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 1972-2011

	Discharges		Total Days of Care		
Type of Entitlement and Year	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
2011 [4]	11,493	318	61,852	1,712	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 1972-2011

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[1]	3,268	1,805	26.1	36.0
495,513	40,152	116,852	9,588	3,285	1,752	23.6	35.3
484,479	42,156	116,720	10,347	3,230	1,887	24.1	34.3

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 1972-2011

Type of Entitlement and Year	Discharges: Number in Thousands	Discharges: Rate per 1,000 HI Enrollees	Total Days of Care: Number in Thousands	Total Days of Care: Rate per 1,000 HI Enrollees	Total Days of Care: 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
2011 [4]	8,998	307	47,698	1,628	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 1972-2011

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[1]	3,186	1,836	26.1	35.3
394,074	40,314	92,450	9,554	3,193	1,775	23.5	34.5
381,109	42,353	91,679	10,357	3,129	1,922	24.1	33.4

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 1972-2011

	Discharges		Total Days of Care		
Type of Entitlement and Year	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
2011 [4]	2,494	365	14,155	2,072	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 Office of Information Products and Data Analytics.

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 1972-2011

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
103,370	41,443	25,041	10,309	3,666	1,769	24.2	37.8

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 1985-2011

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]	
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
2011	11,492,668	151,606	1.3	1,216,932	2.0	8.0	662,760	4,372	545	18	8,678,954

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 1985-2011

	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
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
2011	8,998,424	89,948	1.0	731,633	1.5	8.1	378,608	4,209	517	13	6,943,588

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 1985-2011

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
2011	2,494,244	61,658	2.5	485,299	3.4	7.9	284,151	4,609	586	42	1,735,366

[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 Information Products and Data Analytics.

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 2011

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	11,493	318	61,852	100.0	5.4	$116,720	100.0	$10,347	$1,887
Age									
Under 65 Years	2,433	356	13,805	22.3	5.7	24,374	20.9	10,291	1,766
65-69 Years	1,816	198	9,605	15.5	5.3	20,272	17.4	11,382	2,111
70-74 Years	1,618	243	8,369	13.5	5.2	17,377	14.9	10,950	2,076
75-79 Years	1,622	320	8,639	14.0	5.3	17,163	14.7	10,763	1,987
80-84 Years	1,650	408	8,926	14.4	5.4	16,483	14.1	10,144	1,847
85 Years or Over	2,354	543	12,509	20.2	5.3	21,051	18.0	9,054	1,683
Sex									
Male	5,124	310	28,058	45.4	5.5	55,232	47.3	10,999	1,968
Female	6,368	325	33,794	54.6	5.3	61,488	52.7	9,823	1,820
Race[4]									
White	9,320	311	49,102	79.4	5.3	92,485	79.2	10,096	1,884
Other	2,135	356	12,543	20.3	5.9	23,821	20.4	11,437	1,899
Type of Entitlement									
Aged[5]	8,998	307	47,698	77.1	5.3	91,679	78.5	10,357	1,922
Disabled[6]	2,494	365	14,155	22.9	5.7	25,041	21.5	10,309	1,769
Discharge Status									
Alive	11,129	n/a	59,120	95.6	5.3	109,376	93.7	10,017	1,850
Dead	364	n/a	2,732	4.4	7.5	7,344	6.3	20,293	2,688

[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 Information Products and Data Analytics.

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 2011

	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]
All Areas[4]	11,492,668	318	61,852,214	1,712	5.4	$116,719,998	$10,347	$3,230
United States	11,449,114	323	61,540,679	1,734	5.4	116,448,523	10,362	3,281
Northeast	2,256,482	338	13,349,847	1,997	5.9	25,294,262	11,386	3,784
Midwest	2,819,164	340	14,405,032	1,740	5.1	27,093,100	9,745	3,272
South	4,714,969	334	25,253,386	1,791	5.4	44,074,167	9,523	3,126
West	1,658,499	258	8,532,414	1,328	5.1	19,986,996	12,426	3,110
New England	622,362	307	3,309,658	1,634	5.3	6,780,579	11,076	3,348
Connecticut	152,419	331	880,615	1,910	5.8	1,773,539	11,784	3,846
Maine	57,276	246	293,671	1,263	5.1	553,002	9,874	2,379
Massachusetts	303,554	341	1,543,656	1,733	5.1	3,264,496	10,932	3,665
New Hampshire	51,825	243	273,173	1,278	5.3	536,409	10,500	2,510
Rhode Island	36,896	310	209,699	1,763	5.7	383,221	10,647	3,222
Vermont	20,392	189	108,844	1,008	5.3	269,910	13,483	2,501
Middle Atlantic	1,634,120	351	10,040,189	2,155	6.1	18,513,683	11,504	3,973
New Jersey	398,043	344	2,344,597	2,023	5.9	4,357,504	11,170	3,760
New York	720,723	348	4,863,873	2,349	6.7	9,196,446	12,941	4,442
Pennsylvania	515,354	360	2,831,719	1,979	5.5	4,959,734	9,753	3,466
East North Central	2,019,257	353	10,412,886	1,820	5.2	19,536,874	9,773	3,415
Illinois	609,127	364	3,133,027	1,871	5.1	5,894,741	9,829	3,521
Indiana	283,230	334	1,469,976	1,736	5.2	2,621,784	9,314	3,096
Michigan	472,055	369	2,527,096	1,975	5.4	4,869,313	10,386	3,806
Ohio	475,640	374	2,404,011	1,892	5.1	4,340,314	9,203	3,416
Wisconsin	179,205	276	878,776	1,354	4.9	1,810,723	10,207	2,789
West North Central	799,907	312	3,992,146	1,559	5.0	7,556,225	9,675	2,952
Iowa	120,389	265	606,532	1,335	5.0	1,103,625	9,450	2,430
Kansas	111,083	286	569,432	1,468	5.1	1,002,644	9,265	2,584
Minnesota	168,284	378	787,238	1,767	4.7	1,761,724	10,675	3,955
Missouri	276,585	346	1,416,822	1,771	5.1	2,474,737	9,144	3,093
Nebraska	66,561	267	327,982	1,313	4.9	638,507	9,796	2,557
North Dakota	24,337	248	122,070	1,244	5.0	248,525	10,617	2,533
South Dakota	32,668	263	162,070	1,304	5.0	326,464	10,288	2,627
South Atlantic	2,487,719	330	13,345,341	1,772	5.4	24,202,722	9,900	3,214
Delaware	43,135	294	240,437	1,636	5.6	490,136	11,493	3,336
District of Columbia	25,628	366	156,722	2,238	6.1	330,356	13,162	4,718
Florida	825,436	349	4,463,257	1,885	5.4	7,406,758	9,129	3,127
Georgia	310,133	315	1,669,708	1,699	5.4	2,865,749	9,425	2,915
Maryland	263,614	357	1,360,277	1,841	5.2	3,407,091	13,194	4,610
North Carolina	396,036	315	2,095,474	1,664	5.3	3,943,420	10,128	3,132
South Carolina	202,765	305	1,146,997	1,727	5.7	1,968,582	9,878	2,963
Virginia	310,305	310	1,620,175	1,620	5.2	2,842,163	9,295	2,842
West Virginia	110,667	371	592,294	1,985	5.4	948,467	8,710	3,179

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 2011

	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	920,560	356	4,936,461	1,909	5.4	$7,739,261	$8,555	$2,994
Alabama	243,451	357	1,298,442	1,907	5.3	1,910,397	8,022	2,805
Kentucky	233,016	365	1,206,941	1,890	5.2	2,058,202	8,910	3,224
Mississippi	163,727	359	937,827	2,054	5.7	1,415,073	8,784	3,099
Tennessee	280,366	347	1,493,251	1,846	5.3	2,355,589	8,584	2,911
West South Central	1,306,690	328	6,971,584	1,749	5.3	12,132,183	9,488	3,043
Arkansas	148,459	322	785,607	1,704	5.3	1,251,679	8,560	2,715
Louisiana	186,203	349	1,038,640	1,948	5.6	1,638,256	8,955	3,073
Oklahoma	178,208	342	926,027	1,775	5.2	1,577,036	9,051	3,022
Texas	793,820	321	4,221,310	1,709	5.3	7,665,212	9,887	3,103
Mountain	532,268	253	2,566,671	1,220	4.8	5,483,237	10,603	2,607
Arizona	171,320	283	815,942	1,348	4.8	1,795,550	10,844	2,967
Colorado	108,550	256	506,552	1,193	4.7	1,083,701	10,179	2,553
Idaho	32,959	194	148,910	878	4.5	341,197	10,500	2,013
Montana	29,774	202	138,574	942	4.7	289,068	10,115	1,966
Nevada	71,593	278	404,341	1,572	5.6	777,324	11,164	3,022
New Mexico	55,921	239	277,823	1,188	5.0	563,554	10,319	2,411
Utah	45,116	238	192,936	1,020	4.3	427,541	9,847	2,259
Wyoming	17,035	221	81,593	1,060	4.8	205,303	12,540	2,668
Pacific	1,126,231	261	5,965,743	1,380	5.3	14,503,759	13,290	3,355
Alaska	14,339	211	76,539	1,126	5.3	216,371	15,517	3,183
California	832,432	277	4,538,070	1,508	5.5	11,170,793	13,930	3,712
Hawaii	22,819	188	147,059	1,211	6.4	293,002	13,295	2,413
Oregon	78,799	208	361,477	955	4.6	884,150	11,352	2,337
Washington	177,842	238	842,598	1,130	4.7	1,939,441	11,047	2,601
Outlying Areas [5]	43,554	68	311,535	487	7.2	271,475	6,326	425

[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 listed 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.

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 Information Products and Data Analytics.

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 2011

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	---	11,492,668	318	61,852,214	5.4	$116,719,998	$10,347	$1,887
Leading Diagnoses [5]	---	6,029,793	167	32,986,252	5.5	65,176,058	10,972	1,976
Infectious and Parasitic Diseases (MDC 1)	001-139	696,502	19	5,247,144	7.5	10,304,646	14,953	1,964
Septicemia	038	532,830	15	4,255,933	8.0	8,727,201	16,508	2,051
Neoplasms (MDC 2)	140-239	491,237	14	3,227,928	6.6	7,167,271	14,761	2,220
Malignant Neoplasms	140-208,230-234	424,721	12	2,882,978	6.8	6,342,756	15,100	2,200
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	58,432	2	504,024	8.6	1,040,117	17,883	2,064
Malignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	71,765	2	492,831	6.9	1,047,400	14,663	2,125
Malignant Neoplasm of Breast	174-175,198.81	20,128	1	53,625	2.7	126,296	6,573	2,355
Benign Neoplasms	210-229	43,653	1	214,003	4.9	547,805	12,750	2,560
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	468,076	13	2,111,665	4.5	3,347,048	7,291	1,585
Diabetes Mellitus	250	181,924	5	975,967	5.4	1,608,523	9,011	1,648
Volume Depletion	276.5	84,581	2	306,252	3.6	394,860	4,755	1,289
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	176,640	5	772,882	4.4	1,283,485	7,456	1,661
Mental Disorders (MDC 5)	290-319	480,782	13	4,317,895	9.0	3,301,125	7,022	765
Psychoses	290-299	413,324	11	3,922,256	9.5	2,980,746	7,374	760
Alcohol Dependence Syndrome	303	15,546	(6)	88,749	5.7	73,680	4,846	830
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	277,942	8	1,608,537	5.8	2,275,545	8,337	1,415

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 2011

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	2,614,263	72	12,314,663	4.7	$29,081,570	$11,346	$2,362
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	1,733,270	48	8,325,441	4.8	20,331,987	11,950	2,442
Acute Myocardial Infarction	410	268,848	7	1,388,039	5.2	3,880,980	14,499	2,796
Coronary Atherosclerosis	414.0	264,557	7	1,040,173	3.9	3,748,688	15,045	3,604
Other Ischemic Heart Disease	411-413, 414.1-414.9	24,194	1	70,494	2.9	279,092	11,861	3,959
Cardiac Dysrhythmias	427	397,974	11	1,496,903	3.8	3,238,110	8,253	2,163
Congestive Heart Failure	428.0	145,808	4	681,939	4.7	1,240,251	8,651	1,819
Cerebrovascular Disease	430-438	467,169	13	2,032,418	4.4	4,100,710	8,953	2,018
Diseases of the Respiratory System (MDC 8)	460-519	1,396,094	39	7,824,592	5.6	12,343,074	8,903	1,577
Acute Bronchitis and Bronchocolitis	466	28,438	1	103,803	3.7	124,443	4,422	1,199
Pneumonia	480-486	476,151	13	2,672,578	5.6	3,798,360	8,018	1,421
Asthma	493	93,913	3	424,087	4.5	548,644	5,908	1,294
Diseases of the Digestive System (MDC 9)	520-579	1,125,609	31	5,909,679	5.3	10,205,981	9,263	1,727
Appendicitis	540-543	20,246	1	92,894	4.6	195,938	9,759	2,109
Non Infectious Enteritis and Colitis	555-558	97,449	3	495,938	5.1	760,045	8,054	1,533
Diverticula of Intestine	562	118,131	3	607,841	5.1	954,969	8,228	1,571
Cholelithiasis	574	90,250	2	456,111	5.1	918,487	10,368	2,014
Diseases of the Genitourinary System (MDC 10)	580-629	731,427	20	3,373,107	4.6	4,875,244	6,771	1,445
Calculus of Kidney and Ureter	592	33,968	1	103,057	3.0	221,806	6,704	2,152

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 2011

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	229,800	6	1,208,333	5.3	$1,548,585	$6,796	$1,282
Cellulitis and Abscess	681-682	189,699	5	930,516	4.9	1,147,869	6,094	1,234
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	811,974	22	2,988,359	3.7	10,176,298	12,755	3,405
Osteoarthrosis and Allied Disorders	715	410,256	11	1,320,981	3.2	4,962,645	12,209	3,757
Intervertebral Disc Disorders	722	81,913	2	276,861	3.4	1,210,899	15,158	4,374
Congenital Anomalies (MDC 14)	740-759	10,878	(6)	52,423	4.8	222,583	20,847	4,246
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	593,390	16	1,765,593	3.0	2,708,130	4,862	1,534
Injury and Poisoning (MDC 17)	800-999	1,087,333	30	5,973,356	5.5	13,334,104	12,451	2,232
Fractures, All Sites	800-829	427,918	12	2,252,534	5.3	4,803,682	11,350	2,133
Fracture of Neck of Femur	820	195,961	5	1,110,738	5.7	2,554,401	13,070	2,300
Poisoning by Drugs, Medicinal and Biological Substances	960-989	64,443	2	245,054	3.8	420,005	6,614	1,714
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V91	279,378	8	3,081,583	11.0	4,445,428	16,133	1,443

[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 Office of Information Products and Data Analytics.

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 2011

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	---	6,748,109	187	41,398,836	6.1	$88,682,465	$13,356	$2,142
Leading Procedures [5]	---	2,827,337	78	15,953,561	5.6	33,588,936	12,046	2,105
Operations on the Nervous System (MPC 1)	01-05	158,139	4	993,590	6.3	2,459,055	15,824	2,475
Spinal Tap	03.31	37,153	1	244,530	6.6	334,939	9,124	1,370
Operations on the Endocrine System (MPC 2)	06-07	21,608	1	82,138	3.8	230,519	10,889	2,806
Operations on the Eye (MPC 3)	08-16	7,185	(6)	34,027	4.7	66,962	9,569	1,968
Operations on the Ear (MPC 4)	18-20	2,305	(6)	12,976	5.6	25,237	11,373	1,945
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	25,651	1	128,201	5.0	233,335	9,369	1,820
Operations on the Respiratory System (MPC 6)	30-34	264,839	7	2,574,935	9.7	5,187,864	19,717	2,015
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	56,402	2	487,898	8.7	665,859	11,892	1,365
Operations on the Cardiovascular System (MPC 7)	35-39	1,402,384	39	8,863,119	6.3	22,202,798	16,086	2,505
Removal of Coronary Artery Obstruction	36.0	1,675	(6)	5,705	3.4	24,422	15,001	4,281
Coronary Artery Bypass Graft	36.1	69,470	2	672,745	9.7	2,359,778	34,077	3,508
Cardiac Catheterization	37.21-37.23	203,712	6	831,756	4.1	1,572,163	7,840	1,890
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	104,570	3	532,802	5.1	1,735,084	16,787	3,257
Hemodialysis	39.95	255,910	7	1,245,927	4.9	2,413,130	9,663	1,937
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	45,676	1	362,387	7.9	808,896	18,120	2,232

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 2011

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	1,050,598	29	7,245,312	6.9	$12,733,345	$12,298	$1,757
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	282,032	8	1,510,442	5.4	1,921,527	6,921	1,272
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	91,164	3	494,104	5.4	591,325	6,593	1,197
Partial Excision of Large Intestine	45.7	60,192	2	690,083	11.5	1,520,383	25,333	2,203
Appendectomy, Excluding Incidental	47.0	18,344	1	81,929	4.5	185,457	10,196	2,264
Cholecystectomy	51.2	94,206	3	558,085	5.9	1,183,111	12,759	2,120
Lysis of Peritoneal Adhesions	54.5	30,116	1	292,029	9.7	580,188	19,415	1,987
Operations on the Urinary System (MPC 10)	55-59	200,858	6	1,176,947	5.9	2,295,900	11,608	1,951
Cystoscopy with or Without Biopsy	57.31-57.33	10,942	(6)	73,753	6.7	91,036	8,418	1,234
Operations on the Male Genital Organs (MPC 11)[7]	60-64	60,041	4	201,101	3.3	436,623	7,558	2,171
Prostatectomy	60.2-60.6	51,732	3	154,553	3.0	350,502	7,050	2,268
Operations on the Female Genital Organs (MPC 12)[8]	65-71	73,235	4	238,634	3.3	576,169	8,132	2,414
Unilateral Oophorectomy	65.3-65.6	10,229	1	41,657	4.1	93,764	9,329	2,251
Hysterectomy	68.3-68.7,68.9	37,623	2	113,156	3.0	293,561	7,985	2,594
Obstetrical Procedures (MPC 13)[8]	72-75	15,434	1	50,113	3.2	70,950	4,649	1,416
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	420	(6)	1,203	2.9	1,182	2,841	983
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	13,128	1	53,855	4.1	83,255	6,434	1,546
Repair of Current Obstetric Laceration	75.5-75.6	1,505	(6)	3,939	2.6	4,793	3,206	1,217
Operations on the Musculoskeletal System (MPC 14)	76-84	1,108,821	31	5,365,949	4.8	15,965,019	14,540	2,975
Partial Excision of Bone	76.2-76.3,77.6-77.8	18,112	1	148,745	8.2	309,461	17,350	2,080
Reduction of Facial Fracture	76.7,79.0-79.3	186,850	5	1,014,855	5.4	2,303,485	12,422	2,270
Open Reduction of Fracture with Internal Fixation	79.3	127,531	4	690,121	5.4	1,589,062	12,563	2,303
Excision or Destruction of Intervertebral Disc	80.5	19,066	1	54,076	2.8	151,185	8,217	2,796
Total Hip Replacement	81.51	125,964	3	441,596	3.5	1,585,235	12,662	3,590
Total Knee Replacement	81.54	272,734	8	897,065	3.3	3,343,204	12,371	3,727

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 2011

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	216,242	6	1,507,856	7.0	$2,441,918	$11,490	$1,619
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	71,663	2	653,919	9.1	1,086,696	15,349	1,662
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,755,255	49	11,196,341	6.4	17,617,082	10,187	1,573
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	82,088	2	370,219	4.5	595,873	7,396	1,610
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	41,124	1	189,858	4.6	311,589	7,726	1,641
Diagnostic Ultrasound	88.7	153,936	4	750,281	4.9	1,079,813	7,130	1,439
Respiratory Therapy	93.9,96.7	360,589	10	2,900,565	8.0	5,934,295	16,637	2,046
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	38,736	1	265,807	6.9	520,499	13,532	1,958
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	32,406	1	202,515	6.2	402,794	12,628	1,989

[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 Information Products and Data Analytics.

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 2011

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	----	11,492,668	61,845,214	5.4	$484,479,451	$116,719,998	$10,566	$1,887
Leading DRGs	----	7,043,922	36,193,442	5.1	235,166,231	56,706,722	8,361	1,567
057	Degenerative Nervous System Disorders without MCC	67,707	581,836	8.6	1,751,915	540,424	8,173	929
064	Intracranial Hemorrhage Or Cerebral Infarction with MCC	69,741	463,828	6.7	3,463,114	863,482	12,575	1,862
065	Intracranial Hemorrhage Or Cerebral Infarction with CC	112,199	502,809	4.5	3,457,861	772,738	7,014	1,537
066	Intracranial Hemorrhage Or Cerebral Infarction without CC/MCC	63,021	192,048	3.0	1,482,472	282,654	4,611	1,472
069	Transient Ischemia	92,116	237,659	2.6	1,969,782	339,599	4,027	1,429
101	Seizures without MCC	55,806	181,972	3.3	1,225,509	256,367	4,762	1,409
176	Pulmonary Embolism without MCC	40,387	183,966	4.6	1,088,379	246,177	6,297	1,338
177	Respiratory Infections & Inflammations with MCC	73,185	596,942	8.2	3,741,298	941,611	13,048	1,577
178	Respiratory Infections & Inflammations with CC	62,305	394,536	6.3	2,227,767	557,944	9,104	1,414
189	Pulmonary Edema & Respiratory Failure	102,383	528,344	5.2	3,307,359	801,288	7,993	1,517
190	Chronic Obstructive Pulmonary Disease with MCC	153,425	803,491	5.2	4,653,479	1,078,017	7,169	1,342
191	Chronic Obstructive Pulmonary Disease with CC	151,545	654,927	4.3	3,693,502	847,345	5,728	1,294
192	Chronic Obstructive Pulmonary Disease without CC/MCC	116,303	395,613	3.4	2,111,622	445,179	3,945	1,125
193	Simple Pneumonia & Pleurisy with MCC	134,385	838,789	6.2	5,065,854	1,203,223	9,112	1,434
194	Simple Pneumonia & Pleurisy with CC	199,727	936,708	4.7	5,101,203	1,175,024	6,005	1,254
195	Simple Pneumonia & Pleurisy without CC/MCC	83,077	291,722	3.5	1,509,590	307,912	3,794	1,056
202	Bronchitis & Asthma with CC/MCC	41,085	163,098	4.0	938,383	198,609	4,984	1,218
208	Respiratory System Diagnosis with Ventilator Support <96 Hours	73,663	512,556	7.0	4,617,720	1,099,932	15,289	2,146

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 2011

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
247[3]	Perc Cardiovasc Proc with Drug-Eluting Stent without MCC	118,347	279,796	2.4	$7,387,845	$1,271,187	$12,408	$4,543
253[3]	Other Vascular Procedures with CC	42,085	246,741	5.9	2,902,006	666,305	16,494	2,700
280	Acute Myocardial Infarction, Discharged Alive with MCC	69,785	436,564	6.3	3,204,641	797,991	11,595	1,828
281	Acute Myocardial Infarction, Discharged Alive with CC	48,114	190,736	4.0	1,441,154	331,721	7,021	1,739
287	Circulatory Disorders Except AMI, with Card Cath without MCC	118,625	363,492	3.1	4,046,083	729,613	6,483	2,007
291	Heart Failure & Shock with MCC	190,872	1,144,405	6.0	7,288,270	1,802,419	9,632	1,575
292	Heart Failure & Shock with CC	222,813	1,017,077	4.6	5,619,223	1,376,179	6,328	1,353
293	Heart Failure & Shock without CC/MCC	92,346	288,764	3.1	1,597,599	349,515	3,910	1,210
300	Peripheral Vascular Disorders with CC	46,563	214,075	4.6	1,125,992	273,008	6,011	1,275
308	Cardiac Arrhythmia & Conduction Disorders with MCC	68,195	341,620	5.0	2,182,238	526,937	7,873	1,542
309	Cardiac Arrhythmia & Conduction Disorders with CC	108,480	372,206	3.4	2,319,339	519,699	4,907	1,396
310	Cardiac Arrhythmia & Conduction Disorders without CC/MCC	118,378	273,585	2.3	1,788,878	330,565	2,905	1,208
312	Syncope & Collapse	153,289	433,692	2.8	3,101,608	584,968	4,193	1,349
313	Chest Pain	143,715	288,009	2.0	2,425,567	380,851	3,037	1,322
314	Other Circulatory System Diagnoses with MCC	57,934	390,327	6.7	2,836,426	703,228	12,707	1,802
329[3]	Major Small & Large Bowel Procedures with MCC	44,113	654,926	14.8	5,898,999	1,569,793	36,381	2,397
330[3]	Major Small & Large Bowel Procedures with CC	57,305	494,036	8.6	3,788,710	934,315	16,838	1,891
377	G.I. Hemorrhage with MCC	56,219	349,988	6.2	2,576,965	649,140	11,780	1,855
378	G.I. Hemorrhage with CC	144,583	572,952	4.0	3,774,914	868,850	6,171	1,516
379	G.I. Hemorrhage without CC/MCC	41,760	118,200	2.8	765,398	157,722	3,986	1,334
389	G.I. Obstruction with CC	54,882	248,848	4.5	1,330,797	300,266	5,614	1,207
390	G.I. Obstruction without CC/MCC	40,268	131,016	3.3	693,950	133,185	3,436	1,017

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 2011

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
391	Esophagitis, Gastroent & Misc Digest Disorders with MCC	51,328	260,155	5.1	$1,639,424	$378,358	$7,688	$1,454
392	Esophagitis, Gastroent & Misc Digest Disorders without MCC	256,434	857,858	3.3	5,194,395	972,135	4,139	1,133
394	Other Digestive System Diagnoses with CC	49,084	215,242	4.4	1,300,368	295,595	6,306	1,373
460[3]	Spinal Fusion Except Cervical without MCC	69,530	252,160	3.6	6,532,401	1,633,720	24,897	6,479
470[3]	Major Joint Replacement Or Reattachment Of Lower Extremity without MCC	427,996	1,478,699	3.5	21,709,252	5,125,941	12,582	3,467
481[3]	Hip & Femur Procedures Except Major Joint with CC	82,152	435,091	5.3	4,024,509	942,656	11,611	2,167
491[3]	Back & Neck Proc Exc Spinal Fusion without CC/MCC	39,596	81,606	2.1	1,191,608	207,478	5,721	2,542
552	Medical Back Problems without MCC	72,043	272,163	3.8	1,618,313	318,258	4,831	1,169
603	Cellulitis without MCC	146,711	630,837	4.3	2,975,224	694,781	4,874	1,101
638	Diabetes with CC	55,869	212,062	3.8	1,199,330	274,400	5,085	1,294
640	Nutritional & Misc Metabolic Disorders with MCC	64,597	300,301	4.6	1,835,548	469,997	7,506	1,565
641	Nutritional & Misc Metabolic Disorders without MCC	155,795	527,056	3.4	2,801,228	611,513	4,049	1,160
682	Renal Failure with MCC	108,255	694,602	6.4	4,329,096	1,137,557	10,751	1,638
683	Renal Failure with CC	157,873	726,817	4.6	3,988,393	962,751	6,243	1,325
689	Kidney & Urinary Tract Infections with MCC	74,459	406,555	5.5	2,159,624	540,820	7,368	1,330
690	Kidney & Urinary Tract Infections without MCC	210,231	810,376	3.9	4,198,186	936,877	4,557	1,156
812	Red Blood Cell Disorders without MCC	101,902	353,316	3.5	2,123,060	471,399	4,861	1,334
853[3]	Infectious & Parasitic Diseases with O.R. Procedure with MCC	47,069	692,359	14.7	6,663,738	1,779,326	38,858	2,570

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 2011

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
871	Septicemia Or Severe Sepsis without MV 96+ Hours with MCC	331,889	2,289,784	6.9	$16,576,890	$4,150,421	$12,742	$1,813
872	Septicemia Or Severe Sepsis without MV 96+ Hours without MCC	118,974	596,362	5.0	3,388,333	818,427	7,021	1,372
884	Organic Disturbances & Mental Retardation	40,411	379,580	9.4	1,051,754	328,086	8,299	864
885	Psychoses	326,352	3,290,603	10.1	8,144,397	2,401,663	7,676	730
897	Alcohol/Drug Abuse Or Dependence without Rehabilitation Therapy without MCC	49,892	219,115	4.4	769,465	195,511	4,169	892
945	Rehabilitation with CC/MCC	174,421	2,269,128	13.0	7,829,483	3,036,369	17,748	1,338
946	Rehabilitation without CC/MCC	42,062	436,043	10.4	1,329,559	573,882	14,023	1,316
948	Signs & Symptoms without MCC	58,266	193,673	3.3	1,089,211	233,785	4,157	1,207
All Other	----	4,448,746	25,651,772	5.8	249,313,219	60,013,275	14,072	2,340

[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 2011.

[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 28.0 and 29.0, definitions Manual*. CC is complications and comorbidities. MCC is major complications and comorbidities. Card is cardiac. Cath is catheterization. AMI is acute myocardial infarction. G.I. is gastrointestinal. Proc is procedure. O.R. is operating room. MV is mechanical ventilation. Perc is percutaneous.

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 Information Products and Data Analytics.

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 2011

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	11,492,668	8,974,200	4,212,520	11,472,778	3,959,713	11,410,353
1-8 Days	9,688,228	7,476,394	3,302,859	9,671,543	3,047,362	9,620,561
9-20 Days	1,539,908	1,274,570	753,371	1,537,428	746,072	1,529,203
21-30 Days	180,713	152,279	102,997	180,292	109,551	178,582
31-40 Days	46,922	39,366	29,950	46,794	31,833	46,157
41-50 Days	18,064	15,295	11,490	17,990	12,381	17,683
51-60 Days	7,957	6,753	5,190	7,920	5,495	7,740
61-90 Days	7,521	6,559	4,703	7,478	4,912	7,245
91 Days or More	3,355	2,984	1,960	3,333	2,107	3,182
			Percent of Total Discharges [3]			
Total	100.0	78.1	36.7	99.8	34.5	99.3
1-8 Days	100.0	77.2	34.1	99.8	31.5	99.3
9-20 Days	100.0	82.8	48.9	99.8	48.4	99.3
21-30 Days	100.0	84.3	57.0	99.8	60.6	98.8
31-40 Days	100.0	83.9	63.8	99.7	67.8	98.4
41-50 Days	100.0	84.7	63.6	99.6	68.5	97.9
51-60 Days	100.0	84.9	65.2	99.5	69.1	97.3
61-90 Days	100.0	87.2	62.5	99.4	65.3	96.3
91 Days or More	100.0	88.9	58.4	99.3	62.8	94.8
			Total Charges in Thousands			
Total	$484,479,451	$69,457,807	$59,278,057	$355,765,638	$46,447,000	$63,277,031
1-8 Days	298,219,033	38,626,181	27,947,152	231,647,369	33,637,220	32,866,839
9-20 Days	126,636,637	21,186,846	19,585,032	85,865,080	9,481,669	19,520,013
21-30 Days	30,978,799	4,956,129	5,683,811	20,338,896	1,886,364	5,517,423
31-40 Days	12,299,039	1,831,507	2,492,266	7,975,275	689,806	2,309,894
41-50 Days	6,102,744	944,864	1,285,000	3,872,883	321,812	1,168,313
51-60 Days	3,321,395	523,859	744,932	2,052,605	162,926	625,949
61-90 Days	3,945,820	709,456	874,994	2,361,370	175,293	741,575
91 Days or More	2,975,981	678,960	664,865	1,652,155	91,908	527,021

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 2011

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
Number of Discharges					
11,393,218	10,083,821	9,245,281	8,437,893	5,498,017	10,761,960
9,599,345	8,468,215	7,718,715	7,027,180	4,369,115	9,019,647
1,531,073	1,377,420	1,304,775	1,197,713	949,651	1,487,231
179,637	162,199	152,276	142,794	120,302	174,472
46,630	42,806	39,679	39,261	33,296	45,358
17,904	16,361	14,971	15,179	12,608	17,328
7,874	7,155	6,468	6,703	5,676	7,634
7,438	6,672	5,865	6,276	5,150	7,158
3,317	2,993	2,532	2,787	2,219	3,132
Percent of Total Discharges [3]					
99.1	87.7	80.4	73.4	47.8	93.6
99.1	87.4	79.7	72.5	45.1	93.1
99.4	89.4	84.7	77.8	61.7	96.6
99.4	89.8	84.3	79.0	66.6	96.5
99.4	91.2	84.6	83.7	71.0	96.7
99.1	90.6	82.9	84.0	69.8	95.9
99.0	89.9	81.3	84.2	71.3	95.9
98.9	88.7	78.0	83.4	68.5	95.2
98.9	89.2	75.5	83.1	66.1	93.4
Total Charges in Thousands					
$58,175,374	$38,642,021	$59,940,225	$24,066,798	$17,090,235	$48,126,950
35,895,862	26,661,743	45,171,237	19,062,923	6,955,651	31,395,890
15,444,010	8,831,020	10,750,679	4,008,409	6,052,683	11,776,594
3,630,347	1,809,467	2,199,818	607,768	1,952,600	2,735,106
1,433,066	655,237	838,447	197,667	863,830	987,325
698,004	293,155	391,219	83,492	442,214	474,670
366,805	148,290	204,688	40,008	245,923	258,012
424,560	155,425	226,940	42,525	304,063	290,984
282,716	87,680	157,193	24,002	273,267	208,365

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 2011

		Type of Accommodation		Type of Ancillary Service		
Total Days of Care	All Services	Routine Room and Board	Intensive/ Coronary Care	Total Ancillary	Operating Room	Pharmacy
			Percent of Total Charges [4]			
Total	100.0	14.3	12.2	73.4	9.6	13.1
1-8 Days	100.0	13.0	9.4	77.7	11.3	11.0
9-20 Days	100.0	16.7	15.5	67.8	7.5	15.4
21-30 Days	100.0	16.0	18.3	65.7	6.1	17.8
31-40 Days	100.0	14.9	20.3	64.8	5.6	18.8
41-50 Days	100.0	15.5	21.1	63.5	5.3	19.1
51-60 Days	100.0	15.8	22.4	61.8	4.9	18.8
61-90 Days	100.0	18.0	22.2	59.8	4.4	18.8
91 Days or More	100.0	22.8	22.3	55.5	3.1	17.7
			Average Total Charge Per Discharge			
Total	$42,156	$7,740	$14,072	$31,010	$11,730	$5,546
1-8 Days	30,782	5,166	8,462	23,951	11,038	3,416
9-20 Days	82,236	16,623	25,997	55,850	12,709	12,765
21-30 Days	171,425	32,546	55,184	112,811	17,219	30,896
31-40 Days	262,117	46,525	83,214	170,434	21,670	50,044
41-50 Days	337,840	61,776	111,836	215,280	25,992	66,070
51-60 Days	417,418	77,574	143,532	259,167	29,650	80,872
61-90 Days	524,640	108,165	186,050	315,776	35,687	102,357
91 Days or More	887,029	227,534	339,217	495,696	43,620	165,626

[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 Information Products and Data Analytics.

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 2011

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
Percent of Total Charges [4]					
12.0	8.0	12.4	5.0	3.5	9.9
12.0	8.9	15.1	6.4	2.3	10.5
12.2	7.0	8.5	3.2	4.8	9.3
11.7	5.8	7.1	2.0	6.3	8.8
11.7	5.3	6.8	1.6	7.0	8.0
11.4	4.8	6.4	1.4	7.2	7.8
11.0	4.5	6.2	1.2	7.4	7.8
10.8	3.9	5.8	1.1	7.7	7.4
9.5	2.9	5.3	0.8	9.2	7.0
Average Total Charge Per Discharge					
$5,106	$3,832	$6,483	$2,852	$3,108	$4,472
3,739	3,148	5,852	2,713	1,592	3,481
10,087	6,411	8,239	3,347	6,374	7,918
20,209	11,156	14,446	4,256	16,231	15,676
30,733	15,307	21,131	5,035	25,944	21,767
38,986	17,918	26,132	5,501	35,074	27,393
46,584	20,725	31,646	5,969	43,327	33,798
57,080	23,295	38,694	6,776	59,041	40,652
85,233	29,295	62,083	8,612	123,149	66,528

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 2011

Total Days of Care	Discharges [1]		Total Days of Care			Program Payments			
	Number	Percent	Number	Percent	Per Dis-charge	Amount in Thousands	Percent	Per Dis-charge [2]	Per Day
Total	11,492,668	100.0	61,852,214	100.0	5.4	$116,719,998	100.0	$10,347	$1,887
1 Day	1,569,693	13.7	1,569,693	2.5	1.0	9,521,367	8.2	6,552	6,066
2 Days	1,793,063	15.6	3,586,126	5.8	2.0	11,625,240	10.0	6,623	3,242
3 Days	2,022,473	17.6	6,067,419	9.8	3.0	15,626,319	13.4	7,781	2,575
4 Days	1,437,064	12.5	5,748,256	9.3	4.0	11,986,037	10.3	8,390	2,085
5 Days	1,036,176	9.0	5,180,880	8.4	5.0	9,533,303	8.2	9,255	1,840
6 Days	778,385	6.8	4,670,310	7.6	6.0	7,920,676	6.8	10,237	1,696
7 Days	609,025	5.3	4,263,175	6.9	7.0	6,806,901	5.8	11,248	1,597
8 Days	442,349	3.8	3,538,792	5.7	8.0	5,406,462	4.6	12,300	1,528
9 Days	321,939	2.8	2,897,451	4.7	9.0	4,255,246	3.6	13,313	1,469
10 Days	249,421	2.2	2,494,210	4.0	10.0	3,542,566	3.0	14,311	1,420
11 Days	197,141	1.7	2,168,551	3.5	11.0	3,010,795	2.6	15,390	1,388
12 Days	156,758	1.4	1,881,096	3.0	12.0	2,556,562	2.2	16,446	1,359
13 Days	134,384	1.2	1,746,992	2.8	13.0	2,344,333	2.0	17,598	1,342
14 Days	123,775	1.1	1,732,850	2.8	14.0	2,283,244	2.0	18,615	1,318
15 Days	94,845	0.8	1,422,675	2.3	15.0	1,886,051	1.6	20,069	1,326
16 Days	73,200	0.6	1,171,200	1.9	16.0	1,574,221	1.3	21,702	1,344
17 Days	60,688	0.5	1,031,696	1.7	17.0	1,374,458	1.2	22,892	1,332
18 Days	49,892	0.4	898,056	1.5	18.0	1,193,793	1.0	24,193	1,329
19 Days	41,154	0.4	781,926	1.3	19.0	1,055,315	0.9	25,905	1,350
20 Days	36,711	0.3	734,220	1.2	20.0	992,809	0.9	27,355	1,352
21-30 Days	180,713	1.6	4,391,025	7.1	24.3	6,298,578	5.4	35,326	1,434
31-40 Days	46,922	0.4	1,623,667	2.6	34.6	2,578,512	2.2	55,928	1,588
41-50 Days	18,064	0.2	808,550	1.3	44.8	1,317,737	1.1	74,579	1,630
51-60 Days	7,957	0.1	436,939	0.7	54.9	714,989	0.6	92,567	1,636
61-90 Days	7,521	0.1	537,470	0.9	71.5	825,278	0.7	114,638	1,535
91 Days or More	3,355	(3)	468,989	0.8	139.8	489,207	0.4	158,217	1,043

[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 Information Products and Data Analytics.

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 2011

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]	3,492	100.0	11,454,276	100.0	5.4	$116,529,641	100.0	$10,364
1-99 Beds	1,210	34.7	1,043,454	9.1	4.5	7,902,151	6.8	7,735
100-299 Beds	1,392	39.9	4,137,615	36.1	5.1	36,588,892	31.4	9,005
300-499 Beds	552	15.8	3,187,656	27.8	5.5	32,687,686	28.1	10,440
500 Beds or More	338	9.7	3,085,551	26.9	5.9	39,350,912	33.8	12,997
Total Urban Hospitals	2,517	100.0	9,945,031	100.0	5.5	104,971,535	100.0	10,756
1-99 Beds	607	24.1	528,924	5.3	4.5	4,393,392	4.2	8,494
100-299 Beds	1,049	41.7	3,318,799	33.4	5.2	30,202,797	28.8	9,273
300-499 Beds	526	20.9	3,036,361	30.5	5.5	31,263,054	29.8	10,484
500 Beds or More	335	13.3	3,060,947	30.8	5.9	39,112,292	37.3	13,023
Total Rural Hospitals	974	100.0	1,509,245	100.0	4.8	11,558,106	100.0	7,790
1-99 Beds	603	61.9	514,530	34.1	4.5	3,508,759	30.4	6,956
100-299 Beds	342	35.1	818,816	54.3	4.9	6,386,095	55.3	7,923
300-499 Beds	26	2.7	151,295	10.0	5.2	1,424,632	12.3	9,561
500 Beds or More	3	0.3	24,604	1.6	5.3	238,620	2.1	9,831
Total All Hospitals[3]	3,492	100.0	11,454,276	100.0	5.4	116,529,641	100.0	10,364
Voluntary	2,086	59.7	8,211,288	71.7	5.4	84,621,596	72.6	10,493
Proprietary	748	21.4	1,719,476	15.0	5.3	15,500,055	13.3	9,188
Government	658	18.8	1,523,512	13.3	5.5	16,407,990	14.1	11,001
Total Teaching Hospitals[4]	1,067	100.0	5,471,757	100.0	5.7	64,348,053	100.0	11,984
Voluntary	743	69.6	4,297,388	78.5	5.6	49,948,094	77.6	11,837
Proprietary	135	12.7	481,854	8.8	5.5	4,784,392	7.4	10,100
Government	189	17.7	692,515	12.7	6.1	9,615,567	14.9	14,217
Total Non-Teaching Hospitals	2,425	100.0	5,982,519	100.0	5.1	52,181,588	100.0	8,884
Voluntary	1,343	55.4	3,913,900	65.4	5.1	34,673,502	66.4	9,017
Proprietary	613	25.3	1,237,622	20.7	5.2	10,715,663	20.5	8,832
Government	469	19.3	830,997	13.9	5.0	6,792,423	13.0	8,333

[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]This table is based on state of provider as opposed to state of beneficiary. Data for providers in the 50 states and the District of Columbia are included.

[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. Numbers may not add 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 Information Products and Data Analytics.

Table 5.11

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2011

	Hospitals		Discharges		Covered Days of Care		
Type of Hospital	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals [2]	6,172	100.0	12,336,239	100.0	68,971,312	100.0	5.6
Short-Stay Hospitals	3,549	57.5	11,492,668	93.2	59,485,035	86.2	5.2
Hospitals	3,549	57.5	10,974,516	89.0	53,591,290	77.7	4.9
Psychiatric Hospital Units [3]	NA	----	305,193	2.5	3,254,205	4.7	10.7
Rehabilitation Hospital Units [3]	NA	----	212,959	1.7	2,639,540	3.8	12.4
Specialty Hospitals	2,623	42.5	843,571	6.8	9,486,277	13.8	11.2
Childrens	93	1.5	2,791	(4)	20,781	(4)	7.4
Psychiatric	509	8.2	151,926	1.2	2,076,203	3.0	13.7
Rehabilitation	235	3.8	166,623	1.4	2,203,204	3.2	13.2
Long Term	437	7.1	145,408	1.2	3,827,397	5.5	26.3
Critical Access (formerly Short-Stay)	1,331	21.6	376,447	3.1	1,347,360	2.0	3.6
Religious Non-Medical	18	(4)	376	(4)	11,332	(4)	30.1

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 2011

	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]	$506,426,120	100.0	$41,052	$7,343	$128,599,737	100.0	$10,607	$1,865
Short-Stay Hospitals	476,659,976	94.1	41,475	8,013	116,719,998	90.8	10,347	1,962
Hospitals	459,551,762	90.7	41,874	8,575	110,643,772	86.0	10,274	2,065
Psychiatric Hospital Units [3]	7,875,183	1.6	25,804	2,420	2,464,296	1.9	8,203	757
Rehabilitation Hospital Units [3]	9,233,031	1.8	43,356	3,498	3,611,930	2.8	17,130	1,368
Specialty Hospitals	29,766,144	5.9	35,286	3,138	11,879,739	9.2	14,090	1,252
Childrens	216,383	(4)	77,529	10,413	59,513	(4)	21,338	2,864
Psychiatric	2,797,807	0.6	18,416	1,348	1,388,170	1.1	9,139	669
Rehabilitation	4,581,628	0.9	27,497	2,080	2,819,299	2.2	16,939	1,280
Long Term	17,540,027	3.5	120,626	4,583	5,244,323	4.1	36,122	1,370
Critical Access (formerly Short-Stay)	4,624,354	0.9	12,284	3,432	2,364,359	1.8	6,281	1,755
Religious Non-Medical	5,945	(4)	15,811	525	4,075	(4)	10,839	360

[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 1,160 distinct-part psychiatric units and 794 rehabilitation units participating in the Medicare Program during 2011.

[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 Information Products and Data Analytics.

Table 5.12

Short-Stay Hospital (SSH) Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2011

Location and Bedsize of Hospital	Discharges	Hospital Case-Mix Index[1]	Percent of Discharges				
				With Procedures			
			Total	Total	Surgical	Non-Surgical	Without Procedure
Total All Hospitals [2]	11,454,276	1.5770	100.0	58.7	47.0	11.7	41.3
1-99 Beds	1,043,454	1.3436	100.0	46.2	35.0	11.3	53.8
100-299 Beds	4,137,615	1.4761	100.0	54.6	43.6	11.0	45.4
300-499 Beds	3,187,656	1.6056	100.0	60.4	48.7	11.7	39.6
500 Beds or More	3,085,551	1.7617	100.0	66.6	53.8	12.8	33.4
Total Urban Hospitals	9,945,031	1.6139	100.0	60.5	48.8	11.8	39.5
1-99 Beds	528,924	1.4864	100.0	54.5	44.0	10.5	45.5
100-299 Beds	3,318,799	1.5015	100.0	55.8	44.9	10.9	44.2
300-499 Beds	3,036,361	1.6092	100.0	60.6	48.8	11.8	39.4
500 Beds or More	3,060,947	1.7625	100.0	66.6	53.8	12.9	33.4
Total Rural Hospitals	1,509,245	1.3336	100.0	46.5	35.1	11.4	53.5
1-99 Beds	514,530	1.1967	100.0	37.7	25.7	12.1	62.3
100-299 Beds	818,816	1.3731	100.0	49.6	38.4	11.2	50.4
300-499 Beds	151,295	1.5325	100.0	57.0	46.7	10.2	43.0
500 Beds or More	24,604	1.6585	100.0	59.8	50.8	9.0	40.2

[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.

Note: 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 Information Products and Data Analytics.