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 1972-2008

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
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
			Average Annual Rate of Change		
1972-1983 [6]	5.4	2.3	3.4	0.3	-1.9
1983-2008 [6]	0.1	-0.5	-2.1	-2.7	-2.2
1972-2008	1.7	0.3	-0.4	-1.8	-2.1

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 1972-2008

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
Average Annual Rate of Change							
19.8	13.6	18.0	11.9	14.4	14.0	---	---
8.5	8.4	4.8	4.7	4.1	7.0	---	---
11.9	10.0	8.6	6.8	7.1	9.1	---	---

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 1972-2008

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
Average Annual Rate of Change					
1972-1983 [6]	4.3	2.1	2.4	0.2	-1.9
1983-2008 [6]	-0.3	-0.6	-2.5	-2.8	-2.2
1972-2008	1.1	0.3	-1.1	-1.9	-2.1

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 1972-2008

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
Average Annual Rate of Change							
18.5	13.6	16.7	11.8	14.2	14.0	---	---
8.1	8.4	4.4	4.7	4.1	7.1	---	---
11.2	10.0	8.0	6.8	7.1	9.2	---	---

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 1972-2008

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
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
			Average Annual Rate of Change		
1974-1983 [6]	8.9	4.0	7.1	2.2	-1.6
1983-2008 [6]	2.4	-0.7	0.5	-2.6	-1.9
1974-2008	4.1	0.5	2.2	-1.3	-1.8

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

[2]Based on total Medicare program payments.

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

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

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

[6]Average annual rates of change are provided for periods before and after 1983 to show the impact of the prospective payment system's implementation (beginning October 1, 1983) on short-stay hospital utilization.

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 Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2008

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
Average Annual Rate of Change							
24.8	14.6	22.6	12.6	17.1	14.6	---	---
10.8	8.2	7.0	4.5	3.7	6.4	---	---
14.4	9.8	10.9	6.6	7.1	8.5	---	---

Table 5.2

Discharges, Coinsurance Days, Coinsurance Payments, and Deductible Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Selected Calendar Years 1985-2008

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

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 1985-2008

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

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 1985-2008

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

[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 Research, Development, and Information.

Table 5.3

Enrollees, Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Demographic Characteristics, Type of Entitlement, and Discharge Status: Calendar Year 2008

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	11,821	338	66,591	100.0	5.6	$110,232	100.0	$9,390	$1,655
Age									
Under 65 Years	2,286	359	13,571	20.4	5.9	20,704	18.8	9,203	1,526
65-69 Years	1,801	210	9,854	14.8	5.5	18,305	16.6	10,246	1,858
70-74 Years	1,685	262	9,028	13.6	5.4	16,661	15.1	9,952	1,846
75-79 Years	1,799	342	10,015	15.0	5.6	17,703	16.1	9,883	1,768
80-84 Years	1,862	442	10,595	15.9	5.7	17,187	15.6	9,263	1,622
85 Years or Over	2,389	578	13,527	20.3	5.7	19,673	17.8	8,260	1,454
Sex									
Male	5,216	331	29,682	44.6	5.7	51,916	47.1	10,036	1,749
Female	6,605	344	36,909	55.4	5.6	58,315	52.9	8,881	1,580
Race[4]									
White	9,694	329	53,427	80.2	5.5	88,513	80.3	9,181	1,657
Other	2,094	381	12,975	19.5	6.2	21,399	19.4	10,361	1,649
Type of Entitlement									
Aged[5]	9,481	331	52,694	79.1	5.6	89,000	80.7	9,433	1,689
Disabled[6]	2,340	368	13,896	20.9	5.9	21,232	19.3	9,218	1,528
Discharge Status									
Alive	11,408	N/A	63,187	94.9	5.5	102,636	93.1	9,060	1,624
Dead	413	N/A	3,403	5.1	8.2	7,596	6.9	18,504	2,232

[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 Research, Development, and Information.

Table 5.4

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Area of Residence: Calendar Year 2008

	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 Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
All Areas[4]	11,820,795	338	66,590,540	1,904	5.6	$110,231,605	$9,390	$3,151
United States	11,768,400	343	66,211,820	1,928	5.6	109,951,780	9,408	3,202
Northeast	2,355,520	360	14,638,360	2,235	6.2	24,206,722	10,364	3,695
Midwest	2,943,220	357	15,718,735	1,907	5.3	25,947,839	8,875	3,148
South	4,832,750	357	26,987,550	1,994	5.6	41,874,924	8,719	3,094
West	1,636,910	273	8,867,175	1,476	5.4	17,922,293	11,027	2,984
New England	628,540	323	3,514,600	1,806	5.6	6,245,111	10,005	3,210
Connecticut	157,745	338	922,545	1,977	5.8	1,733,915	11,099	3,716
Maine	63,270	266	344,465	1,449	5.4	563,028	8,929	2,369
Massachusetts	298,045	360	1,621,670	1,958	5.4	2,835,637	9,576	3,424
New Hampshire	51,125	255	291,870	1,457	5.7	503,884	9,896	2,516
Rhode Island	37,465	335	221,520	1,980	5.9	358,944	9,670	3,209
Vermont	20,890	207	112,530	1,113	5.4	249,700	12,014	2,471
Middle Atlantic	1,726,980	375	11,123,760	2,416	6.4	17,961,610	10,495	3,901
New Jersey	421,400	373	2,627,545	2,326	6.2	4,330,623	10,360	3,833
New York	762,235	367	5,411,515	2,607	7.1	8,983,327	11,903	4,328
Pennsylvania	543,345	388	3,084,700	2,204	5.7	4,647,659	8,627	3,321
East North Central	2,113,660	372	11,392,225	2,004	5.4	18,815,769	8,970	3,310
Illinois	628,045	396	3,375,070	2,126	5.4	5,545,788	8,934	3,493
Indiana	286,185	341	1,558,890	1,856	5.4	2,479,282	8,696	2,951
Michigan	473,230	384	2,639,335	2,141	5.6	4,553,755	9,669	3,694
Ohio	528,515	388	2,812,440	2,064	5.3	4,438,224	8,465	3,256
Wisconsin	197,685	299	1,006,490	1,524	5.1	1,798,718	9,155	2,724
West North Central	829,560	324	4,326,510	1,691	5.2	7,132,069	8,635	2,787
Iowa	126,850	285	658,305	1,479	5.2	1,057,449	8,373	2,376
Kansas	120,655	319	637,985	1,687	5.3	986,614	8,212	2,609
Minnesota	169,740	345	826,255	1,680	4.9	1,587,133	9,389	3,226
Missouri	286,795	365	1,560,740	1,985	5.4	2,402,264	8,421	3,055
Nebraska	68,700	286	355,000	1,477	5.2	606,681	8,860	2,524
North Dakota	26,190	267	135,600	1,383	5.2	231,174	8,844	2,357
South Dakota	30,630	257	152,625	1,282	5.0	260,751	8,527	2,190
South Atlantic	2,509,545	346	14,116,685	1,948	5.6	22,659,731	9,083	3,127
Delaware	45,390	337	279,505	2,073	6.2	484,918	10,716	3,597
District of Columbia	26,000	396	180,290	2,745	6.9	310,431	12,074	4,726
Florida	828,790	355	4,723,565	2,021	5.7	7,065,474	8,562	3,023
Georgia	324,865	328	1,818,730	1,834	5.6	2,854,324	8,827	2,878
Maryland	277,000	402	1,418,685	2,061	5.1	3,159,275	11,480	4,590
North Carolina	391,220	332	2,164,610	1,840	5.5	3,513,071	9,051	2,986
South Carolina	204,300	328	1,201,755	1,930	5.9	1,843,524	9,121	2,961
Virginia	305,500	325	1,713,200	1,822	5.6	2,553,309	8,403	2,716
West Virginia	106,480	368	616,345	2,130	5.8	875,402	8,273	3,025

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 2008

	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	980,600	391	5,407,450	2,158	5.5	$7,752,876	$7,947	$3,094
Alabama	268,195	412	1,446,705	2,222	5.4	1,959,094	7,354	3,009
Kentucky	235,830	380	1,290,015	2,077	5.5	2,000,708	8,524	3,221
Mississippi	173,935	398	1,023,470	2,343	5.9	1,374,487	7,933	3,147
Tennessee	302,640	380	1,647,260	2,067	5.4	2,418,587	8,031	3,035
West South Central	1,342,605	355	7,463,415	1,973	5.6	11,462,316	8,601	3,030
Arkansas	154,335	346	854,545	1,916	5.5	1,238,634	8,048	2,777
Louisiana	200,490	385	1,142,650	2,195	5.7	1,614,241	8,122	3,101
Oklahoma	190,505	381	1,011,540	2,024	5.3	1,509,975	7,957	3,021
Texas	797,275	344	4,454,680	1,923	5.6	7,099,465	8,983	3,065
Mountain	529,330	272	2,668,510	1,372	5.0	4,907,896	9,313	2,522
Arizona	163,470	298	825,050	1,503	5.0	1,580,945	9,712	2,879
Colorado	109,275	284	540,820	1,404	4.9	975,819	8,971	2,533
Idaho	33,925	210	163,555	1,014	4.8	315,124	9,314	1,954
Montana	33,790	248	158,595	1,165	4.7	282,156	8,371	2,072
Nevada	67,080	292	389,770	1,699	5.8	660,828	9,909	2,880
New Mexico	58,225	261	295,045	1,324	5.1	520,577	9,009	2,336
Utah	44,870	237	206,130	1,087	4.6	402,402	8,991	2,123
Wyoming	18,695	260	89,545	1,244	4.8	170,043	9,103	2,363
Pacific	1,107,580	273	6,198,665	1,526	5.6	13,014,397	11,850	3,205
Alaska	13,530	229	77,020	1,306	5.7	186,766	13,881	3,166
California	818,050	289	4,716,340	1,664	5.8	9,980,284	12,322	3,522
Hawaii	24,360	201	167,415	1,379	6.9	285,762	11,803	2,353
Oregon	77,295	225	382,505	1,112	4.9	760,570	9,876	2,210
Washington	174,345	248	855,385	1,218	4.9	1,801,013	10,372	2,563
Outlying Areas[5]	52,395	81	378,720	585	7.2	279,825	5,452	433

[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 Research, Development, and Information.

Table 5.5

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Diagnoses Within Major Diagnostic Classifications (MDCs): Calendar Year 2008

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	---	11,820,795	338	66,590,540	5.6	$110,231,606	$9,390	$1,655
Leading Diagnoses[5]	---	6,244,805	179	35,415,900	5.7	61,858,300	9,966	1,747
Infectious and Parasitic Diseases (MDC 1)	001-139	576,065	16	4,658,155	8.1	7,868,323	13,763	1,689
Septicemia	038	414,740	12	3,596,560	8.7	6,420,464	15,604	1,785
Neoplasms (MDC 2)	140-239	557,250	16	3,831,920	6.9	7,249,745	13,069	1,892
Malignant Neoplasms	140-208,230-234	484,395	14	3,452,535	7.1	6,467,737	13,413	1,873
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	66,920	2	621,870	9.3	1,153,085	17,275	1,854
Malignant Neoplasm of Trachea, Bronchus, and Lun	162,176.4,197.0, 197.3	80,965	2	591,950	7.3	1,118,320	13,865	1,889
Malignant Neoplasm of Breast	174-175,198.81	24,740	1	62,805	2.5	135,170	5,496	2,152
Benign Neoplasms	210-229	53,135	2	267,325	5.0	581,725	10,993	2,176
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	490,675	14	2,352,195	4.8	3,143,556	6,467	1,336
Diabetes Mellitus	250	180,625	5	1,047,020	5.8	1,454,334	8,144	1,389
Volume Depletion	276.5	128,965	4	514,500	4.0	578,948	4,517	1,125
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	162,840	5	763,645	4.7	1,042,386	6,553	1,365
Mental Disorders (MDC 5)	290-319	468,325	13	4,346,265	9.3	2,924,629	6,381	673
Psychoses	290-299	402,285	11	3,939,745	9.8	2,640,315	6,710	670
Alcohol Dependence Syndrome	303	14,965	(6)	93,180	6.2	58,874	4,008	632
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	266,695	8	1,625,630	6.1	1,952,839	7,379	1,201

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 2008

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	2,873,930	82	14,002,870	4.9	$30,255,379	$10,582	$2,161
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	1,948,675	56	9,534,180	4.9	21,739,740	11,210	2,280
Acute Myocardial Infarction	410	290,880	8	1,647,815	5.7	3,956,605	13,652	2,401
Coronary Atherosclerosis	414.0	394,150	11	1,488,900	3.8	5,330,055	13,614	3,580
Other Ischemic Heart Disease	411-413, 414.1-414.9	35,000	1	97,490	2.8	381,491	10,978	3,913
Cardiac Dysrhythmias	427	404,185	12	1,573,470	3.9	3,236,129	8,042	2,057
Congestive Heart Failure	428.0	299,810	9	1,533,180	5.1	2,457,820	8,237	1,603
Cerebrovascular Disease	430-438	484,635	14	2,247,505	4.6	3,848,768	7,983	1,712
Diseases of the Respiratory System (MDC 8)	460-519	1,479,260	42	8,939,595	6.0	12,283,803	8,343	1,374
Acute Bronchitis and Bronchocolitis	466	30,770	1	119,795	3.9	117,330	3,830	979
Pneumonia	480-486	495,490	14	2,955,110	6.0	3,602,235	7,298	1,219
Asthma	493	101,700	3	487,630	4.8	541,089	5,348	1,110
Diseases of the Digestive System (MDC 9)	520-579	1,129,725	32	6,321,210	5.6	9,631,799	8,577	1,524
Appendicitis	540-543	21,055	1	103,175	4.9	195,794	9,355	1,898
Non Infectious Enteritis and Colitis	555-558	95,060	3	527,080	5.5	733,492	7,757	1,392
Diverticula of Intestine	562	119,690	3	659,250	5.5	909,669	7,629	1,380
Cholelithiasis	574	100,090	3	529,390	5.3	966,096	9,698	1,825
Diseases of the Genitourinary System (MDC 10)	580-629	706,545	20	3,438,765	4.9	4,468,331	6,357	1,299
Calculus of Kidney and Ureter	592	30,290	1	96,780	3.2	186,489	6,191	1,927

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 2008

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	216,285	6	1,256,950	5.8	$1,355,102	$6,303	$1,078
Cellulitis and Abscess	681-682	171,755	5	915,475	5.3	956,354	5,595	1,045
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	808,500	23	3,233,810	4.0	8,646,073	10,740	2,674
Osteoarthrosis and Allied Disorders	715	389,995	11	1,388,625	3.6	4,273,860	10,985	3,078
Intervertebral Disc Disorders	722	83,325	2	295,260	3.5	968,619	11,683	3,281
Congenital Anomalies (MDC 14)	740-759	11,150	(6)	55,805	5.0	194,587	17,530	3,487
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	665,780	19	2,081,990	3.1	2,898,890	4,399	1,392
Injury and Poisoning (MDC 17)	800-999	1,085,185	31	6,298,345	5.8	11,801,109	10,949	1,874
Fractures, All Sites	800-829	437,430	13	2,436,800	5.6	4,297,311	9,864	1,764
Fracture of Neck of Femur	820	204,785	6	1,241,965	6.1	2,357,405	11,536	1,898
Poisoning by Drugs, Medicinal and Biological Substances	960-989	55,735	2	208,980	3.7	319,057	5,776	1,527
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	302,960	9	3,313,175	10.9	4,442,725	14,832	1,341

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

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

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

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

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

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

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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.6

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2008

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	---	6,941,190	198	44,512,570	6.4	$83,399,144	$12,096	$1,874
Leading Procedures [5]	---	2,946,020	84	17,542,445	6.0	32,180,779	10,992	1,834
Operations on the Nervous System (MPC 1)	01-05	163,690	5	1,069,035	6.5	2,197,259	13,492	2,055
Spinal Tap	03.31	36,615	1	262,335	7.2	297,182	8,163	1,133
Operations on the Endocrine System (MPC 2)	06-07	25,540	1	100,165	3.9	238,326	9,388	2,379
Operations on the Eye (MPC 3)	08-16	8,150	(6)	35,205	4.3	63,494	7,853	1,804
Operations on the Ear (MPC 4)	18-20	2,620	(6)	13,525	5.2	25,982	10,032	1,921
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	26,800	1	138,460	5.2	218,612	8,267	1,579
Operations on the Respiratory System (MPC 6)	30-34	272,080	8	2,889,635	10.6	5,181,800	19,146	1,793
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	63,535	2	589,330	9.3	729,114	11,547	1,237
Operations on the Cardiovascular System (MPC 7)	35-39	1,487,250	43	9,694,535	6.5	21,680,042	14,688	2,236
Removal of Coronary Artery Obstruction	36.0	3,410	(6)	11,270	3.3	47,996	14,242	4,259
Coronary Artery Bypass Graft	36.1	86,625	2	876,110	10.1	2,733,358	31,664	3,120
Cardiac Catheterization	37.21-37.23	226,915	6	935,655	4.1	1,640,845	7,275	1,754
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	132,045	4	656,685	5.0	1,969,684	14,977	2,999
Hemodialysis	39.95	235,980	7	1,224,330	5.2	1,902,880	8,200	1,554
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	46,280	1	360,955	7.8	664,304	14,426	1,840

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 2008

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	1,124,640	32	8,303,465	7.4	$12,751,594	$11,401	$1,536
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	302,340	9	1,746,620	5.8	1,873,484	6,232	1,073
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	107,655	3	628,705	5.8	657,146	6,132	1,045
Partial Excision of Large Intestine	45.7	90,275	3	1,002,155	11.1	1,969,691	21,871	1,965
Appendectomy, Excluding Incidental	47.0	19,155	1	88,870	4.6	174,765	9,181	1,967
Cholecystectomy	51.2	103,215	3	643,010	6.2	1,210,010	11,780	1,882
Lysis of Peritoneal Adhesions	54.5	30,595	1	317,430	10.4	559,899	18,381	1,764
Operations on the Urinary System (MPC 10)	55-59	201,305	6	1,224,330	6.1	2,075,210	10,364	1,695
Cystoscopy with or Without Biopsy	57.31-57.33	12,805	(6)	94,865	7.4	95,271	7,475	1,004
Operations on the Male Genital Organs (MPC 11)[7]	60-64	75,635	5	247,665	3.3	470,850	6,264	1,901
Prostatectomy	60.2-60.6	66,200	4	194,285	2.9	377,843	5,740	1,945
Operations on the Female Genital Organs (MPC 12)[8]	65-71	91,775	5	310,875	3.4	611,996	6,709	1,969
Unilateral Oophorectomy	65.3-65.6	8,910	(6)	40,600	4.6	73,095	8,255	1,800
Hysterectomy	68.3-68.7,68.9	48,425	3	161,215	3.3	324,503	6,740	2,013
Obstetrical Procedures (MPC 13)	72-75	14,140	1	46,155	3.3	50,957	3,653	1,104
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	520	(6)	1,235	2.4	1,055	2,049	854
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	6,240	(6)	26,695	4.3	31,439	5,150	1,178
Repair of Current Obstetric Laceration	75.5-75.6	1,350	(6)	3,205	2.4	3,050	2,268	952
Operations on the Musculoskeletal System (MPC 14)	76-84	1,089,765	31	5,672,650	5.2	13,691,872	12,610	2,414
Partial Excision of Bone	76.2-76.3,77.6-77.8	15,050	(6)	132,435	8.8	236,932	15,918	1,789
Reduction of Facial Fracture	76.7,79.0-79.3	193,910	6	1,116,385	5.8	2,108,989	10,915	1,889
Open Reduction of Fracture with Internal Fixation	79.3	138,655	4	796,660	5.7	1,531,861	11,091	1,923
Excision or Destruction of Intervertebral Disc	80.5	25,065	1	69,020	2.8	172,470	6,908	2,499
Total Hip Replacement	81.51	114,730	3	448,835	3.9	1,322,659	11,551	2,947
Total Knee Replacement	81.54	265,845	8	956,235	3.6	2,981,910	11,242	3,118

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 2008

		Discharges[2]		Total Days of Care		Program Payments		
Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Operations on the Integumentary System (MPC 15)	85-86	236,825	7	1,834,800	7.7	$2,555,415	$10,880	$1,393
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	73,960	2	763,765	10.3	1,180,021	16,100	1,545
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,690,120	48	11,178,530	6.6	15,204,352	9,076	1,360
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	98,415	3	468,865	4.8	637,386	6,514	1,359
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	48,580	1	233,080	4.8	321,831	6,674	1,381
Diagnostic Ultrasound	88.7	150,430	4	785,665	5.2	976,729	6,524	1,243
Respiratory Therapy	93.9,96.7	298,930	9	2,548,205	8.5	4,675,724	15,788	1,835
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	40,010	1	292,160	7.3	506,237	12,744	1,733
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	37,985	1	222,565	5.9	386,891	10,257	1,738

[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 Research, Development, and Information.

Table 5.7

Discharges, Total Days of Care, Total Charges and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs): Calendar Year 2008

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	-----	11,820,795	66,590,540	5.6	$420,205,543	$110,231,606	$9,573	$1,655
Leading DRGs[2]	-----	7,103,730	37,112,750	5.2	198,755,889	51,997,805	7,497	1,401
039[3]	Extracranial Procedures without CC or MCC	45,325	77,415	1.7	1,094,018	250,132	5,709	3,231
057	Degenerative Nervous system Disorders without MCC	74,375	618,490	8.3	1,555,180	508,147	6,940	822
064	Intracranial Hemorrhage or Cerebral Infarction with MCC	68,780	488,500	7.1	2,856,068	690,943	10,195	1,414
065	Intracranial Hemorrhage or Cerebral Infarction with CC	108,280	543,115	5.0	2,868,039	713,246	6,687	1,313
066	Intracranial Hemorrhage or Cerebral Infarction without CC or MCC	71,405	244,205	3.4	1,400,846	371,048	5,330	1,519
069	Transient Ischemia	96,940	281,825	2.9	1,727,976	360,999	3,804	1,281
101	Seizures without MCC	55,305	193,145	3.5	1,014,309	250,654	4,659	1,298
177	Respiratory Infections & Inflammations with MCC	81,295	710,460	8.7	3,613,063	904,764	11,286	1,273
178	Respiratory Infections & Inflammations with CC	64,860	448,020	6.9	2,021,872	557,054	8,714	1,243
189	Pulmonary Edema & Respiratory Failure	123,980	734,850	5.9	3,728,819	968,513	7,960	1,318
190	Chronic Obstructive Pulmonary Disease with MCC	139,290	797,005	5.7	3,725,903	901,678	6,585	1,131
191	Chronic Obstructive Pulmonary Disease with CC	140,865	668,905	4.7	2,968,341	714,697	5,169	1,068
192	Chronic Obstructive Pulmonary Disease without CC or MCC	153,225	576,765	3.8	2,412,957	618,455	4,127	1,072
193	Simple Pneumonia & Pleurisy with MCC	120,375	792,170	6.6	3,800,559	892,928	7,543	1,127
194	Simple Pneumonia & Pleurisy with CC	206,580	1,036,520	5.0	4,474,919	1,121,859	5,525	1,082
195	Simple Pneumonia & Pleurisy without CC or MCC	102,245	388,160	3.8	1,566,095	416,032	4,142	1,072
208	Respiratory System Diagnosis with Ventilator Support < 96 Hours	77,265	551,690	7.1	4,124,353	1,067,067	14,105	1,934
244[3]	Permanent Cardiac Pacemaker Implant without CC or MCC	49,085	135,570	2.8	2,179,553	600,590	12,501	4,430
247[3]	Percutaneous Cardiovascular Proc with Drug-Eluting Stent without MCC	148,435	311,300	2.1	7,554,377	1,772,945	12,484	5,695
249[3]	Percutaneous Cardiovascular Proc with Non-Drug-Eluting Stent without MCC	61,265	155,940	2.5	2,817,088	616,453	10,740	3,953
252[3]	Other Vascular Procedures with MCC	45,875	375,325	8.2	3,242,756	876,137	19,489	2,334
254[3]	Other Vascular Procedures without CC or MCC	43,025	112,160	2.6	1,644,416	411,878	9,835	3,672
280	Acute Myocardial Infarction, Discharged Alive with MCC	81,520	549,835	6.7	3,197,986	839,994	10,439	1,528
281	Acute Myocardial Infarction, Discharged Alive with CC	48,080	209,460	4.4	1,270,105	338,312	7,140	1,615
287	Circulatory Disorders Except AMI, with Cardiac Cath							

	without MCC	136,920	417,190	3.0	3,810,686	827,659	6,257	1,984

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 2008

DRG Code	Description	Discharges	Total Days of Care		Total	Program Payments		
			Number	Per Discharge	Charges in Thousands	Amount in Thousands	Per Discharge [1]	Per Day
291	Heart Failure & Shock with MCC	214,425	1,350,185	6.3	$6,780,589	$1,678,115	$7,951	$1,243
292	Heart Failure & Shock with CC	197,950	921,815	4.7	4,157,961	1,115,688	5,716	1,210
293	Heart Failure & Shock without CC or MCC	132,030	447,140	3.4	2,034,149	598,926	4,603	1,339
300	Peripheral Vascular Disorders with CC	43,815	211,110	4.8	870,258	227,996	5,319	1,080
303	Atherosclerosis without MCC	56,605	139,890	2.5	787,989	172,935	3,133	1,236
308	Cardiac Arrhythmia & Conduction Disorders with MCC	61,515	322,410	5.2	1,689,979	415,788	6,869	1,290
309	Cardiac Arrhythmia & Conduction Disorders with CC	91,225	337,975	3.7	1,663,955	406,371	4,519	1,202
310	Cardiac Arrhythmia & Conduction Disorders without CC or MCC	133,795	344,490	2.6	1,768,771	407,298	3,122	1,182
312	Syncope & Collapse	165,185	503,700	3.0	2,849,406	633,845	3,916	1,258
313	Chest Pain	183,070	384,585	2.1	2,564,235	490,778	2,786	1,276
314	Other Circulatory System Diagnoses with MCC	67,145	472,145	7.0	2,749,440	682,415	10,551	1,445
329 [3]	Major Small & Large Bowel Procedures with MCC	51,335	803,575	15.7	5,945,273	1,583,091	31,417	1,970
330 [3]	Major Small & Large Bowel Procedures with CC	59,000	539,360	9.1	3,262,891	972,473	16,946	1,803
377	G.I. Hemorrhage with MCC	65,330	405,645	6.2	2,339,158	555,989	8,657	1,371
378	G.I. Hemorrhage with CC	120,055	502,510	4.2	2,616,735	668,552	5,659	1,330
379	G.I. Hemorrhage without CC or MCC	58,585	182,080	3.1	945,238	251,692	4,403	1,382
389	G.I. Obstruction with CC	45,900	220,105	4.8	967,019	235,476	5,251	1,070
391	Esophagitis, Gastroent & Misc Digest Disorders with MCC	52,780	266,505	5.0	1,343,778	308,303	6,010	1,157
392	Esophagitis, Gastroent & Misc Digest Disorders without MCC	240,055	822,420	3.4	3,972,468	863,131	3,707	1,050
394	Other Digestive System Diagnoses with CC	46,070	214,115	4.6	1,015,775	267,410	5,925	1,249
460 [3]	Spinal Fusion Except Cervical without MCC	56,650	227,120	4.0	4,499,738	1,166,250	21,615	5,135
470 [3]	Major Joint Replacement or Reattachment of Lower Extremity without MCC	403,595	1,514,895	3.8	17,467,246	4,397,625	11,304	2,903
481 [3]	Hip & Femur Procedures Except Major Joint with CC	75,320	425,925	5.7	3,013,818	783,806	10,536	1,840
491 [3]	Back & Neck Proc Except Spinal Fusion without CC or MCC	48,370	101,390	2.1	1,124,750	246,710	5,298	2,433
552	Medical Back Problems without MCC	77,165	310,680	4.0	1,367,556	309,880	4,148	997
603	Cellulitis without MCC	125,740	570,615	4.5	2,132,785	535,007	4,359	938
638	Diabetes with CC	46,290	191,305	4.1	845,030	209,431	4,638	1,095

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 2008

DRG Code	Description	Discharges	Total Days of Care		Total Charges in Thousands	Program Payments		
			Number	Per Discharge		Amount in Thousands	Per Discharge1	Per Day
640	Nutritional & Misc Metabolic Disorders with MCC	71,775	360,925	5.0	$1,707,345	$436,827	$6,217	$1,210
641	Nutritional & Misc Metabolic Disorders without MCC	178,825	643,430	3.6	2,667,661	671,006	3,826	1,043
682	Renal Failure with MCC	107,325	745,790	6.9	3,881,042	996,689	9,474	1,336
683	Renal Failure with CC	125,910	640,505	5.1	2,864,036	832,739	6,738	1,300
689	Kidney & Urinary Tract Infections with MCC	76,220	447,010	5.9	1,938,986	477,185	6,339	1,068
690	Kidney & Urinary Tract Infections without MCC	189,975	769,790	4.1	3,145,426	792,603	4,230	1,030
812	Red Blood Cell Disorders without MCC	90,440	331,680	3.7	1,561,778	376,492	4,360	1,135
871	Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours with MCC	273,550	1,993,460	7.3	11,539,834	2,979,617	11,080	1,495
872	Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours without MCC	79,720	425,630	5.3	1,910,536	576,621	7,358	1,355
885	Psychoses	318,725	3,329,545	10.4	6,864,633	2,155,123	7,027	647
897	Alcohol /Drug Abuse or Dependence without Rehabilitation Therapy without MCC	45,305	201,705	4.5	586,591	154,621	3,628	767
945	Rehabilitation with CC or MCC	178,220	2,367,460	13.3	6,561,491	2,936,383	16,853	1,240
946	Rehabilitation without CC or MCC	51,765	524,020	10.1	1,289,011	651,627	12,929	1,244
948	Signs and Symptoms without MCC	52,380	180,090	3.4	791,214	183,073	3,587	1,017
All Other DRGs		4,717,065	29,477,790	6.2	221,449,654	58,233,799	12,719	1,976

[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 2008.
[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 25.0 and 26.0, 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.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.8

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2008

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	11,820,795	9,451,000	4,074,525	11,789,395	4,102,575	11,713,870
1-8 Days	9,803,730	7,734,900	3,112,320	9,779,035	3,095,275	9,717,050
9-20 Days	1,704,240	1,447,110	780,380	1,699,290	807,440	1,689,125
21-30 Days	209,450	180,620	115,425	208,605	126,925	206,925
31-40 Days	56,750	48,105	35,675	56,375	39,310	55,690
41-50 Days	22,425	19,135	14,570	22,250	16,000	21,915
51-60 Days	10,135	8,725	6,970	10,035	7,650	9,820
61-90 Days	9,690	8,505	6,450	9,530	6,965	9,280
91 Days or More	4,375	3,900	2,735	4,275	3,010	4,065
			Percent of Total Discharges [3]			
Total	100.0	80.0	34.5	99.7	34.7	99.1
1-8 Days	100.0	78.9	31.7	99.7	31.6	99.1
9-20 Days	100.0	84.9	45.8	99.7	47.4	99.1
21-30 Days	100.0	86.2	55.1	99.6	60.6	98.8
31-40 Days	100.0	84.8	62.9	99.3	69.3	98.1
41-50 Days	100.0	85.3	65.0	99.2	71.3	97.7
51-60 Days	100.0	86.1	68.8	99.0	75.5	96.9
61-90 Days	100.0	87.8	66.6	98.3	71.9	95.8
91 Days or More	100.0	89.1	62.5	97.7	68.8	92.9
			Total Charges in Thousands			
Total	$420,205,543	$63,904,198	$48,666,291	$307,637,492	$36,431,887	$58,191,671
1-8 Days	247,015,483	33,615,272	21,348,575	192,053,573	25,673,057	28,226,998
9-20 Days	113,497,480	20,367,575	16,107,419	77,022,902	7,758,826	18,360,535
21-30 Days	29,193,483	4,933,909	4,964,854	19,294,774	1,614,497	5,528,468
31-40 Days	12,357,421	1,938,157	2,374,766	8,044,513	627,934	2,481,386
41-50 Days	6,561,884	1,001,942	1,353,931	4,206,016	311,469	1,322,896
51-60 Days	3,676,750	567,716	782,255	2,326,781	155,928	744,632
61-90 Days	4,467,640	743,697	963,074	2,760,870	179,897	901,958
91 Days or More	3,435,399	735,926	771,414	1,928,059	110,276	624,794

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 2008

Type of Ancillary Service					
Laboratory	Radiology[1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
Number of Discharges					
11,686,735	10,326,515	9,825,445	8,727,550	5,645,575	10,858,490
9,684,790	8,505,345	8,082,250	7,142,550	4,382,950	8,917,715
1,692,065	1,536,355	1,473,405	1,330,945	1,047,380	1,639,015
207,680	189,925	181,045	166,550	140,595	202,380
56,230	52,145	49,210	47,725	40,680	54,680
22,215	20,585	19,380	18,935	16,270	21,640
9,985	9,390	8,725	8,865	7,560	9,765
9,510	8,820	7,995	8,325	7,140	9,210
4,260	3,950	3,435	3,655	3,000	4,085
Percent of Total Discharges[3]					
98.9	87.4	83.1	73.8	47.8	91.9
98.8	86.8	82.4	72.9	44.7	91.0
99.3	90.1	86.5	78.1	61.5	96.2
99.2	90.7	86.4	79.5	67.1	96.6
99.1	91.9	86.7	84.1	71.7	96.4
99.1	91.8	86.4	84.4	72.6	96.5
98.5	92.6	86.1	87.5	74.6	96.3
98.1	91.0	82.5	85.9	73.7	95.0
97.4	90.3	78.5	83.5	68.6	93.4
Total Charges in Thousands					
$49,537,340	$33,638,871	$55,133,678	$22,479,773	$14,357,475	$37,866,793
28,979,671	22,257,362	40,652,875	17,640,001	5,359,289	23,264,316
13,744,529	8,152,278	10,304,959	3,818,018	4,992,989	9,890,764
3,404,569	1,756,357	2,190,491	602,248	1,712,532	2,485,609
1,430,773	670,070	849,279	204,866	851,491	928,710
748,171	325,245	439,551	90,247	488,357	480,076
418,404	173,112	234,420	45,853	286,722	267,706
484,872	191,162	275,068	50,317	362,915	314,678
326,348	113,281	187,032	28,219	303,177	234,930

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 2008

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	15.2	11.6	73.2	8.7	13.8
1-8 Days	100.0	13.6	8.6	77.7	10.4	11.4
9-20 Days	100.0	17.9	14.2	67.9	6.8	16.2
21-30 Days	100.0	16.9	17.0	66.1	5.5	18.9
31-40 Days	100.0	15.7	19.2	65.1	5.1	20.1
41-50 Days	100.0	15.3	20.6	64.1	4.7	20.2
51-60 Days	100.0	15.4	21.3	63.3	4.2	20.3
61-90 Days	100.0	16.6	21.6	61.8	4.0	20.2
91 Days or More	100.0	21.4	22.5	56.1	3.2	18.2
			Average Total Charge Per Discharge			
Total	$35,548	$6,762	$11,944	$26,094	$8,880	$4,968
1-8 Days	25,196	4,346	6,859	19,639	8,294	2,905
9-20 Days	66,597	14,075	20,640	45,327	9,609	10,870
21-30 Days	139,382	27,317	43,014	92,494	12,720	26,717
31-40 Days	217,752	40,290	66,567	142,696	15,974	44,557
41-50 Days	292,615	52,362	92,926	189,034	19,467	60,365
51-60 Days	362,778	65,068	112,232	231,867	20,383	75,828
61-90 Days	461,057	87,442	149,314	289,703	25,829	97,194
91 Days or More	785,234	188,699	282,053	451,008	36,637	153,701

[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 Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.8--Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2008

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
		Percent of Total Charges [4]			
11.8	8.0	13.1	5.3	3.4	9.0
11.7	9.0	16.5	7.1	2.2	9.4
12.1	7.2	9.1	3.4	4.4	8.7
11.7	6.0	7.5	2.1	5.9	8.5
11.6	5.4	6.9	1.7	6.9	7.5
11.4	5.0	6.7	1.4	7.4	7.3
11.4	4.7	6.4	1.2	7.8	7.3
10.9	4.3	6.2	1.1	8.1	7.0
9.5	3.3	5.4	0.8	8.8	6.8
		Average Total Charge Per Dischar g			
$4,239	$3,258	$5,611	$2,576	$2,543	$3,487
2,992	2,617	5,030	2,470	1,223	2,609
8,123	5,306	6,994	2,869	4,767	6,035
16,393	9,248	12,099	3,616	12,181	12,282
25,445	12,850	17,258	4,293	20,931	16,984
33,679	15,800	22,681	4,766	30,016	22,185
41,903	18,436	26,868	5,172	37,926	27,415
50,986	21,674	34,405	6,044	50,828	34,167
76,608	28,679	54,449	7,721	101,059	57,510

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 2008

Total Days of Care	Discharges[1]		Total Days of Care			Program Payments			
	Number	Percent	Number	Percent	Per Discharge	Amount in Thousands	Percent	Per Discharge[2]	Per Day
Total	11,820,795	100.0	66,590,540	100.0	5.6	$110,231,606	100.0	$9,390	$1,655
1 Day	1,593,920	13.5	1,593,920	2.4	1.0	10,278,246	9.3	6,535	6,448
2 Days	1,738,505	14.7	3,477,010	5.2	2.0	10,332,290	9.4	5,978	2,972
3 Days	1,946,585	16.5	5,839,755	8.8	3.0	13,312,264	12.1	6,874	2,280
4 Days	1,478,495	12.5	5,913,980	8.9	4.0	11,044,370	10.0	7,506	1,868
5 Days	1,082,320	9.2	5,411,600	8.1	5.0	8,864,898	8.0	8,230	1,638
6 Days	829,870	7.0	4,979,220	7.5	6.0	7,429,568	6.7	9,002	1,492
7 Days	653,605	5.5	4,575,235	6.9	7.0	6,443,599	5.8	9,915	1,408
8 Days	480,430	4.1	3,843,440	5.8	8.0	5,108,885	4.6	10,698	1,329
9 Days	351,685	3.0	3,165,165	4.8	9.0	4,023,229	3.6	11,516	1,271
10 Days	271,240	2.3	2,712,400	4.1	10.0	3,302,374	3.0	12,262	1,218
11 Days	218,700	1.9	2,405,700	3.6	11.0	2,867,384	2.6	13,198	1,192
12 Days	172,810	1.5	2,073,720	3.1	12.0	2,408,316	2.2	14,044	1,161
13 Days	149,355	1.3	1,941,615	2.9	13.0	2,224,292	2.0	15,023	1,146
14 Days	136,495	1.2	1,910,930	2.9	14.0	2,155,030	2.0	15,933	1,128
15 Days	105,435	0.9	1,581,525	2.4	15.0	1,796,881	1.6	17,179	1,136
16 Days	82,280	0.7	1,316,480	2.0	16.0	1,480,459	1.3	18,122	1,125
17 Days	67,800	0.6	1,152,600	1.7	17.0	1,303,382	1.2	19,387	1,131
18 Days	58,150	0.5	1,046,700	1.6	18.0	1,175,477	1.1	20,424	1,123
19 Days	47,470	0.4	901,930	1.4	19.0	1,010,208	0.9	21,533	1,120
20 Days	42,820	0.4	856,400	1.3	20.0	976,147	0.9	22,982	1,140
21-30 Days	209,450	1.8	5,098,380	7.7	24.3	6,133,289	5.6	29,604	1,203
31-40 Days	56,750	0.5	1,966,520	3.0	34.7	2,705,404	2.5	48,428	1,376
41-50 Days	22,425	0.2	1,004,725	1.5	44.8	1,444,641	1.3	65,725	1,438
51-60 Days	10,135	0.1	557,025	0.8	55.0	822,025	0.7	82,782	1,476
61-90 Days	9,690	0.1	692,260	1.0	71.4	978,884	0.9	104,862	1,414
91 Days or More	4,375	(3)	572,305	0.9	130.8	610,067	0.6	150,820	1,066

[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 totals because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.10

Number of Participating Short-Stay Hospitals (SSHs), Medicare Utilization and Program Payments for Beneficiaries Discharged from SSHs, by Location and Bedsize of Hospital, and by Medical School Affiliation (MSA), and Type of Control: Calendar Year 2008

Location and Bedsize of Hospital	Hospitals Number	Hospitals Percent	Discharges[1] Number	Discharges[1] Percent	Total Days of Care per Discharge	Program Payments Amount in Thousands	Program Payments Percent	Program Payments Per Discharge[2]
Total All Hospitals[3]	3,601	100.0	11,773,140	100.0	5.6	$110,026,508	100.0	$9,410
1-99 Beds	1,274	35.4	1,178,495	10.0	4.7	7,824,959	7.1	6,671
100-299 Beds	1,427	39.6	4,281,925	36.4	5.4	34,931,183	31.7	8,208
300-499 Beds	562	15.6	3,269,645	27.8	5.8	31,543,126	28.7	9,709
500 Beds or More	338	9.4	3,043,075	25.8	6.2	35,727,241	32.5	11,852
Total Urban Hospitals	2,410	100.0	10,091,715	100.0	5.7	98,749,031	100.0	9,857
1-99 Beds	556	23.1	573,460	5.7	4.8	4,319,173	4.4	7,576
100-299 Beds	1,002	41.6	3,372,865	33.4	5.5	28,595,607	29.0	8,533
300-499 Beds	520	21.6	3,128,010	31.0	5.8	30,333,690	30.7	9,759
500 Beds or More	332	13.8	3,017,380	29.9	6.2	35,500,562	36.0	11,878
Total Rural Hospitals	1,191	100.0	1,681,425	100.0	4.9	11,277,477	100.0	6,736
1-99 Beds	718	60.3	605,035	36.0	4.5	3,505,786	31.1	5,816
100-299 Beds	425	35.7	909,060	54.1	5.1	6,335,576	56.2	7,001
300-499 Beds	42	3.5	141,635	8.4	5.5	1,209,436	10.7	8,594
500 Beds or More	6	0.5	25,695	1.5	5.4	226,678	2.0	8,837
Total All Hospitals[3]	3,601	100.0	11,773,140	100.0	5.6	110,026,508	100.0	9,410
Voluntary	2,174	60.4	8,515,395	72.3	5.6	80,532,538	73.2	9,526
Proprietary	721	20.0	1,624,440	13.8	5.5	14,084,058	12.8	8,713
Government	706	19.6	1,633,305	13.9	5.7	15,409,912	14.0	9,503
Total Teaching Hospitals[4]	1,067	100.0	5,558,265	100.0	5.9	59,930,368	100.0	10,873
Voluntary	773	72.4	4,479,285	80.6	5.9	47,783,558	79.7	10,757
Proprietary	100	9.4	361,585	6.5	6.0	3,611,999	6.0	10,049
Government	194	18.2	717,395	12.9	6.2	8,534,811	14.2	12,010
Total Non-Teaching Hospitals	2,534	100.0	6,214,875	100.0	5.4	50,096,140	100.0	8,106
Voluntary	1,401	55.3	4,036,110	64.9	5.4	32,748,980	65.4	8,162
Proprietary	621	24.5	1,262,855	20.3	5.4	10,472,059	20.9	8,331
Government	512	20.2	915,910	14.7	5.3	6,875,101	13.7	7,547

[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 totals because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.11

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2008

Type of Hospital	Hospitals		Discharges		Covered Days of Care		
	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals[2]	6,212	100.0	12,661,180	100.0	73,336,305	100.0	5.8
Short-Stay Hospitals	3,689	59.4	11,820,795	93.4	64,262,950	87.6	5.4
Hospitals	3,689	59.4	11,275,745	89.1	58,005,385	79.1	5.1
Psychiatric Hospital Units[3]	NA	----	317,395	2.5	3,418,370	4.7	10.8
Rehabilitation Hospital Units[3]	NA	----	227,655	1.8	2,839,195	3.9	12.5
Specialty Hospitals	2,523	40.6	840,385	6.6	9,073,355	12.4	10.8
Childrens	79	1.3	2,430	(4)	18,385	(4)	7.6
Psychiatric	494	8.0	132,415	1.0	1,891,085	2.6	14.3
Rehabilitation	224	3.6	144,600	1.1	1,969,190	2.7	13.6
Long Term	404	6.5	135,255	1.1	3,641,045	5.0	26.9
Critical Access (formerly Short-Stay)	1,305	21.0	425,220	3.4	1,537,850	2.1	3.6
Religious Non-Medical	17	0.3	465	(4)	15,800	(4)	34.0

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 2008

Type of Hospital	Covered Charges				Program Payments			
	Amount in Thousands	Percent	Per Discharge	Per Covered Day	Amount in Thousands	Percent	Per Discharge[1]	Per Covered Day
Total All Hospitals[2]	$440,304,112	100.0	$34,776	$6,004	$120,343,396	100.0	$9,567	$1,641
Short-Stay Hospitals	416,187,561	94.5	35,208	6,476	110,231,606	91.6	9,390	1,715
Hospitals	401,260,203	91.1	35,586	6,918	104,225,180	86.6	9,243	1,797
Psychiatric Hospital Units[3]	6,960,399	1.6	21,930	2,036	2,371,085	2.0	7,611	694
Rehabilitation Hospital Units[3]	7,966,959	1.8	34,996	2,806	3,635,341	3.0	16,170	1,280
Specialty Hospitals	24,116,551	5.5	28,697	2,658	10,111,791	8.4	12,033	1,114
Childrens	147,177	(4)	60,567	8,005	47,668	(4)	19,657	2,593
Psychiatric	2,231,932	0.5	16,856	1,180	1,120,124	0.9	8,459	592
Rehabilitation	3,573,384	0.8	24,712	1,815	2,275,152	1.9	15,738	1,155
Long Term	13,976,388	3.2	103,334	3,839	4,502,278	3.7	33,293	1,237
Critical Access (formerly Short-Stay)	4,178,885	0.9	9,828	2,717	2,159,865	1.8	5,079	1,404
Religious Non-Medical	8,786	(4)	18,894	556	6,705	(4)	14,419	424

[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 1,268 distinct-part psychiatric units and 857 rehabilitation units participating in the Medicare Program during 2008.

[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 totals because of rounding. NA is not applicable.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.12

Short-Stay Hospital (SSH) Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2008

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]	11,755,505	1.5271	100.0	58.7	47.5	11.2	41.3
1-99 Beds	1,162,305	1.2743	100.0	44.0	33.3	10.7	56.0
100-299 Beds	4,280,480	1.4243	100.0	54.6	43.9	10.7	45.4
300-499 Beds	3,269,645	1.5728	100.0	61.2	50.4	10.8	38.8
500 Beds or More	3,043,075	1.7191	100.0	67.5	54.9	12.6	32.5
Total Urban Hospitals	10,075,160	1.5687	100.0	61.0	49.7	11.3	39.0
1-99 Beds	558,350	1.4035	100.0	52.5	42.1	10.4	47.5
100-299 Beds	3,371,420	1.4543	100.0	56.2	45.6	10.6	43.9
300-499 Beds	3,128,010	1.5757	100.0	61.4	50.5	10.9	38.7
500 Beds or More	3,017,380	1.7198	100.0	67.5	54.9	12.6	32.5
Total Rural Hospitals	1,680,345	1.2776	100.0	45.2	34.5	10.7	54.8
1-99 Beds	603,955	1.1548	100.0	36.1	25.2	10.9	63.9
100-299 Beds	909,060	1.3131	100.0	48.9	37.9	11.0	51.1
300-499 Beds	141,635	1.5084	100.0	57.3	48.2	9.1	42.7
500 Beds or More	25,695	1.6348	100.0	62.4	56.1	6.3	37.6

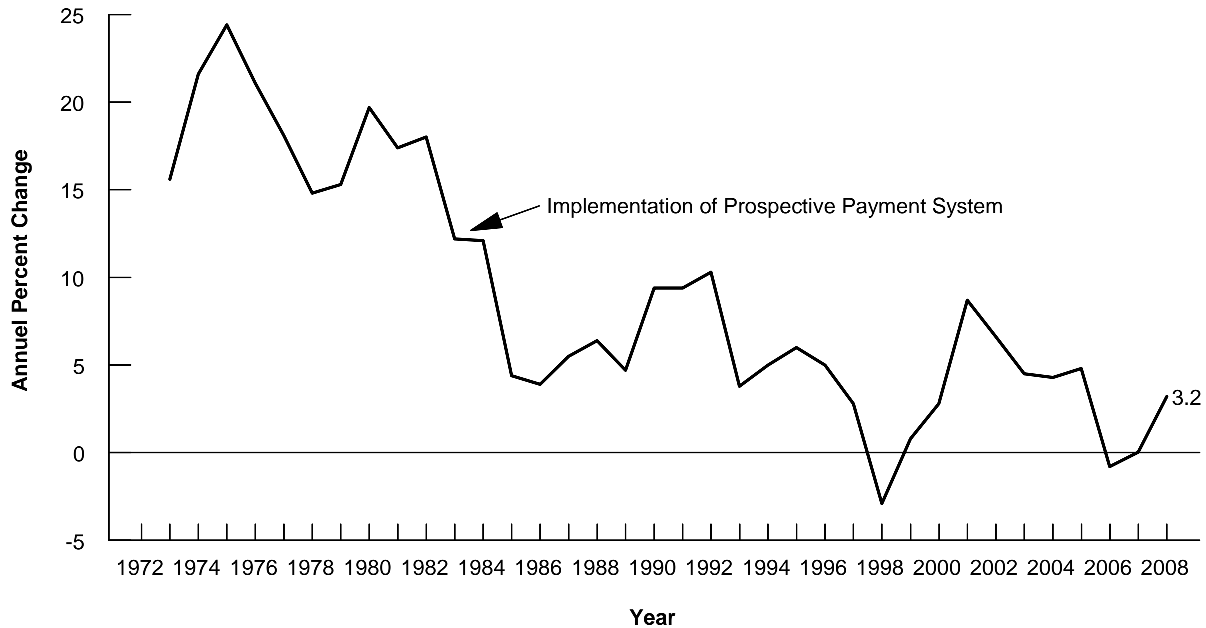
[1]For hospitals participating in the Medicare prospective payment system, the hospital case-mix index is a relative measure of the hospital's average cost per case relative to the average cost per case for all hospitals in some base or reference year. The case-mix index is presented by selected provider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

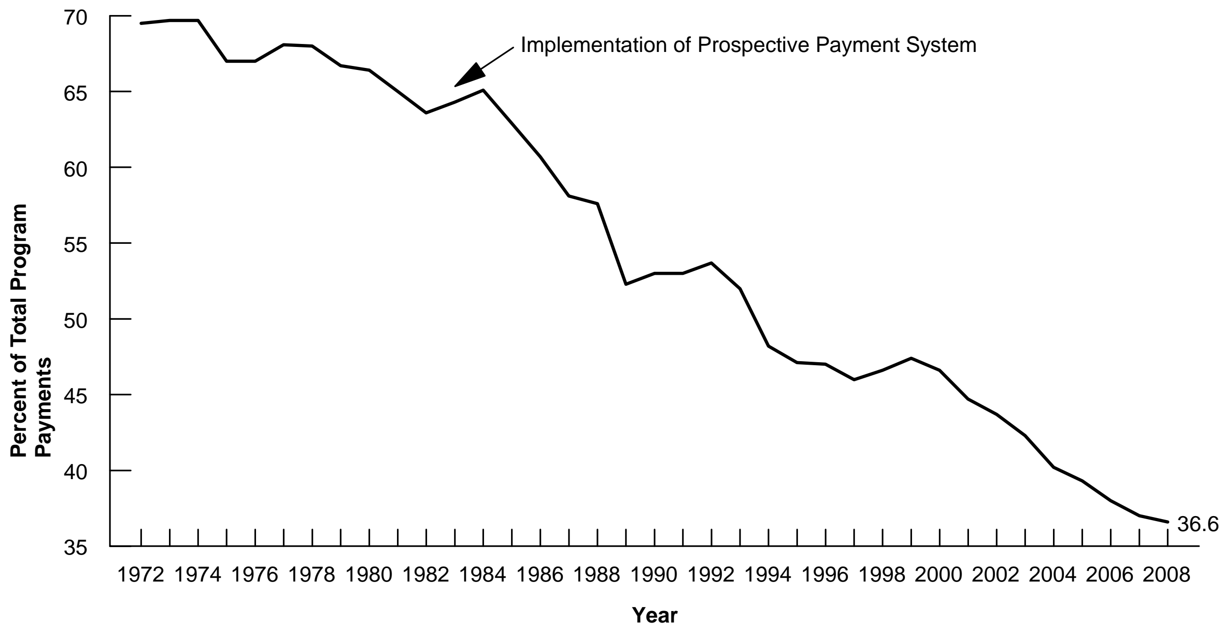
[2]Includes discharges from SSH in the 50 States and District of Columbia; excludes discharges from SSH in all outlying areas.

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 totals because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 5.1
Changes in Medicare Short-Stay Hospital Program Payments: Calendar Years 1972-2008

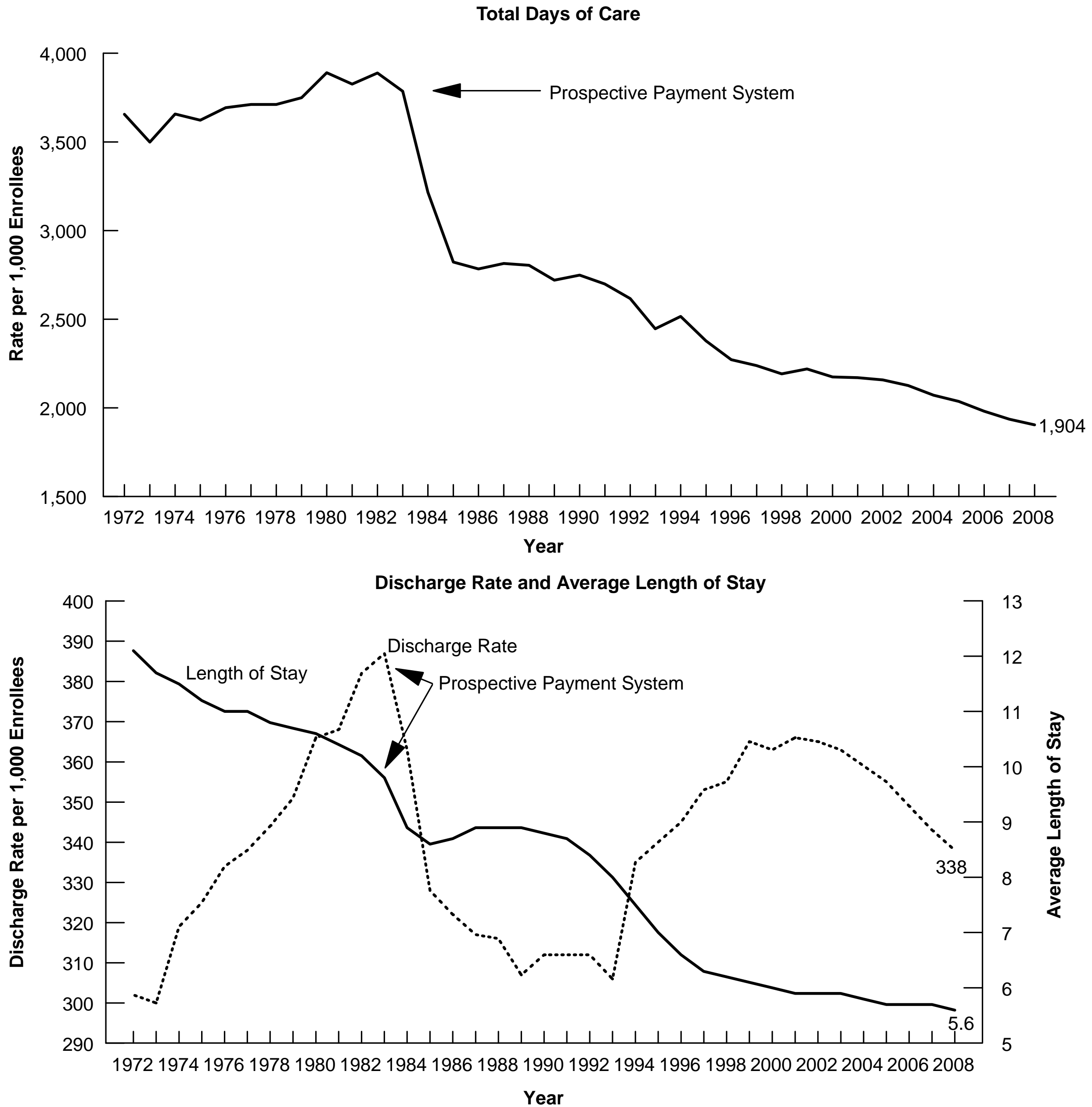




NOTE: The Medicare short-stay hospital prospective payment system was phased in by providers' fiscal years beginning on or after October 1, 1983.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

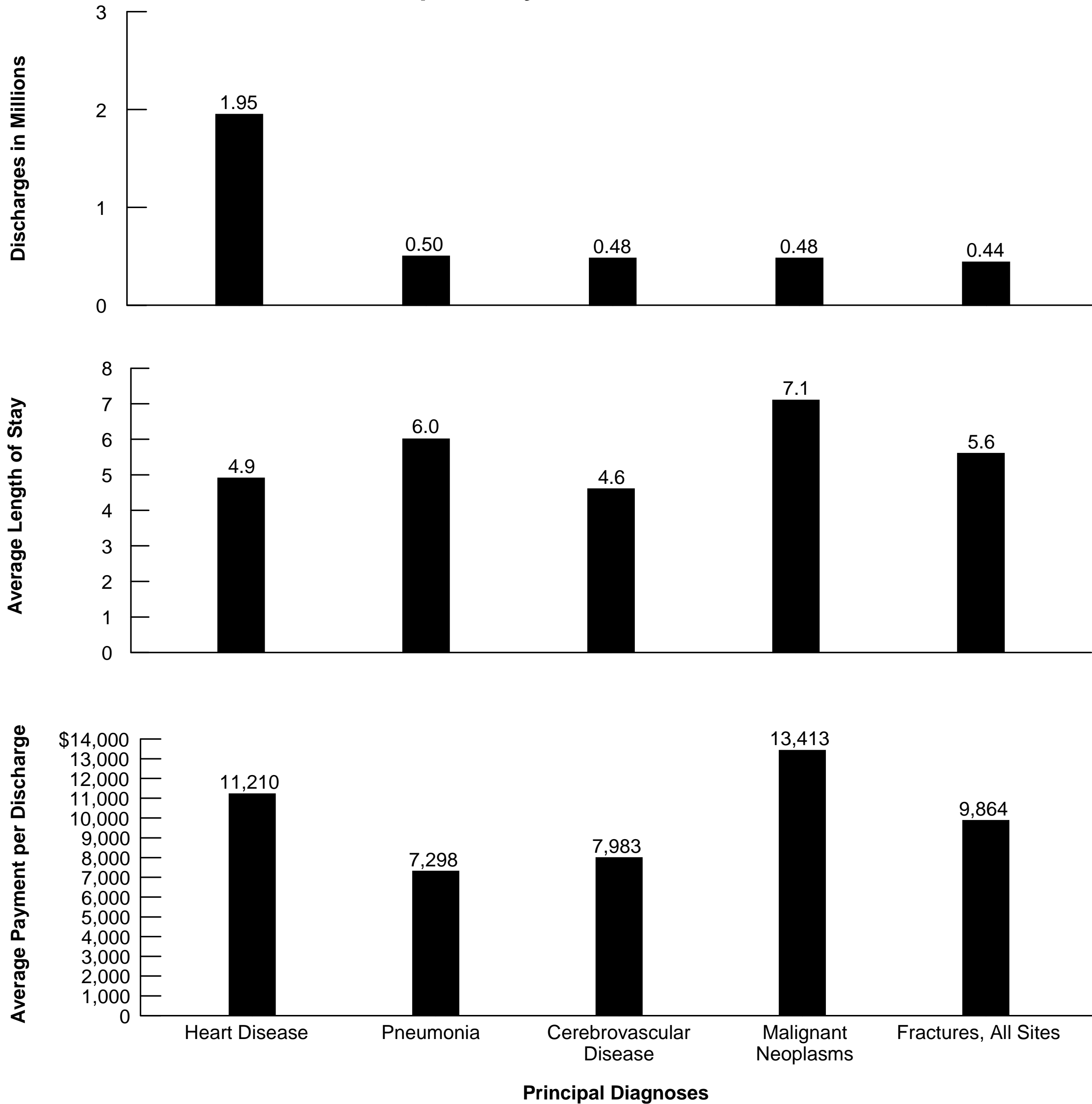
Figure 5.2
Trends in Parameters of Medicare Beneficiary Stays in Short-Stay Hospitals: Calendar Years 1972-2008



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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

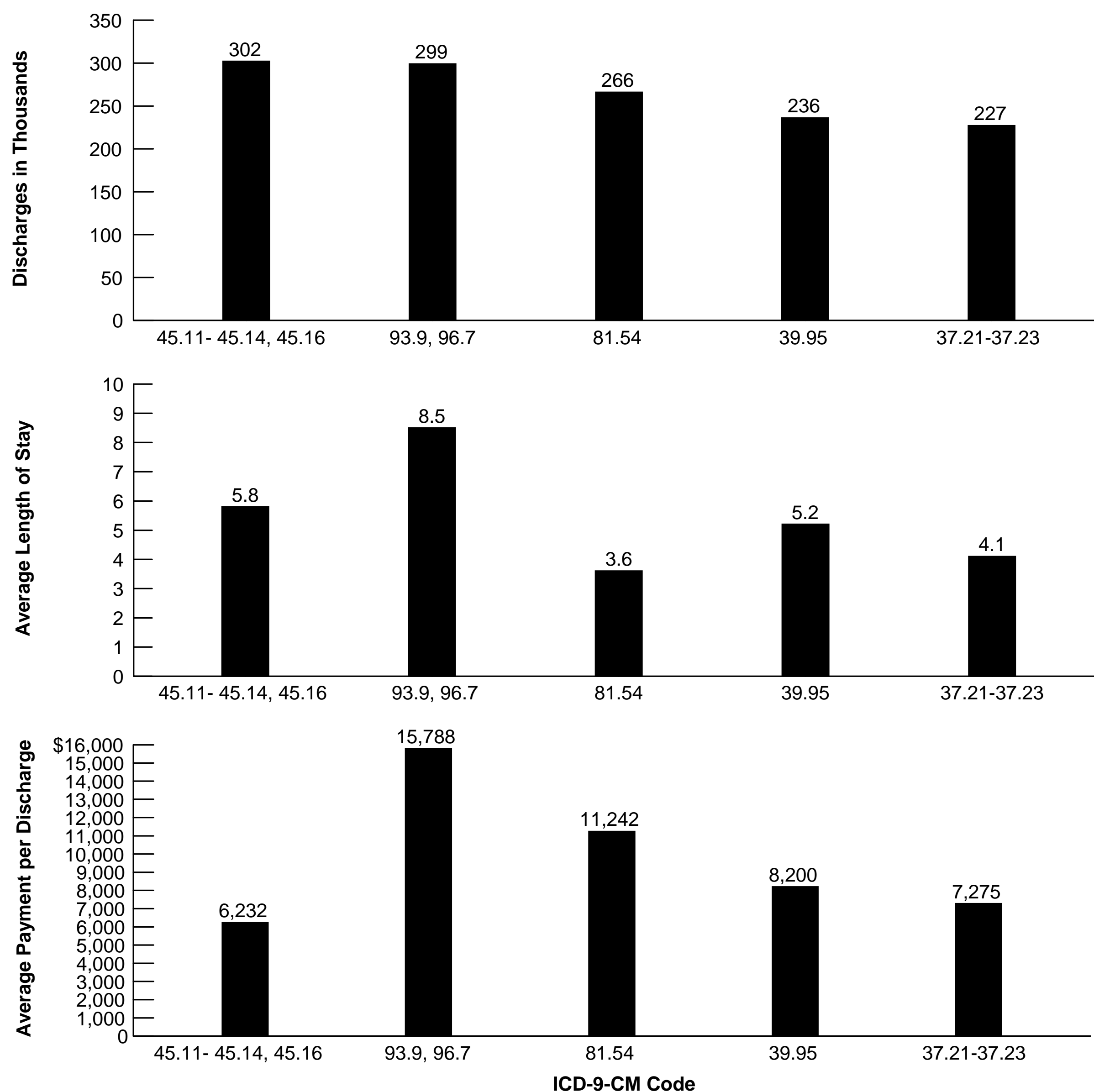
Figure 5.3
Leading Principal Diagnostic Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2008



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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

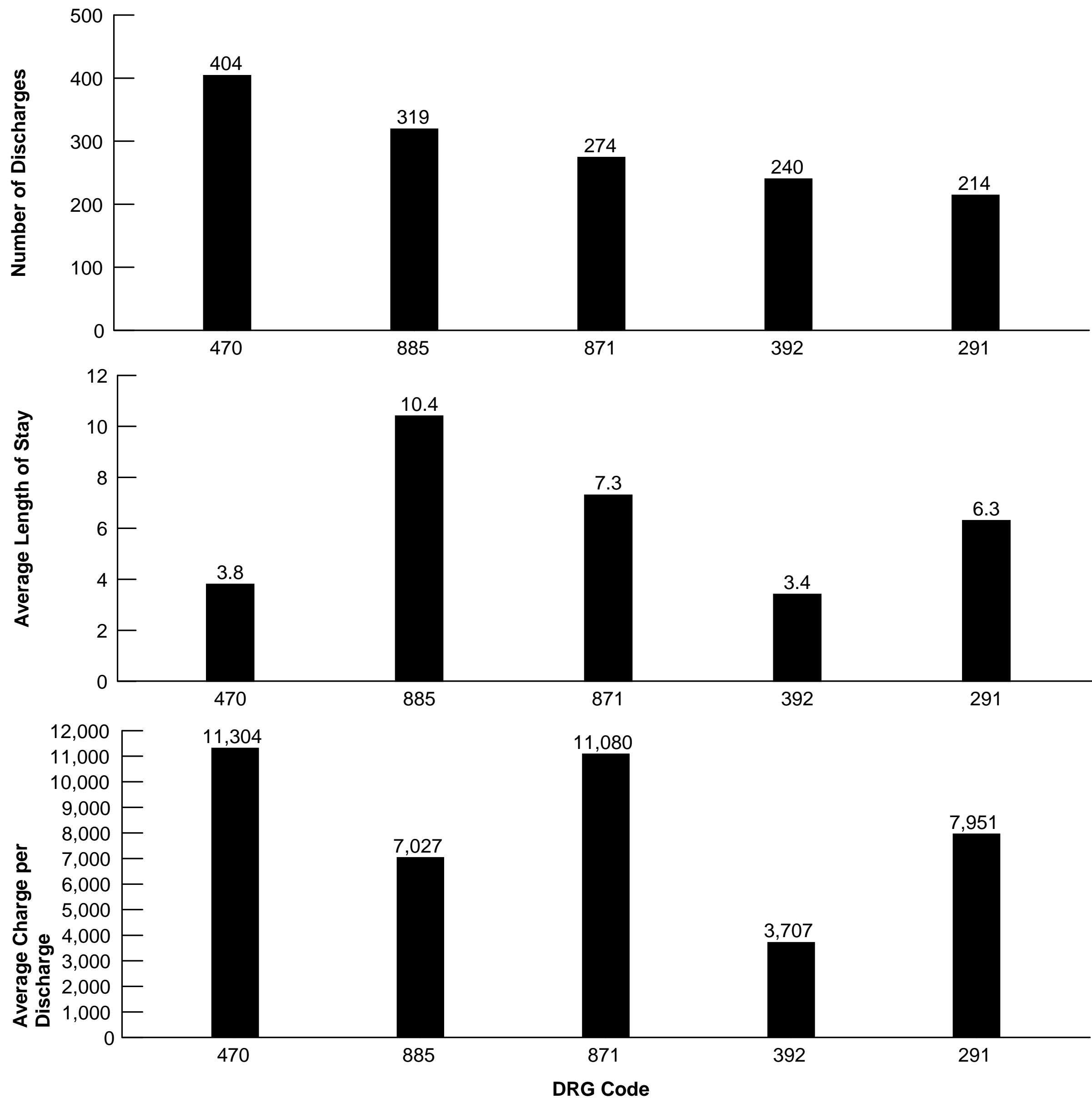
Figure 5.4
Medicare Principal Procedure Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2008



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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

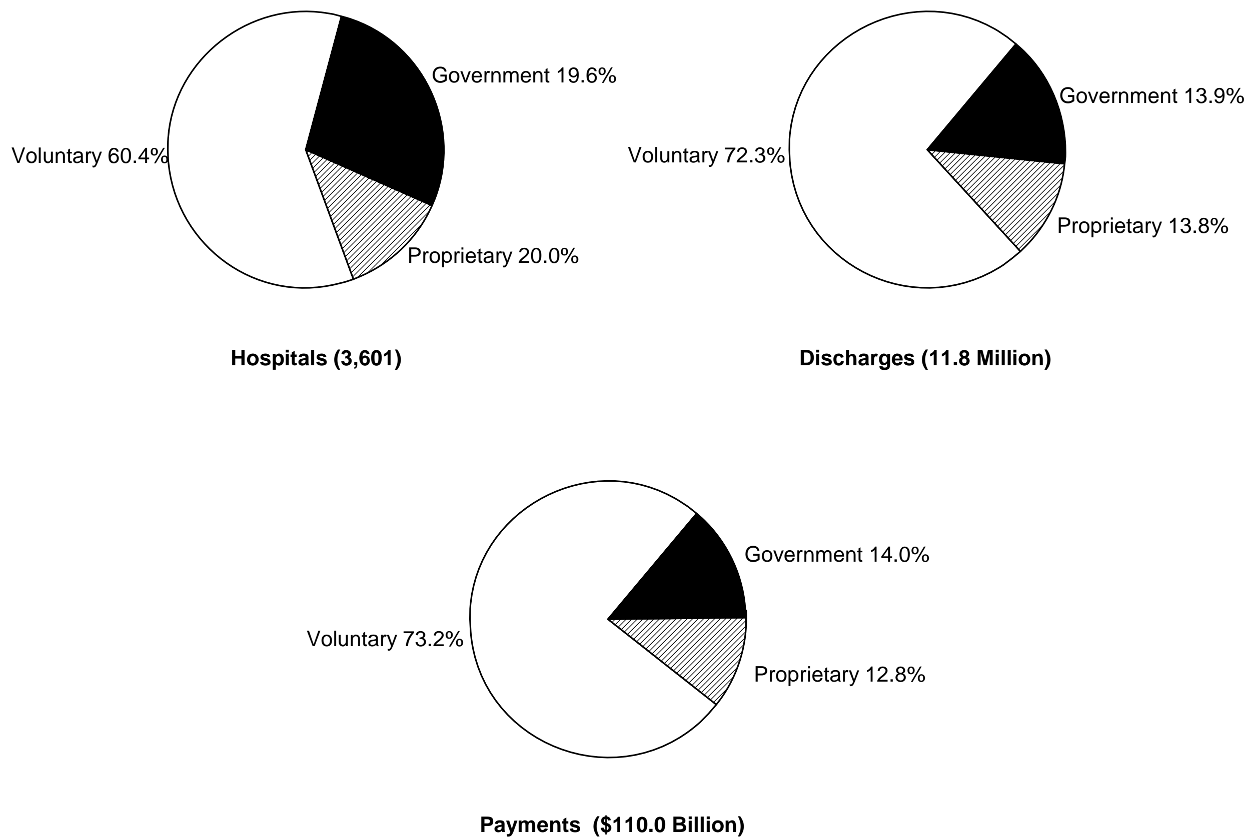
Figure 5.5
Five Most Frequent Medicare Diagnosis-Related Groups (DRGs) for Beneficiaries Discharged from Short-Stay Hospitals: Calendar Year 2008



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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

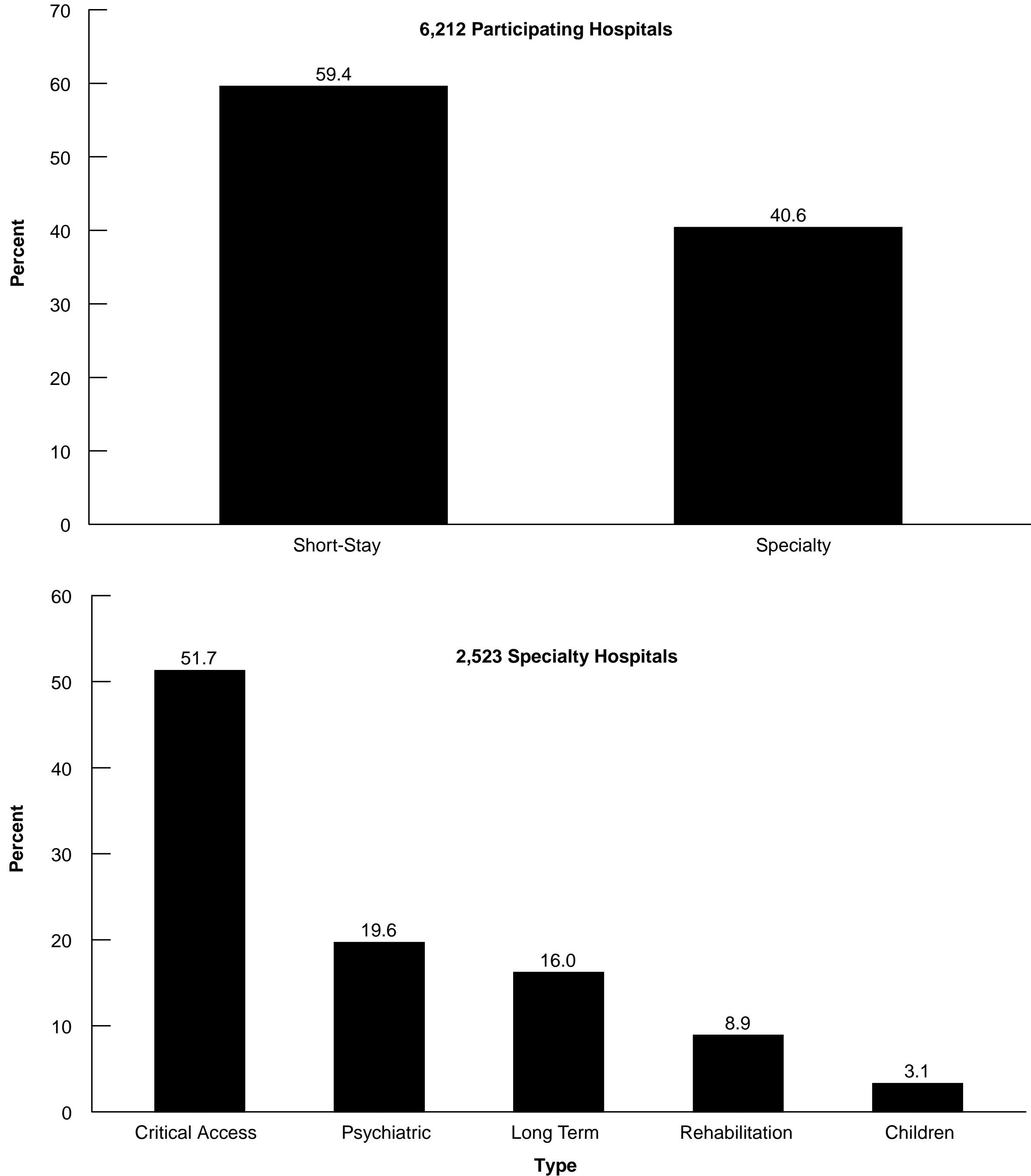
Figure 5.6
Distribution of Medicare Short-Stay Hospitals, Discharges, and Payments, by Type of Control: Calendar Year 2008



NOTE: Short-stay hospital payments excludes outlying areas.

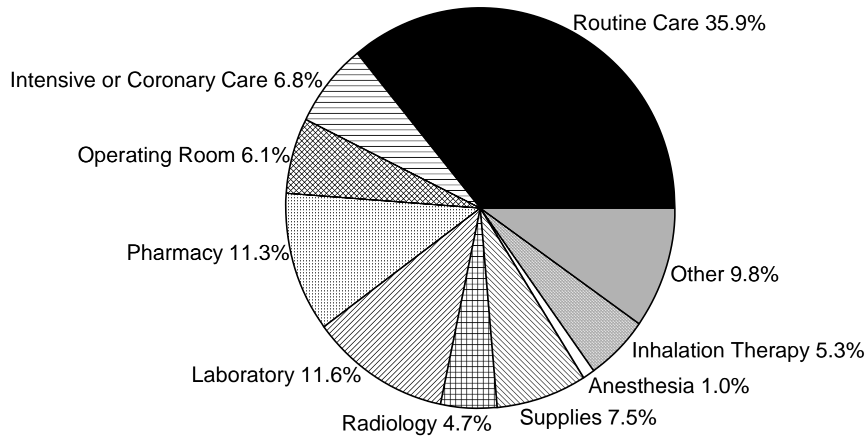
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 5.7
Medicare Participating Hospitals, by Type of Hospital: Calendar Year 2008



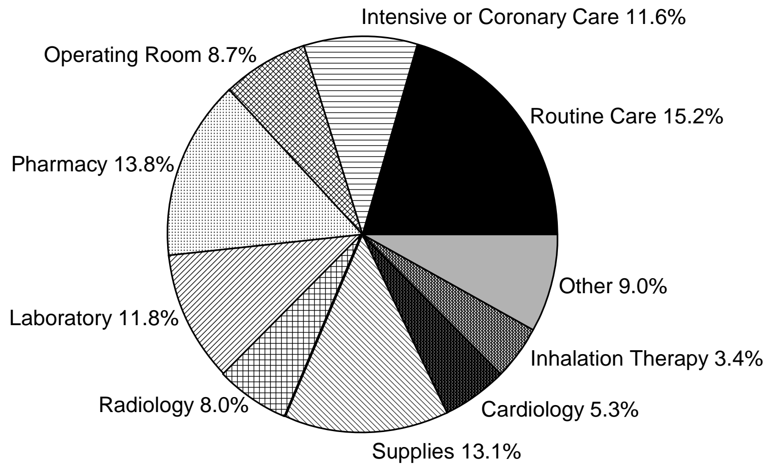
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Data Extract System; data development by the Office of Research, Development, and Information.

Figure 5.8
Percent Distribution of Medicare Short-Stay Hospital Charges, by Type of Service: Calendar Years 1983 and 2008



1983

(Total Charges = $54.8 Billion)



2008

(Total Charges = $420.2 Billion)

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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.