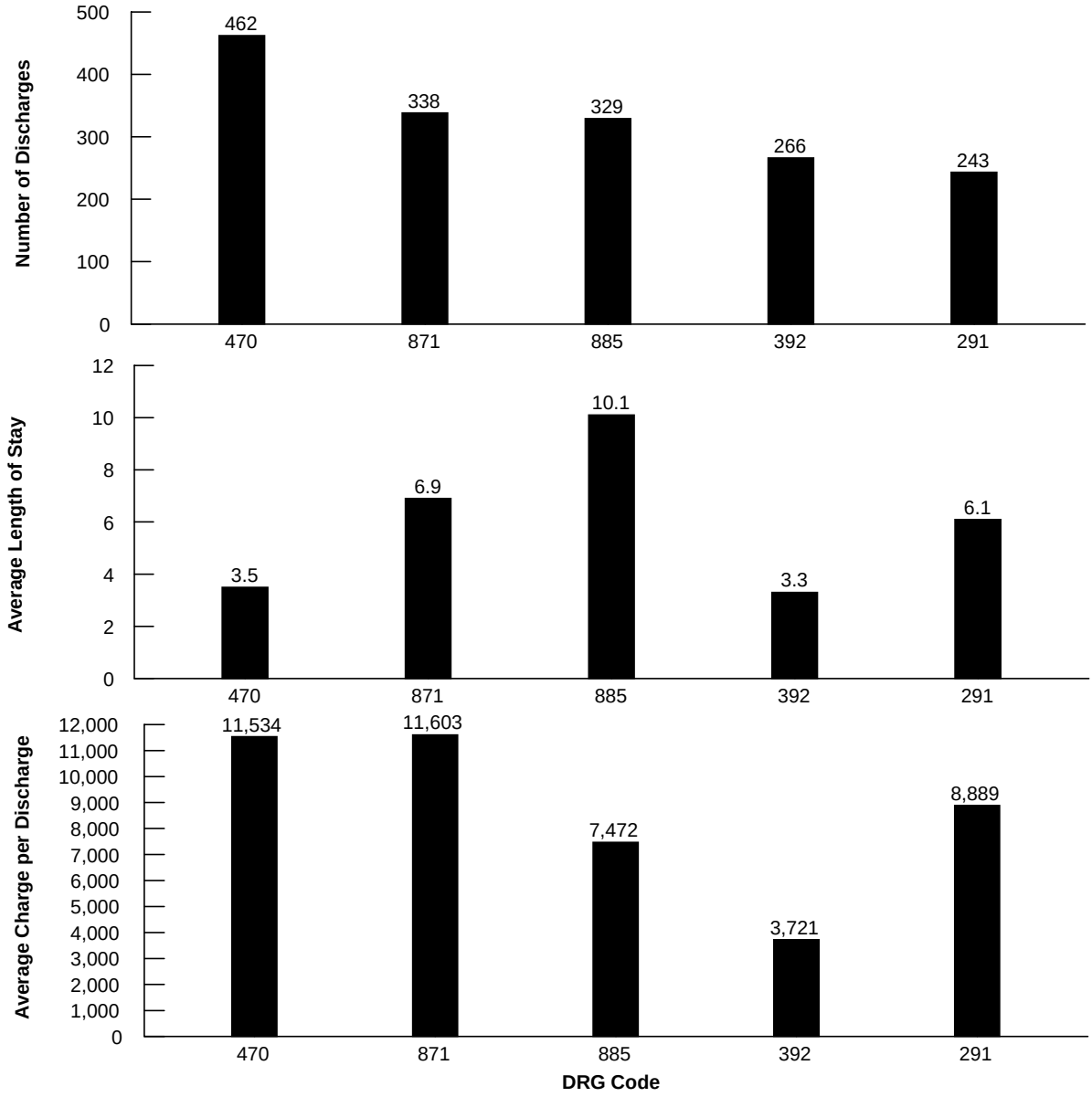
Figure 5.4
Medicare Principal Procedure Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2010



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 Center for Strategic Planning. See Table 5.6.

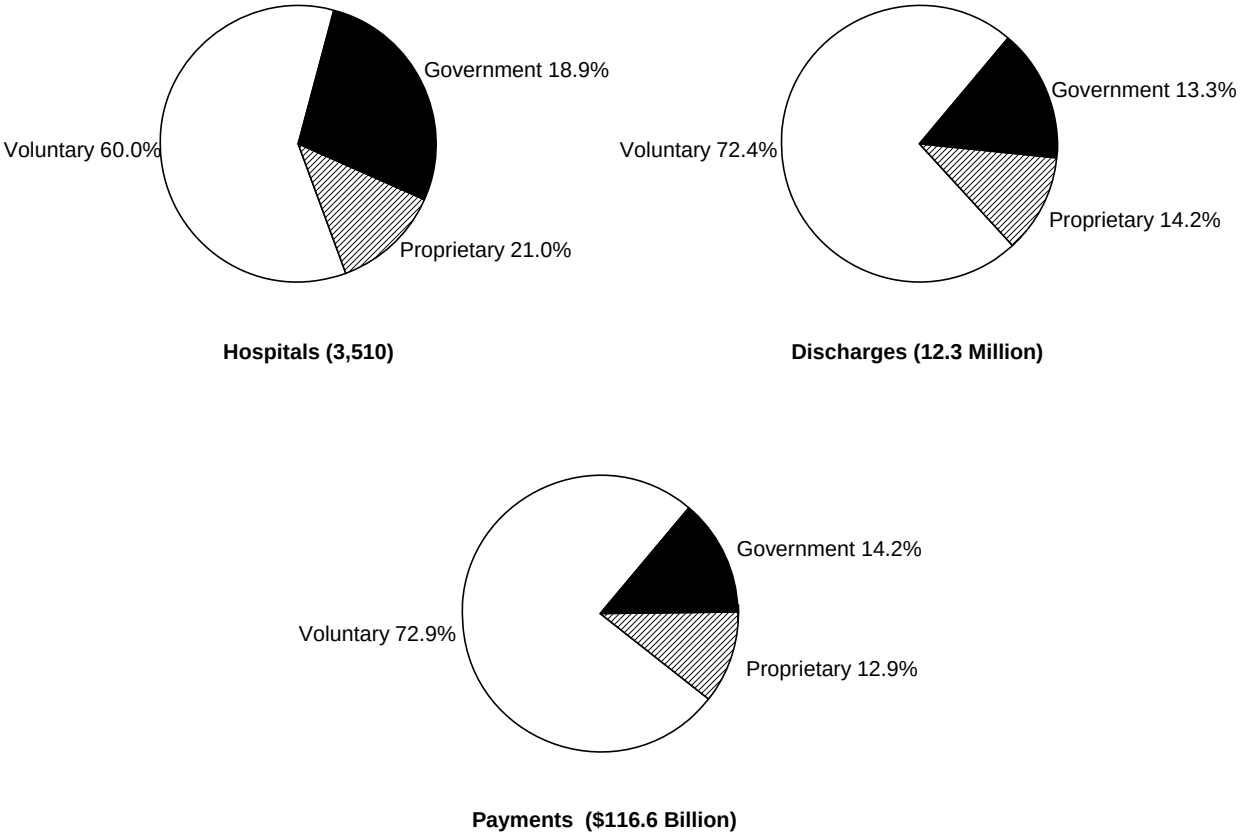
Figure 5.5
Five Most Frequent Medicare Diagnosis-Related Groups (DRGs) for Beneficiaries Discharged from Short-Stay Hospitals: Calendar Year 2010



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 Center for Strategic Planning. See Table 5.7.

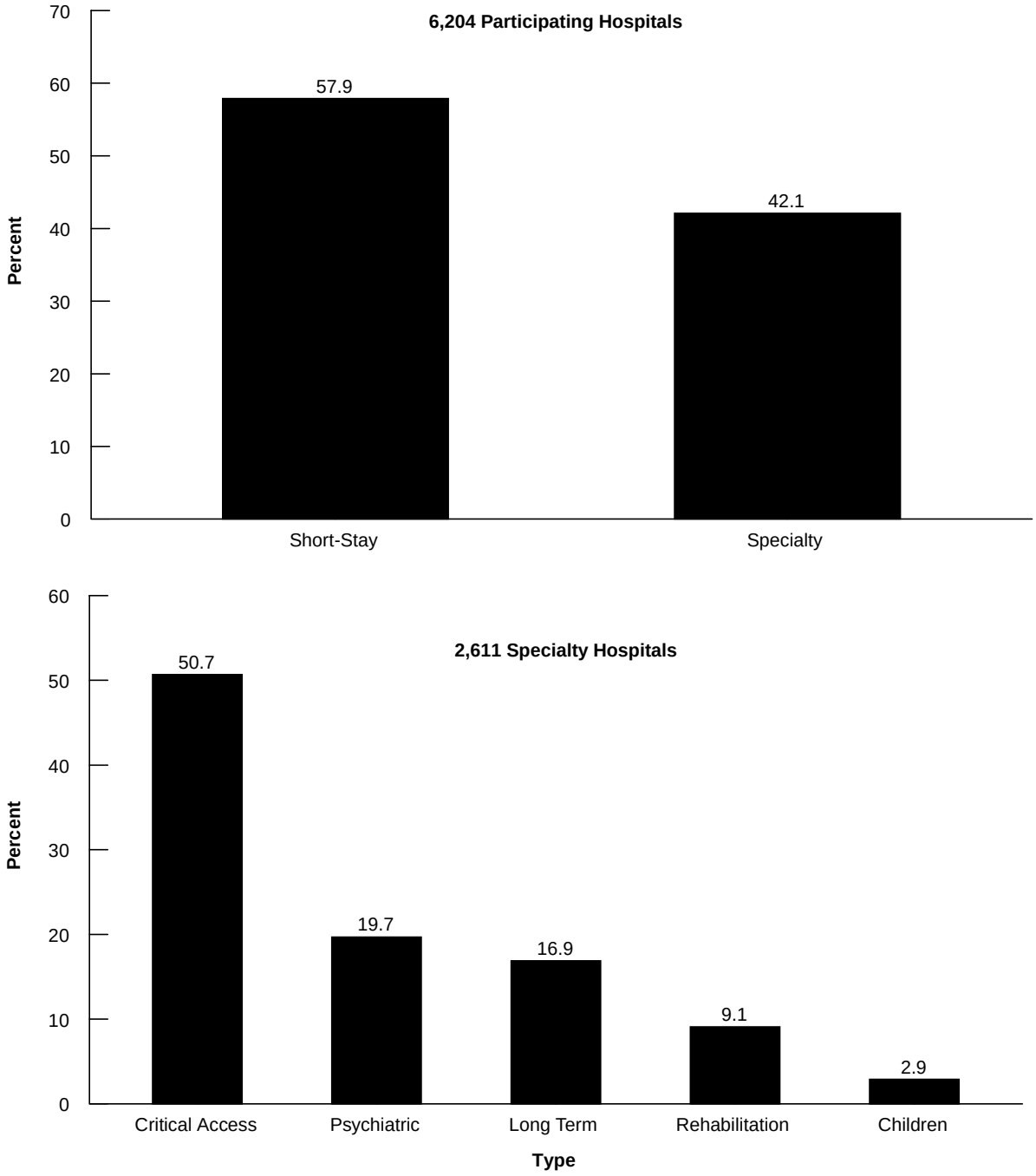
Figure 5.6
Distribution of Medicare Short-Stay Hospitals, Discharges, and Payments, by Type of Control: Calendar Year 2010



NOTE: Short-stay hospital payments excludes outlying areas.

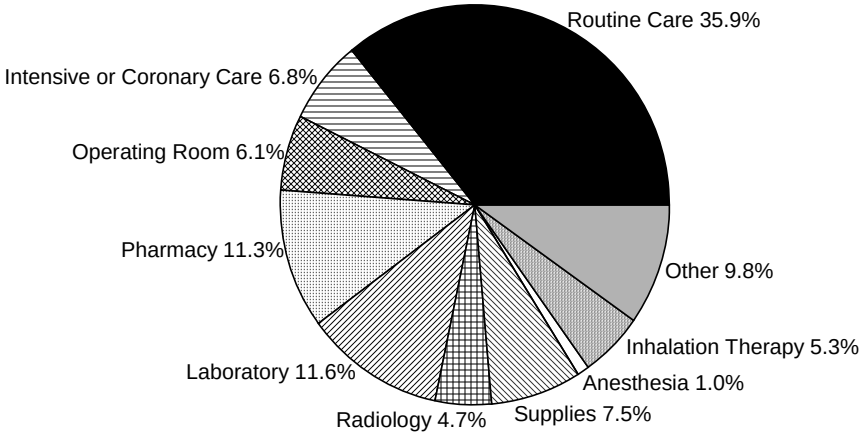
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Center for Strategic Planning. See Table 5.10.

Figure 5.7
Medicare Participating Hospitals, by Type of Hospital: Calendar Year 2010



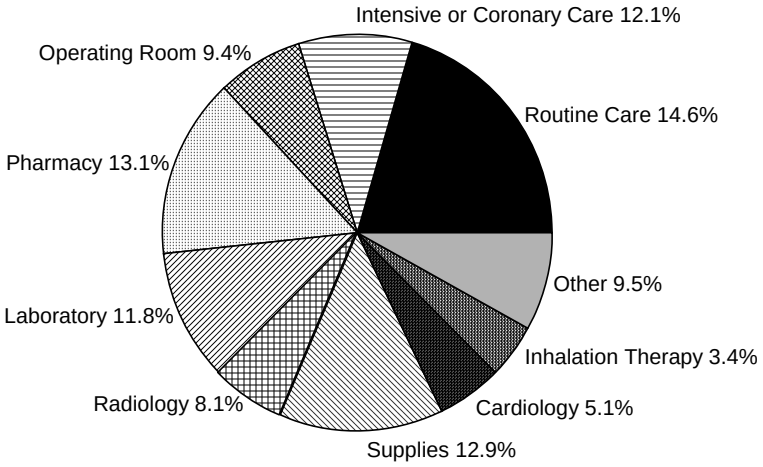
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Center for Strategic Planning. See Table 5.11.

Figure 5.8
Percent Distribution of Medicare Short-Stay Hospital Charges, by Type of Service: Calendar Years 1983 and 2010



1983

(Total Charges = $54.8 Billion)



2010

(Total Charges = $495.5 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 Center for Strategic Planning. See Table 5.8.