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 1972-2012

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
2011 [4]	11,493	318	61,852	1,712	5.4
2012 [4]	11,180	303	59,557	1,614	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 1972-2012

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
484,479	42,156	116,720	10,347	3,230	1,887	24.1	34.3
497,280	44,481	115,432	10,658	3,128	1,938	23.2	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 1972-2012

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
2011 [4]	8,998	307	47,698	1,628	5.3
2012 [4]	8,727	291	45,740	1,523	5.2

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 1972-2012

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
381,109	42,353	91,679	10,357	3,129	1,922	24.1	33.4
390,467	44,741	90,460	10,676	3,012	1,978	23.2	32.6

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 1972-2012

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
2011 [4]	2,494	365	14,155	2,072	5.7
2012 [4]	2,452	357	13,817	2,010	5.6

[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 1991-2012 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 & 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 1972-2012

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
106,812	43,556	24,972	10,592	3,633	1,807	23.4	36.6

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 1985-2012

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
2012	11,179,587	141,598	1.3	1,135,732	1.9	8.0	622,693	4,398	548	17	8,536,587

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 1985-2012

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
2011	8,998,424	89,948	1.0	731,633	1.5	8.1	378,608	4,209	517	13	6,943,588
2012	8,727,268	82,653	0.9	674,744	1.5	8.2	351,625	4,254	521	12	6,815,936

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 1985-2012

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				
	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
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
2012	2,452,319	58,945	2.4	460,988	3.3	7.8	271,068	4,599	588	39	1,720,652

[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 Medicare Data Extract System; data development by the Office of Information Products & 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 2012

Demographic Characteristics, Medicare Status, and Discharge Status	Discharges[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	11,180	303	59,557	100.0	5.3	$115,432	100.0	$10,658	$1,938
Age									
Under 65 Years	2,392	348	13,477	22.6	5.6	24,320	21.1	10,574	1,805
65-69 Years	1,810	183	9,477	15.9	5.2	20,414	17.7	11,661	2,154
70-74 Years	1,596	236	8,186	13.7	5.1	17,474	15.1	11,322	2,135
75-79 Years	1,554	308	8,190	13.8	5.3	16,726	14.5	11,098	2,042
80-84 Years	1,550	392	8,282	13.9	5.3	15,745	13.6	10,448	1,901
85 Years or Over	2,277	522	11,945	20.1	5.2	20,753	18.0	9,336	1,737
Sex									
Male	5,020	296	27,210	45.7	5.4	54,955	47.6	11,315	2,020
Female	6,159	309	32,347	54.3	5.3	60,477	52.4	10,123	1,870
Race[4]									
White	9,038	296	47,113	79.1	5.2	91,297	79.1	10,414	1,938
Other	2,095	341	12,202	20.5	5.8	23,626	20.5	11,699	1,936
Type of Entitlement									
Aged[5]	8,727	291	45,740	76.8	5.2	90,460	78.4	10,676	1,978
Disabled[6]	2,452	357	13,817	23.2	5.6	24,972	21.6	10,592	1,807
Discharge Status									
Alive	10,830	n/a	57,001	95.7	5.3	108,327	93.8	10,332	1,900
Dead	349	n/a	2,556	4.3	7.3	7,104	6.2	20,522	2,779

[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 Medicare Data Extract System; data development by the Office of Information Products & 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 2012

	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]	11,179,587	303	59,557,003	1,614	5.3	$115,431,744	$10,658	$3,128
United States	11,136,935	307	59,246,016	1,634	5.3	115,164,858	10,674	3,176
Northeast	2,159,776	317	12,656,071	1,858	5.9	24,760,353	11,811	3,635
Midwest	2,730,817	326	13,803,797	1,646	5.1	26,703,739	10,027	3,184
South	4,603,187	320	24,426,638	1,697	5.3	43,425,901	9,732	3,017
West	1,643,155	247	8,359,510	1,254	5.1	20,274,865	12,935	3,042
New England	600,090	289	3,181,993	1,530	5.3	6,860,333	11,865	3,298
Connecticut	145,095	313	834,467	1,800	5.8	1,719,003	12,141	3,708
Maine	54,791	233	277,613	1,178	5.1	532,689	10,208	2,261
Massachusetts	292,555	318	1,493,841	1,624	5.1	3,409,037	12,106	3,705
New Hampshire	50,841	224	268,250	1,181	5.3	547,340	11,167	2,410
Rhode Island	35,668	292	195,204	1,598	5.5	374,114	11,160	3,063
Vermont	21,140	190	112,618	1,010	5.3	278,150	13,695	2,495
Middle Atlantic	1,559,686	330	9,474,078	2,002	6.1	17,900,020	11,791	3,783
New Jersey	377,092	321	2,192,603	1,868	5.8	4,191,214	11,437	3,572
New York	688,763	329	4,601,690	2,199	6.7	8,848,694	13,212	4,229
Pennsylvania	493,831	337	2,679,785	1,828	5.4	4,860,113	10,084	3,315
East North Central	1,953,635	337	9,947,656	1,716	5.1	19,189,895	10,003	3,310
Illinois	583,299	341	2,968,865	1,738	5.1	5,771,072	10,092	3,378
Indiana	277,823	324	1,437,877	1,677	5.2	2,623,120	9,611	3,060
Michigan	458,852	352	2,417,686	1,857	5.3	4,790,958	10,586	3,680
Ohio	457,125	358	2,279,807	1,788	5.0	4,215,516	9,404	3,306
Wisconsin	176,536	270	843,421	1,288	4.8	1,789,229	10,356	2,732
West North Central	777,182	300	3,856,141	1,489	5.0	7,513,844	10,089	2,901
Iowa	116,511	252	585,659	1,267	5.0	1,108,526	9,971	2,398
Kansas	109,145	275	551,329	1,388	5.1	1,004,967	9,580	2,531
Minnesota	167,495	378	781,319	1,762	4.7	1,792,426	11,061	4,043
Missouri	262,410	324	1,334,256	1,646	5.1	2,398,702	9,568	2,960
Nebraska	64,247	253	313,963	1,235	4.9	629,838	10,170	2,477
North Dakota	25,293	258	127,970	1,304	5.1	255,752	10,894	2,607
South Dakota	32,081	257	161,645	1,296	5.0	323,634	10,600	2,595
South Atlantic	2,434,502	316	12,922,053	1,676	5.3	23,811,102	10,107	3,089
Delaware	42,483	279	229,777	1,509	5.4	481,510	11,620	3,163
District of Columbia	26,052	362	159,251	2,210	6.1	340,741	13,533	4,730
Florida	805,716	338	4,303,334	1,803	5.3	7,221,354	9,290	3,026
Georgia	303,599	300	1,621,455	1,602	5.3	2,833,550	9,650	2,800
Maryland	254,749	331	1,318,064	1,713	5.2	3,278,513	13,209	4,261
North Carolina	390,745	302	2,047,609	1,582	5.2	3,888,480	10,292	3,004
South Carolina	196,459	287	1,088,414	1,592	5.5	1,916,577	10,075	2,804
Virginia	309,558	299	1,595,935	1,542	5.2	2,896,245	9,654	2,798
West Virginia	105,141	347	558,214	1,842	5.3	954,129	9,334	3,148

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 2012

	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	894,642	339	4,785,583	1,814	5.3	$7,635,381	$8,807	$2,894
Alabama	237,685	340	1,272,695	1,823	5.4	1,875,404	8,217	2,686
Kentucky	226,789	345	1,168,830	1,777	5.2	2,056,609	9,232	3,126
Mississippi	158,506	342	904,626	1,952	5.7	1,393,669	9,013	3,007
Tennessee	271,662	332	1,439,432	1,757	5.3	2,309,698	8,837	2,819
West South Central	1,274,043	315	6,719,002	1,660	5.3	11,979,419	9,668	2,959
Arkansas	145,651	313	750,537	1,611	5.2	1,240,992	8,708	2,664
Louisiana	180,704	333	1,001,765	1,845	5.5	1,594,034	9,049	2,935
Oklahoma	173,400	325	885,618	1,659	5.1	1,553,712	9,211	2,910
Texas	774,288	309	4,081,082	1,629	5.3	7,590,681	10,097	3,030
Mountain	524,603	240	2,516,138	1,152	4.8	5,540,910	11,021	2,536
Arizona	165,219	263	777,693	1,236	4.7	1,766,295	11,201	2,808
Colorado	106,704	240	499,065	1,124	4.7	1,110,622	10,716	2,502
Idaho	33,334	191	148,772	853	4.5	359,927	11,139	2,063
Montana	29,817	196	140,913	926	4.7	296,538	10,621	1,949
Nevada	71,127	264	402,797	1,497	5.7	789,835	11,663	2,936
New Mexico	54,645	229	268,764	1,125	4.9	565,721	10,695	2,368
Utah	45,928	233	193,196	982	4.2	438,766	10,089	2,230
Wyoming	17,829	221	84,938	1,052	4.8	213,206	12,489	2,640
Pacific	1,118,552	250	5,843,372	1,305	5.2	14,733,954	13,839	3,290
Alaska	14,555	202	76,408	1,061	5.2	218,453	15,840	3,032
California	826,216	264	4,432,910	1,415	5.4	11,355,156	14,526	3,624
Hawaii	22,416	183	146,046	1,194	6.5	293,535	13,667	2,400
Oregon	78,627	200	355,238	902	4.5	884,842	11,679	2,248
Washington	176,738	233	832,770	1,099	4.7	1,981,968	11,527	2,616
Outlying Areas [5]	42,652	66	310,987	481	7.3	266,886	6,368	412

[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 Medicare Data Extract System; data development by the Office of Information Products & 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 2012

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	---	11,179,587	303	59,557,003	5.3	$115,431,744	$10,658	$1,938
Leading Diagnoses [5]	---	5,917,689	160	32,028,180	5.4	64,843,608	11,237	2,025
Infectious and Parasitic Diseases (MDC 1)	001-139	737,546	20	5,413,282	7.3	10,915,942	15,021	2,017
Septicemia	038	576,629	16	4,461,382	7.7	9,360,526	16,386	2,098
Neoplasms (MDC 2)	140-239	468,609	13	3,069,344	6.5	7,049,484	15,321	2,297
Malignant Neoplasms	140-208,230-234	404,868	11	2,740,111	6.8	6,233,459	15,663	2,275
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	55,694	2	470,203	8.4	995,209	18,015	2,117
Malignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	70,043	2	467,233	6.7	1,025,889	14,794	2,196
Malignant Neoplasm of Breast	174-175,198.81	17,885	(6)	48,880	2.7	118,775	7,041	2,430
Benign Neoplasms	210-229	41,464	1	200,252	4.8	531,270	13,164	2,653
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	444,917	12	1,989,711	4.5	3,217,688	7,542	1,617
Diabetes Mellitus	250	175,664	5	929,836	5.3	1,577,519	9,236	1,697
Volume Depletion	276.5	72,520	2	254,064	3.5	328,400	4,851	1,293
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	173,057	5	751,853	4.3	1,262,632	7,576	1,679
Mental Disorders (MDC 5)	290-319	481,584	13	4,329,615	9.0	3,372,070	7,188	779
Psychoses	290-299	414,647	11	3,944,693	9.5	3,051,762	7,547	774
Alcohol Dependence Syndrome	303	15,801	(6)	89,308	5.7	77,660	5,089	870
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	269,642	7	1,526,123	5.7	2,249,794	8,617	1,474

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 2012

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	2,528,249	69	11,756,882	4.7	$28,354,855	$11,602	$2,412
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	1,672,530	45	7,965,787	4.8	19,766,131	12,203	2,481
Acute Myocardial Infarction	410	271,679	7	1,364,919	5.0	3,971,422	14,731	2,910
Coronary Atherosclerosis	414.0	232,421	6	923,808	4.0	3,314,663	15,587	3,588
Other Ischemic Heart Disease	411-413, 414.1-414.9	21,782	1	64,183	2.9	244,494	11,989	3,809
Cardiac Dysrhythmias	427	391,632	11	1,446,583	3.7	3,123,363	8,224	2,159
Congestive Heart Failure	428.0	115,230	3	521,176	4.5	953,504	8,550	1,830
Cerebrovascular Disease	430-438	459,360	12	1,948,470	4.2	4,077,121	9,169	2,092
Diseases of the Respiratory System (MDC 8)	460-519	1,323,014	36	7,224,249	5.5	11,756,548	8,992	1,627
Acute Bronchitis and Bronchocolitis	466	27,215	1	96,826	3.6	121,761	4,547	1,258
Pneumonia	480-486	448,468	12	2,449,575	5.5	3,590,856	8,076	1,466
Asthma	493	86,757	2	382,490	4.4	509,658	5,975	1,332
Diseases of the Digestive System (MDC 9)	520-579	1,100,618	30	5,673,500	5.2	10,002,068	9,439	1,763
Appendicitis	540-543	19,807	1	88,330	4.5	190,348	9,887	2,155
Non Infectious Enteritis and Colitis	555-558	93,463	3	462,074	4.9	721,531	8,178	1,562
Diverticula of Intestine	562	116,752	3	588,332	5.0	938,756	8,327	1,596
Cholelithiasis	574	87,144	2	426,860	4.9	881,002	10,472	2,064
Diseases of the Genitourinary System (MDC 10)	580-629	709,040	19	3,242,786	4.6	4,751,080	6,901	1,465
Calculus of Kidney and Ureter	592	33,644	1	101,323	3.0	221,706	6,886	2,188

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 2012

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	225,710	6	1,155,482	5.1	$1,535,877	$6,940	$1,329
Cellulitis and Abscess	681-682	188,442	5	904,431	4.8	1,136,302	6,150	1,256
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	814,251	22	2,917,359	3.6	10,415,963	13,209	3,570
Osteoarthrosis and Allied Disorders	715	425,892	12	1,326,032	3.1	5,126,100	12,248	3,866
Intervertebral Disc Disorders	722	77,312	2	260,632	3.4	1,193,109	16,380	4,578
Congenital Anomalies (MDC 14)	740-759	11,108	(6)	51,443	4.6	232,494	21,517	4,519
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	534,133	14	1,583,386	3.0	2,413,312	5,075	1,524
Injury and Poisoning (MDC 17)	800-999	1,060,043	29	5,765,333	5.4	13,308,259	12,863	2,308
Fractures, All Sites	800-829	415,103	11	2,161,571	5.2	4,777,945	11,749	2,210
Fracture of Neck of Femur	820	192,098	5	1,068,662	5.6	2,541,766	13,301	2,378
Poisoning by Drugs, Medicinal and Biological Substances	960-989	64,207	2	245,801	3.8	430,686	6,876	1,752
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V86	276,175	7	3,030,241	11.0	4,487,325	16,681	1,481

[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 Medicare Data Extract System; data development by the Office of Information Products & 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 2012

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	---	6,568,353	178	39,797,001	6.1	$87,705,284	$13,720	$2,204
Leading Procedures [5]	---	2,763,097	75	15,375,035	5.6	33,102,391	12,303	2,153
Operations on the Nervous System (MPC 1)	01-05	154,882	4	966,816	6.2	2,467,836	16,613	2,553
Spinal Tap	03.31	37,524	1	245,466	6.5	345,520	9,408	1,408
Operations on the Endocrine System (MPC 2)	06-07	19,155	1	74,872	3.9	206,004	11,407	2,751
Operations on the Eye (MPC 3)	08-16	6,973	(6)	31,487	4.5	66,081	9,913	2,099
Operations on the Ear (MPC 4)	18-20	2,118	(6)	11,728	5.5	23,374	11,503	1,993
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	24,464	1	121,437	5.0	233,213	9,982	1,920
Operations on the Respiratory System (MPC 6)	30-34	257,173	7	2,411,389	9.4	4,950,964	19,475	2,053
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	54,301	1	458,243	8.4	654,763	12,203	1,429
Operations on the Cardiovascular System (MPC 7)	35-39	1,349,834	37	8,463,209	6.3	21,763,130	16,594	2,571
Removal of Coronary Artery Obstruction	36.0	1,539	(6)	5,439	3.5	22,557	15,283	4,147
Coronary Artery Bypass Graft	36.1	65,324	2	634,091	9.7	2,258,216	34,765	3,561
Cardiac Catheterization	37.21-37.23	198,363	5	806,998	4.1	1,516,412	8,025	1,879
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	95,303	3	486,906	5.1	1,590,671	17,255	3,267
Hemodialysis	39.95	252,889	7	1,226,812	4.9	2,407,737	9,857	1,963
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	43,260	1	358,548	8.3	822,905	19,619	2,295

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 2012

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	1,010,527	27	6,848,029	6.8	$12,387,732	$12,575	$1,809
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	266,431	7	1,401,971	5.3	1,826,371	7,067	1,303
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	83,894	2	442,689	5.3	544,472	6,704	1,230
Partial Excision of Large Intestine	45.7	57,349	2	645,191	11.3	1,452,936	25,486	2,252
Appendectomy, Excluding Incidental	47.0	17,914	(6)	77,528	4.3	181,292	10,427	2,338
Cholecystectomy	51.2	91,282	2	526,388	5.8	1,149,778	12,997	2,184
Lysis of Peritoneal Adhesions	54.5	28,995	1	280,571	9.7	573,043	20,073	2,042
Operations on the Urinary System (MPC 10)	55-59	193,675	5	1,133,261	5.9	2,282,782	12,071	2,014
Cystoscopy with or Without Biopsy	57.31-57.33	9,760	(6)	64,953	6.7	81,535	8,622	1,255
Operations on the Male Genital Organs (MPC 11)[7]	60-64	48,871	3	169,251	3.5	377,109	8,316	2,228
Prostatectomy	60.2-60.6	41,342	2	125,638	3.0	295,650	7,737	2,353
Operations on the Female Genital Organs (MPC 12)[8]	65-71	62,649	3	217,371	3.5	531,389	8,970	2,445
Unilateral Oophorectomy	65.3-65.6	6,226	(6)	28,711	4.6	67,075	11,012	2,336
Hysterectomy	68.3-68.7,68.9	35,704	2	110,963	3.1	295,878	8,671	2,666
Obstetrical Procedures (MPC 13)[8]	72-75	16,089	1	51,734	3.2	77,889	4,906	1,506
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	399	(6)	978	2.5	1,103	2,784	1,127
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	13,761	1	55,363	4.0	93,015	6,871	1,680
Repair of Current Obstetric Laceration	75.5-75.6	1,514	(6)	3,687	2.4	4,776	3,175	1,295
Operations on the Musculoskeletal System (MPC 14)	76-84	1,112,778	30	5,254,055	4.7	16,344,617	14,972	3,111
Partial Excision of Bone	76.2-76.3,77.6-77.8	17,520	(6)	144,870	8.3	311,210	18,200	2,148
Reduction of Facial Fracture	76.7,79.0-79.3	180,911	5	977,372	5.4	2,295,296	12,929	2,348
Open Reduction of Fracture with Internal Fixation	79.3	121,341	3	653,914	5.4	1,554,480	13,103	2,377
Excision or Destruction of Intervertebral Disc	80.5	17,124	(6)	49,753	2.9	128,287	8,682	2,578
Total Hip Replacement	81.51	133,655	4	449,406	3.4	1,670,683	12,656	3,718
Total Knee Replacement	81.54	279,393	8	892,419	3.2	3,389,212	12,347	3,798

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 2012

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Operations on the Integumentary System (MPC 15)	85-86	208,046	6	1,426,441	6.9	$2,388,400	$11,804	$1,674
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	68,534	2	605,306	8.8	1,034,490	15,354	1,709
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,730,983	47	10,936,310	6.3	17,623,769	10,432	1,611
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	78,341	2	349,921	4.5	566,220	7,496	1,618
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	39,807	1	182,311	4.6	307,976	8,024	1,689
Diagnostic Ultrasound	88.7	153,250	4	734,350	4.8	1,066,794	7,176	1,453
Respiratory Therapy	93.9,96.7	373,297	10	2,934,669	7.9	6,093,523	16,568	2,076
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	37,182	1	253,898	6.8	512,383	13,923	2,018
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	31,039	1	199,119	6.4	409,048	13,520	2,054

[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 Medicare Data Extract System; data development by the Office of Information Products & 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 2012

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	----	11,179,587	59,557,003	5.3	$497,279,572	$115,431,743	$10,904	$1,938
Leading DRGs	----	6,886,385	35,150,655	5.1	242,571,555	56,459,265	8,643	1,606
057	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	60,898	524,746	8.6	1,671,263	500,885	8,483	955
064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	71,290	451,022	6.3	3,574,384	880,929	12,579	1,953
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	110,241	478,065	4.3	3,525,251	753,430	6,999	1,576
066	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	61,817	179,849	2.9	1,516,966	275,634	4,602	1,533
069	TRANSIENT ISCHEMIA	89,624	222,670	2.5	2,003,793	317,299	4,097	1,425
101	SEIZURES W/O MCC	53,808	173,253	3.2	1,261,190	246,136	4,861	1,421
176	PULMONARY EMBOLISM W/O MCC	41,034	179,562	4.4	1,133,746	246,230	6,276	1,371
177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	71,356	562,992	7.9	3,732,007	924,233	13,174	1,642
178	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	56,051	344,295	6.1	2,065,436	503,843	9,163	1,463
189	PULMONARY EDEMA & RESPIRATORY FAILURE	106,841	536,558	5.0	3,547,449	830,072	7,989	1,547
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	147,073	744,376	5.1	4,612,150	1,024,506	7,132	1,376
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	141,164	589,228	4.2	3,561,812	784,261	5,720	1,331
192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	101,514	335,323	3.3	1,937,442	380,657	3,912	1,135
193	SIMPLE PNEUMONIA & PLEURISY W MCC	136,177	823,644	6.0	5,249,715	1,233,345	9,248	1,497
194	SIMPLE PNEUMONIA & PLEURISY W CC	185,072	839,792	4.5	4,863,426	1,085,240	6,006	1,292
195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	75,233	255,862	3.4	1,420,075	276,763	3,796	1,082
202	BRONCHITIS & ASTHMA W CC/MCC	39,329	151,853	3.9	939,627	193,823	5,111	1,276
208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	71,974	493,023	6.9	4,690,581	1,086,683	15,522	2,204
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	113,900	273,863	2.4	7,482,766	1,224,697	12,612	4,472

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 2012

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
253	OTHER VASCULAR PROCEDURES W CC	40,429	232,006	5.7	$2,976,197	$654,663	$17,077	$2,822
280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	68,900	415,144	6.0	3,247,809	776,005	11,459	1,869
281	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	48,181	182,619	3.8	1,489,752	322,670	6,845	1,767
287	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	112,648	343,730	3.1	4,096,953	657,003	6,524	1,911
291	HEART FAILURE & SHOCK W MCC	191,188	1,126,255	5.9	7,572,569	1,832,701	9,805	1,627
292	HEART FAILURE & SHOCK W CC	211,078	941,330	4.5	5,499,088	1,281,285	6,353	1,361
293	HEART FAILURE & SHOCK W/O CC/MCC	81,415	248,721	3.1	1,469,669	302,491	3,897	1,216
300	PERIPHERAL VASCULAR DISORDERS W CC	44,170	198,024	4.5	1,111,079	259,571	6,065	1,311
308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	69,696	342,024	4.9	2,317,145	539,277	7,917	1,577
309	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	109,818	364,243	3.3	2,443,322	512,015	4,844	1,406
310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	114,055	258,269	2.3	1,822,598	306,955	2,865	1,189
312	SYNCOPE & COLLAPSE	135,098	377,433	2.8	2,885,562	496,254	4,302	1,315
313	CHEST PAIN	124,707	248,126	2.0	2,256,862	299779	3,067	1,208
314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	54,709	367,346	6.7	2,804,520	676,929	13,052	1,843
329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	42,543	619,402	14.6	5,871,316	1,523,296	36,828	2,459
330	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	55,771	475,554	8.5	3,889,794	919,612	17,139	1,934
372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	37,346	212,902	5.7	1,152,676	294,897	8,134	1,385
377	G.I. HEMORRHAGE W MCC	56,714	345,380	6.1	2,706,176	661,375	11,976	1,915
378	G.I. HEMORRHAGE W CC	144,743	562,224	3.9	3,961,245	863,282	6,211	1,535
379	G.I. HEMORRHAGE W/O CC/MCC	37,983	103,490	2.7	725,023	137,483	3,965	1,328
389	G.I. OBSTRUCTION W CC	55,443	247,677	4.5	1,396,587	303,387	5,686	1,225
390	G.I. OBSTRUCTION W/O CC/MCC	39,608	126,149	3.2	715,618	130,732	3,481	1,036
391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	50,722	253,684	5.0	1,707,963	381,450	7,972	1,504

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 2012

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
392	ESOPHAGITIS, GASTROENT & MISC							
	DIGEST DISORDERS W/O MCC	239,049	792,945	3.3	$5,145,270	$889,853	$4,284	$1,122
394	OTHER DIGESTIVE SYSTEM DIAGNOSES							
	W CC	49,060	210,671	4.3	1,350,041	293,483	6,353	1,393
460	SPINAL FUSION EXCEPT CERVICAL W/O							
	MCC	73,272	259,272	3.5	7,158,998	1,735,767	25,323	6,695
470	MAJOR JOINT REPLACEMENT OR							
	REATTACHMENT OF LOWER EXTREMITY							
	W/O MCC	440,755	1,471,465	3.3	23,278,001	5,240,601	12,657	3,561
481	HIP & FEMUR PROCEDURES EXCEPT							
	MAJOR JOINT W CC	81,931	424,207	5.2	4,228,213	961,775	11,908	2,267
552	MEDICAL BACK PROBLEMS W/O MCC	64,669	241,788	3.7	1,563,563	290,783	5,076	1,203
603	CELLULITIS W/O MCC	145,387	612,849	4.2	3,077,945	690,497	4,973	1,127
638	DIABETES W CC	54,370	202,986	3.7	1,225,439	265,619	5,092	1,309
640	MISC DISORDERS OF							
	NUTRITION,METABOLISM,FLUIDS/ELEC	64,944	294,093	4.5	1,935,216	465,077	7,474	1,581
641	MISC DISORDERS OF							
	NUTRITION,METABOLISM,FLUIDS/ELEC	142,135	471,931	3.3	2,709,527	546,093	4,164	1,157
682	RENAL FAILURE W MCC	111,617	693,409	6.2	4,546,325	1,168,845	10,770	1,686
683	RENAL FAILURE W CC	160,247	712,470	4.4	4,137,479	966,201	6,250	1,356
689	KIDNEY & URINARY TRACT INFECTIONS							
	W MCC	75,960	401,291	5.3	2,268,003	546,859	7,317	1,363
690	KIDNEY & URINARY TRACT INFECTIONS							
	W/O MCC	200,416	760,622	3.8	4,202,127	884,996	4,613	1,164
812	RED BLOOD CELL DISORDERS W/O MCC	94,777	326,651	3.4	2,085,020	433,463	4,888	1,327
853	INFECTIOUS & PARASITIC DISEASES W							
	O.R. PROCEDURE W MCC	50,144	716,660	14.3	7,310,036	1,892,141	38,960	2,640
871	SEPTICEMIA OR SEVERE SEPSIS W/O							
	MV 96+ HOURS W MCC	363,555	2,445,560	6.7	18,573,528	4,573,658	12,847	1,870
872	SEPTICEMIA OR SEVERE SEPSIS W/O							
	MV 96+ HOURS W/O MCC	126,002	608,810	4.8	3,683,573	859,593	6,986	1,412

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 2012

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
884	ORGANIC DISTURBANCES & MENTAL RETARDATION	44,162	427,928	9.7	$1,249,208	$376,482	$8,764	$880
885	PSYCHOSES	322,553	3,264,236	10.1	8,464,366	2,408,579	7,828	738
897	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	50,502	217,995	4.3	807,547	203,043	4,282	931
945	REHABILITATION W CC/MCC	174,842	2,249,764	12.9	8,239,926	3,089,891	18,245	1,373
946	REHABILITATION W/O CC/MCC	40,037	412,602	10.3	1,339,710	553,548	14,534	1,342
948	SIGNS & SYMPTOMS W/O MCC	54,638	178,742	3.3	1,083,856	220,611	4,286	1,234
All Other DRGs	----	4,293,202	24,406,348	5.7	254,708,016	58,972,477	14,549	2,416

[1]The average program payment per discharge does not reflect discharges with covered services, but for whom no claim payment amounts were reported.
[2]Based on frequency of occurrence in 2012.
[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 29.0, Definitions Manual*. CC is complications and comorbidities. MCC is major complications and comorbidities. Cath is catheterization. AMI is acute myocardial infarction. G.I. is gastrointestinal. Proc is procedure. O.R. is operating room

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Information Products & 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 2012

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	11,179,587	8,663,192	4,158,966	11,156,216	3,861,256	11,096,901
1-8 Days	9,457,165	7,242,781	3,285,816	9,437,862	2,991,416	9,389,833
9-20 Days	1,472,598	1,210,681	727,028	1,469,432	713,920	1,461,267
21-30 Days	170,731	142,882	96,933	170,220	103,433	168,601
31-40 Days	44,625	37,305	27,994	44,456	29,788	43,827
41-50 Days	16,950	14,322	10,677	16,870	11,511	16,562
51-60 Days	7,230	6,182	4,552	7,185	4,833	7,020
61-90 Days	7,262	6,342	4,318	7,208	4,623	6,956
91 Days or More	3,026	2,697	1,648	2,983	1,732	2,835
			Percent of Total Discharges [3]			
Total	100.0	77.5	37.2	99.8	34.5	99.3
1-8 Days	100.0	76.6	34.7	99.8	31.6	99.3
9-20 Days	100.0	82.2	49.4	99.8	48.5	99.2
21-30 Days	100.0	83.7	56.8	99.7	60.6	98.8
31-40 Days	100.0	83.6	62.7	99.6	66.8	98.2
41-50 Days	100.0	84.5	63.0	99.5	67.9	97.7
51-60 Days	100.0	85.5	63.0	99.4	66.8	97.1
61-90 Days	100.0	87.3	59.5	99.3	63.7	95.8
91 Days or More	100.0	89.1	54.5	98.6	57.2	93.7
			Total Charges in Thousands			
Total	$497,279,572	$70,700,948	$61,314,443	$365,266,034	$49,485,370	$63,157,505
1-8 Days	310,404,731	39,580,527	29,574,378	241,251,342	36,133,245	33,468,098
9-20 Days	128,204,038	21,442,385	20,168,042	86,593,896	9,923,603	19,248,649
21-30 Days	30,777,253	4,935,539	5,695,724	20,146,023	1,959,116	5,327,404
31-40 Days	12,199,163	1,867,328	2,488,064	7,843,780	716,361	2,226,573
41-50 Days	6,017,784	956,739	1,262,944	3,798,103	330,824	1,121,244
51-60 Days	3,151,058	515,102	697,706	1,938,250	159,563	591,535
61-90 Days	3,875,153	739,732	840,275	2,295,146	171,906	723,612
91 Days or More	2,650,389	663,593	587,306	1,399,490	90,747	450,386

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 2012

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
Number of Discharges					
11,080,826	9,788,138	8,835,873	8,138,367	5,328,341	10,504,222
9,370,079	8,256,585	7,397,160	6,803,686	4,256,856	8,843,307
1,462,838	1,308,248	1,231,840	1,134,494	904,023	1,420,797
169,523	152,120	142,359	134,050	113,109	164,375
44,283	40,400	37,270	37,256	30,997	42,963
16,800	15,272	13,852	14,275	11,784	16,218
7,156	6,452	5,762	6,084	4,971	6,886
7,182	6,425	5,506	6,052	4,748	6,867
2,965	2,636	2,124	2,470	1,853	2,809
Percent of Total Discharges [3]					
99.1	87.6	79.0	72.8	47.7	94.0
99.1	87.3	78.2	71.9	45.0	93.5
99.3	88.8	83.7	77.0	61.4	96.5
99.3	89.1	83.4	78.5	66.2	96.3
99.2	90.5	83.5	83.5	69.5	96.3
99.1	90.1	81.7	84.2	69.5	95.7
99.0	89.2	79.7	84.1	68.8	95.2
98.9	88.5	75.8	83.3	65.4	94.6
98.0	87.1	70.2	81.6	61.2	92.8
Total Charges in Thousands					
$59,400,853	$39,536,142	$61,060,244	$24,773,668	$17,508,436	$50,343,813
37,153,500	27,628,693	46,424,964	19,740,276	7,324,791	33,377,772
15,559,865	8,840,707	10,718,785	4,033,879	6,216,207	12,052,199
3,598,234	1,776,114	2,190,316	612,152	1,948,286	2,734,397
1,410,582	642,632	808,612	199,677	852,547	986,791
683,448	284,537	388,420	85,680	429,618	474,328
350,605	138,438	184,642	38,337	232,387	242,738
410,313	152,363	214,076	42,778	282,553	297,541
234,303	72,654	130,425	20,885	222,043	178,043

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 2012

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	14.2	12.3	73.5	10.0	12.7
1-8 Days	100.0	12.8	9.5	77.7	11.6	10.8
9-20 Days	100.0	16.7	15.7	67.5	7.7	15.0
21-30 Days	100.0	16.0	18.5	65.5	6.4	17.3
31-40 Days	100.0	15.3	20.4	64.3	5.9	18.3
41-50 Days	100.0	15.9	21.0	63.1	5.5	18.6
51-60 Days	100.0	16.3	22.1	61.5	5.1	18.8
61-90 Days	100.0	19.1	21.7	59.2	4.4	18.7
91 Days or More	100.0	25.0	22.2	52.8	3.4	17.0
			Average Total Charge Per Discharge			
Total	$44,481	$8,161	$14,743	$32,741	$12,816	$5,691
1-8 Days	32,822	5,465	9,001	25,562	12,079	3,564
9-20 Days	87,060	17,711	27,740	58,930	13,900	13,173
21-30 Days	180,268	34,543	58,759	118,353	18,941	31,598
31-40 Days	273,371	50,056	88,878	176,439	24,049	50,804
41-50 Days	355,032	66,802	118,287	225,140	28,740	67,700
51-60 Days	435,831	83,323	153,275	269,763	33,015	84,264
61-90 Days	533,621	116,640	194,598	318,417	37,185	104,027
91 Days or More	875,872	246,049	356,375	469,155	52,395	158,866

[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 & 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 2012

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
Percent of Total Charges [4]					
11.9	8.0	12.3	5.0	3.5	10.1
12.0	8.9	15.0	6.4	2.4	10.8
12.1	6.9	8.4	3.1	4.8	9.4
11.7	5.8	7.1	2.0	6.3	8.9
11.6	5.3	6.6	1.6	7.0	8.1
11.4	4.7	6.5	1.4	7.1	7.9
11.1	4.4	5.9	1.2	7.4	7.7
10.6	3.9	5.5	1.1	7.3	7.7
8.8	2.7	4.9	0.8	8.4	6.7
Average Total Charge Per Discharge					
$5,361	$4,039	$6,910	$3,044	$3,286	$4,793
3,965	3,346	6,276	2,901	1,721	3,774
10,637	6,758	8,701	3,556	6,876	8,483
21,226	11,676	15,386	4,567	17,225	16,635
31,854	15,907	21,696	5,360	27,504	22,968
40,681	18,631	28,041	6,002	36,458	29,247
48,995	21,457	32,045	6,301	46,749	35,251
57,131	23,714	38,881	7,069	59,510	43,329
79,023	27,562	61,406	8,456	119,829	63,383

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 2012

Total Days of Care	Discharges [1]		Total Days of Care			Program Payments			
					Per	Amount		Per	
Total Days					Dis-	in		Dis-	Per
of Care	Number	Percent	Number	Percent	charge	Thousands	Percent	charge [2]	Day
Total	11,179,587	100.0	59,557,003	100.0	5.3	$115,431,744	100.0	$10,658	$1,938
1 Day	1,523,489	13.6	1,523,489	2.6	1.0	8,943,585	7.7	6,713	5,870
2 Days	1,779,259	15.9	3,558,518	6.0	2.0	11,750,211	10.2	6,904	3,302
3 Days	1,999,307	17.9	5,997,921	10.1	3.0	15,895,829	13.8	8,043	2,650
4 Days	1,396,813	12.5	5,587,252	9.4	4.0	11,970,102	10.4	8,640	2,142
5 Days	1,004,099	9.0	5,020,495	8.4	5.0	9,524,347	8.3	9,559	1,897
6 Days	749,072	6.7	4,494,432	7.5	6.0	7,828,182	6.8	10,537	1,742
7 Days	581,998	5.2	4,073,986	6.8	7.0	6,717,544	5.8	11,645	1,649
8 Days	423,128	3.8	3,385,024	5.7	8.0	5,328,210	4.6	12,714	1,574
9 Days	307,620	2.8	2,768,580	4.6	9.0	4,169,419	3.6	13,692	1,506
10 Days	238,912	2.1	2,389,120	4.0	10.0	3,494,179	3.0	14,785	1,463
11 Days	189,285	1.7	2,082,135	3.5	11.0	2,981,370	2.6	15,933	1,432
12 Days	149,621	1.3	1,795,452	3.0	12.0	2,529,134	2.2	17,108	1,409
13 Days	129,086	1.2	1,678,118	2.8	13.0	2,318,988	2.0	18,195	1,382
14 Days	117,856	1.1	1,649,984	2.8	14.0	2,234,465	1.9	19,222	1,354
15 Days	90,225	0.8	1,353,375	2.3	15.0	1,855,548	1.6	20,846	1,371
16 Days	69,476	0.6	1,111,616	1.9	16.0	1,531,611	1.3	22,314	1,378
17 Days	57,905	0.5	984,385	1.7	17.0	1,361,803	1.2	23,849	1,383
18 Days	47,845	0.4	861,210	1.4	18.0	1,183,853	1.0	25,094	1,375
19 Days	39,652	0.4	753,388	1.3	19.0	1,059,783	0.9	27,086	1,407
20 Days	35,115	0.3	702,300	1.2	20.0	987,283	0.9	28,534	1,406
21-30 Days	170,731	1.5	4,147,504	7.0	24.3	6,144,813	5.3	36,592	1,482
31-40 Days	44,625	0.4	1,543,649	2.6	34.6	2,485,738	2.2	56,930	1,610
41-50 Days	16,950	0.2	758,957	1.3	44.8	1,250,791	1.1	76,179	1,648
51-60 Days	7,230	0.1	397,428	0.7	55.0	656,297	0.6	93,610	1,651
61-90 Days	7,262	0.1	519,927	0.9	71.6	810,538	0.7	116,591	1,559
91 Days or More	3,026	(3)	418,758	0.7	138.4	418,120	0.4	153,608	998

[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 & 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 2012

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]	3,464	100.0	11,141,765	100.0	5.3	$115,240,311	100.0	$10,677
1-99 Beds	1,187	34.3	969,720	8.7	4.5	7,567,616	6.6	8,062
100-299 Beds	1,387	40.0	3,988,884	35.8	5.0	35,821,134	31.1	9,282
300-499 Beds	545	15.7	3,077,889	27.6	5.4	31,694,443	27.5	10,618
500 Beds or More	345	10.0	3,105,272	27.9	5.9	40,157,117	34.8	13,338
Total Urban Hospitals	2,507	100.0	9,710,593	100.0	5.4	104,070,171	100.0	11,064
1-99 Beds	597	23.8	493,379	5.1	4.5	4,231,984	4.1	8,870
100-299 Beds	1,050	41.9	3,212,591	33.1	5.1	29,688,277	28.5	9,555
300-499 Beds	518	20.7	2,923,986	30.1	5.4	30,236,905	29.1	10,664
500 Beds or More	342	13.6	3,080,637	31.7	5.9	39,913,005	38.4	13,364
Total Rural Hospitals	957	100.0	1,431,172	100.0	4.7	11,170,141	100.0	8,050
1-99 Beds	590	61.7	476,341	33.3	4.4	3,335,633	29.9	7,227
100-299 Beds	337	35.2	776,293	54.2	4.8	6,132,858	54.9	8,152
300-499 Beds	27	2.8	153,903	10.8	5.2	1,457,538	13.0	9,744
500 Beds or More	3	0.3	24,635	1.7	5.3	244,112	2.2	10,123
Total All Hospitals[3]	3,464	100.0	11,141,765	100.0	5.3	115,240,311	100.0	10,677
Voluntary	2,063	59.6	7,956,884	71.4	5.3	83,198,543	72.2	10,790
Proprietary	730	21.1	1,710,093	15.3	5.2	15,949,472	13.8	9,604
Government	671	19.4	1,474,788	13.2	5.5	16,092,297	14.0	11,314
Total Teaching Hospitals[4]	1,091	100.0	5,470,722	100.0	5.6	65,343,872	100.0	12,318
Voluntary	763	69.9	4,267,183	78.0	5.6	50,492,436	77.3	12,198
Proprietary	142	13.0	526,448	9.6	5.5	5,429,226	8.3	10,584
Government	186	17.0	677,091	12.4	6.0	9,422,210	14.4	14,443
Total Non-Teaching Hospitals	2,373	100.0	5,671,043	100.0	5.0	49,896,439	100.0	9,091
Voluntary	1,300	54.8	3,689,701	65.1	5.0	32,706,107	65.5	9,159
Proprietary	588	24.8	1,183,645	20.9	5.1	10,520,246	21.1	9,166
Government	485	20.4	797,697	14.1	5.0	6,670,087	13.4	8,662

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

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

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

[4]Represents hospitals with an approved resident program.

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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Information Products & 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 2012

Type of Hospital	Hospitals		Discharges		Covered Days of Care		
	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals [2]	6,170	100.0	12,010,398	100.0	66,517,606	100.0	5.5
Short-Stay Hospitals	3,521	57.1	11,179,587	93.1	56,992,093	85.7	5.1
Hospitals	3,521	57.1	10,669,487	88.8	51,237,516	77.0	4.8
Psychiatric Hospital Units [3]	NA	----	299,329	2.5	3,198,509	4.8	10.7
Rehabilitation Hospital Units [3]	NA	----	210,771	1.8	2,556,068	3.8	12.1
Specialty Hospitals	2,649	42.9	830,811	6.9	9,525,513	14.3	11.5
Childrens	97	1.6	2,704	(4)	20,211	(4)	7.5
Psychiatric	527	8.5	156,379	1.3	2,125,848	3.2	13.6
Rehabilitation	241	3.9	174,925	1.5	2,286,055	3.4	13.1
Long Term	437	7.1	145,519	1.2	3,829,237	5.8	26.3
Critical Access (formerly Short-Stay)	1,331	21.6	350,900	2.9	1,252,747	1.9	3.6
Religious Non-Medical	16	(4)	384	(4)	11,415	(4)	29.7

See footnotes at end of table.

Table 5.11--Continued

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2012

	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]	$517,073,419	100.0	$43,052	$7,773	$127,679,718	100.0	$10,949	$1,919
Short-Stay Hospitals	486,203,952	94.0	43,490	8,531	115,431,744	90.4	10,658	2,025
Hospitals	468,574,357	90.6	43,917	9,145	109,337,155	85.6	10,583	2,134
Psychiatric Hospital Units [3]	8,112,167	1.6	27,101	2,536	2,457,037	1.9	8,368	768
Rehabilitation Hospital Units [3]	9,517,428	1.8	45,155	3,723	3,637,552	2.8	17,667	1,423
Specialty Hospitals	30,869,467	6.0	37,156	3,241	12,247,974	9.6	14,754	1,286
Childrens	210,327	(4)	77,784	10,407	55,087	(4)	20,373	2,726
Psychiatric	2,927,830	0.6	18,723	1,377	1,440,209	1.1	9,212	677
Rehabilitation	4,821,907	0.9	27,566	2,109	3,037,531	2.4	17,381	1,329
Long Term	18,314,787	3.5	125,858	4,783	5,378,933	4.2	37,055	1,405
Critical Access (formerly Short-Stay)	4,588,204	0.9	13,076	3,663	2,331,696	1.8	6,647	1,861
Religious Non-Medical	6,413	(4)	16,701	562	4,517	(4)	11,762	396

[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 1,137 distinct-part psychiatric units and 780 rehabilitation units participating in the Medicare Program during 2012.

[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 & 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 2012

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]	11,141,765	1.5953	100.0	58.7	46.9	11.8	41.3
1-99 Beds	969,720	1.3660	100.0	46.5	35.2	11.3	53.5
100-299 Beds	3,988,884	1.4925	100.0	54.7	43.5	11.3	45.3
300-499 Beds	3,077,889	1.6146	100.0	60.2	48.4	11.8	39.8
500 Beds or More	3,105,272	1.7797	100.0	66.2	53.6	12.7	33.8
Total Urban Hospitals	9,710,593	1.6309	100.0	60.5	48.7	11.9	39.5
1-99 Beds	493,379	1.5110	100.0	54.8	44.2	10.6	45.2
100-299 Beds	3,212,591	1.5173	100.0	56.1	44.8	11.3	43.9
300-499 Beds	2,923,986	1.6183	100.0	60.4	48.5	11.9	39.6
500 Beds or More	3,080,637	1.7805	100.0	66.3	53.6	12.7	33.7
Total Rural Hospitals	1,431,172	1.3535	100.0	46.4	35.1	11.3	53.6
1-99 Beds	476,341	1.2159	100.0	37.9	25.9	12.0	62.1
100-299 Beds	776,293	1.3901	100.0	49.2	38.0	11.2	50.8
300-499 Beds	153,903	1.5426	100.0	56.6	46.6	10.0	43.4
500 Beds or More	24,635	1.6811	100.0	60.0	50.9	9.1	40.0

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

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

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

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