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 1972-2007

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
			Average Annual Rate of Change		
1972-1983 [6]	5.4	2.3	3.4	0.3	-1.9
1983-2007 [6]	0.2	-0.5	-2.1	-2.8	-2.3
1972-2007	1.8	0.4	-0.4	-1.8	-2.2

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 1972-2007

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	3,009	1,569	26.8	37.0
			Average Annual Rate of Change				
19.8	13.6	18.0	11.9	14.4	14.0	---	---
8.7	8.4	4.8	4.6	4.0	7.0	---	---
12.1	10.0	8.8	6.9	7.2	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 1972-2007

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
			Average Annual Rate of Change		
1972-1983 [6]	4.3	2.1	2.4	0.2	-1.9
1983-2007 [6]	-0.2	-0.5	-2.5	-2.8	-2.3
1972-2007	1.2	0.3	-1.0	-1.9	-2.2

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 1972-2007

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
			Average Annual Rate of Change				
18.5	13.6	16.7	11.8	14.2	14.0	---	---
8.3	8.5	4.5	4.7	4.1	7.2	---	---
11.4	10.1	8.2	6.9	7.2	9.3	---	---

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 1972-2007

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	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
			Average Annual Rate of Change		
1974-1983 [6]	8.9	4.0	7.1	2.2	-1.6
1983-2007 [6]	2.5	-0.7	0.6	-2.6	-1.9
1974-2007	4.2	0.6	2.3	-1.3	-1.9

[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 1972-2007

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
			Average Annual Rate of Change				
24.8	14.6	22.6	12.6	17.1	14.6	---	---
11.0	8.2	7.0	4.4	3.6	6.4	---	---
14.6	9.9	11.1	6.6	7.1	8.6	---	---

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 1985-2007

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments
	Number	Number With Coinsurance	Percent With Coinsurance	Number	Percent of TDOC	Per Discharge With Coinsurance	Amount in Thousands	Per Discharge With Coinsurance	Per Day With Coinsurance	Per HI Enrollee[1]	in Thousands
All Beneficiaries											
1985	10,333,990	201,340	1.9	2,230,005	2.6	11.1	386,145	1,918	173	13	2,867,199
1987	10,109,560	186,300	1.8	2,223,675	2.5	11.9	506,323	2,718	228	16	3,818,919
1989[2]	10,147,665	9,075	0.1	140,285	0.2	15.5	39,013	4,299	278	1	3,607,489
1990	10,521,925	159,405	1.5	1,990,245	2.1	12.5	495,351	3,107	249	15	4,519,088
1991	10,887,700	208,650	1.9	2,564,295	2.7	12.3	740,119	3,547	289	21	4,938,491
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
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
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

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 1985-2007

Type of Entitlement and Year	Discharges			Coinsurance Days		Per Discharge With Coinsurance	Coinsurance Payments				Deductible Payments
	Number	Number With Coinsurance	Percent With Coinsurance	Number	Percent of TDOC		Amount in Thousands	Per Discharge With Coinsurance	Per Day With Coinsurance	Per HI Enrollee[1]	in Thousands
Aged Beneficiaries											
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
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
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

[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 2007

Demographic Characteristics, Medicare Status, and Discharge Status	Discharge[1]		Total Days of Care			Program Payments			
	Number in Thousands	Rate Per 1,000 HI Enrollees[2]	Number in Thousands	Percent	Per Discharge	Amount in Millions	Percent	Per Discharge[3]	Per Day
Total	12,036	343	68,048	100.0	5.7	$106,784	100.0	$8,926	$1,569
Age									
Under 65 Years	2,285	362	13,674	20.1	6.0	19,418	18.2	8,632	1,420
65-69 Years	1,815	216	9,943	14.6	5.5	17,483	16.4	9,695	1,758
70-74 Years	1,726	266	9,285	13.6	5.4	16,458	15.4	9,577	1,773
75-79 Years	1,904	347	10,610	15.6	5.6	17,908	16.8	9,437	1,688
80-84 Years	1,925	445	10,976	16.1	5.7	16,960	15.9	8,833	1,545
85 Years or Over	2,380	577	13,561	19.9	5.7	18,558	17.4	7,816	1,368
Sex									
Male	5,299	336	30,272	44.5	5.7	50,252	47.1	9,554	1,660
Female	6,737	348	37,777	55.5	5.6	56,531	52.9	8,433	1,496
Race[4]									
White	9,890	334	54,620	80.3	5.5	86,258	80.8	8,762	1,579
Other	2,108	387	13,214	19.4	6.3	20,176	18.9	9,693	1,527
Type of Entitlement									
Aged[5]	9,695	336	54,034	79.4	5.6	86,828	81.3	8,990	1,607
Disabled[6]	2,341	371	14,014	20.6	6.0	19,956	18.7	8,657	1,424
Discharge Status									
Alive	11,615		64,561	94.9	5.6	99,640	93.3	8,631	1,543
Dead	421	N/A	3,488	5.1	8.3	7,144	6.7	17,049	2,048

[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 2007

Area of Residence	Discharges[1]		Total Days of Care			Program Payments		
	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
All Areas[4]	12,036,270	343	68,048,295	1,936	5.7	$106,783,834	$8,926	$3,039
United States	11,979,420	347	67,632,020	1,961	5.6	106,495,119	8,943	3,087
Northeast	2,401,460	362	15,059,520	2,269	6.3	23,582,707	9,892	3,553
Midwest	3,034,380	359	16,117,105	1,909	5.3	25,484,679	8,449	3,019
South	4,906,705	363	27,544,450	2,040	5.6	40,678,284	8,332	3,013
West	1,636,875	277	8,910,945	1,506	5.4	16,749,448	10,304	2,831
New England	635,500	327	3,551,775	1,826	5.6	6,026,737	9,545	3,099
Connecticut	162,780	341	955,100	2,002	5.9	1,694,897	10,484	3,553
Maine	65,095	273	347,760	1,457	5.3	563,523	8,686	2,362
Massachusetts	298,860	364	1,619,660	1,972	5.4	2,726,202	9,188	3,320
New Hampshire	50,025	253	288,700	1,462	5.8	470,370	9,437	2,383
Rhode Island	37,770	339	224,750	2,020	6.0	338,215	9,021	3,039
Vermont	20,970	211	115,805	1,167	5.5	233,528	11,208	2,354
Middle Atlantic	1,765,960	376	11,507,745	2,453	6.5	17,555,969	10,017	3,742
New Jersey	422,510	377	2,714,355	2,424	6.4	4,203,659	10,051	3,755
New York	778,880	369	5,564,365	2,637	7.1	8,690,626	11,255	4,118
Pennsylvania	564,570	386	3,229,025	2,208	5.7	4,661,683	8,293	3,188
East North Central	2,185,100	373	11,696,590	1,994	5.4	18,552,896	8,546	3,163
Illinois	631,065	401	3,381,530	2,149	5.4	5,295,433	8,479	3,366
Indiana	284,375	337	1,541,625	1,825	5.4	2,351,122	8,305	2,783
Michigan	492,265	378	2,732,120	2,100	5.6	4,498,137	9,195	3,457
Ohio	571,565	389	3,009,210	2,050	5.3	4,593,287	8,071	3,129
Wisconsin	205,830	303	1,032,105	1,521	5.0	1,814,915	8,850	2,675
West North Central	849,280	330	4,420,515	1,716	5.2	6,931,783	8,199	2,691
Iowa	129,115	293	670,850	1,522	5.2	1,036,128	8,085	2,351
Kansas	122,155	323	649,985	1,718	5.3	947,278	7,780	2,503
Minnesota	174,610	343	841,745	1,654	4.8	1,527,777	8,784	3,001
Missouri	297,865	378	1,608,745	2,042	5.4	2,365,458	7,982	3,002
Nebraska	68,280	283	360,440	1,494	5.3	593,303	8,705	2,460
North Dakota	25,840	264	128,170	1,309	5.0	206,868	8,037	2,113
South Dakota	31,415	260	160,580	1,329	5.1	254,968	8,143	2,110
South Atlantic	2,550,520	354	14,417,080	1,998	5.7	21,898,478	8,630	3,035
Delaware	45,840	348	278,865	2,118	6.1	440,650	9,646	3,347
District of Columbia	25,440	388	171,360	2,611	6.7	293,370	11,742	4,469
Florida	840,225	358	4,802,115	2,043	5.7	6,813,389	8,150	2,899
Georgia	331,470	338	1,872,555	1,911	5.6	2,823,835	8,559	2,882
Maryland	270,235	400	1,395,305	2,064	5.2	2,972,345	11,070	4,396
North Carolina	401,395	345	2,251,815	1,937	5.6	3,434,805	8,582	2,955
South Carolina	211,645	340	1,263,735	2,033	6.0	1,790,838	8,514	2,881
Virginia	306,385	328	1,717,750	1,838	5.6	2,421,931	7,951	2,592
West Virginia	117,885	402	663,580	2,265	5.6	907,312	7,743	3,096

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 2007

Area of Residence	Discharges[1]		Total Days of Care			Program Payments		
	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
East South Central	986,335	391	5,478,210	2,173	5.6	$7,486,032	$7,624	$2,970
Alabama	275,210	413	1,476,305	2,215	5.4	1,927,638	7,049	2,892
Kentucky	232,495	374	1,274,600	2,049	5.5	1,860,726	8,040	2,992
Mississippi	172,120	397	1,018,980	2,350	5.9	1,312,773	7,648	3,028
Tennessee	306,510	384	1,708,325	2,138	5.6	2,384,894	7,809	2,985
West South Central	1,369,850	364	7,649,160	2,033	5.6	11,293,773	8,286	3,001
Arkansas	155,760	349	858,025	1,923	5.5	1,235,074	7,946	2,768
Louisiana	203,905	388	1,164,115	2,217	5.7	1,587,272	7,831	3,023
Oklahoma	194,215	392	1,052,365	2,123	5.4	1,485,824	7,682	2,997
Texas	815,970	355	4,574,655	1,992	5.6	6,985,601	8,609	3,042
Mountain	534,845	278	2,681,055	1,393	5.0	4,712,102	8,845	2,448
Arizona	162,215	299	818,510	1,511	5.0	1,508,868	9,346	2,786
Colorado	111,955	296	551,885	1,461	4.9	944,525	8,465	2,500
Idaho	35,560	219	163,645	1,007	4.6	302,910	8,557	1,864
Montana	35,540	261	167,085	1,225	4.7	276,162	7,784	2,025
Nevada	63,095	284	368,280	1,657	5.8	590,724	9,420	2,658
New Mexico	57,670	264	288,310	1,317	5.0	491,981	8,554	2,248
Utah	49,800	256	231,760	1,189	4.7	430,191	8,657	2,208
Wyoming	19,010	269	91,580	1,297	4.8	166,739	8,806	2,361
Pacific	1,102,030	276	6,229,890	1,561	5.7	12,037,346	11,016	3,015
Alaska	13,610	242	75,590	1,346	5.6	167,412	12,369	2,981
California	807,665	291	4,717,470	1,697	5.8	9,126,518	11,414	3,284
Hawaii	24,975	207	186,750	1,551	7.5	260,959	10,546	2,167
Oregon	84,145	249	416,300	1,231	4.9	799,912	9,544	2,365
Washington	171,635	246	833,780	1,195	4.9	1,682,543	9,836	2,412
Outlying Areas[5]	56,850	88	416,275	644	7.3	288,714	5,208	447

[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 2007

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Total All Diagnoses		12,036,270	343	68,048,295	5.7	$106,783,834	$8,926	$1,569
Leading Diagnoses[5]	---	6,436,380	183	36,570,475	5.7	60,507,998	9,451	1,655
Infectious and Parasitic Diseases (MDC 1)	---	528,925	15	4,298,520	8.1	6,750,865	12,852	1,571
Septicemia	001-139	369,210	11	3,252,365	8.8	5,396,501	14,730	1,659
	038							
Neoplasms (MDC 2)	140-239	582,475	17	4,042,560	6.9	7,101,536	12,233	1,757
Malignant Neoplasms	140-208,230-234	508,435	14	3,652,280	7.2	6,346,678	12,524	1,738
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	70,985	2	674,860	9.5	1,138,455	16,094	1,687
Malignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	83,555	2	625,090	7.5	1,121,672	13,455	1,794
Malignant Neoplasm of Breast	174-175,198.81	25,835	1	65,490	2.5	120,486	4,678	1,840
Benign Neoplasms	210-229	54,395	2	276,630	5.1	563,656	10,395	2,038
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	505,705	14	2,484,880	4.9	3,052,251	6,086	1,228
Diabetes Mellitus	250	186,170	5	1,097,265	5.9	1,408,652	7,652	1,284
Volume Depletion	276.5	143,420	4	603,975	4.2	636,624	4,460	1,054
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	155,390	4	727,690	4.7	923,473	6,116	1,269
Mental Disorders (MDC 5)	290-319	485,925	14	4,515,675	9.3	2,892,974	6,067	641
Psychoses	290-299	414,860	12	4,083,695	9.8	2,595,665	6,380	636
Alcohol Dependence Syndrome	303	15,655	(6)	96,900	6.2	57,228	3,707	591
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	251,725	7	1,563,530	6.2	1,745,874	6,976	1,117

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 2007

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2]		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Diseases of the Circulatory System (MDC 7)	390-459	3,024,070	86	14,741,810	4.9	$30,799,144	$10,229	$2,089
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	2,065,680	59	10,058,635	4.9	22,332,327	10,854	2,220
Acute Myocardial Infarction	410	300,195	9	1,716,080	5.7	4,096,536	13,692	2,387
Coronary Atherosclerosis	414.0	448,655	13	1,654,980	3.7	5,813,604	13,019	3,513
Other Ischemic Heart Disease	411-413, 414.1-414.9	39,640	1	107,705	2.7	432,994	11,032	4,020
Cardiac Dysrhythmias	427	401,655	11	1,551,905	3.9	3,119,483	7,791	2,010
Congestive Heart Failure	428.0	500,970	14	2,675,240	5.3	4,044,234	8,107	1,512
Cerebrovascular Disease	430-438	498,650	14	2,340,160	4.7	3,767,675	7,589	1,610
Diseases of the Respiratory System (MDC 8)	460-519	1,417,490	40	8,731,400	6.2	11,393,446	8,073	1,305
Acute Bronchitis and Bronchocolitis	466	26,785	1	105,970	4.0	98,825	3,707	933
Pneumonia	480-486	527,050	15	3,122,800	5.9	3,537,682	6,736	1,133
Asthma	493	91,990	3	444,275	4.8	458,837	5,018	1,033
Diseases of the Digestive System (MDC 9)	520-579	1,174,975	33	6,613,605	5.6	9,525,409	8,149	1,440
Appendicitis	540-543	21,705	1	111,235	5.1	205,283	9,495	1,845
Non Infectious Enteritis and Colitis	555-558	100,935	3	552,080	5.5	743,408	7,397	1,347
Diverticula of Intestine	562	129,460	4	730,145	5.6	969,939	7,518	1,328
Cholelithiasis	574	101,620	3	538,390	5.3	944,808	9,326	1,755
Diseases of the Genitourinary System (MDC 10)	580-629	710,750	20	3,509,345	4.9	4,286,136	6,055	1,221
Calculus of Kidney and Ureter	592	31,535	1	98,220	3.1	178,777	5,700	1,820

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 2007

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM	Discharges[2]		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	Code	219,590	6	1,293,610	5.9	$1,271,292	$5,821	$983
Cellulitis and Abscess	680-709	172,070	5	926,210	5.4	883,484	5,159	954
	681-682							
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	822,815	23	3,336,440	4.1	8,244,540	10,054	2,471
Osteoarthrosis and Allied Disorders	715	392,645	11	1,436,070	3.7	4,178,397	10,662	2,910
Intervertebral Disc Disorders	722	83,520	2	307,055	3.7	872,000	10,478	2,840
Congenital Anomalies (MDC 14)	740-759	10,980	(6)	53,150	4.8	173,203	15,883	3,259
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	725,155	21	2,289,865	3.2	3,056,807	4,251	1,335
Injury and Poisoning (MDC 17)	800-999	1,093,880	31	6,408,130	5.9	11,051,621	10,164	1,725
Fractures, All Sites	800-829	447,130	13	2,533,185	5.7	4,058,417	9,104	1,602
Fracture of Neck of Femur	820	212,375	6	1,317,420	6.2	2,251,565	10,618	1,709
Poisoning by Drugs, Medicinal and Biological Substances	960-989	53,460	2	202,935	3.8	273,134	5,162	1,346
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	308,300	9	3,375,425	10.9	4,456,843	14,592	1,320

[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 2007

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM	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	Code	7,086,110	202	45,488,345	6.4	$80,538,060	$11,431	$1,771
Leading Procedures [5]	---	3,021,540	86	18,086,870	6.0	31,229,447	10,389	1,727
Operations on the Nervous System (MPC 1)	---	170,550	5	1,114,925	6.5	2,117,794	12,472	1,899
Spinal Tap	01-05	36,690	1	261,145	7.1	272,758	7,473	1,044
Operations on the Endocrine System (MPC 2)	03.31	26,100	1	99,365	3.8	227,599	8,742	2,291
Operations on the Eye (MPC 3)	06-07	8,545	(6)	36,880	4.3	63,625	7,507	1,725
Operations on the Ear (MPC 4)	08-16	2,580	(6)	13,520	5.2	22,450	8,787	1,660
Operations on the Nose, Mouth, and Pharynx (MPC 5)	18-20	29,200	1	146,350	5.0	230,807	7,974	1,577
Operations on the Respiratory System (MPC 6)	21-29	272,955	8	2,929,020	10.7	4,946,344	18,193	1,689
Bronchoscopy with or Without Biopsy	30-34	65,780	2	608,085	9.2	705,510	10,770	1,160
Operations on the Cardiovascular System (MPC 7)	33.21-33.24,33.27	1,528,880	44	9,874,200	6.5	21,103,464	13,898	2,137
Removal of Coronary Artery Obstruction	35-39	4,740	(6)	13,465	2.8	67,436	14,363	5,008
Coronary Artery Bypass Graft	36.0	94,135	3	941,055	10.0	2,869,257	30,558	3,049
Cardiac Catheterization	36.1	240,890	7	984,460	4.1	1,696,848	7,081	1,724
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.21-37.23	136,845	4	657,925	4.8	1,919,109	14,053	2,917
Hemodialysis	37.7-37.8	229,735	7	1,201,105	5.2	1,577,909	6,975	1,314
Operations on the Hemic and Lymphatic System (MPC 8)	39.95	42,300	1	363,470	8.6	631,770	14,989	1,738
See footnotes at end of table.	40-41							

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 2007

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM	Discharges[2]		Total Days of Care		Program Payments		
		Number	Per 1,000 HI[3] Enrollees	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Operations on the Digestive System (MPC 9)	42-54	1,175,550	33	8,768,810	7.5	$12,476,502	$10,659	$1,423
Endoscopy of Small Intestine with or Without Biopsy	Code 45.11-45.14,45.16	320,505	9	1,859,380	5.8	1,829,098	5,734	984
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	117,285	3	690,705	5.9	672,014	5,753	973
Partial Excision of Large Intestine	45.7	101,005	3	1,110,040	11.0	2,039,657	20,241	1,837
Appendectomy, Excluding Incidental	47.0	19,820	1	94,075	4.7	178,302	9,028	1,895
Cholecystectomy	51.2	107,005	3	677,150	6.3	1,209,866	11,337	1,787
Lysis of Peritoneal Adhesions	54.5	31,195	1	335,590	10.8	555,506	17,882	1,655
Operations on the Urinary System (MPC 10)	55-59	204,580	6	1,240,735	6.1	1,991,696	9,780	1,605
Cystoscopy with or Without Biopsy	57.31-57.33	14,420	(6)	104,880	7.3	105,155	7,308	1,003
Operations on the Male Genital Organs (MPC 11)[7]	60-64	82,580	5	278,620	3.4	481,961	5,858	1,730
Prostatectomy	60.2-60.6	72,700	5	220,800	3.0	388,795	5,366	1,761
Operations on the Female Genital Organs (MPC 12)[8]	65-71	96,990	5	335,060	3.5	609,947	6,300	1,820
Unilateral Oophorectomy	65.3-65.6	9,515	(6)	44,080	4.6	76,089	8,014	1,726
Hysterectomy	68.3-68.7,68.9	50,710	3	176,820	3.5	323,027	6,380	1,827
Obstetrical Procedures (MPC 13)	72-75	13,010	1	42,545	3.3	40,214	3,113	945
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	625	(6)	1,655	2.6	1,011	1,618	611
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	5,350	(6)	22,760	4.3	24,081	4,548	1,058
Repair of Current Obstetric Laceration	75.5-75.6	1,345	(6)	3,435	2.6	2,767	2,065	805
Operations on the Musculoskeletal System (MPC 14)	76-84	1,101,815	31	5,837,415	5.3	12,937,796	11,776	2,216
Partial Excision of Bone	76.2-76.3,77.6-77.8	14,680	(6)	124,935	8.5	214,071	14,708	1,713
Reduction of Facial Fracture	76.7,79.0-79.3	199,610	6	1,169,105	5.9	2,007,819	10,085	1,717
Open Reduction of Fracture with Internal Fixation	79.3	143,690	4	845,430	5.9	1,470,944	10,266	1,740
Excision or Destruction of Intervertebral Disc	80.5	26,440	1	73,835	2.8	172,204	6,533	2,332
Total Hip Replacement	81.51	113,765	3	459,230	4.0	1,262,182	11,115	2,748
Total Knee Replacement	81.54	268,990	8	991,675	3.7	2,940,256	10,951	2,965

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 2007

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	252,615	7	1,949,360	7.7	$2,518,078	$10,046	$1,292
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	80,725	2	837,510	10.4	1,198,798	14,993	1,431
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,667,540	47	11,054,295	6.6	14,146,553	8,554	1,280
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	103,725	3	501,160	4.8	624,667	6,059	1,246
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	51,060	1	240,755	4.7	315,468	6,210	1,310
Diagnostic Ultrasound	88.7	145,175	4	755,455	5.2	883,565	6,112	1,170
Respiratory Therapy	93.9,96.7	280,085	8	2,410,765	8.6	4,269,308	15,384	1,771
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	39,590	1	295,295	7.5	465,589	11,830	1,577
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	37,145	1	217,820	5.9	360,821	9,768	1,657

[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): January 1 - September 30, 2007[1]

DRG Code	Description	Discharges	Total Days of Care		Total Charges	Program Payments		
			Number	Per Discharge	in Thousands	Amount in Thousands	Per Discharge[2]	Per Day
Total All DRGs		9,090,015	51,437,415	5.7	$297,884,239	$79,740,240	$8,984	$1,550
Leading DRGs[3]		6,333,525	35,206,510	5.6	184,774,552	49,604,141	8,003	1,409
012	Degenerative Nervous System Disorders	69,630	584,920	8.4	1,437,691	461,374	6,705	789
014	Intracranial Hemorrhage or Cerebral Infarction	189,475	991,880	5.2	4,971,733	1,261,985	6,756	1,272
075[4]	Major Chest Procedures	35,595	326,235	9.2	2,345,092	658,934	19,042	2,020
076[4]	Other Respiratory System O.R. Procedures with CC	33,355	329,845	9.9	1,945,289	561,680	17,261	1,703
078	Pulmonary Embolism	40,195	230,680	5.7	1,012,888	263,810	6,717	1,144
079	Respiratory Infections & Inflammations Age >17 with CC	118,095	921,825	7.8	4,039,159	1,048,549	8,996	1,137
082	Respiratory Neoplasms	44,300	290,695	6.6	1,393,461	357,735	8,225	1,231
087	Pulmonary Edema & Respiratory Failure	87,085	534,090	6.1	2,529,394	669,584	7,834	1,254
088	Chronic Obstructive Pulmonary Disease	273,165	1,289,585	4.7	5,210,031	1,274,306	4,757	988
089	Simple Pneumonia & Pleurisy Age >17 with CC	336,280	1,791,690	5.3	7,346,652	1,832,672	5,532	1,023
096	Bronchitis & Asthma Age >17 with CC	37,155	152,135	4.1	604,748	136,823	3,772	899
110[4]	Major Cardiovascular Procedures with CC	41,070	299,990	7.3	3,529,702	1,003,687	25,095	3,346
121	Circulatory Disorders with AMI & Major Comp Discharged Alive	95,645	572,670	6.0	3,096,630	838,216	8,870	1,464
122	Circulatory Disorders with AMI & Without Major Comp Discharged Alive	33,110	107,200	3.2	670,033	160,973	4,958	1,502
124	Circulatory Disorders Except AMI, with Card Cath and Complex Diagnosis	76,635	336,520	4.4	2,441,471	605,267	8,129	1,799
125	Circulatory Disorders Except AMI, with Card Cath Without Complex Diagnosis	60,255	161,670	2.7	1,467,365	327,339	5,620	2,025
127	Heart Failure & Shock	442,495	2,235,795	5.1	9,842,028	2,565,026	5,878	1,147
130	Peripheral Vascular Disorders with CC	60,755	311,540	5.1	1,251,934	323,221	5,427	1,037
132	Atherosclerosis with CC	54,730	153,575	2.8	764,377	179,010	3,348	1,166
138	Cardiac Arrhythmia & Conduction Disorders with CC	158,515	605,350	3.8	2,797,276	698,233	4,479	1,153
139	Cardiac Arrhythmia & Conduction Disorders Without CC	49,905	119,195	2.4	568,369	118,905	2,445	998
141	Syncope & Collapse with CC	94,035	312,810	3.3	1,579,886	378,842	4,097	1,211
143	Chest Pain	160,235	336,910	2.1	2,090,326	432,836	2,794	1,285
144	Other Circulatory System Diagnoses with CC	79,485	464,325	5.8	2,411,122	627,187	8,146	1,351
174	GI Hemorrhage with CC	172,830	797,500	4.6	3,903,079	978,492	5,745	1,227
180	GI Obstruction with CC	66,555	350,275	5.3	1,472,511	359,293	5,496	1,026
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 with CC	194,735	773,880	4.0	3,378,531	793,614	4,178	1,026

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): January 1 - September 30, 2007[1]

DRG Code		Discharges	Total Days of Care		Total Charges	Program Payments		
			Number	Per Discharge	in Thousands	Amount in Thousands	Per Discharge[2]	Per Day
183	Esophagitis, Gastroent & Misc Digest Disorders Age >17 Without CC	52,040	145,950	2.8	$684,474	$140,380	$2,786	$962
188	Other Digestive System Diagnoses Age >17 with CC	63,000	333,070	5.3	1,557,037	398,278	6,448	1,196
204	Disorders of Pancreas Except Malignancy	48,515	249,460	5.1	1,160,332	296,853	6,311	1,190
210[4]	Hip & Femur Procedures Except Major Joint Age >17 with CC	93,650	606,880	6.5	3,837,033	995,018	10,724	1,640
243	Medical Back Problems	71,840	322,610	4.5	1,286,622	295,662	4,222	916
277	Cellulitis Age >17 with CC	94,395	504,880	5.3	1,825,322	446,819	4,837	885
294	Diabetes Age >35	71,515	298,885	4.2	1,268,971	310,129	4,444	1,038
296	Nutritional & Misc Metabolic Disorders Age >17 with CC	174,710	767,980	4.4	3,056,350	784,287	4,572	1,021
316	Renal Failure	201,060	1,171,855	5.8	5,180,263	1,440,927	7,292	1,230
320	Kidney & Urinary Tract Infections Age >17 with CC	171,555	825,735	4.8	3,206,348	794,709	4,692	962
331	Other Kidney & Urinary Tract Diagnoses Age >17 with CC	42,760	228,675	5.3	1,046,928	276,229	6,637	1,208
395	Red Blood Cell Disorders Age >17	86,220	354,745	4.1	1,568,049	361,566	4,417	1,019
429	Organic Disturbances & Mental Retardation	31,895	296,065	9.3	638,399	212,949	6,752	719
430	Psychoses	250,350	2,612,175	10.4	4,983,990	1,598,823	6,576	612
449	Poisoning and Toxic Effects of Drugs Age>17 with CC	34,360	131,785	3.8	708,236	171,525	5,137	1,302
462	Rehabilitation	178,755	2,243,065	12.5	5,682,929	2,732,357	15,619	1,218
463	Signs and Symptoms with CC	38,845	154,160	4.0	622,000	149,980	3,939	973
468[4]	Extensive OR Procedure Unrelated to Principal Diagnoses	38,000	464,240	12.2	3,233,812	926,148	24,960	1,995
493[4]	Laparoscopic Cholecystectomy Without CDE with CC	43,605	259,810	6.0	1,764,600	449,528	10,528	1,730
500[4]	Back and Neck Procedures Except Spinal Fusion Without CC	32,170	63,690	2.0	709,788	151,396	4,879	2,377
515[4]	Cardiac Defibrillator Implant without Cardiac Cath	37,515	140,885	3.8	4,185,091	1,189,879	33,094	8,446
524	Transient Ischemia	77,645	231,115	3.0	1,262,122	284,630	3,731	1,232
544[4]	Major Joint Replacement or Reattachment of Lower Extremity	333,590	1,398,585	4.2	13,963,841	3,579,973	11,079	2,560
545[4]	Revision of Hip or Knee Replacement	32,630	161,125	4.9	1,821,009	470,624	14,933	2,921
551[4]	Permanent Cardiac Pacemaker Implant with Major CV Diagnosis or AICD Lead or Generator	35,715	217,875	6.1	2,347,968	656,737	18,647	3,014
552[4]	Other Permanent Cardiac Pacemaker Implant Without Major CV Diagnosis	56,805	191,410	3.4	2,484,025	675,696	12,072	3,530

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): January 1 - September 30, 2007[1]

DRG Code		Discharges	Total Days of Care		Total Charges	Program Payments		
			Number	Per Discharge	in Thousands	Amount in Thousands	Per Discharge[2]	Per Day
553[4]	Other Vascular Procedures with CC with Major CV Diagnosis	32,000	278,375	8.7	$2,157,617	$599,956	$19,089	$2,155
554[4]	Other Vascular Procedures with CC Without Major CV Diagnosis	56,960	284,195	5.0	2,597,803	696,569	12,538	2,451
555[4]	Percutaneous Cardiovascular Proc with Major CV Diagnosis	52,260	233,450	4.5	2,785,941	712,215	14,038	3,051
5564	Percutaneous Cardiovascular Proc with Non-Drug-Eluting Stent Without Major CV Diagnosis	33,045	61,700	1.9	1,258,908	320,793	10,025	5,199
557[4]	Percutaneous Cardiovascular Proc with Drug-Eluting Stent with Major CV Diagnosis	62,490	236,720	3.8	3,751,599	1,002,774	16,659	4,236
558[4]	Percutaneous Cardiovascular Proc with Drug-Eluting Stent Without Major CV Diagnosis	91,235	157,320	1.7	4,145,823	1,056,188	12,044	6,714
562	Seizure Age > 17 with CC	41,045	191,990	4.7	948,666	248,511	6,174	1,294
566	Respiratory System Diagnosis with Ventilator Support < 96 Hours	57,320	419,275	7.3	2,887,957	791,921	14,084	1,889
569[4]	Major Small & Large Bowel Procedures with CC with Major G.I. Diagnosis	45,770	659,835	14.4	4,330,454	1,231,043	27,424	1,866
570[4]	Major Small & Large Bowel Procedures with CC without Major G.I. Diagnosis	46,420	434,175	9.4	2,551,975	728,972	16,074	1,679
572	Major Gastrointestinal Disorders & Peritoneal Infections	51,925	364,420	7.0	1,491,308	402,016	7,873	1,103
576	Septicemia Without Mechanical Ventilation 96+ Hours Age > 17	232,855	1,623,775	7.0	8,198,070	2,142,512	9,360	1,319
578[4]	Infectious & Parasitic Diseases with O.R. Procedure	31,740	501,785	15.8	3,482,080	961,942	31,050	1,917
All Other DRGs		2,756,490	16,230,905	5.9	113,109,686	30,136,098	11,254	1,857

[1]Table reflects only January thru September for 2007 due to the major revision in the twenty-fifth version of the DRGs definitions manual, effective for all Medicare discharges on or after October 1, 2007. For the purpose of this table version 24.0 was used.

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

[3]Based on frequency of occurrence in 2007.

[4]Represents surgical DRGs.

NOTES: Composition of some DRGs have changed over time. For complete DRG description, refer to *Diagnosis Related Groups, Version 24.0 and 25.0 Definitions Manual. TIA is transient ischemic* attack. CC is complications and/or comorbidities. Cath is catheterization, AMI is acute myocardial infarction. CV is cardiovascular. Card is cardiac. G.I. Is gastrointestinal. O.R. is operating room. CDE is common duct exploration. Conn is connective. Tiss is tissue. Resp is respiratory. Proc is procedure. PTCA is percutaneous transluminal coronary angioplasty. Perm is permanent. Comp is complications. Circ is circulatory. PDX is primary diagnosis. CVA is cerebrovascular accident. AICD is automatic implantation cardioverter/defifrillator.

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 2007

Total Days of Care	All Services	Type of Accommodation: Routine Room and Board	Type of Accommodation: Intensive/ Coronary Care	Type of Ancillary Service: Total Ancillary	Type of Ancillary Service: Operating Room	Type of Ancillary Service: Pharmacy
			Number of Discharges			
Total	12,036,270	9,687,545	4,077,480	12,004,560	4,201,705	11,930,705
1-8 Days	9,959,940	7,906,855	3,104,585	9,934,790	3,165,780	9,874,140
9-20 Days	1,750,480	1,498,555	785,075	1,745,780	827,810	1,736,040
21-30 Days	218,125	189,340	118,465	217,175	131,690	215,220
31-40 Days	59,235	50,660	37,100	58,880	41,190	58,320
41-50 Days	22,875	19,675	15,145	22,655	16,760	22,325
51-60 Days	10,625	9,300	7,190	10,515	7,700	10,295
61-90 Days	10,615	9,210	7,115	10,485	7,710	10,240
91 Days or More	4,375	3,950	2,805	4,280	3,065	4,125
			Percent of Total Discharges [3]			
Total	100.0	80.5	33.9	99.7	34.9	99.1
1-8 Days	100.0	79.4	31.2	99.7	31.8	99.1
9-20 Days	100.0	85.6	44.8	99.7	47.3	99.2
21-30 Days	100.0	86.8	54.3	99.6	60.4	98.7
31-40 Days	100.0	85.5	62.6	99.4	69.5	98.5
41-50 Days	100.0	86.0	66.2	99.0	73.3	97.6
51-60 Days	100.0	87.5	67.7	99.0	72.5	96.9
61-90 Days	100.0	86.8	67.0	98.8	72.6	96.5
91 Days or More	100.0	90.3	64.1	97.8	70.1	94.3
			Total Charges in Thousands			
Total	$397,851,554	$61,684,714	$45,228,697	$290,940,742	$33,952,482	$55,950,530
1-8 Days	231,800,191	32,076,093	19,554,639	180,171,521	23,818,640	26,706,405
9-20 Days	107,958,413	19,875,438	14,895,074	73,188,347	7,308,498	17,724,466
21-30 Days	28,348,380	4,925,373	4,737,235	18,685,831	1,537,734	5,456,254
31-40 Days	11,976,919	1,889,628	2,254,356	7,832,952	583,194	2,461,265
41-50 Days	6,318,628	973,387	1,294,382	4,050,865	282,681	1,280,139
51-60 Days	3,645,398	572,571	773,018	2,299,811	154,783	757,452
61-90 Days	4,735,020	747,540	1,050,531	2,936,951	180,985	962,039
91 Days or More	3,068,601	624,681	669,460	1,774,460	85,965	602,506

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 2007

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
		Number of Discharges			
11,886,120	10,460,225	10,090,275	8,852,450	5,689,335	10,976,500
9,825,805	8,587,250	8,286,510	7,225,145	4,398,415	8,982,810
1,737,620	1,575,475	1,521,685	1,362,405	1,067,435	1,679,180
216,155	198,005	188,845	173,380	145,430	210,670
58,720	54,830	51,800	49,925	42,405	57,315
22,585	21,170	19,940	19,550	16,840	22,055
10,490	9,745	9,050	9,145	7,775	10,200
10,465	9,745	8,885	9,110	7,880	10,200
4,280	4,005	3,560	3,790	3,155	4,070
		Percent of Total Discharges [3]			
98.8	86.9	83.8	73.5	47.3	91.2
98.7	86.2	83.2	72.5	44.2	90.2
99.3	90.0	86.9	77.8	61.0	95.9
99.1	90.8	86.6	79.5	66.7	96.6
99.1	92.6	87.4	84.3	71.6	96.8
98.7	92.5	87.2	85.5	73.6	96.4
98.7	91.7	85.2	86.1	73.2	96.0
98.6	91.8	83.7	85.8	74.2	96.1
97.8	91.5	81.4	86.6	72.1	93.0
		Total Charges in Thousands			
$46,194,176	$31,502,490	$53,542,239	$21,543,807	$13,324,984	$34,930,031
26,717,523	20,648,501	39,317,773	16,956,096	4,888,410	21,118,170
12,892,545	7,717,905	10,053,875	3,604,437	4,621,550	9,265,067
3,275,933	1,679,266	2,153,525	578,309	1,633,129	2,371,677
1,380,260	661,372	851,851	199,377	787,134	908,496
725,784	317,548	426,530	88,172	454,212	475,794
393,104	170,929	237,085	43,275	280,645	262,536
504,541	205,289	312,242	47,183	395,558	329,111
304,482	101,676	189,354	26,955	264,343	199,176

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 2007

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	15.5	11.4	73.1	8.5	14.1
1-8 Days	100.0	13.8	8.4	77.7	10.3	11.5
9-20 Days	100.0	18.4	13.8	67.8	6.8	16.4
21-30 Days	100.0	17.4	16.7	65.9	5.4	19.2
31-40 Days	100.0	15.8	18.8	65.4	4.9	20.6
41-50 Days	100.0	15.4	20.5	64.1	4.5	20.3
51-60 Days	100.0	15.7	21.2	63.1	4.2	20.8
61-90 Days	100.0	15.8	22.2	62.0	3.8	20.3
91 Days or More	100.0	20.4	21.8	57.8	2.8	19.6
			Average Total Charge Per Discharge			
Total	$33,054	$6,367	$11,092	$24,236	$8,081	$4,690
1-8 Days	23,273	4,057	6,299	18,135	7,524	2,705
9-20 Days	61,674	13,263	18,973	41,923	8,829	10,210
21-30 Days	129,964	26,013	39,988	86,040	11,677	25,352
31-40 Days	202,193	37,300	60,764	133,032	14,159	42,203
41-50 Days	276,224	49,473	85,466	178,807	16,866	57,341
51-60 Days	343,096	61,567	107,513	218,717	20,102	73,575
61-90 Days	446,069	81,166	147,650	280,110	23,474	93,949
91 Days or More	701,395	158,147	238,667	414,594	28,047	146,062

[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 2007

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
Percent of Total Charges [4]					
11.6	7.9	13.5	5.4	3.3	8.8
11.5	8.9	17.0	7.3	2.1	9.1
11.9	7.1	9.3	3.3	4.3	8.6
11.6	5.9	7.6	2.0	5.8	8.4
11.5	5.5	7.1	1.7	6.6	7.6
11.5	5.0	6.8	1.4	7.2	7.5
10.8	4.7	6.5	1.2	7.7	7.2
10.7	4.3	6.6	1.0	8.4	7.0
9.9	3.3	6.2	0.9	8.6	6.5
Average Total Charge Per Discharge					
$3,886	$3,012	$5,306	$2,434	$2,342	$3,182
2,719	2,405	4,745	2,347	1,111	2,351
7,420	4,899	6,607	2,646	4,330	5,518
15,155	8,481	11,404	3,336	11,230	11,258
23,506	12,062	16,445	3,994	18,562	15,851
32,136	15,000	21,391	4,510	26,972	21,573
37,474	17,540	26,197	4,732	36,096	25,739
48,212	21,066	35,143	5,179	50,198	32,266
71,141	25,388	53,189	7,112	83,786	48,938

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 2007

Total Days of Care	Discharges [1]		Total Days of Care			Program Payments			
					Per	Amount		Per	
Total Days					Dis-	in		Dis-	Per
of Care	Number	Percent	Number	Percent	charge	Thousands	Percent	charge [2]	Day
Total	12,036,270	100.0	68,048,295	100.0	5.7	$106,783,834	100.0	$8,926	$1,569
1 Day	1,672,440	13.9	1,672,440	2.5	1.0	10,850,725	10.2	6,556	6,488
2 Days	1,750,675	14.5	3,501,350	5.1	2.0	10,174,045	9.5	5,842	2,906
3 Days	1,943,940	16.2	5,831,820	8.6	3.0	12,888,724	12.1	6,660	2,210
4 Days	1,496,170	12.4	5,984,680	8.8	4.0	10,780,877	10.1	7,236	1,801
5 Days	1,097,970	9.1	5,489,850	8.1	5.0	8,567,059	8.0	7,841	1,561
6 Days	842,235	7.0	5,053,410	7.4	6.0	7,154,618	6.7	8,536	1,416
7 Days	664,020	5.5	4,648,140	6.8	7.0	6,127,879	5.7	9,276	1,318
8 Days	492,490	4.1	3,939,920	5.8	8.0	4,939,978	4.6	10,082	1,254
9 Days	359,530	3.0	3,235,770	4.8	9.0	3,843,100	3.6	10,755	1,188
10 Days	281,955	2.3	2,819,550	4.1	10.0	3,207,947	3.0	11,447	1,138
11 Days	224,195	1.9	2,466,145	3.6	11.0	2,705,668	2.5	12,141	1,097
12 Days	176,750	1.5	2,121,000	3.1	12.0	2,265,487	2.1	12,908	1,068
13 Days	153,255	1.3	1,992,315	2.9	13.0	2,062,462	1.9	13,555	1,035
14 Days	141,755	1.2	1,984,570	2.9	14.0	2,041,176	1.9	14,511	1,029
15 Days	109,260	0.9	1,638,900	2.4	15.0	1,680,855	1.6	15,496	1,026
16 Days	83,850	0.7	1,341,600	2.0	16.0	1,360,872	1.3	16,347	1,014
17 Days	68,855	0.6	1,170,535	1.7	17.0	1,183,621	1.1	17,307	1,011
18 Days	59,305	0.5	1,067,490	1.6	18.0	1,084,970	1.0	18,457	1,016
19 Days	48,200	0.4	915,800	1.3	19.0	938,582	0.9	19,650	1,025
20 Days	43,570	0.4	871,400	1.3	20.0	876,579	0.8	20,303	1,006
21-30 Days	218,125	1.8	5,315,540	7.8	24.4	5,776,289	5.4	26,731	1,087
31-40 Days	59,235	0.5	2,055,140	3.0	34.7	2,539,991	2.4	43,430	1,236
41-50 Days	22,875	0.2	1,026,820	1.5	44.9	1,387,860	1.3	61,738	1,352
51-60 Days	10,625	0.1	584,300	0.9	55.0	788,614	0.7	75,719	1,350
61-90 Days	10,615	0.1	761,600	1.1	71.7	1,018,228	1.0	98,332	1,337
91 Days or More	4,375	(3)	558,210	0.8	127.6	537,626	0.5	128,773	963

[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 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 2007

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]	3,618	100.0	11,985,465	100.0	5.6	$106,574,918	100.0	$8,945
1-99 Beds	1,270	35.1	1,194,840	10.0	4.7	7,638,496	7.2	6,418
100-299 Beds	1,440	39.8	4,359,020	36.4	5.4	33,846,903	31.8	7,803
300-499 Beds	571	15.8	3,361,255	28.0	5.8	30,834,706	28.9	9,232
500 Beds or More	337	9.3	3,070,350	25.6	6.2	34,254,813	32.1	11,244
Total Urban Hospitals	2,404	100.0	10,243,585	100.0	5.8	95,329,104	100.0	9,366
1-99 Beds	533	22.2	574,625	5.6	4.8	4,165,241	4.4	7,279
100-299 Beds	1,012	42.1	3,410,070	33.3	5.5	27,489,155	28.8	8,105
300-499 Beds	528	22.0	3,214,810	31.4	5.8	29,653,195	31.1	9,283
500 Beds or More	331	13.8	3,044,080	29.7	6.2	34,021,513	35.7	11,265
Total Rural Hospitals	1,214	100.0	1,741,880	100.0	4.9	11,245,813	100.0	6,479
1-99 Beds	737	60.7	620,215	35.6	4.5	3,473,255	30.9	5,621
100-299 Beds	428	35.3	948,950	54.5	5.1	6,357,748	56.5	6,722
300-499 Beds	43	3.5	146,445	8.4	5.6	1,181,511	10.5	8,098
500 Beds or More	6	0.5	26,270	1.5	5.5	233,300	2.1	8,906
Total All Hospitals[3]	3,618	100.0	11,985,465	100.0	5.6	106,574,918	100.0	$8,945
Voluntary	2,182	60.3	8,661,090	72.3	5.6	77,756,791	73.0	9,033
Proprietary	726	20.1	1,655,430	13.8	5.6	13,717,135	12.9	8,330
Government	710	19.6	1,668,945	13.9	5.7	15,100,992	14.2	9,102
Total Teaching Hospitals[4]	1,060	100.0	5,606,300	100.0	5.9	57,431,341	100.0	10,318
Voluntary	778	73.4	4,531,230	80.8	5.9	45,823,592	79.8	10,185
Proprietary	93	8.8	354,520	6.3	6.0	3,387,881	5.9	9,620
Government	189	17.8	720,550	12.9	6.3	8,219,867	14.3	11,493
Total Non-Teaching Hospitals	2,558	100.0	6,379,165	100.0	5.4	49,143,577	100.0	7,742
Voluntary	1,404	54.9	4,129,860	64.7	5.4	31,933,199	65.0	7,771
Proprietary	633	24.7	1,300,910	20.4	5.5	10,329,254	21.0	7,979
Government	521	20.4	948,395	14.9	5.3	6,881,124	14.0	7,290

[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 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 2007

Type of Hospital	Hospitals		Discharges		Covered Days of Care		
	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals [2]	6,231	100.0	12,873,385	100.0	74,793,905	100.0	5.8
Short-Stay Hospitals	3,713	59.6	12,036,270	93.5	65,852,955	88.0	5.5
Hospitals	3,713	59.6	11,467,180	89.1	59,312,180	79.3	5.2
Psychiatric Hospital Units [3]	NA	----	333,430	2.6	3,591,595	4.8	10.8
Rehabilitation Hospital Units [3]	NA	----	235,660	1.8	2,949,180	3.9	12.5
Specialty Hospitals	2,518	40.4	837,115	6.5	8,940,950	12.0	10.7
Childrens	82	1.3	2,765	(4)	19,655		7.1
Psychiatric	497	8.0	131,430	1.0	1,839,790	2.5	14.0
Rehabilitation	224	3.6	138,575	1.1	1,911,380	(4) 2.6	13.8
Long Term	407	6.5	134,275	1.0	3,621,455	4.8	27.0
Critical Access (formerly Short-Stay)	1,292	20.7	429,720	3.3	1,536,460	2.1	3.6
Religious Non-Medical	16	0.3	350	(4)	12,210		34.9

See footnotes at end of table.

(4)

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 2007

	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]	$416,859,220	100.0	$32,381	$5,573	$116,384,496	100.0	$9,092	$1,556
Short-Stay Hospitals	394,439,756	94.6	32,771	5,990	106,783,834	91.8	8,926	1,622
Hospitals	379,811,367	91.1	33,122	6,404	100,638,150	86.5	8,776	1,697
Psychiatric Hospital Units [3]	6,874,390	1.6	20,617	1,914	2,413,530	2.1	7,338	672
Rehabilitation Hospital Units [3]	7,753,999	1.9	32,903	2,629	3,732,153	3.2	15,997	1,265
Specialty Hospitals	22,419,464	5.4	26,782	2,508	9,600,662	8.2	11,469	1,074
Childrens	162,223	(4)	58,670	8,254	44,061	(4)	15,935	2,242
Psychiatric	2,084,080	0.5	15,857	1,133	1,002,188	0.9	7,625	545
Rehabilitation	3,390,244	0.8	24,465	1,774	2,182,845	1.9	15,753	1,142
Long Term	12,862,210	3.1	95,790	3,552	4,327,300	3.7	32,228	1,195
Critical Access (formerly Short-Stay)	3,914,192	0.9	9,109	2,548	2,039,275	1.8	4,746	1,327
Religious Non-Medical	6,514	(4)	18,611	533	4,993	(4)	14,265	409

[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 1,281 distinct-part psychiatric units and 871 rehabilitation units participating in the Medicare Program during 2007.

[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 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 2007

Location and Bedsize of Hospital	Discharges	Hospital Case-Mix Index[1]	Percent of Discharges				
			Total	Surgical			Without Procedure
				Total	With Procedures	Non-Surgical	
Total All Hospitals[2]	11,974,855	1.4842	100.0	58.8	47.9	10.9	41.1
1-99 Beds	1,185,540	1.2515	100.0	43.9	33.6	10.3	56.1
100-299 Beds	4,357,710	1.3852	100.0	54.8	44.4	10.4	45.1
300-499 Beds	3,361,255	1.5245	100.0	61.3	50.6	10.7	38.7
500 Beds or More	3,070,350	1.6704	100.0	67.6	55.4	12.2	32.4
Total Urban Hospitals	10,233,890	1.5230	100.0	61.1	50.1	11.0	38.9
1-99 Beds	566,240	1.3732	100.0	52.5	42.4	10.1	47.5
100-299 Beds	3,408,760	1.4120	100.0	56.2	45.9	10.3	43.7
300-499 Beds	3,214,810	1.5272	100.0	61.5	50.7	10.8	38.5
500 Beds or More	3,044,080	1.6706	100.0	67.6	55.4	12.2	32.3
Total Rural Hospitals	1,740,965	1.2564	100.0	45.8	35.4	10.4	54.3
1-99 Beds	619,300	1.1403	100.0	36.1	25.6	10.5	63.9
100-299 Beds	948,950	1.2890	100.0	49.8	39.0	10.8	50.2
300-499 Beds	146,445	1.4649	100.0	56.9	48.8	8.1	43.1
500 Beds or More	26,270	1.6543	100.0	63.5	57.2	6.3	36.5

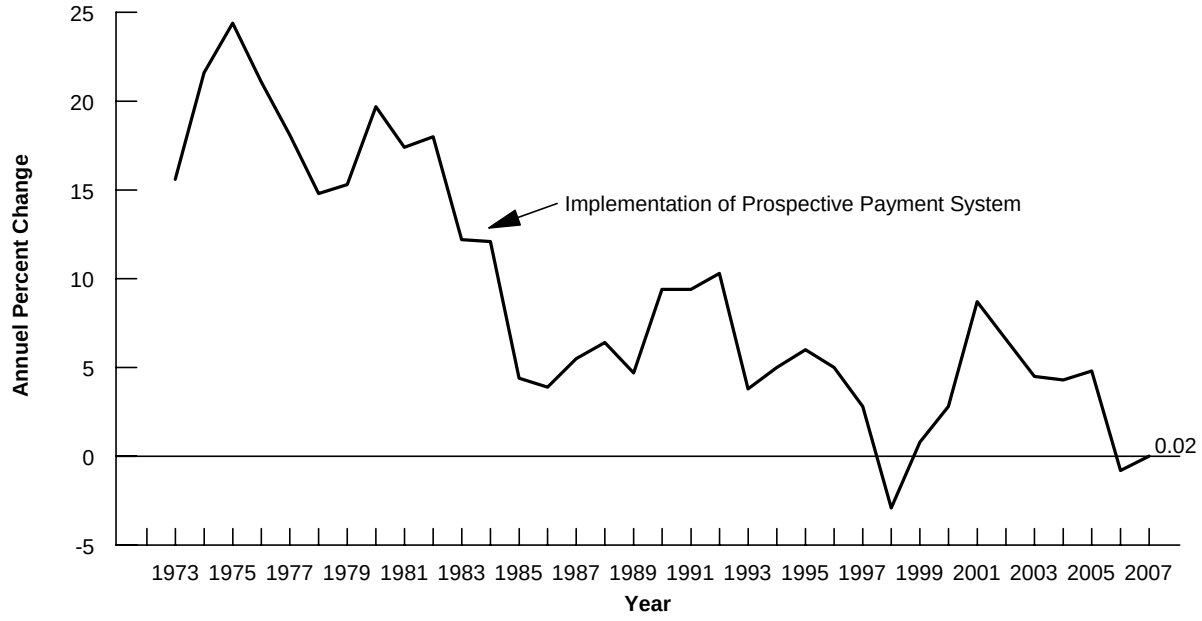
[1]For hospitals participating in the Medicare prospective payment system, the hospital case-mix index is a relative measure of the hospital's average cost per case relative to the average cost per case for all hospitals in some base or reference year. The case-mix index is presented by selected provider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

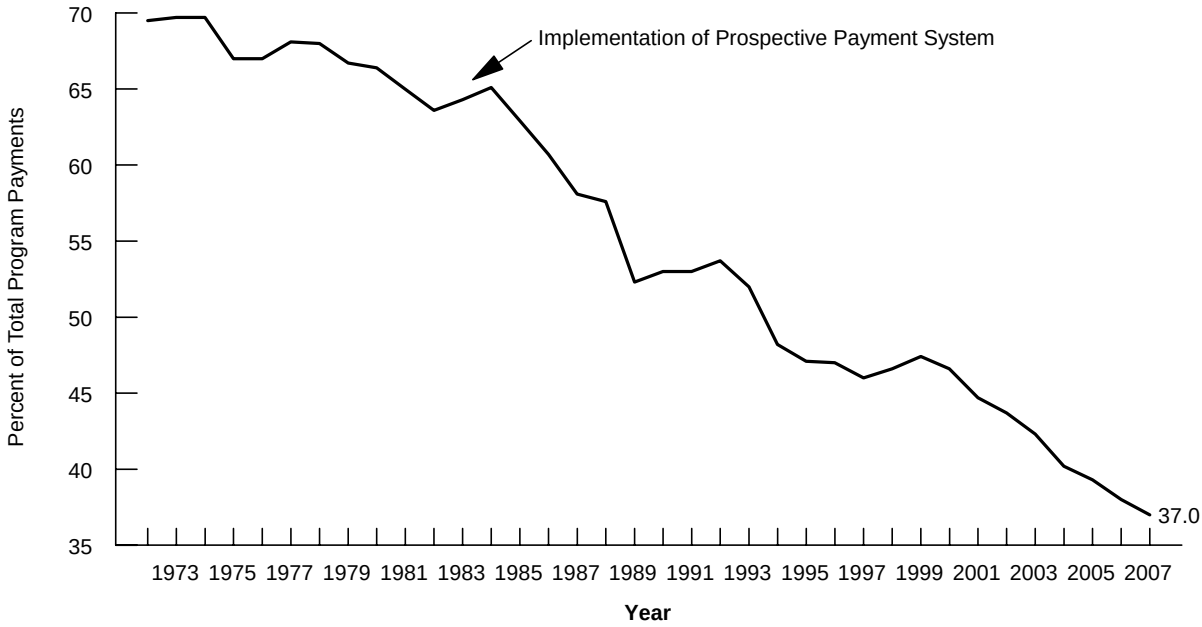
[2]Includes discharges from SSH in the 50 States and District of Columbia; excludes discharges from SSH in all outlying areas.

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 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 1972-2007

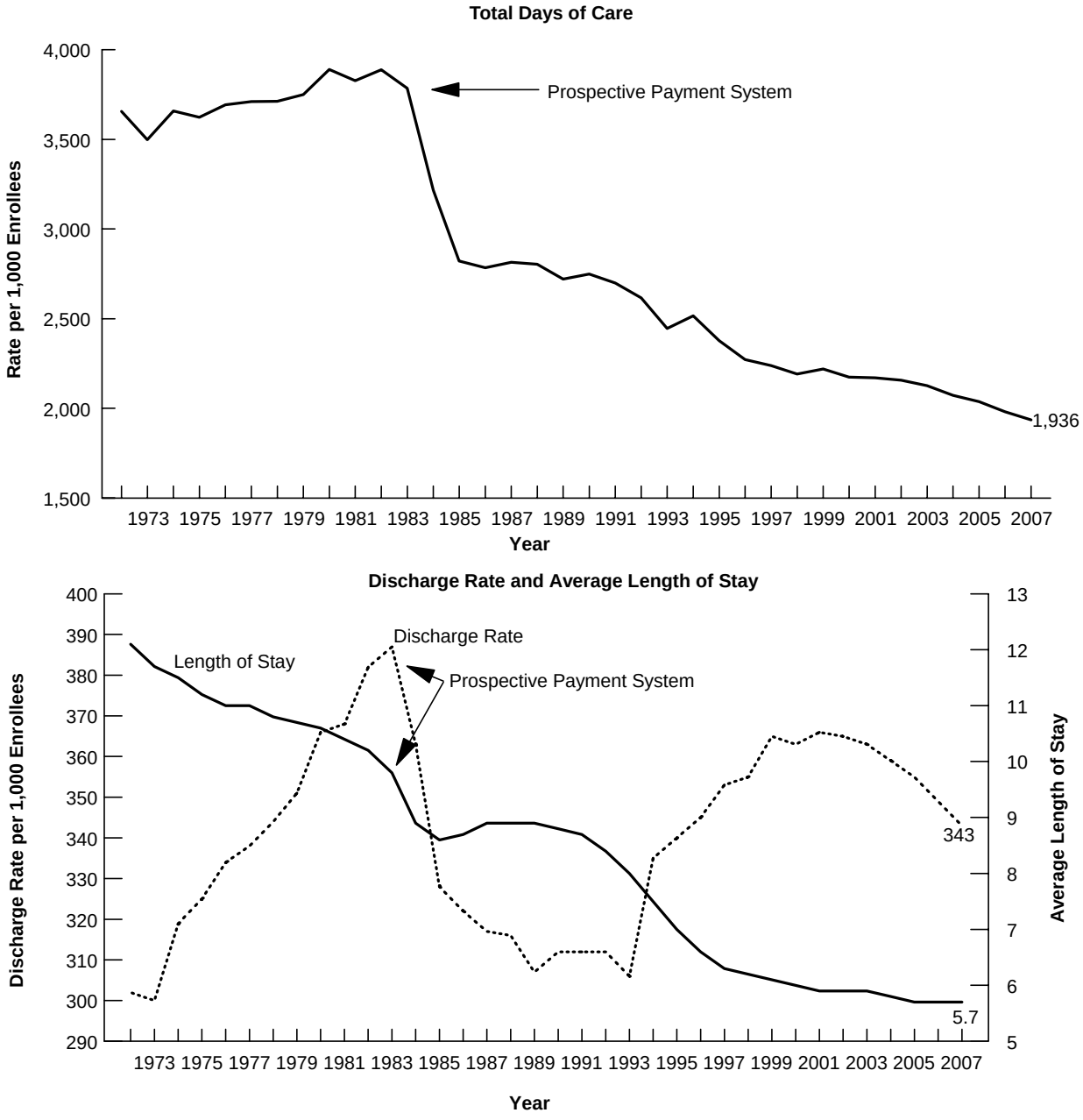




NOTE: The Medicare short-stay hospital prospective payment system was phased in by providers' fiscal years beginning on or after October 1, 1983.

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.

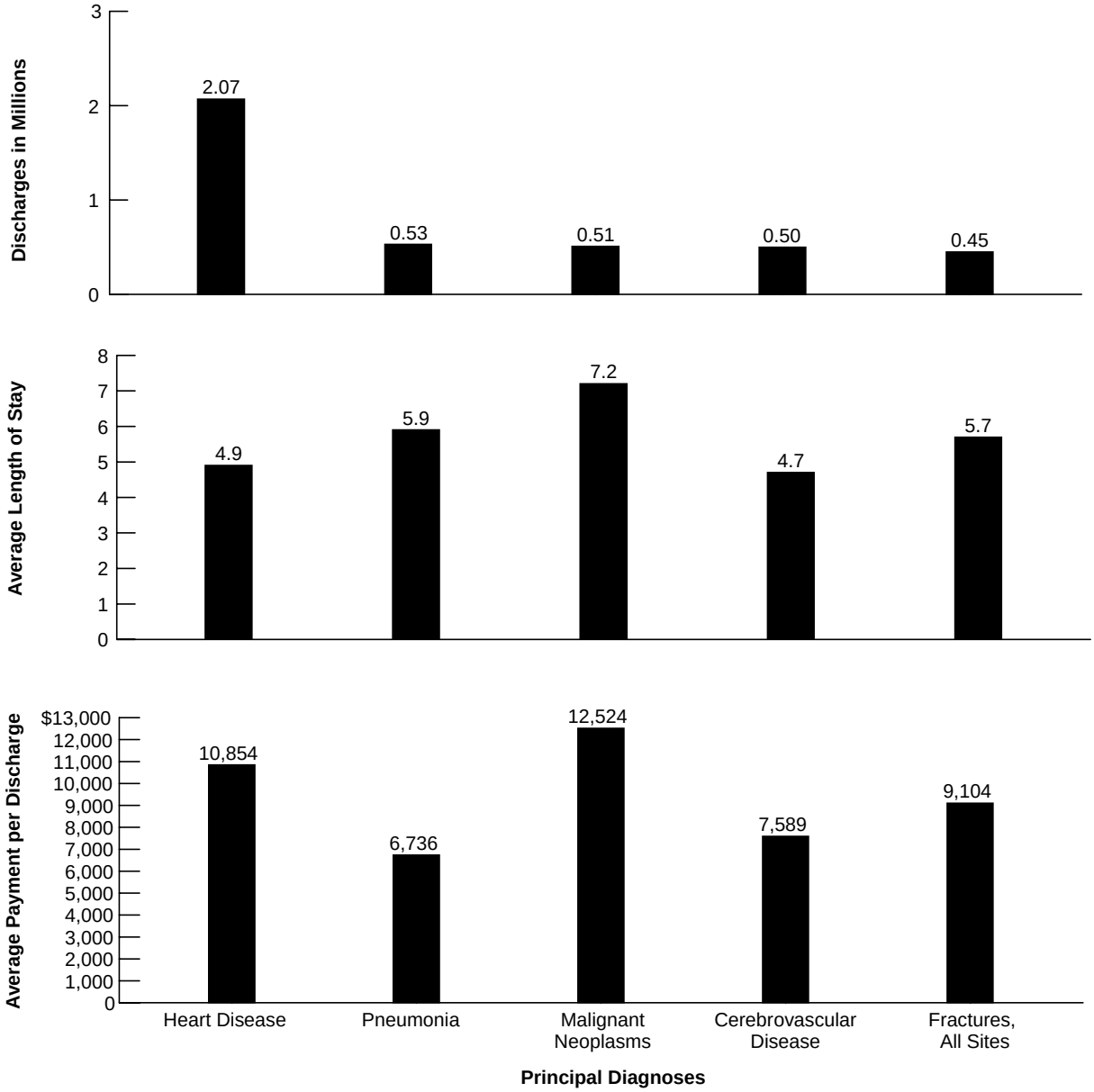
Figure 5.2
Trends in Parameters of Medicare Beneficiary Stays in Short-Stay Hospitals: Calendar Years 1972-2007



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.

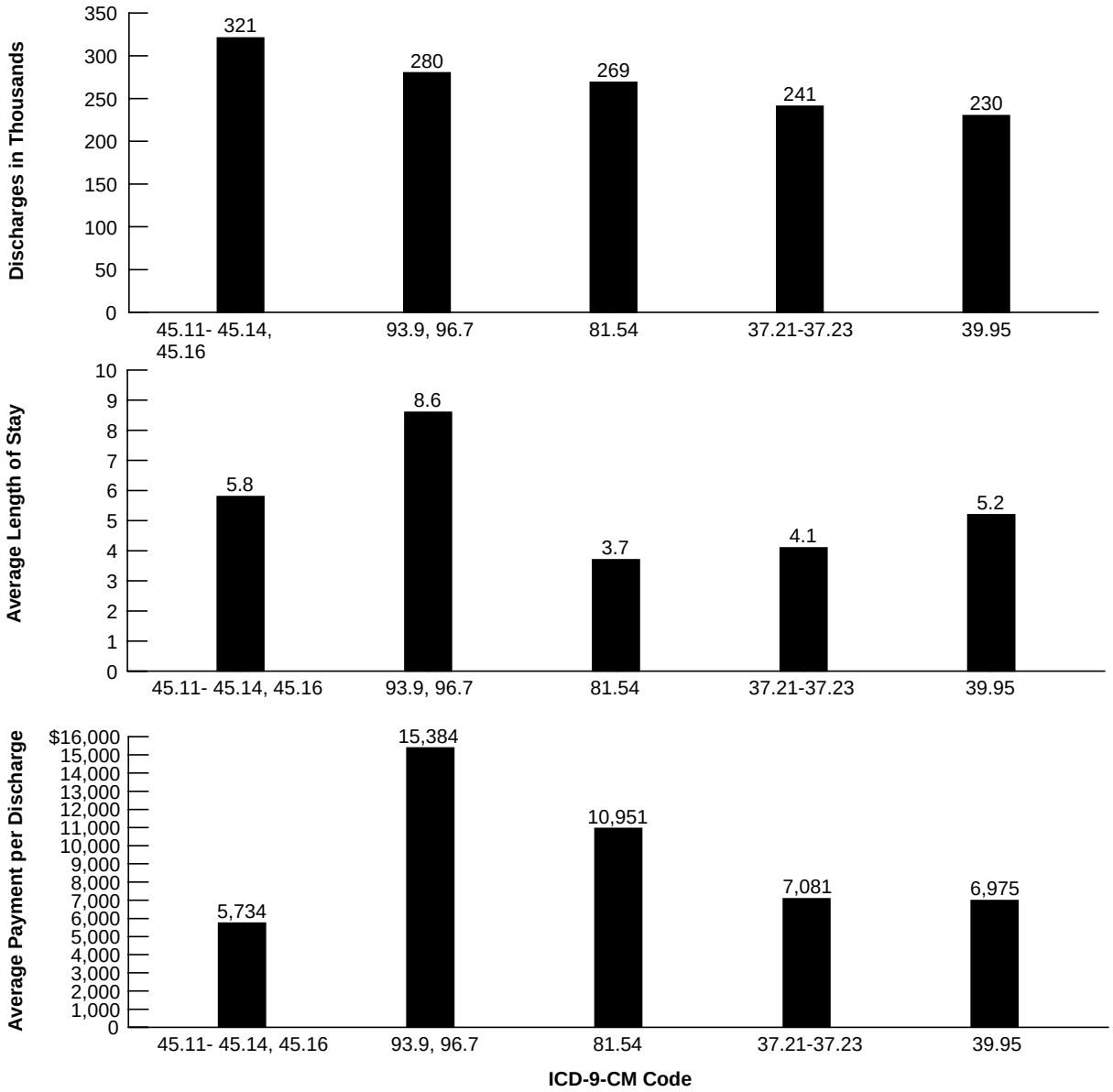
Figure 5.3
Leading Principal Diagnostic Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2007



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; malignant neoplasms, 140-208 and 230-234; cerebrovascular disease, 430-438; 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.

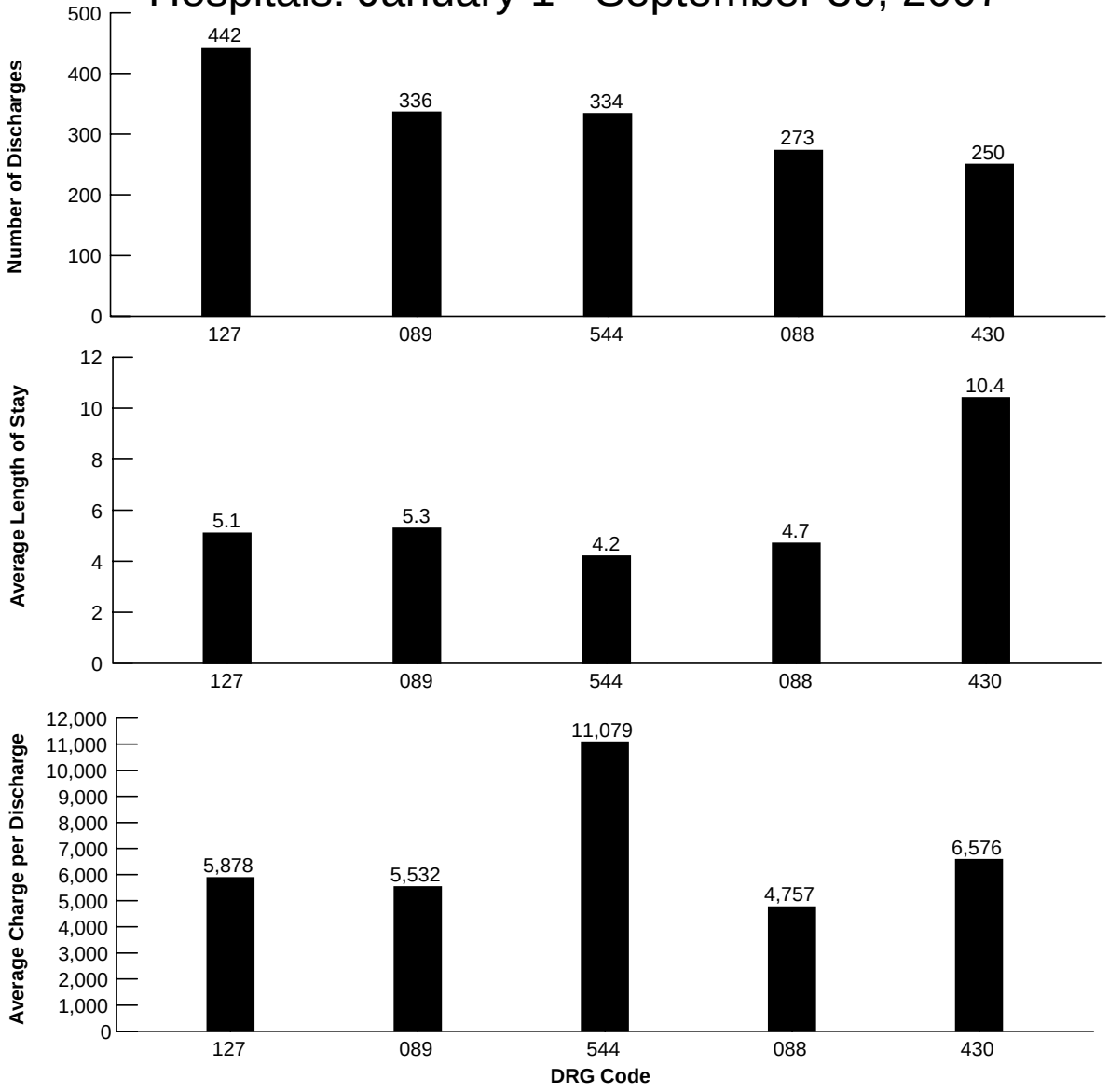
Figure 5.4
Medicare Principal Procedure Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2007



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; cardiac catheterization, 37.21-37.23; and hemodialysis, 39.95.

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: January 1 - September 30, 2007[1]

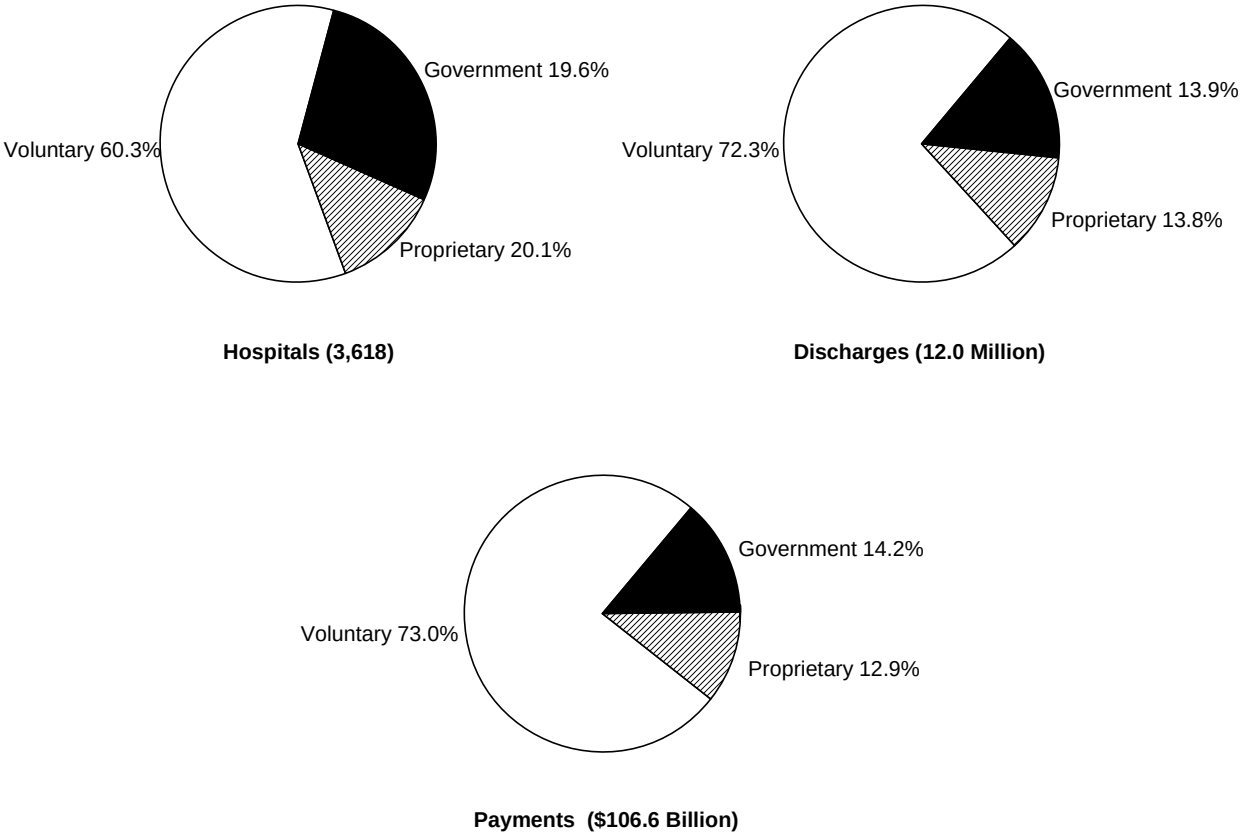


[1] Table reflects only January thru September for 2007 due to the major revision in the twenty-fifth version of the DRGs definitions manual, effective for all Medicare discharges on or after October 1, 2007. For the purpose of this table, version 24.0 was used.

NOTE: DRG codes are as follows: heart failure & shock, 127; simple pneumonia & pleurisy, 089; major joint replacement or reattachment of lower extremity, 544; chronic obstructive pulmonary disease, 088; and psychoses, 430.

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.

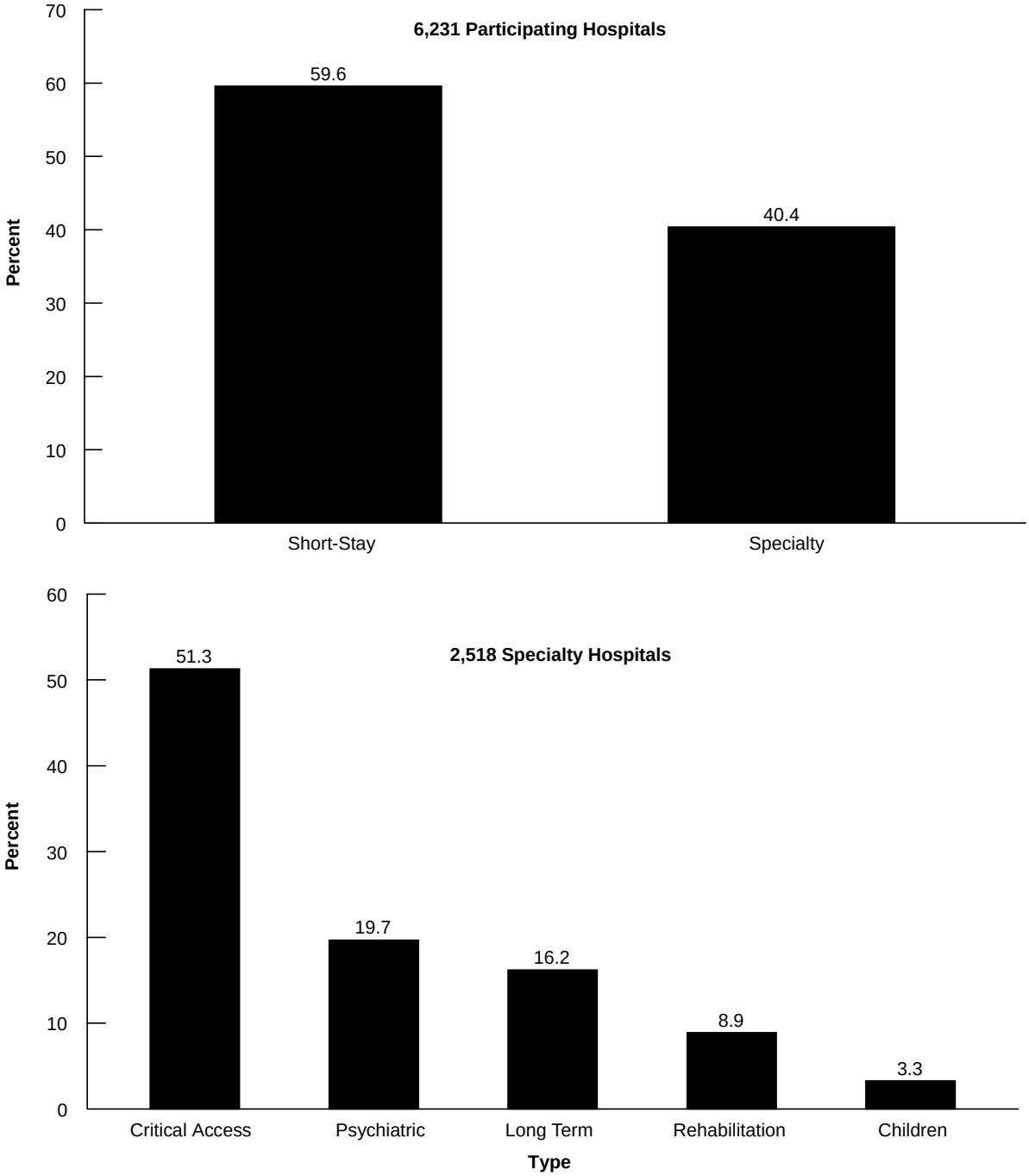
Figure 5.6
Distribution of Medicare Short-Stay Hospitals, Discharges, and Payments, by Type of Control: Calendar Year 2007



NOTE: Short-stay hospital payments excludes outlying areas.

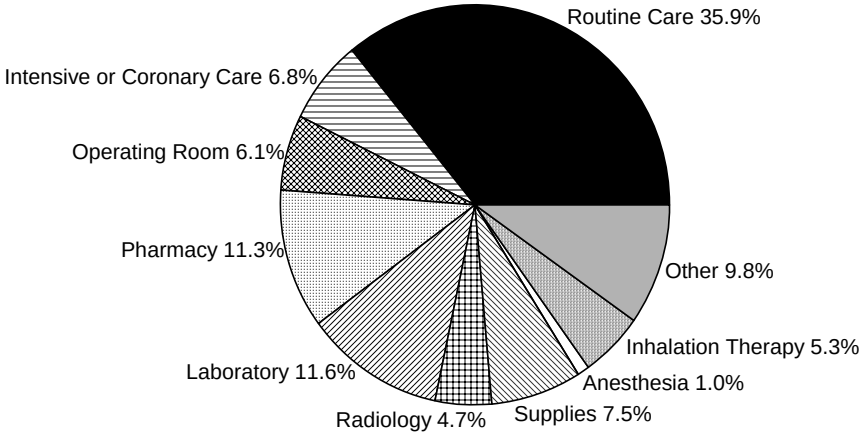
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 5.7
Medicare Participating Hospitals, by Type of Hospital: Calendar Year 2007



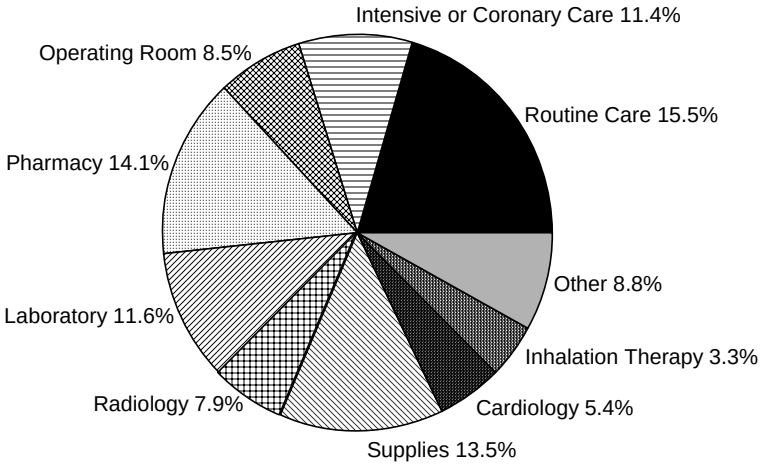
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Data Extract System; data development by the Office of Research, Development, and Information.

Figure 5.8
Percent Distribution of Medicare Short-Stay Hospital Charges, by Type of Service: Calendar Years 1983 and 2007



1983

(Total Charges = $54.8 Billion)



2007

(Total Charges = $397.9 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.