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 1972-2005

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
			Average Annual Rate of Change		
1972-1983 [6]	5.4	2.3	3.4	0.3	-1.9
1983-2005 [6]	0.6	-0.4	-1.9	-2.8	-2.4
1972-2005	2.2	0.5	-0.1	-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 1972-2005

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
			Average Annual Rate of Change				
19.8	13.6	18.0	11.9	14.4	14.0	---	---
9.1	8.5	5.3	4.8	4.4	7.3	---	---
12.6	10.2	9.4	7.1	7.6	9.5	---	---

Table 5.1-Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2005

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
			Average Annual Rate of Change		
1972-1983 [6]	4.3	2.1	2.4	0.2	-1.9
1983-2005 [6]	0.2	-0.4	-2.3	-2.8	-2.5
1972-2005	1.5	0.4	-0.8	-1.8	-2.3

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 1972-2005

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
			Average Annual Rate of Change				
18.5	13.6	16.7	11.8	14.2	14.0	---	---
8.7	8.6	5.0	4.8	4.4	7.5	---	---
11.9	10.2	8.7	7.1	7.6	9.6	---	---

Table 5.1-Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2005

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
			Average Annual Rate of Change		
1974-1983 [6]	8.9	4.0	7.1	2.2	-1.6
1983-2005 [6]	2.9	-0.6	0.8	-2.7	-2.1
1974-2005	4.6	0.7	2.6	-1.3	-2.0

[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 1972-2005

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
			Average Annual Rate of Change				
24.8	14.6	22.6	12.6	17.1	14.6	---	---
11.4	8.3	7.4	4.5	3.8	6.6	---	---
15.2	10.1	11.6	6.8	7.5	8.9	---	---

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 1972-2006

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
			Average Annual Rate of Change		
1972-1983 [6]	5.4	2.3	3.4	0.3	-1.9
1983-2006 [6]	0.3	-0.4	-2.0	-2.8	-2.3
1972-2006	2.0	0.4	-0.3	-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 1972-2006

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
			Average Annual Rate of Change				
19.8	13.6	18.0	11.9	14.4	14.0	---	---
8.9	8.5	5.1	4.7	4.2	7.2	---	---
12.3	10.1	9.1	7.0	7.4	9.4	---	---

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2006

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
			Average Annual Rate of Change		
1972-1983 [6]	4.3	2.1	2.4	0.2	-1.9
1983-2006 [6]	0.0	-0.5	-2.5	-2.9	-2.4
1972-2006	1.3	0.4	-0.9	-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 1972-2006

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
			Average Annual Rate of Change				
18.5	13.6	16.7	11.8	14.2	14.0	---	---
8.5	8.5	4.7	4.8	4.3	7.3	---	---
11.6	10.1	8.4	7.0	7.4	9.4	---	---

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2006

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
			Average Annual Rate of Change		
1974-1983 [6]	8.9	4.0	7.1	2.2	-1.6
1983-2006 [6]	2.6	-0.7	0.6	-2.7	-2.0
1974-2006	4.4	0.6	2.4	-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 1972-2006

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
			Average Annual Rate of Change				
24.8	14.6	22.6	12.6	17.1	14.6	---	---
11.2	8.3	7.2	4.5	3.7	6.5	---	---
14.8	10.0	11.3	6.7	7.3	8.7	---	---

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 1985-2005

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	Thousands in
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 [1]	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 [2]	11,470,605	181,110	1.6	2,015,355	2.4	11.1	637,692	3,521	316	19	5,656,015
1995 [2]	11,680,885	164,535	1.4	1,738,950	2.1	10.6	535,923	3,257	308	16	5,880,735
1996 [2]	11,795,535	149,265	1.3	1,492,815	1.9	10.0	472,289	3,164	316	14	6,066,239
1997 [2]	11,919,085	144,780	1.2	1,400,900	1.9	9.7	454,071	3,136	324	14	6,274,527
1998 [2]	11,677,045	137,380	1.2	1,288,950	1.8	9.4	412,001	2,999	320	13	6,157,044
1999 [2]	11,604,590	137,940	1.2	1,278,785	1.8	9.3	423,526	3,070	331	13	6,077,414
2000 [2]	11,719,960	145,880	1.2	1,379,135	2.0	9.5	492,771	3,378	357	15	6,214,175
2001 [2]	12,230,660	156,340	1.3	1,454,450	2.0	9.3	530,950	3,396	365	16	6,579,229
2002 [2]	12,607,370	162,690	1.3	1,506,820	2.0	9.3	578,659	3,557	384	17	6,959,581
2003 [2]	12,857,535	168,950	1.3	1,531,665	2.0	9.1	594,767	3,520	388	17	7,299,864
2004 [2]	12,918,130	169,810	1.3	1,517,310	2.0	8.9	607,671	3,579	400	17	7,660,837
2005 [2]	12,903,875	172,875	1.3	1,521,535	2.1	8.8	645,944	3,736	425	18	7,977,547
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 [1]	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 [2]	9,981,910	140,710	1.4	1,587,770	2.1	11.3	490,226	3,484	309	17	4,988,249
1995 [2]	10,110,745	125,305	1.2	1,348,065	1.9	10.8	407,180	3,250	302	14	5,160,234
1996 [2]	10,154,130	109,210	1.1	1,118,230	1.7	10.2	347,960	3,186	311	12	5,300,481
1997 [2]	10,238,610	105,800	1.0	1,041,835	1.6	9.8	325,899	3,080	313	12	5,469,574
1998 [2]	9,981,860	97,640	1.0	930,890	1.5	9.4	287,393	2,943	309	11	5,343,214
1999 [2]	9,872,680	97,240	1.0	921,210	1.5	9.5	296,315	3,047	322	11	5,245,762
2000 [2]	9,912,740	102,475	1.0	982,075	1.7	9.6	339,119	3,309	345	12	5,335,548
2001 [2]	10,288,530	109,450	1.1	1,025,070	1.7	9.4	359,299	3,283	351	13	5,619,671
2002 [2]	10,509,835	112,105	1.1	1,045,585	1.7	9.3	381,837	3,406	365	13	5,892,427
2003 [2]	10,647,510	113,995	1.1	1,040,375	1.7	9.1	384,424	3,372	370	13	6,142,079
2004 [2]	10,594,875	112,690	1.1	1,014,715	1.7	9.0	385,968	3,425	380	13	6,386,647
2005 [2]	10,501,475	113,530	1.1	1,005,315	1.7	8.9	402,672	3,547	401	13	6,604,040

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 1985-2005

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	Thousands in
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[1]	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[2]	1,488,695	40,400	2.7	427,585	3.8	11.0	147,466	3,650	345	37	667,766
1995[2]	1,570,140	39,230	2.5	390,885	3.5	10.0	128,743	3,282	329	30	720,502
1996[2]	1,641,405	40,055	2.4	374,585	3.4	9.4	124,329	3,104	332	29	765,758
1997[2]	1,680,475	38,980	2.3	359,065	3.3	9.2	128,172	3,288	357	28	804,953
1998[2]	1,695,185	39,740	2.3	358,060	3.3	9.0	124,608	3,136	348	27	813,830
1999[2]	1,731,910	40,700	2.4	357,575	3.3	8.8	127,211	3,126	356	27	831,652
2000[2]	1,807,220	43,405	2.4	397,060	3.5	9.1	153,652	3,540	387	31	878,628
2001[2]	1,942,130	46,890	2.4	429,380	3.5	9.2	171,651	3,661	400	33	959,558
2002[2]	2,097,535	50,585	2.4	461,235	3.5	9.1	196,822	3,891	427	35	1,067,155
2003[2]	2,210,025	54,955	2.5	491,290	3.6	8.9	210,343	3,828	428	37	1,157,786
2004[2]	2,323,255	57,120	2.5	502,595	3.5	8.8	221,703	3,881	441	37	1,274,191
2005[2]	2,402,400	59,345	2.5	516,220	3.6	8.7	243,272	4,099	471	39	1,373,508

[1]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.

[2]Beginning with 1994, Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates and average payments.

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 5.2

Discharges, Coinsurance Days, Coinsurance Payments, and Deductible Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Selected Calendar Years 1985-2006

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	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]	
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
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
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

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 1985-2006

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	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]	
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

[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 2005

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	12,904	355	73,996	100.0	5.7	$107,615	100.0	$8,383	$1,454
Age									
Under 65 Years	2,350	374	14,210	19.2	6.0	18,642	17.3	8,042	1,312
65-69 Years	1,908	223	10,506	14.2	5.5	17,166	16.0	9,049	1,634
70-74 Years	1,926	280	10,487	14.2	5.4	17,362	16.1	9,052	1,656
75-79 Years	2,177	364	12,383	16.7	5.7	19,326	18.0	8,901	1,561
80-84 Years	2,113	462	12,273	16.6	5.8	17,447	16.2	8,275	1,422
85 Years or Over	2,429	598	14,136	19.1	5.8	17,672	16.4	7,287	1,250
Sex									
Male	5,669	351	32,669	44.2	5.8	50,751	47.2	9,011	1,553
Female	7,235	358	41,326	55.8	5.7	56,864	52.8	7,892	1,376
Race[4]									
White	10,606	346	59,368	80.2	5.6	87,117	81.0	8,247	1,467
Other	2,249	405	14,353	19.4	6.4	20,082	18.7	9,021	1,399
Type of Entitlement									
Aged[5]	10,501	350	59,473	80.4	5.7	88,525	82.3	9,457	1,488
Disabled[6]	2,402	382	14,523	19.6	6.0	19,090	17.7	8,054	1,315
Discharge Status									
Alive	12,422	N/A	69,894	94.5	5.6	100,298	93.2	8,116	1,435
Dead	482	N/A	4,101	5.5	8.5	7,318	6.8	15,247	1,784

[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 5.3

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 2006

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	12,384	349	70,301	100.0	5.7	$106,758	100.0	$8,669	$1,519
Age									
Under 65 Years	2,289	368	13,769	19.6	6.0	18,852	17.7	8,358	1,369
65-69 Years	1,847	220	10,125	14.4	5.5	17,258	16.2	9,402	1,704
70-74 Years	1,808	273	9,737	13.8	5.4	16,867	15.8	9,368	1,732
75-79 Years	2,038	356	11,435	16.3	5.6	18,664	17.5	9,185	1,632
80-84 Years	2,008	452	11,523	16.4	5.7	17,130	16.0	8,553	1,487
85 Years or Over	2,393	586	13,712	19.5	5.7	17,987	16.8	7,531	1,312
Sex									
Male	5,453	344	31,176	44.3	5.7	50,425	47.2	9,312	1,617
Female	6,931	353	39,126	55.7	5.6	56,332	52.8	8,164	1,440
Race[4]									
White	10,177	339	56,351	80.2	5.5	86,294	80.8	8,516	1,531
Other	2,165	398	13,715	19.5	6.3	20,096	18.8	9,389	1,465
Type of Entitlement									
Aged[5]	10,042	343	56,222	80.0	5.6	87,430	81.9	8,737	1,555
Disabled[6]	2,342	376	14,080	20.0	6.0	19,328	18.1	8,374	1,373
Discharge Status									
Alive	11,940	N/A	66,546	94.7	5.6	99,548	93.2	8,384	1,496
Dead	444	N/A	3,756	5.3	8.5	7,209	6.8	16,307	1,920

[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 2005

	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]	12,903,875	355	73,995,570	2,037	5.7	$107,615,219	$8,383	$2,963
United States	12,781,815	360	73,131,340	2,061	5.7	107,102,382	8,421	3,018
Northeast	2,536,490	371	16,186,655	2,367	6.4	23,985,690	9,519	3,508
Midwest	3,263,815	368	17,546,035	1,979	5.4	25,962,781	7,988	2,928
South	5,251,405	379	29,923,995	2,160	5.7	40,779,175	7,798	2,944
West	1,730,105	292	9,474,655	1,598	5.5	16,374,735	9,527	2,761
New England	629,830	326	3,599,630	1,864	5.7	5,686,973	9,093	2,944
Connecticut	163,065	331	964,820	1,959	5.9	1,618,602	9,978	3,287
Maine	67,015	287	367,760	1,573	5.5	532,273	7,979	2,277
Massachusetts	291,845	361	1,623,680	2,009	5.6	2,554,285	8,828	3,160
New Hampshire	46,935	248	277,815	1,467	5.9	419,064	8,982	2,213
Rhode Island	38,390	343	239,155	2,134	6.2	335,575	8,839	2,994
Vermont	22,580	236	126,400	1,321	5.6	227,172	10,099	2,374
Middle Atlantic	1,906,660	389	12,587,025	2,566	6.6	18,298,716	9,659	3,730
New Jersey	429,170	387	2,832,875	2,556	6.6	4,066,126	9,546	3,668
New York	830,940	377	6,012,480	2,731	7.2	9,111,298	11,044	4,139
Pennsylvania	646,550	405	3,741,670	2,344	5.8	5,121,292	7,959	3,209
East North Central	2,340,390	379	12,726,885	2,061	5.4	18,906,877	8,114	3,062
Illinois	653,590	415	3,602,775	2,285	5.5	5,197,143	8,007	3,296
Indiana	306,820	349	1,695,750	1,926	5.5	2,343,138	7,660	2,662
Michigan	544,385	374	3,022,520	2,076	5.6	4,816,581	8,885	3,308
Ohio	604,590	400	3,255,775	2,157	5.4	4,691,224	7,786	3,108
Wisconsin	231,005	307	1,150,065	1,529	5.0	1,858,789	8,069	2,471

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 2005

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]
West North Central	923,425	343	4,819,150	1,790	5.2	$7,055,903	$7,667	$2,620
Iowa	140,210	303	741,430	1,603	5.3	1,047,867	7,494	2,266
Kansas	134,625	349	708,230	1,838	5.3	980,832	7,302	2,546
Minnesota	196,790	341	938,875	1,628	4.8	1,605,624	8,193	2,785
Missouri	314,080	395	1,721,520	2,167	5.5	2,333,412	7,459	2,938
Nebraska	75,695	305	397,790	1,600	5.3	610,461	8,086	2,456
North Dakota	28,865	283	143,455	1,408	5.0	224,098	7,783	2,200
South Dakota	33,160	267	167,850	1,353	5.1	253,606	7,682	2,045
South Atlantic	2,717,360	366	15,627,580	2,105	5.8	21,902,275	8,092	2,950
Delaware	46,210	366	287,100	2,276	6.2	434,150	9,436	3,441
District of Columbia	27,025	410	188,710	2,860	7.0	297,013	11,147	4,501
Florida	900,395	369	5,221,960	2,139	5.8	6,912,546	7,705	2,831
Georgia	353,280	353	1,988,330	1,987	5.6	2,790,891	7,930	2,789
Maryland	268,900	407	1,390,350	2,104	5.2	2,673,281	9,999	4,045
North Carolina	431,285	360	2,473,875	2,066	5.7	3,526,761	8,204	2,946
South Carolina	231,990	364	1,451,850	2,280	6.3	1,855,107	8,031	2,913
Virginia	327,055	340	1,901,075	1,974	5.8	2,469,969	7,584	2,565
West Virginia	131,220	394	724,330	2,177	5.5	942,553	7,202	2,834
East South Central	1,063,575	407	5,958,075	2,280	5.6	7,587,639	7,156	2,903
Alabama	289,380	425	1,557,805	2,286	5.4	1,940,466	6,732	2,847
Kentucky	257,895	396	1,396,010	2,142	5.4	1,908,916	7,425	2,929
Mississippi	189,520	421	1,162,460	2,585	6.1	1,357,395	7,185	3,018
Tennessee	326,780	394	1,841,800	2,218	5.6	2,380,861	7,303	2,867
West South Central	1,470,470	385	8,338,340	2,185	5.7	11,289,260	7,717	2,959
Arkansas	170,295	363	956,615	2,041	5.6	1,209,015	7,126	2,579
Louisiana	238,295	444	1,399,280	2,605	5.9	1,729,095	7,298	3,219
Oklahoma	201,710	407	1,078,425	2,178	5.3	1,437,256	7,143	2,903
Texas	860,170	372	4,904,020	2,119	5.7	6,913,893	8,086	2,987

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 2005

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]
Mountain	576,690	290	2,916,860	1,469	5.1	$4,741,202	$8,249	$2,388
Arizona	182,190	318	923,365	1,612	5.1	1,532,605	8,447	2,676
Colorado	114,125	305	565,995	1,511	5.0	941,910	8,273	2,515
Idaho	41,235	241	191,930	1,122	4.7	337,733	8,209	1,974
Montana	40,830	280	193,910	1,329	4.7	300,965	7,381	2,063
Nevada	63,660	302	388,125	1,844	6.1	563,012	8,882	2,675
New Mexico	57,295	262	290,275	1,326	5.1	454,303	7,970	2,075
Utah	57,645	260	267,730	1,206	4.6	452,648	7,879	2,039
Wyoming	19,710	282	95,530	1,369	4.8	158,021	8,021	2,265
Pacific	1,153,415	292	6,557,795	1,662	5.7	11,633,532	10,168	2,949
Alaska	12,385	241	74,105	1,440	6.0	143,796	11,700	2,795
California	844,925	310	4,983,940	1,829	5.9	8,789,788	10,507	3,225
Hawaii	26,655	221	186,210	1,546	7.0	251,274	9,513	2,087
Oregon	93,035	259	457,850	1,275	4.9	815,140	8,784	2,271
Washington	176,415	256	855,690	1,243	4.9	1,633,532	9,282	2,372
Outlying Areas[5]	122,060	147	864,230	1,044	7.1	512,836	4,291	619

[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 5.4

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Area of Residence: Calendar Year 2006

	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]	12,384,100	349	70,301,460	1,981	5.7	$106,757,630	$8,669	$3,008
United States	12,310,895	354	69,779,355	2,004	5.7	106,419,962	8,691	3,056
Northeast	2,443,060	365	15,406,415	2,303	6.3	23,283,192	9,598	3,481
Midwest	3,149,035	364	16,805,000	1,940	5.3	25,879,732	8,257	2,988
South	5,063,600	372	28,478,865	2,090	5.6	40,773,461	8,089	2,992
West	1,655,200	284	9,089,075	1,557	5.5	16,483,575	10,027	2,823
New England	635,245	326	3,583,000	1,842	5.6	5,851,113	9,274	3,007
Connecticut	166,490	341	979,510	2,007	5.9	1,677,795	10,140	3,437
Maine	63,710	269	346,330	1,462	5.4	533,723	8,407	2,253
Massachusetts	297,580	365	1,637,920	2,007	5.5	2,643,076	8,955	3,238
New Hampshire	47,790	246	272,670	1,401	5.7	434,938	9,151	2,235
Rhode Island	38,900	349	231,365	2,074	5.9	334,784	8,672	3,001
Vermont	20,775	212	115,205	1,174	5.5	226,794	10,970	2,311
Middle Atlantic	1,807,815	381	11,823,415	2,493	6.5	17,432,079	9,712	3,675
New Jersey	424,450	382	2,736,780	2,466	6.4	4,045,042	9,625	3,645
New York	801,200	372	5,752,250	2,674	7.2	8,695,933	10,938	4,042
Pennsylvania	582,165	393	3,334,385	2,250	5.7	4,691,104	8,094	3,165
East North Central	2,283,390	377	12,302,175	2,032	5.4	18,963,861	8,346	3,133
Illinois	646,255	411	3,494,275	2,220	5.4	5,294,493	8,252	3,364
Indiana	292,915	340	1,605,285	1,863	5.5	2,352,299	8,063	2,730
Michigan	534,745	376	2,961,185	2,080	5.5	4,801,260	9,021	3,372
Ohio	590,405	397	3,150,545	2,119	5.3	4,667,876	7,935	3,140
Wisconsin	219,070	310	1,090,885	1,542	5.0	1,847,931	8,466	2,613

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 2006

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]
West North Central	865,645	332	4,502,825	1,726	5.2	$6,915,871	$8,023	$2,651
Iowa	132,230	296	695,105	1,557	5.3	1,056,675	8,015	2,367
Kansas	126,685	333	661,720	1,741	5.2	954,254	7,575	2,511
Minnesota	178,500	338	851,250	1,613	4.8	1,520,565	8,550	2,881
Missouri	299,460	379	1,641,220	2,078	5.5	2,320,339	7,788	2,938
Nebraska	69,905	288	361,930	1,491	5.2	597,353	8,563	2,461
North Dakota	26,230	266	130,165	1,321	5.0	209,468	8,013	2,126
South Dakota	32,635	264	161,435	1,306	4.9	257,213	7,919	2,081
South Atlantic	2,635,935	362	15,008,220	2,060	5.7	21,961,460	8,369	3,014
Delaware	46,890	363	282,010	2,184	6.0	436,866	9,349	3,384
District of Columbia	26,515	402	179,910	2,729	6.8	300,202	11,511	4,554
Florida	866,455	366	4,991,585	2,108	5.8	6,813,303	7,894	2,878
Georgia	346,515	351	1,952,370	1,975	5.6	2,846,082	8,250	2,879
Maryland	271,900	407	1,414,450	2,117	5.2	2,900,121	10,722	4,340
North Carolina	413,165	352	2,334,120	1,991	5.6	3,431,968	8,331	2,927
South Carolina	222,725	355	1,349,770	2,152	6.1	1,853,729	8,371	2,956
Virginia	313,940	334	1,794,580	1,912	5.7	2,424,643	7,769	2,583
West Virginia	127,830	388	709,425	2,155	5.5	954,541	7,508	2,899
East South Central	1,019,830	398	5,641,380	2,204	5.5	7,569,879	7,449	2,958
Alabama	281,145	420	1,504,645	2,245	5.4	1,941,888	6,934	2,898
Kentucky	245,885	385	1,323,780	2,071	5.4	1,896,942	7,746	2,968
Mississippi	175,705	397	1,049,160	2,370	6.0	1,305,765	7,457	2,950
Tennessee	317,095	393	1,763,795	2,185	5.6	2,425,282	7,672	3,004
West South Central	1,407,835	372	7,829,265	2,069	5.6	11,242,121	8,027	2,972
Arkansas	162,505	355	901,610	1,968	5.5	1,225,893	7,589	2,676
Louisiana	211,950	398	1,231,960	2,314	5.8	1,607,203	7,623	3,019
Oklahoma	196,820	398	1,042,060	2,107	5.3	1,456,307	7,427	2,945
Texas	836,560	364	4,653,635	2,025	5.6	6,952,716	8,356	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 2006

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]
Mountain	539,255	284	2,742,310	1,443	5.1	$4,609,260	$8,585	$2,426
Arizona	159,915	306	816,890	1,561	5.1	1,426,206	8,966	2,725
Colorado	111,585	300	551,205	1,482	4.9	923,053	8,303	2,483
Idaho	37,820	229	178,855	1,081	4.7	320,032	8,474	1,935
Montana	37,675	270	179,760	1,289	4.8	287,001	7,636	2,058
Nevada	64,590	300	390,320	1,815	6.0	595,783	9,278	2,771
New Mexico	57,245	267	293,645	1,367	5.1	472,820	8,295	2,202
Utah	51,385	256	239,555	1,193	4.7	422,746	8,263	2,105
Wyoming	19,040	275	92,080	1,328	4.8	161,615	8,522	2,331
Pacific	1,115,945	283	6,346,765	1,612	5.7	11,874,315	10,727	3,015
Alaska	13,990	260	75,955	1,411	5.4	167,098	11,991	3,105
California	817,205	299	4,827,350	1,768	5.9	8,995,453	11,113	3,295
Hawaii	25,330	215	179,855	1,524	7.1	254,922	10,177	2,160
Oregon	85,560	250	417,565	1,222	4.9	785,985	9,225	2,300
Washington	173,860	250	846,040	1,218	4.9	1,670,855	9,642	2,405
Outlying Areas[5]	73,205	109	522,105	780	7.1	337,668	4,775	505

[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 2005

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	---	12,903,875	355	73,995,570	5.7	$107,615,220	$8,383	$1,454
Leading Diagnoses [5]	---	7,070,270	195	40,575,415	5.7	62,450,801	8,872	1,539
Infectious and Parasitic Diseases (MDC 1)	001-139	458,760	13	3,707,970	8.1	4,799,292	10,528	1,294
Septicemia	038	318,535	9	2,762,620	8.7	3,766,205	11,903	1,363
Neoplasms (MDC 2)	140-239	642,515	18	4,552,645	7.1	7,483,713	11,682	1,644
Malignant Neoplasms	140-208,230-234	558,200	15	4,108,500	7.4	6,633,049	11,918	1,614
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	80,555	2	766,540	9.5	1,280,908	15,928	1,671
alignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	90,305	2	694,185	7.7	1,156,218	12,834	1,666
Malignant Neoplasm of Breast	174-175,198.81	30,140	1	75,825	2.5	129,480	4,310	1,708
Benign Neoplasms	210-229	62,450	2	311,360	5.0	617,673	9,920	1,984
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	542,005	15	2,791,440	5.2	3,105,788	5,767	1,113
Diabetes Mellitus	250	199,295	5	1,215,510	6.1	1,424,239	7,210	1,172
Volume Depletion	276.5	163,650	5	749,050	4.6	701,798	4,309	937
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	159,015	4	750,585	4.7	880,593	5,673	1,173
Mental Disorders (MDC 5)	290-319	525,360	14	4,878,445	9.3	3,020,333	5,838	619
Psychoses	290-299	449,220	12	4,434,770	9.9	2,713,333	6,135	612
Alcohol Dependence Syndrome	303	16,975	(6)	100,165	5.9	55,865	3,348	558
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	209,945	6	1,331,500	6.3	1,421,741	6,806	1,068

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 2005

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	3,384,780	93	16,857,380	5.0	$33,670,513	$9,985	$1,997
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	2,357,825	65	11,587,215	4.9	25,108,789	10,684	2,167
Acute Myocardial Infarction	410	348,245	10	2,063,240	5.9	4,722,366	13,600	2,289
Coronary Atherosclerosis	414.0	565,910	16	2,097,025	3.7	7,225,935	12,820	3,446
Other Ischemic Heart Disease	411-413, 414.1-414.9	51,940	1	137,495	2.6	491,436	9,535	3,574
Cardiac Dysrhythmias	427	408,480	11	1,595,260	3.9	3,150,537	7,733	1,975
Congestive Heart Failure	428.0	637,360	18	3,427,980	5.4	5,042,945	7,936	1,471
Cerebrovascular Disease	430-438	546,560	15	2,656,710	4.9	3,892,944	7,159	1,465
Diseases of the Respiratory System (MDC 8)	460-519	1,663,240	46	10,460,305	6.3	12,545,355	7,572	1,199
Acute Bronchitis and Bronchocolitis	466	36,235	1	147,205	4.1	120,289	3,332	817
Pneumonia	480-486	669,250	18	4,073,020	6.1	4,230,865	6,342	1,039
Asthma	493	111,720	3	559,325	5.0	516,811	4,645	924
Diseases of the Digestive System (MDC 9)	520-579	1,254,915	35	7,154,595	5.7	9,421,099	7,543	1,317
Appendicitis	540-543	21,075	1	113,090	5.4	190,015	9,046	1,680
Non Infectious Enteritis and Colitis	555-558	101,345	3	585,525	5.8	732,327	7,257	1,251
Diverticula of Intestine	562	146,745	4	826,630	5.6	981,873	6,709	1,188
Cholelithiasis	574	113,150	3	614,300	5.4	987,936	8,756	1,608
Diseases of the Genitourinary System (MDC 10)	580-629	691,510	19	3,438,985	5.0	3,828,648	5,558	1,113
Calculus of Kidney and Ureter	592	34,345	1	109,035	3.2	178,886	5,221	1,641

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 2005

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	228,595	6	1,384,745	6.1	$1,256,473	$5,526	$907
Cellulitis and Abscess	681-682	174,705	5	958,015	5.5	839,503	4,827	876
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	843,705	23	3,552,785	4.2	7,660,497	9,106	2,156
Osteoarthrosis and Allied Disorders	715	399,870	11	1,548,765	3.9	4,028,302	10,089	2,601
Intervertebral Disc Disorders	722	84,330	2	312,990	3.7	717,236	8,537	2,292
Congenital Anomalies (MDC 14)	740-759	11,445	(6)	57,455	5.0	172,543	15,115	3,003
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	802,035	22	2,597,830	3.2	3,278,171	4,115	1,262
Injury and Poisoning (MDC 17)	800-999	1,108,980	31	6,534,355	5.9	10,364,928	9,397	1,586
Fractures, All Sites	800-829	455,185	13	2,622,915	5.8	3,784,806	8,336	1,443
Fracture of Neck of Femur	820	225,000	6	1,415,945	6.3	2,194,891	9,764	1,550
Poisoning by Drugs, Medicinal and Biological Substances	960-989	49,605	1	178,700	3.6	228,056	4,648	1,276
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	359,235	10	3,881,245	10.8	4,654,566	13,034	1,199

[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 5.5

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 2006

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	---	12,384,100	349	70,301,460	5.7	$106,757,631	$8,669	$1,519
Leading Diagnoses[5]	---	6,689,455	188	38,082,975	5.7	61,177,564	9,190	1,606
Infectious and Parasitic Diseases (MDC 1)	001-139	494,160	14	4,003,865	8.1	5,639,083	11,487	1,408
Septicemia	038	341,155	10	3,004,110	8.8	4,473,701	13,211	1,489
Neoplasms (MDC 2)	140-239	608,675	17	4,271,770	7.0	7,284,499	12,005	1,705
Malignant Neoplasms	140-208,230-234	529,560	15	3,853,255	7.3	6,467,202	12,252	1,678
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	74,695	2	712,135	9.5	1,213,797	16,275	1,704
Malignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	86,975	2	666,665	7.7	1,157,910	13,352	1,737
Malignant Neoplasm of Breast	174-175,198.81	26,565	1	69,755	2.6	120,296	4,545	1,725
Benign Neoplasms	210-229	58,080	2	292,800	5.0	591,795	10,218	2,021
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	497,625	14	2,496,400	5.0	2,904,687	5,878	1,164
Diabetes Mellitus	250	191,360	5	1,142,710	6.0	1,400,493	7,383	1,226
Volume Depletion	276.5	139,400	4	603,785	4.3	598,493	4,315	991
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	157,405	4	735,165	4.7	891,114	5,816	1,212
Mental Disorders (MDC 5)	290-319	500,100	14	4,656,460	9.3	2,886,433	5,869	620
Psychoses	290-299	427,390	12	4,218,710	9.9	2,578,801	6,138	611
Alcohol Dependence Syndrome	303	16,170	(6)	96,690	6.0	54,969	3,455	569
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	217,835	6	1,399,755	6.4	1,504,886	6,944	1,075

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 2006

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	3,217,150	91	15,760,625	4.9	$32,693,020	$10,201	$2,074
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	2,223,555	63	10,782,790	4.8	24,076,215	10,866	2,233
Acute Myocardial Infarction	410	315,925	9	1,825,050	5.8	4,414,092	14,009	2,419
Coronary Atherosclerosis	414.0	528,840	15	1,892,425	3.6	6,834,022	12,977	3,611
Other Ischemic Heart Disease	411-413, 414.1-414.9	45,585	1	120,090	2.6	481,198	10,630	4,007
Cardiac Dysrhythmias	427	400,455	11	1,550,160	3.9	3,107,122	7,783	2,004
Congestive Heart Failure	428.0	588,365	17	3,162,250	5.4	4,690,685	8,001	1,483
Cerebrovascular Disease	430-438	519,345	15	2,489,315	4.8	3,852,186	7,449	1,547
Diseases of the Respiratory System (MDC 8)	460-519	1,487,470	42	9,289,165	6.2	11,763,827	7,944	1,266
Acute Bronchitis and Bronchocolitis	466	29,570	1	118,965	4.0	103,782	3,531	872
Pneumonia	480-486	570,130	16	3,418,810	6.0	3,716,705	6,543	1,087
Asthma	493	98,765	3	478,270	4.8	468,854	4,775	980
Diseases of the Digestive System (MDC 9)	520-579	1,229,495	35	6,909,420	5.6	9,527,113	7,787	1,379
Appendicitis	540-543	21,225	1	116,030	5.5	200,229	9,478	1,726
Non Infectious Enteritis and Colitis	555-558	109,845	3	609,420	5.5	786,681	7,193	1,291
Diverticula of Intestine	562	136,120	4	771,200	5.7	967,664	7,139	1,255
Cholelithiasis	574	108,865	3	577,115	5.3	981,135	9,043	1,700
Diseases of the Genitourinary System (MDC 10)	580-629	700,850	20	3,469,800	5.0	4,028,363	5,771	1,161
Calculus of Kidney and Ureter	592	32,130	1	100,745	3.1	176,107	5,500	1,748

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 2006

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	220,715	6	1,319,760	6.0	$1,224,282	$5,579	$928
Cellulitis and Abscess	681-682	170,655	5	930,010	5.4	836,513	4,925	899
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	824,490	23	3,416,030	4.1	7,791,190	9,480	2,281
Osteoarthrosis and Allied Disorders	715	387,935	11	1,467,990	3.8	3,976,071	10,269	2,709
Intervertebral Disc Disorders	722	83,515	2	306,145	3.7	784,471	9,429	2,562
Congenital Anomalies (MDC 14)	740-759	10,670	(6)	51,715	4.8	161,600	15,238	3,125
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	781,900	22	2,524,450	3.2	3,282,206	4,230	1,300
Injury and Poisoning (MDC 17)	800-999	1,088,750	31	6,399,850	5.9	10,572,604	9,769	1,652
Fractures, All Sites	800-829	444,295	13	2,520,355	5.7	3,840,880	8,673	1,524
Fracture of Neck of Femur	820	216,320	6	1,347,880	6.2	2,204,304	10,207	1,635
Poisoning by Drugs, Medicinal and Biological Substances	960-989	50,390	1	183,755	3.6	244,615	4,897	1,331
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	329,130	9	3,535,760	10.7	4,551,132	13,930	1,287

[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 2005

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	---	7,450,030	205	48,656,990	6.5	$80,556,533	$10,867	$1,656
Leading Procedures [5]	---	3,503,350	96	20,516,895	5.9	35,215,719	10,096	1,716
Operations on the Nervous System (MPC 1)	01-05	184,670	5	1,201,980	6.5	2,100,638	11,420	1,748
Spinal Tap	03.31	40,380	1	285,170	7.1	283,769	7,064	995
Operations on the Endocrine System (MPC 2)	06-07	25,720	1	91,120	3.5	194,586	7,585	2,135
Operations on the Eye (MPC 3)	08-16	10,290	(6)	44,150	4.3	72,748	7,115	1,648
Operations on the Ear (MPC 4)	18-20	2,710	(6)	15,105	5.6	22,823	8,437	1,511
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	32,295	1	160,650	5.0	230,255	7,192	1,433
Operations on the Respiratory System (MPC 6)	30-34	287,035	8	3,235,120	11.3	5,163,166	18,056	1,596
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	70,835	2	668,175	9.4	708,969	10,042	1,061
Operations on the Cardiovascular System (MPC 7)	35-39	1,890,790	52	11,331,915	6.0	25,429,691	13,524	2,244
Removal of Coronary Artery Obstruction	36.0	288,115	8	856,410	3.0	3,891,901	13,542	4,544
Coronary Artery Bypass Graft	36.1	116,115	3	1,167,665	10.1	3,404,454	29,421	2,916
Cardiac Catheterization	37.21-37.23	280,450	8	1,155,235	4.1	1,952,973	6,996	1,691
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	143,425	4	690,640	4.8	1,902,631	13,293	2,755
Hemodialysis	39.95	217,710	6	1,159,995	5.3	1,373,727	6,403	1,184
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	44,115	1	400,890	9.1	623,874	14,187	1,556

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 2005

		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 Digestive System (MPC 9)	42-54	1,287,220	35	9,727,185	7.6	$12,568,865	$9,798	$1,292
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	353,980	10	2,114,905	6.0	1,888,396	5,358	893
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	138,735	4	830,160	6.0	734,170	5,309	884
Partial Excision of Large Intestine	45.7	109,810	3	1,213,970	11.1	2,123,218	19,365	1,749
Appendectomy, Excluding Incidental	47.0	19,545	1	99,380	5.1	168,259	8,635	1,693
Cholecystectomy	51.2	118,135	3	749,500	6.3	1,205,093	10,223	1,608
Lysis of Peritoneal Adhesions	54.5	30,380	1	331,365	10.9	499,776	16,481	1,508
Operations on the Urinary System (MPC 10)	55-59	201,415	6	1,258,945	6.3	1,839,375	9,166	1,461
Cystoscopy with or Without Biopsy	57.31-57.33	17,605	(6)	127,650	7.3	112,821	6,430	884
Operations on the Male Genital Organs (MPC 11)[7]	60-64	93,435	6	332,410	3.6	490,584	5,272	1,476
Prostatectomy	60.2-60.6	81,930	5	268,800	3.3	395,580	4,846	1,472
Operations on the Female Genital Organs (MPC 12)[8]	65-71	108,860	5	389,370	3.6	630,538	5,809	1,619
Unilateral Oophorectomy	65.3-65.6	10,650	1	52,125	4.9	78,635	7,397	1,509
Hysterectomy	68.3-68.7,68.9	56,965	3	203,840	3.6	334,091	5,881	1,639
Obstetrical Procedures (MPC 13)	72-75	12,655	1	42,755	3.4	34,524	2,742	807
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	595	(6)	1,495	2.5	831	1,397	556
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	5,340	(6)	24,170	4.5	21,561	4,080	892
Repair of Current Obstetric Laceration	75.5-75.6	1,310	(6)	3,240	2.5	2,416	1,845	746
Operations on the Musculoskeletal System (MPC 14)	76-84	1,149,760	32	6,251,030	5.4	12,257,998	10,686	1,961
Partial Excision of Bone	76.2-76.3,77.6-77.8	14,530	(6)	126,975	8.7	195,656	13,521	1,541
Reduction of Facial Fracture	76.7,79.0-79.3	205,505	6	1,204,230	5.9	1,854,267	9,038	1,540
Open Reduction of Fracture with Internal Fixation	79.3	153,510	4	906,210	5.9	1,411,044	9,205	1,557
Excision or Destruction of Intervertebral Disc	80.5	31,245	1	91,045	2.9	198,207	6,366	2,177
Total Hip Replacement	81.51	118,450	3	502,200	4.3	1,243,379	10,513	2,476
Total Knee Replacement	81.54	273,350	8	1,062,050	3.9	2,842,832	10,415	2,677

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 2005

		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	280,065	8	2,208,905	7.9	$2,680,405	$9,641	$1,213
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	96,170	3	1,019,360	10.6	1,393,967	14,599	1,367
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,671,205	46	11,310,435	6.8	13,243,579	7,980	1,171
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	109,290	3	552,725	5.1	634,763	5,837	1,148
Arteriography and Angiocardiography Using Contrast Mater	88.4-88.5	54,600	2	274,360	5.0	329,124	6,054	1,200
Diagnostic Ultrasound	88.7	145,625	4	777,305	5.3	858,998	5,921	1,105
Respiratory Therapy	93.9,96.7	265,620	7	2,296,315	8.6	3,691,869	14,027	1,608
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	47,100	1	371,670	7.9	522,610	11,155	1,406
Injection of Infusion of Cancer Chemotherapeutic Substanc	99.25	39,635	1	234,270	5.9	366,465	9,294	1,564

[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 5.6

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 2006

		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
Total All Procedures	---	7,250,960	204	46,740,595	6.4	$80,485,858	$11,160	$1,722
Leading Procedures[5]	---	3,091,230	87	18,675,275	6.0	30,956,600	10,065	1,658
Operations on the Nervous System (MPC 1	01-05	176,290	5	1,150,435	6.5	2,067,168	11,785	1,797
Spinal Tap	03.31	38,950	1	277,125	7.1	278,543	7,207	1,005
Operations on the Endocrine System (MPC 2	06-07	26,990	1	102,620	3.8	228,932	8,510	2,231
Operations on the Eye (MPC 3	08-16	9,500	(6)	41,330	4.4	68,964	7,302	1,669
Operations on the Ear (MPC 4)	18-20	2,640	(6)	13,965	5.3	22,587	8,605	1,617
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	30,105	1	149,150	5.0	216,924	7,279	1,454
Operations on the Respiratory System (MPC 6)	30-34	276,745	8	3,029,240	10.9	5,067,247	18,382	1,673
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	67,835	2	631,900	9.3	715,174	10,586	1,132
Operations on the Cardiovascular System (MPC 7)	35-39	1,574,395	44	10,225,105	6.5	21,475,969	13,728	2,100
Removal of Coronary Artery Obstruction	36.0	7,835	(6)	20,715	2.6	122,496	15,674	5,913
Coronary Artery Bypass Graft	36.1	105,025	3	1,042,815	9.9	3,115,831	29,745	2,988
Cardiac Catheterization	37.21-37.23	259,765	7	1,063,120	4.1	1,832,507	7,090	1,724
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	140,630	4	669,330	4.8	1,912,256	13,629	2,857
Hemodialysis	39.95	222,595	6	1,182,655	5.3	1,450,490	6,617	1,226
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	40,985	1	365,640	8.9	588,659	14,407	1,610

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 2006

		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 Digestive System (MPC 9)	42-54	1,226,995	35	9,172,195	7.5	$12,490,172	$10,223	$1,362
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	338,830	10	1,974,265	5.8	1,865,023	5,529	945
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	126,555	4	748,990	5.9	693,620	5,503	926
Partial Excision of Large Intestine	45.7	104,895	3	1,161,775	11.1	2,083,975	19,907	1,794
Appendectomy, Excluding Incidental	47.0	19,585	1	100,465	5.1	177,906	9,123	1,771
Cholecystectomy	51.2	113,865	3	717,160	6.3	1,223,292	10,782	1,706
Lysis of Peritoneal Adhesions	54.5	30,075	1	321,775	10.7	506,776	16,890	1,575
Operations on the Urinary System (MPC 10)	55-59	204,040	6	1,245,500	6.1	1,908,941	9,395	1,533
Cystoscopy with or Without Biopsy	57.31-57.33	15,770	(6)	118,650	7.5	111,511	7,096	940
Operations on the Male Genital Organs (MPC 11[7]	60-64	85,780	5	297,870	3.5	472,562	5,534	1,586
Prostatectomy	60.2-60.6	75,090	5	239,425	3.2	379,215	5,072	1,584
Operations on the Female Genital Organs (MPC 12[8]	65-71	103,000	5	358,605	3.5	616,203	6,001	1,718
Unilateral Oophorectomy	65.3-65.6	9,945	1	48,085	4.8	75,200	7,577	1,564
Hysterectomy	68.3-68.7,68.9	52,770	3	187,480	3.6	324,104	6,162	1,729
Obstetrical Procedures (MPC 13)	72-75	12,615	1	42,135	3.3	35,495	2,833	842
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	490	(6)	1,195	2.4	670	1,367	561
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	5,375	(6)	23,965	4.5	22,436	4,217	936
Repair of Current Obstetric Laceration	75.5-75.6	1,375	(6)	3,100	2.3	2,382	1,745	768
Operations on the Musculoskeletal System (MPC 14)	76-84	1,092,955	31	5,882,615	5.4	12,172,303	11,171	2,069
Partial Excision of Bone	76.2-76.3,77.6-77.8	14,265	(6)	126,420	8.9	199,211	14,074	1,576
Reduction of Facial Fracture	76.7,79.0-79.3	197,340	6	1,157,780	5.9	1,887,611	9,595	1,630
Open Reduction of Fracture with Internal Fixation	79.3	143,110	4	847,080	5.9	1,399,030	9,802	1,652
Excision or Destruction of Intervertebral Disc	80.5	28,590	1	82,735	2.9	187,510	6,578	2,266
Total Hip Replacement	81.51	113,435	3	470,255	4.1	1,209,583	10,686	2,572
Total Knee Replacement	81.54	264,975	7	1,008,460	3.8	2,803,893	10,597	2,780

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 2006

		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	262,765	7	2,046,340	7.8	$2,532,914	$9,708	$1,238
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	87,955	2	929,780	10.6	1,276,679	14,622	1,373
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,654,700	47	11,049,480	6.7	13,512,476	8,227	1,223
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	106,090	3	517,475	4.9	616,572	5,846	1,192
Arteriography and Angiocardiography Using Contrast Materi	88.4-88.5	53,470	2	263,115	4.9	326,521	6,132	1,241
Diagnostic Ultrasound	88.7	141,210	4	744,470	5.3	843,551	5,995	1,133
Respiratory Therapy	93.9,96.7	266,175	8	2,283,845	8.6	3,837,694	14,552	1,680
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	42,930	1	336,990	7.8	513,538	12,039	1,524
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	37,305	1	219,405	5.9	360,463	9,700	1,643

[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, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2005: Calendar Years 1984, 1990, and 2005

Leading DRG Code Number in 2005	Description	Discharges					
		Number			Percent Change	Percent Change	Percent Change
		1984	1990	2005	1984-1990	1990-2005	1984-2005
Total All DRGs	-----	10,894,925	10,521,925	12,903,875	-3.4	22.6	18.4
Leading DRGs[1]	-----	5,694,400	6,107,000	9,109,285	7.2	49.2	60.0
012	Degenerative Nervous System Disorders	56,410	25,915	90,005	-54.1	247.3	59.6
014	Intracranial Hemorrhage or Cerebral Infarction	318,405	336,080	284,250	5.6	-15.4	-10.7
024	Seizure & Headache Age >17 with CC	55,510	53,255	63,650	-4.1	19.5	14.7
075[2]	Major Chest Procedures	28,675	31,690	48,555	10.5	53.2	69.3
076[2]	Other Respiratory System O.R. Procedures with CC	10,055	38,855	47,795	286.4	23.0	375.3
078	Pulmonary Embolism	29,405	26,050	50,965	-11.4	95.6	73.3
079	Respiratory Infections & Inflammations Age >17 with CC	51,635	129,780	160,570	151.3	23.7	211.0
082	Respiratory Neoplasms	120,990	72,840	64,025	-39.8	-12.1	-47.1
087	Pulmonary Edema & Respiratory Failure	94,770	67,520	100,975	-28.8	49.5	6.5
088	Chronic Obstructive Pulmonary Disease	212,480	144,825	429,355	-31.8	196.5	102.1
089	Simple Pneumonia & Pleurisy Age >17 with CC	314,980	391,725	553,650	24.4	41.3	75.8
090	Simple Pneumonia & Pleurisy Age >17 without CC	24,740	53,105	43,475	114.7	-18.1	75.7
096	Bronchitis & Asthma Age >17 with CC	178,075	189,710	60,755	6.5	-68.0	-65.9
107[2,4]	Coronary Bypass Without Cardiac Cath	38,285	46,765	-----	22.1	-----	-----
107[2,4]	Coronary Bypass With Cardiac Cath	-----	-----	47,210	-----	-----	-----
110[2]	Major Cardiovascular Procedures with CC	56,230	75,660	58,205	34.6	-23.1	3.5
116[2]	Other Perm Cardiac Pacemaker Implant	53,905	62,050	86,695	15.1	39.7	60.8
121	Circulatory Disorders with AMI & Major Comp Discharged Alive	102,930	137,625	145,880	33.7	6.0	41.7
122	Circulatory Disorders with AMI & Without Major Comp Discharged Alive	158,400	102,935	54,415	-35.0	-47.1	-65.6
124	Circulatory Disorders Except AMI, with Card Cath and Complex Diagnosis	31,120	113,890	118,945	266.0	4.4	282.2
125	Circulatory Disorders Except AMI, with Card Cath Without Complex Diagnosis	64,085	93,045	90,565	45.2	-2.7	41.3
127	Heart Failure & Shock	515,865	586,335	663,360	13.7	13.1	28.6
130	Peripheral Vascular Disorders with CC	91,655	68,330	88,720	-25.4	29.8	-3.2
132	Atherosclerosis with CC	100,810	18,250	98,350	-81.9	438.9	-2.4

See footnotes at end of table.

Table 5.7- Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2005: Calendar Years 1984, 1990, and 2005

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2005	1984-1990	1990-2005	1984-2005	1984	1990	2005	1984-1990	1990-2005	1984-2005
8.8	8.8	5.7	0.0	-35.2	-35.2	$4,855	$9,765	$28,471	101.1	191.6	486.4
9.6	9.4	5.7	-2.1	-39.4	-40.6	5,160	9,612	25,826	86.3	168.7	400.5
13.0	13.0	7.9	0.0	-39.2	-39.2	5,239	9,022	18,211	72.2	101.9	247.6
12.4	10.5	5.5	-15.3	-47.6	-55.6	5,591	8,971	23,286	60.5	159.6	316.5
6.9	7.7	4.7	11.6	-39.0	-31.9	3,422	7,389	19,900	115.9	169.3	481.5
16.3	14.1	9.3	-13.5	-34.0	-42.9	13,500	22,075	57,454	63.5	160.3	325.6
15.4	15.0	10.5	-2.6	-30.0	-31.8	12,061	17,221	54,644	42.8	217.3	353.1
11.5	10.3	6.2	-10.4	-39.8	-46.1	6,154	9,876	23,184	60.5	134.8	276.7
12.8	12.2	8.0	-4.7	-34.4	-37.5	8,385	12,281	29,726	46.5	142.0	254.5
9.7	9.6	6.7	-1.0	-30.2	-30.9	4,860	8,785	27,258	80.8	210.3	460.9
10.0	8.3	6.3	-17.0	-24.1	-37.0	7,731	9,294	25,704	20.2	176.6	232.5
8.6	7.4	4.9	-14.0	-33.8	-43.0	4,709	6,932	16,783	47.2	142.1	256.4
9.4	8.9	5.5	-5.3	-38.2	-41.5	4,863	7,889	19,245	62.2	143.9	295.7
8.3	6.4	3.7	-22.9	-42.2	-55.4	4,084	4,817	11,599	17.9	140.8	184.0
7.2	7.3	4.3	1.4	-41.1	-40.3	3,501	6,361	14,162	81.7	122.6	304.5
14.5	12.3	-----	-15.2	-----	-----	21,949	33,394	-----	52.1	-----	-----
-----	-----	10.4	-----	-----	-----	-----	-----	100,426	-----	-----	-----
16.3	15.3	7.9	-6.1	-48.4	-51.5	15,072	27,264	76,065	80.9	179.0	404.7
9.2	7.5	4.2	-18.5	-44.0	-54.3	12,002	17,112	42,723	42.6	149.7	256.0
12.2	10.0	6.2	-18.0	-38.0	-49.2	7,341	11,335	28,803	54.4	154.1	292.4
10.3	7.1	3.3	-31.1	-53.5	-68.0	5,422	7,970	17,712	47.0	122.2	226.7
7.0	5.9	4.4	-15.7	-25.4	-37.1	5,703	8,719	28,099	52.9	222.3	392.7
3.7	3.2	2.7	-13.5	-15.6	-27.0	3,220	5,370	21,147	66.8	293.8	556.7
8.7	7.9	5.1	-9.2	-35.4	-41.4	4,264	7,207	19,531	69.0	171.0	358.0
8.1	8.3	5.3	2.5	-36.1	-34.6	3,523	6,627	18,057	88.1	172.5	412.5
7.0	6.1	2.8	-12.9	-54.1	-60.0	3,323	6,229	12,150	87.5	95.1	265.6

Table 5.7– Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2005: Calendar Years 1984, 1990, and 2005

Leading DRG Code Number in 2005	Description	Discharges					
		Number			Percent Change	Percent Change	Percent Change
		1984	1990	2005	1984-1990	1990-2005	1984-2005
138	Cardiac Arrhythmia & Conduction Disorders with CC	212,265	180,470	208,455	-15.0	15.5	-1.8
139	Cardiac Arrhythmia & Conduction Disorders Without CC	28,345	73,020	72,280	157.6	-1.0	155.0
141	Syncope & Collapse with CC	86,675	77,205	123,945	-10.9	60.5	43.0
142	Syncope & Collapse Without CC	11,315	39,370	48,345	247.9	22.8	327.3
143	Chest Pain	75,690	112,905	233,875	49.2	107.1	209.0
144	Other Circulatory System Diagnoses with CC	40,825	54,995	107,735	34.7	95.9	163.9
148 [2]	Major Small & Large Bowel Procedures with CC	106,455	140,245	132,945	31.7	-5.2	24.9
174	GI Hemorrhage with CC	144,620	157,895	257,840	9.2	63.3	78.3
180	GI Obstruction with CC	65,930	66,485	91,775	0.8	38.0	39.2
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 with CC	372,580	254,750	303,210	-31.6	19.0	-18.6
183	Esophagitis, Gastroent & Misc Digest Disorders Age >17 Without CC	72,525	81,770	80,130	12.7	-2.0	10.5
188	Other Digestive System Diagnoses Age >17 with CC	54,075	50,110	95,045	-7.3	89.7	75.8
204	Disorders of Pancreas Except Malignancy	31,890	37,715	69,710	18.3	84.8	118.6
209 [2]	Major Joint & Limb Reattachment Procedures of Lower Extremity	149,660	257,780	374,750	72.2	45.4	150.4
210 [2]	Hip & Femur Procedures Except Major Joint Age >17 with CC	120,100	112,470	128,590	-6.4	14.3	7.1
236	Fractures of Hip & Pelvis	47,350	41,255	44,140	-12.9	7.0	-6.8
243	Medical Back Problems	200,190	112,455	100,905	-43.8	-10.3	-49.6
277	Cellulitis Age >17 with CC	58,155	66,830	122,410	14.9	83.2	110.5
294	Diabetes Age >35	141,500	92,520	99,770	-34.6	7.8	-29.5
296	Nutritional & Misc Metabolic Disorders Age >17 with CC	176,150	206,595	241,850	17.3	17.1	37.3
316	Renal Failure	46,410	48,670	212,975	4.9	337.6	358.9
320	Kidney & Urinary Tract Infections Age>17 with CC	137,845	157,780	229,245	14.5	45.3	66.3
331	Other Kidney & Urinary Tract Diagnoses Age>17 with CC	38,080	28,380	58,390	-25.5	105.7	53.3

See footnotes at end of table.

Table 5.7– Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2005: Calendar Years 1984, 1990, and 2005

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2005	1984-1990	1990-2005	1984-2005	1984	1990	2005	1984-1990	1990-2005	1984-2005
6.3	6.0	3.9	-4.8	-35.0	-38.1	$3,376	$5,848	$15,833	73.2	170.7	369.0
4.9	3.9	2.4	-20.4	-38.5	-51.0	2,685	3,624	10,118	35.0	179.2	276.8
5.8	5.7	3.4	-1.7	-40.4	-41.4	2,672	4,987	14,825	86.6	197.3	454.8
4.5	4.0	2.5	-11.1	-37.5	-44.4	2,207	3,554	11,714	61.0	229.6	430.8
4.4	3.4	2.1	-22.7	-38.2	-52.3	2,427	3,577	11,146	47.4	211.6	359.3
8.3	7.3	5.8	-12.0	-20.5	-30.1	4,765	7,867	25,853	65.1	228.6	442.6
17.7	16.6	11.9	-6.2	-28.3	-32.8	12,686	23,471	64,680	85.0	175.6	409.9
7.4	7.0	4.7	-5.4	-32.9	-36.5	3,860	6,944	19,966	79.9	187.5	417.3
7.4	7.8	5.3	5.4	-32.1	-28.4	3,281	6,632	18,570	102.1	180.0	466.0
6.1	6.4	4.5	4.9	-29.7	-26.2	2,526	5,374	16,436	112.7	205.8	550.7
5.0	4.9	2.9	-2.0	-40.8	-42.0	2,103	3,630	11,332	72.6	212.2	438.8
6.4	7.5	5.5	17.2	-26.7	-14.1	3,100	7,392	21,745	138.5	194.2	601.5
8.1	8.1	5.4	0.0	-33.3	-33.3	4,050	8,099	21,136	100.0	161.0	421.9
15.6	11.1	4.4	-28.8	-60.4	-71.8	10,205	16,542	36,901	62.1	123.1	261.6
16.8	13.9	6.6	-17.3	-52.5	-60.7	8,600	14,236	34,919	65.5	145.3	306.0
12.7	10.0	4.9	-21.3	-51.0	-61.4	4,573	6,530	14,544	42.8	122.7	218.0
8.0	6.9	4.5	-13.8	-34.8	-43.8	2,858	4,657	15,370	62.9	230.0	437.8
9.1	8.6	5.4	-5.5	-37.2	-40.7	3,740	6,570	16,722	75.7	154.5	347.1
8.4	7.5	4.2	-10.7	-44.0	-50.0	3,267	5,491	15,146	68.1	175.8	363.6
8.4	8.5	4.6	1.2	-45.9	-45.2	3,556	6,840	15,717	92.4	129.8	342.0
9.6	9.4	6.1	-2.1	-35.1	-36.5	5,572	9,555	23,781	71.5	148.9	326.8
8.2	8.6	5.0	4.9	-41.9	-39.0	3,581	7,174	16,283	100.3	127.0	354.7
7.3	7.6	5.5	4.1	-27.6	-24.7	3,456	7,338	21,490	112.3	192.9	521.8

Table 5.7– Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2005: Calendar Years 1984, 1990, and 2005

Leading DRG Code Number in 2005	Description	Discharges			Percent Change 1984-1990	Percent Change 1990-2005	Percent Change 1984-2005
		Number					
		1984	1990	2005			
395	Red Blood Cell Disorders Age >17	93,510	72,730	118,905	-22.2	63.5	27.2
415 [2]	OR Procedure for Infectious & Parasitic Diseases	16,165	27,735	57,230	71.6	106.3	254.0
416	Septicemia Age >17	66,180	128,085	298,290	93.5	132.9	350.7
429	Organic Disturbances & Mental Retardation	52,710	49,305	54,955	-6.5	11.5	4.3
430	Psychoses	118,455	195,595	349,840	65.1	78.9	195.3
449	Poisoning and Toxic Effects of Drugs >17 with CC	43,030	30,045	42,265	-30.2	40.7	-1.8
462	Rehabilitation	9,490	106,680	279,870	1,024.1	162.3	2,849.1
468 [2]	Extensive OR Procedure Unrelated to Principal Diagnosis	166,815	75,885	52,605	-54.5	-30.7	-68.5
475	Respiratory System Diagnosis with Ventilator Support	-----	78,805	126,165	-----	60.1	-----
478 [2]	Other Vascular Procedures with CC	-----	24,230	88,000	-----	263.2	-----
493 [2]	Laparoscopic Cholecystectomy Without CDE with CC	-----	-----	61,205	-----	-----	-----
500 [2]	Back and Neck Procedures Except Spinal Fusion Without CC	-----	-----	46,310	-----	-----	-----
515 [2]	Cardiac Defibrillator Implant without Cardiac Cath	-----	-----	51,290	-----	-----	-----
524	Transient Ischemia	-----	-----	107,720	-----	-----	-----
526 [2]	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with AMI	-----	-----	57,860	-----	-----	-----
527 [2]	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent without AMI	-----	-----	181,070	-----	-----	-----
533 [2]	Extracranial Procedures with CC	-----	-----	46,845	-----	-----	-----
534 [2]	Extracranial Procedures without CC	-----	-----	43,135	-----	-----	-----
544 [2]	Major Joint Replacement or Reattachment of Lower Extremity	-----	-----	111,790	-----	-----	-----
558 [2]	Percutaneous Cardiovascular Proc with Drug-Eluting Stent without Major Cardiovascular Diagnosis	-----	-----	45,250	-----	-----	-----
All Other DRGs	-----	5,200,525	4,414,925	3,794,590	-15.1	-14.1	-27.0

[1]Based on frequency of occurrence in 2005.
[2]Represents surgical DRGs.
[3]Prior to 1999, DRG code 107 was defined as coronary bypass without cardiac cath.
[4]In 1999, the DRG code 107 was revised and defined as coronary bypass with cardiac cath. In addition, DRG code 109 was introduced and defined as coronary bypass without cardiac cath.

NOTES: Composition of some DRGs have changed over time. For complete DRG description, refer to *Diagnosis Related Groups, Version 3.0* (1984), *Version 7.0* and *8.0* (1990), *Versions 22.0* and *23.0* (2005), *Definitions Manual.* The most recent description is used in this table. 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.

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– Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2005: Calendar Years 1984, 1990, and 2005

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2005	1984-1990	1990-2005	1984-2005	1984	1990	2005	1984-1990	1990-2005	1984-2005
6.6	6.5	4.3	-1.5	-33.8	-34.8	$3,000	$5,639	$16,666	88.0	195.5	455.5
19.9	21.2	13.8	6.5	-34.9	-30.7	14,476	27,339	75,757	88.9	177.1	423.3
11.4	10.7	7.4	-6.1	-30.8	-35.1	6,811	10,981	33,886	61.2	208.6	397.5
11.3	14.5	9.2	28.3	-36.6	-18.6	3,717	8,417	17,457	126.4	107.4	369.7
16.1	16.9	10.5	5.0	-37.9	-34.8	5,069	9,359	18,100	84.6	93.4	257.1
6.4	6.3	3.7	-1.6	-41.3	-42.2	2,972	6,113	17,292	105.7	182.9	481.8
22.5	21.2	12.2	-5.8	-42.5	-45.8	9,151	15,745	26,964	72.1	71.3	194.7
16.6	19.3	12.3	16.3	-36.3	-25.9	10,595	24,871	73,672	134.7	196.2	595.3
-----	14.3	10.5	-----	-26.6	-----	-----	25,548	65,849	-----	157.7	-----
-----	10.4	6.6	-----	-36.5	-----	-----	16,682	45,626	-----	173.5	-----
-----	-----	6.0	-----	-----	-----	-----	-----	34,524	-----	-----	-----
-----	-----	2.2	-----	-----	-----	-----	-----	18,034	-----	-----	-----
-----	-----	3.7	-----	-----	-----	-----	-----	98,008	-----	-----	-----
-----	-----	3.1	-----	-----	-----	-----	-----	14,189	-----	-----	-----
-----	-----	4.4	-----	-----	-----	-----	-----	56,463	-----	-----	-----
-----	-----	2.2	-----	-----	-----	-----	-----	43,333	-----	-----	-----
-----	-----	3.5	-----	-----	-----	-----	-----	29,527	-----	-----	-----
-----	-----	1.7	-----	-----	-----	-----	-----	19,768	-----	-----	-----
-----	-----	4.4	-----	-----	-----	-----	-----	37,216	-----	-----	-----
-----	-----	1.8	-----	-----	-----	-----	-----	42,469	-----	-----	-----
8.0	8.1	5.8	1.3	-28.4	-27.5	4,521	9,977	34,820	120.7	249.0	670.2

Table 5.7

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2006: Calendar Years 1984, 1990, and 2006

Leading DRG Code Number in 2006	Description	Discharges					
		Number			Percent Change	Percent Change	Percent Change
		1984	1990	2006	1984-1990	1990-2006	1984-2006
Total All DRGs	-----	10,894,925	10,521,925	12,384,100	-3.4	17.7	13.7
Leading DRGs[1]	-----	5,427,810	5,663,070	8,679,810	4.3	53.3	59.9
012	Degenerative Nervous System Disorders	56,410	25,915	91,720	-54.1	253.9	62.6
014	Intracranial Hemorrhage or Cerebral Infarction	318,405	336,080	262,550	5.6	-21.9	-17.5
024	Seizure & Headache Age >17 with CC	55,510	53,255	48,010	-4.1	-9.8	-13.5
075[2]	Major Chest Procedures	28,675	31,690	46,820	10.5	47.7	63.3
076[2]	Other Respiratory System O.R. Procedures with CC	10,055	38,855	45,765	286.4	17.8	355.1
078	Pulmonary Embolism	29,405	26,050	53,850	-11.4	106.7	83.1
079	Respiratory Infections & Inflammations Age >17 with CC	51,635	129,780	152,155	151.3	17.2	194.7
082	Respiratory Neoplasms	120,990	72,840	61,000	-39.8	-16.3	-49.6
087	Pulmonary Edema & Respiratory Failure	94,770	67,520	108,880	-28.8	61.3	14.9
088	Chronic Obstructive Pulmonary Disease	212,480	144,825	381,545	-31.8	163.5	79.6
089	Simple Pneumonia & Pleurisy Age >17 with CC	314,980	391,725	469,020	24.4	19.7	48.9
096	Bronchitis & Asthma Age >17 with CC	178,075	189,710	52,295	6.5	-72.4	-70.6
110[2]	Major Cardiovascular Procedures with CC	56,230	75,660	56,120	34.6	-25.8	-0.2
121	Circulatory Disorders with AMI & Major Comp Discharged Alive	102,930	137,625	130,935	33.7	-4.9	27.2
122	Circulatory Disorders with AMI & Without Major Comp Discharged Alive	158,400	102,935	47,510	-35.0	-53.8	-70.0
124	Circulatory Disorders Except AMI, with Card Cath and Complex Diagnosis	31,120	113,890	109,595	266.0	-3.8	252.2
125	Circulatory Disorders Except AMI, with Card Cath Without Complex Diagnosis	64,085	93,045	84,990	45.2	-8.7	32.6
127	Heart Failure & Shock	515,865	586,335	621,820	13.7	6.1	20.5
130	Peripheral Vascular Disorders with CC	91,655	68,330	83,395	-25.4	22.0	-9.0
132	Atherosclerosis with CC	100,810	18,250	82,880	-81.9	354.1	-17.8
138	Cardiac Arrhythmia & Conduction Disorders with CC	212,265	180,470	207,925	-15.0	15.2	-2.0
139	Cardiac Arrhythmia & Conduction Disorders Without CC	28,345	73,020	67,155	157.6	-8.0	136.9
141	Syncope & Collapse with CC	86,675	77,205	127,995	-10.9	65.8	47.7
142	Syncope & Collapse Without CC	11,315	39,370	43,940	247.9	11.6	288.3

See footnotes at end of table.

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2006: Calendar Years 1984, 1990, and 2006

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2006	1984-1990	1990-2006	1984-2006	1984	1990	2006	1984-1990	1990-2006	1984-2006
8.8	8.8	5.7	0.0	-35.2	-35.2	$4,855	$9,765	$30,699	101.1	214.4	532.3
9.4	9.3	5.6	-2.1	-39.8	-40.4	4,839	9,033	27,704	86.7	206.7	472.5
13.0	13.0	8.1	0.0	-37.7	-37.7	5,239	9,022	19,430	72.2	115.4	270.9
12.4	10.5	5.4	-15.3	-48.6	-56.5	5,591	8,971	24,794	60.5	176.4	343.5
6.9	7.7	4.5	11.6	-41.6	-34.8	3,422	7,389	20,184	115.9	173.2	489.8
16.3	14.1	9.2	-13.5	-34.8	-43.6	13,500	22,075	62,788	63.5	184.4	365.1
15.4	15.0	10.2	-2.6	-32.0	-33.8	12,061	17,221	56,515	42.8	228.2	368.6
11.5	10.3	5.9	-10.4	-42.7	-48.7	6,154	9,876	24,100	60.5	144.0	291.6
12.8	12.2	7.9	-4.7	-35.2	-38.3	8,385	12,281	32,124	46.5	161.6	283.1
9.7	9.6	6.5	-1.0	-32.3	-33.0	4,860	8,785	28,762	80.8	227.4	491.8
10.0	8.3	6.3	-17.0	-24.1	-37.0	7,731	9,294	27,684	20.2	197.9	258.1
8.6	7.4	4.8	-14.0	-35.1	-44.2	4,709	6,932	18,050	47.2	160.4	283.3
9.4	8.9	5.4	-5.3	-39.3	-42.6	4,863	7,889	20,574	62.2	160.8	323.1
7.2	7.3	4.2	1.4	-42.5	-41.7	3,501	6,361	15,274	81.7	140.1	336.3
16.3	15.3	7.8	-6.1	-49.0	-52.1	15,072	27,264	82,586	80.9	202.9	447.9
12.2	10.0	6.0	-18.0	-40.0	-50.8	7,341	11,335	29,956	54.4	164.3	308.1
10.3	7.1	3.2	-31.1	-54.9	-68.9	5,422	7,970	19,335	47.0	142.6	256.6
7.0	5.9	4.4	-15.7	-25.4	-37.1	5,703	8,719	29,962	52.9	243.6	425.4
3.7	3.2	2.7	-13.5	-15.6	-27.0	3,220	5,370	22,918	66.8	326.8	611.7
8.7	7.9	5.1	-9.2	-35.4	-41.4	4,264	7,207	20,894	69.0	189.9	390.0
8.1	8.3	5.2	2.5	-37.3	-35.8	3,523	6,627	19,218	88.1	190.0	445.5
7.0	6.1	2.8	-12.9	-54.1	-60.0	3,323	6,229	13,100	87.5	110.3	294.2
6.3	6.0	3.8	-4.8	-36.7	-39.7	3,376	5,848	16,841	73.2	188.0	398.8
4.9	3.9	2.4	-20.4	-38.5	-51.0	2,685	3,624	10,682	35.0	194.8	297.8
5.8	5.7	3.4	-1.7	-40.4	-41.4	2,672	4,987	15,909	86.6	219.0	495.4
4.5	4.0	2.4	-11.1	-40.0	-46.7	2,207	3,554	12,763	61.0	259.1	478.3

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2006: Calendar Years 1984, 1990, and 2006

Leading DRG Code Number in 2006	Description	Discharges					
		Number			Percent Change	Percent Change	Percent Change
		1984	1990	2006	1984-1990	1990-2006	1984-2006
143	Chest Pain	75,690	112,905	222,260	49.2	96.9	193.6
144	Other Circulatory System Diagnoses with CC	40,825	54,995	106,450	34.7	93.6	160.7
148 [2]	Major Small & Large Bowel Procedures with CC	106,455	140,245	96,980	31.7	-30.8	-8.9
174	GI Hemorrhage with CC	144,620	157,895	244,760	9.2	55.0	69.2
180	GI Obstruction with CC	65,930	66,485	91,990	0.8	38.4	39.5
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 with CC	372,580	254,750	323,890	-31.6	27.1	-13.1
183	Esophagitis, Gastroent & Misc Digest Disorders Age >17 Without CC	72,525	81,770	75,025	12.7	-8.2	3.4
188	Other Digestive System Diagnoses Age >17 with CC	54,075	50,110	91,210	-7.3	82.0	68.7
204	Disorders of Pancreas Except Malignancy	31,890	37,715	67,785	18.3	79.7	112.6
210 [2]	Hip & Femur Procedures Except Major Joint Age >17 with CC	120,100	112,470	125,255	-6.4	11.4	4.3
236	Fractures of Hip & Pelvis	47,350	41,255	42,860	-12.9	3.9	-9.5
243	Medical Back Problems	200,190	112,455	99,085	-43.8	-11.9	-50.5
277	Cellulitis Age >17 with CC	58,155	66,830	122,695	14.9	83.6	111.0
294	Diabetes Age >35	141,500	92,520	97,435	-34.6	5.3	-31.1
296	Nutritional & Misc Metabolic Disorders Age >17 with CC	176,150	206,595	213,895	17.3	3.5	21.4
316	Renal Failure	46,410	48,670	242,050	4.9	397.3	421.5
320	Kidney & Urinary Tract Infections Age>17 with CC	137,845	157,780	230,670	14.5	46.2	67.3
331	Other Kidney & Urinary Tract Diagnoses Age>17 with CC	38,080	28,380	57,450	-25.5	102.4	50.9
395	Red Blood Cell Disorders Age >17	93,510	72,730	117,205	-22.2	61.2	25.3
415 [2]	OR Procedure for Infectious & Parasitic Diseases	16,165	27,735	45,060	71.6	62.5	178.8
416	Septicemia Age >17	66,180	128,085	235,420	93.5	83.8	255.7
429	Organic Disturbances & Mental Retardation	52,710	49,305	46,625	-6.5	-5.4	-11.5
430	Psychoses	118,455	195,595	337,545	65.1	72.6	185.0
449	Poisoning and Toxic Effects of Drugs Age>17 with CC	43,030	30,045	43,200	-30.2	43.8	0.4
462	Rehabilitation	9,490	106,680	252,560	1,024.1	136.7	2,561.3

See footnotes at end of table.

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2006: Calendar Years 1984, 1990, and 2006

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2006	1984-1990	1990-2006	1984-2006	1984	1990	2006	1984-1990	1990-2006	1984-2006
4.4	3.4	2.1	-22.7	-38.2	-52.3	$2,427	$3,577	$12,229	47.4	241.9	403.9
8.3	7.3	5.9	-12.0	-19.2	-28.9	4,765	7,867	28,154	65.1	257.9	490.8
17.7	16.6	11.9	-6.2	-28.3	-32.8	12,686	23,471	68,951	85.0	193.8	443.5
7.4	7.0	4.6	-5.4	-34.3	-37.8	3,860	6,944	21,459	79.9	209.0	455.9
7.4	7.8	5.2	5.4	-33.3	-29.7	3,281	6,632	20,322	102.1	206.4	519.4
6.1	6.4	4.4	4.9	-31.3	-27.9	2,526	5,374	17,497	112.7	225.6	592.7
5.0	4.9	2.8	-2.0	-42.9	-44.0	2,103	3,630	12,239	72.6	237.2	482.0
6.4	7.5	5.5	17.2	-26.7	-14.1	3,100	7,392	23,539	138.5	218.4	659.3
8.1	8.1	5.3	0.0	-34.6	-34.6	4,050	8,099	22,906	100.0	182.8	465.6
16.8	13.9	6.5	-17.3	-53.2	-61.3	8,600	14,236	38,109	65.5	167.7	343.1
12.7	10.0	4.7	-21.3	-53.0	-63.0	4,573	6,530	15,346	42.8	135.0	235.6
8.0	6.9	4.5	-13.8	-34.8	-43.8	2,858	4,657	16,630	62.9	257.1	481.9
9.1	8.6	5.4	-5.5	-37.2	-40.7	3,740	6,570	18,263	75.7	178.0	388.3
8.4	7.5	4.2	-10.7	-44.0	-50.0	3,267	5,491	16,453	68.1	199.6	403.6
8.4	8.5	4.4	1.2	-48.2	-47.6	3,556	6,840	16,378	92.4	139.4	360.6
9.6	9.4	6.0	-2.1	-36.2	-37.5	5,572	9,555	24,941	71.5	161.0	347.6
8.2	8.6	4.9	4.9	-43.0	-40.2	3,581	7,174	17,610	100.3	145.5	391.8
7.3	7.6	5.5	4.1	-27.6	-24.7	3,456	7,338	23,473	112.3	219.9	579.2
6.6	6.5	4.1	-1.5	-36.9	-37.9	3,000	5,639	17,447	88.0	209.4	481.6
19.9	21.2	14.0	6.5	-34.0	-29.6	14,476	27,339	83,631	88.9	205.9	477.7
11.4	10.7	7.5	-6.1	-29.9	-34.2	6,811	10,981	37,649	61.2	242.9	452.8
11.3	14.5	9.1	28.3	-37.2	-19.5	3,717	8,417	18,390	126.4	118.5	394.8
16.1	16.9	10.5	5.0	-37.9	-34.8	5,069	9,359	19,117	84.6	104.3	277.1
6.4	6.3	3.7	-1.6	-41.3	-42.2	2,972	6,113	18,824	105.7	207.9	533.4
22.5	21.2	12.3	-5.8	-42.0	-45.3	9,151	15,745	29,078	72.1	84.7	217.8

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2006: Calendar Years 1984, 1990, and 2006

Leading DRG Code Number in 2006	Description	Discharges			Percent Change 1984-1990	Percent Change 1990-2006	Percent Change 1984-2006
		Number					
		1984	1990	2006			
468 [2]	Extensive OR Procedure Unrelated to Principal Diagnosis	166,815	75,885	52,650	-54.5	-30.6	-68.4
475	Respiratory System Diagnosis with Ventilator Support	-----	78,805	95,130	-----	20.7	-----
493 [2]	Laparoscopic Cholecystectomy Without CDE with CC	-----	-----	60,595	-----	-----	-----
500 [2]	Back and Neck Procedures Except Spinal Fusion Without CC	-----	-----	44,040	-----	-----	-----
515 [2]	Cardiac Defibrillator Implant without Cardiac Cath	-----	-----	55,465	-----	-----	-----
524	Transient Ischemia	-----	-----	104,695	-----	-----	-----
533 [2]	Extracranial Procedures with CC	-----	-----	45,985	-----	-----	-----
544 [2]	Major Joint Replacement or Reattachment of Lower Extremity	-----	-----	439,380	-----	-----	-----
545 [2]	Revision of Hip or Knee Replacement	-----	-----	41,380	-----	-----	-----
551 [2]	Permanent Cardiac Pacemaker Implant with Major CV Diagnosis or AICD Lead or Generator	-----	-----	50,800	-----	-----	-----
552 [2]	Other Permanent Cardiac Pacemaker Implant Without Major CV Diagnosis	-----	-----	78,485	-----	-----	-----
553 [2]	Other Vascular Procedures with CC with Major CV Diagnosis	-----	-----	44,305	-----	-----	-----
554 [2]	Other Vascular Procedures with CC Without Major CV Diagnosis	-----	-----	78,390	-----	-----	-----
555 [2]	Percutaneous Cardiovascular Proc with Major CV Diagnosis	-----	-----	42,110	-----	-----	-----
557 [2]	Percutaneous Cardiovascular Proc with Drug-Eluting Stent with Major CV Diagnosis	-----	-----	125,095	-----	-----	-----
558 [2]	Percutaneous Cardiovascular Proc with Drug-Eluting Stent Without Major CV Diagnosis	-----	-----	178,990	-----	-----	-----
576	Septicemia Without Mechanical Ventilation 96+ Hours Age > 17	-----	-----	75,085	-----	-----	-----
All Other DRGs	-----	5,467,115	4,858,855	3,704,290	-11.1	-23.8	-32.2

[1]Based on frequency of occurrence in 2006.
[2]Represents surgical DRGs.

NOTES: Composition of some DRGs have changed over time. For complete DRG description, refer to *Diagnosis Related Groups, Version 3.0* (1984), *Version 7.0* and *8.0* (1990), *Versions 23.0* and *24.0* (2006), *Definitions Manual.* The most recent description is used in this table. 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/defibrillator.

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—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2006: Calendar Years 1984, 1990, and 2006

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2006	1984-1990	1990-2006	1984-2006	1984	1990	2006	1984-1990	1990-2006	1984-2006
16.6	19.3	12.2	16.3	-36.8	-26.5	$10,595	$24,871	$79,638	134.7	220.2	651.7
-----	14.3	10.2	-----	-28.7	-----	-----	25,548	68,316	-----	167.4	-----
-----	-----	5.9	-----	-----	-----	-----	-----	37,417	-----	-----	-----
-----	-----	2.1	-----	-----	-----	-----	-----	20,261	-----	-----	-----
-----	-----	3.6	-----	-----	-----	-----	-----	104,653	-----	-----	-----
-----	-----	3.1	-----	-----	-----	-----	-----	15,473	-----	-----	-----
-----	-----	3.5	-----	-----	-----	-----	-----	31,571	-----	-----	-----
-----	-----	4.3	-----	-----	-----	-----	-----	39,306	-----	-----	-----
-----	-----	5.0	-----	-----	-----	-----	-----	51,999	-----	-----	-----
-----	-----	6.1	-----	-----	-----	-----	-----	62,206	-----	-----	-----
-----	-----	3.4	-----	-----	-----	-----	-----	41,599	-----	-----	-----
-----	-----	9.0	-----	-----	-----	-----	-----	64,451	-----	-----	-----
-----	-----	5.0	-----	-----	-----	-----	-----	42,295	-----	-----	-----
-----	-----	4.6	-----	-----	-----	-----	-----	49,207	-----	-----	-----
-----	-----	3.9	-----	-----	-----	-----	-----	57,606	-----	-----	-----
-----	-----	1.7	-----	-----	-----	-----	-----	43,682	-----	-----	-----
-----	-----	7.0	-----	-----	-----	-----	-----	33,468	-----	-----	-----
8.2	8.3	5.9	1.2	-28.9	-28.0	4,871	10,619	37,717	118.0	255.2	674.3

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 2005

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	12,903,875	10,580,805	4,173,040	12,867,115	4,414,710	12,785,060
1-8 Days	10,621,415	8,584,950	3,149,775	10,592,245	3,308,785	10,524,845
9-20 Days	1,920,530	1,677,310	820,005	1,915,220	877,370	1,904,860
21-30 Days	240,615	212,540	126,340	239,455	143,090	237,095
31-40 Days	67,085	58,455	40,665	66,645	45,675	65,805
41-50 Days	25,890	22,745	16,940	25,625	18,650	25,235
51-60 Days	11,845	10,245	7,985	11,735	8,910	11,565
61-90 Days	11,685	10,310	8,110	11,485	8,745	11,185
91 Days or More	4,810	4,250	3,220	4,705	3,485	4,470
			Percent of Total Discharges [3]			
Total	100.0	82.0	32.3	99.7	34.2	99.1
1-8 Days	100.0	80.8	29.7	99.7	31.2	99.1
9-20 Days	100.0	87.3	42.7	99.7	45.7	99.2
21-30 Days	100.0	88.3	52.5	99.5	59.5	98.5
31-40 Days	100.0	87.1	60.6	99.3	68.1	98.1
41-50 Days	100.0	87.9	65.4	99.0	72.0	97.5
51-60 Days	100.0	86.5	67.4	99.1	75.2	97.6
61-90 Days	100.0	88.2	69.4	98.3	74.8	95.7
91 Days or More	100.0	88.4	66.9	97.8	72.5	92.9
			Total Charges in Thousands			
Total	$369,774,747	$60,520,090	$40,665,258	$268,592,425	$29,626,280	$53,657,309
1-8 Days	211,914,948	30,873,113	17,158,252	163,885,976	20,592,446	25,175,485
9-20 Days	101,310,058	19,821,618	13,348,927	68,140,036	6,439,050	17,008,003
21-30 Days	26,815,011	4,980,692	4,267,565	17,566,825	1,375,921	5,233,102
31-40 Days	11,806,330	1,937,096	2,144,246	7,725,008	543,140	2,478,394
41-50 Days	6,201,981	980,561	1,198,184	4,023,243	265,342	1,340,957
51-60 Days	3,633,270	522,074	749,007	2,362,191	140,360	782,158
61-90 Days	4,751,840	769,990	1,040,188	2,941,665	176,793	982,086
91 Days or More	3,341,305	634,942	758,887	1,947,477	93,225	657,120

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 2005

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other [2]
			Number of Discharges		
12,717,950	11,132,205	11,124,510	9,457,460	6,270,995	11,659,965
10,454,890	9,080,165	9,108,045	7,683,305	4,836,935	9,478,420
1,904,925	1,722,005	1,698,315	1,481,385	1,184,440	1,834,090
238,380	218,240	211,620	190,430	161,015	231,575
66,405	61,760	59,410	55,810	48,030	64,605
25,520	23,920	22,715	22,050	19,135	24,685
11,710	11,015	10,435	10,360	8,975	11,270
11,435	10,735	9,970	10,035	8,885	10,960
4,685	4,365	4,000	4,085	3,580	4,360
			Percent of Total Discharges [3]		
98.6	86.3	86.2	73.3	48.6	90.4
98.4	85.5	85.8	72.3	45.5	89.2
99.2	89.7	88.4	77.1	61.7	95.5
99.1	90.7	87.9	79.1	66.9	96.2
99.0	92.1	88.6	83.2	71.6	96.3
98.6	92.4	87.7	85.2	73.9	95.3
98.9	93.0	88.1	87.5	75.8	95.1
97.9	91.9	85.3	85.9	76.0	93.8
97.4	90.7	83.2	84.9	74.4	90.6
			Total Charges in Thousands		
$41,329,215	$27,446,787	$52,045,233	$20,651,796	$12,654,948	$31,180,854
23,545,089	17,652,773	37,795,726	16,228,725	4,575,598	18,320,131
11,618,216	6,892,604	9,989,249	3,462,649	4,296,362	8,433,900
2,968,520	1,528,641	2,163,989	560,215	1,512,400	2,224,032
1,305,601	608,509	873,886	191,602	808,806	915,066
678,339	301,149	440,856	89,303	446,229	461,065
393,747	163,587	267,010	44,719	294,553	276,055
499,724	192,564	311,502	50,156	405,243	323,593
319,976	106,956	203,012	24,423	315,753	227,009

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 2005

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	16.4	11.0	72.6	8.0	14.5
1-8 Days	100.0	14.6	8.1	77.3	9.7	11.9
9-20 Days	100.0	19.6	13.2	67.3	6.4	16.8
21-30 Days	100.0	18.6	15.9	65.5	5.1	19.5
31-40 Days	100.0	16.4	18.2	65.4	4.6	21.0
41-50 Days	100.0	15.8	19.3	64.9	4.3	21.6
51-60 Days	100.0	14.4	20.6	65.0	3.9	21.5
61-90 Days	100.0	16.2	21.9	61.9	3.7	20.7
91 Days or More	100.0	19.0	22.7	58.3	2.8	19.7
			Average Total Charge Per Discharge			
Total	$28,656	$5,720	$9,745	$20,874	$6,711	$4,197
1-8 Days	19,952	3,596	5,447	15,472	6,224	2,392
9-20 Days	52,751	11,818	16,279	35,578	7,339	8,929
21-30 Days	111,444	23,434	33,778	73,362	9,616	22,072
31-40 Days	175,991	33,138	52,730	115,913	11,891	37,663
41-50 Days	239,551	43,111	70,731	157,005	14,227	53,139
51-60 Days	306,735	50,959	93,802	201,295	15,753	67,631
61-90 Days	406,662	74,684	128,260	256,131	20,261	87,804
91 Days or More	694,658	149,398	235,679	413,917	26,750	147,007

[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 2005

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
Percent of Total Charges [4]					
11.2	7.4	14.1	5.6	3.4	8.4
11.1	8.3	17.8	7.7	2.2	8.6
11.5	6.8	9.9	3.4	4.2	8.3
11.1	5.7	8.1	2.1	5.6	8.3
11.1	5.2	7.4	1.6	6.9	7.8
10.9	4.9	7.1	1.4	7.2	7.4
10.8	4.5	7.3	1.2	8.1	7.6
10.5	4.1	6.6	1.1	8.5	6.8
9.6	3.2	6.1	0.7	9.5	6.8
Average Total Charge Per Discharge					
$3,250	$2,466	$4,678	$2,184	$2,018	$2,674
2,252	1,944	4,150	2,112	946	1,933
6,099	4,003	5,882	2,337	3,627	4,598
12,453	7,004	10,226	2,942	9,393	9,604
19,661	9,853	14,709	3,433	16,840	14,164
26,581	12,590	19,408	4,050	23,320	18,678
33,625	14,851	25,588	4,317	32,819	24,495
43,701	17,938	31,244	4,998	45,610	29,525
68,298	24,503	50,753	5,979	88,199	52,066

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 2006

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	12,384,100	10,029,290	4,119,445	12,349,380	4,296,595	12,271,040
1-8 Days	10,225,730	8,160,690	3,132,315	10,198,305	3,229,600	10,133,385
9-20 Days	1,820,070	1,573,895	792,975	1,814,815	850,320	1,804,955
21-30 Days	225,215	197,105	121,530	224,240	136,550	222,240
31-40 Days	62,205	53,560	38,900	61,785	43,130	61,160
41-50 Days	24,575	21,245	16,035	24,335	17,655	24,060
51-60 Days	11,015	9,545	7,440	10,825	8,260	10,600
61-90 Days	10,895	9,380	7,435	10,800	8,050	10,495
91 Days or More	4,395	3,870	2,815	4,275	3,030	4,145
			Percent of Total Discharges [3]			
Total	100.0	81.0	33.3	99.7	34.7	99.1
1-8 Days	100.0	79.8	30.6	99.7	31.6	99.1
9-20 Days	100.0	86.5	43.6	99.7	46.7	99.2
21-30 Days	100.0	87.5	54.0	99.6	60.6	98.7
31-40 Days	100.0	86.1	62.5	99.3	69.3	98.3
41-50 Days	100.0	86.4	65.2	99.0	71.8	97.9
51-60 Days	100.0	86.7	67.5	98.3	75.0	96.2
61-90 Days	100.0	86.1	68.2	99.1	73.9	96.3
91 Days or More	100.0	88.1	64.1	97.3	68.9	94.3
			Total Charges in Thousands			
Total	$382,766,437	$60,592,548	$42,695,948	$279,480,831	$31,604,904	$54,469,982
1-8 Days	221,946,952	31,213,683	18,380,083	172,355,474	22,046,197	25,768,049
9-20 Days	103,953,423	19,733,234	13,912,819	70,307,867	6,845,686	17,272,388
21-30 Days	27,404,399	4,896,356	4,475,565	18,032,545	1,446,484	5,325,921
31-40 Days	11,907,875	1,888,992	2,201,208	7,817,693	576,506	2,469,965
41-50 Days	6,337,675	1,000,106	1,255,660	4,081,916	280,867	1,358,096
51-60 Days	3,502,868	569,013	697,597	2,236,261	149,265	751,066
61-90 Days	4,512,156	706,469	989,934	2,815,756	167,895	947,715
91 Days or More	3,201,085	584,692	783,079	1,833,315	91,999	576,778

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 2006

Type of Ancillary Service					
Laboratory	Radiology[1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
		Number of Discharges			
12,214,535	10,710,885	10,517,280	9,105,220	5,892,165	11,224,675
10,074,450	8,767,725	8,630,135	7,420,780	4,548,250	9,156,315
1,805,170	1,634,615	1,592,425	1,409,760	1,111,275	1,742,385
223,230	204,205	196,635	178,800	150,595	217,360
61,605	57,550	54,580	52,315	44,840	59,995
24,280	22,650	21,320	20,935	17,810	23,735
10,795	10,135	9,440	9,425	8,215	10,435
10,755	9,975	9,210	9,425	8,085	10,375
4,250	4,030	3,535	3,780	3,095	4,075
		Percent of Total Discharges[3]			
98.6	86.5	84.9	73.5	47.6	90.6
98.5	85.7	84.4	72.6	44.5	89.5
99.2	89.8	87.5	77.5	61.1	95.7
99.1	90.7	87.3	79.4	66.9	96.5
99.0	92.5	87.7	84.1	72.1	96.4
98.8	92.2	86.8	85.2	72.5	96.6
98.0	92.0	85.7	85.6	74.6	94.7
98.7	91.6	84.5	86.5	74.2	95.2
96.7	91.7	80.4	86.0	70.4	92.7
		Total Charges in Thousands			
$43,482,964	$29,471,471	$53,135,116	$21,599,042	$12,791,088	$32,926,262
24,976,746	19,162,037	39,067,012	17,082,124	4,635,716	19,617,589
12,171,400	7,291,026	9,939,817	3,555,882	4,363,085	8,868,579
3,109,751	1,617,223	2,116,060	562,459	1,589,011	2,265,633
1,358,877	639,673	864,517	191,627	797,852	918,671
697,821	308,886	427,455	89,168	468,280	451,340
379,803	161,517	236,106	40,672	262,515	255,311
478,245	189,089	291,087	50,502	367,128	324,092
310,316	102,017	193,058	26,605	307,496	225,043

Table 5.8—Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2006

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	15.8	11.2	73.0	8.3	14.2
1-8 Days	100.0	14.1	8.3	77.7	9.9	11.6
9-20 Days	100.0	19.0	13.4	67.6	6.6	16.6
21-30 Days	100.0	17.9	16.3	65.8	5.3	19.4
31-40 Days	100.0	15.9	18.5	65.7	4.8	20.7
41-50 Days	100.0	15.8	19.8	64.4	4.4	21.4
51-60 Days	100.0	16.2	19.9	63.8	4.3	21.4
61-90 Days	100.0	15.7	21.9	62.4	3.7	21.0
91 Days or More	100.0	18.3	24.5	57.3	2.9	18.0
			Average Total Charge Per Discharge			
Total	$30,908	$6,042	$10,364	$22,631	$7,356	$4,439
1-8 Days	21,705	3,825	5,868	16,900	6,826	2,543
9-20 Days	57,115	12,538	17,545	38,741	8,051	9,569
21-30 Days	121,681	24,841	36,827	80,416	10,593	23,965
31-40 Days	191,430	35,269	56,586	126,531	13,367	40,385
41-50 Days	257,891	47,075	78,307	167,738	15,909	56,446
51-60 Days	318,009	59,614	93,763	206,583	18,071	70,855
61-90 Days	414,149	75,317	133,145	260,718	20,857	90,302
91 Days or More	728,347	151,083	278,181	428,846	30,363	139,150

[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 2006

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
Percent of Total Charges [4]					
11.4	7.7	13.9	5.6	3.3	8.6
11.3	8.6	17.6	7.7	2.1	8.8
11.7	7.0	9.6	3.4	4.2	8.5
11.3	5.9	7.7	2.1	5.8	8.3
11.4	5.4	7.3	1.6	6.7	7.7
11.0	4.9	6.7	1.4	7.4	7.1
10.8	4.6	6.7	1.2	7.5	7.3
10.6	4.2	6.5	1.1	8.1	7.2
9.7	3.2	6.0	0.8	9.6	7.0
Average Total Charge Per Discharge					
$3,560	$2,752	$5,052	$2,372	$2,171	$2,933
2,479	2,186	4,527	2,302	1,019	2,143
6,743	4,460	6,242	2,522	3,926	5,090
13,931	7,920	10,761	3,146	10,552	10,423
22,058	11,115	15,839	3,663	17,793	15,312
28,741	13,637	20,049	4,259	26,293	19,016
35,183	15,937	25,011	4,315	31,956	24,467
44,467	18,956	31,606	5,358	45,409	31,238
73,016	25,314	54,613	7,038	99,353	55,225

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 2005

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	12,903,875	100.0	73,995,570	100.0	5.7	$107,615,220	100.0	$8,383	$1,454
1 Day	1,779,075	13.8	1,779,075	2.4	1.0	11,463,550	10.7	6,500	6,444
2 Days	1,840,530	14.3	3,681,060	5.0	2.0	10,225,980	9.5	5,581	2,778
3 Days	2,014,585	15.6	6,043,755	8.2	3.0	12,444,843	11.6	6,201	2,059
4 Days	1,606,535	12.5	6,426,140	8.7	4.0	10,996,931	10.2	6,870	1,711
5 Days	1,191,145	9.2	5,955,725	8.0	5.0	8,783,639	8.2	7,403	1,475
6 Days	912,560	7.1	5,475,360	7.4	6.0	7,316,757	6.8	8,053	1,336
7 Days	735,225	5.7	5,146,575	7.0	7.0	6,407,299	6.0	8,753	1,245
8 Days	541,760	4.2	4,334,080	5.9	8.0	5,056,211	4.7	9,377	1,167
9 Days	397,725	3.1	3,579,525	4.8	9.0	3,944,820	3.7	9,961	1,102
10 Days	308,850	2.4	3,088,500	4.2	10.0	3,205,338	3.0	10,436	1,038
11 Days	245,465	1.9	2,700,115	3.6	11.0	2,688,736	2.5	11,006	966
12 Days	195,845	1.5	2,350,140	3.2	12.0	2,250,487	2.1	11,556	958
13 Days	166,710	1.3	2,167,230	2.9	13.0	2,012,683	1.9	12,151	929

See footnotes at end of table.

Table 5.9-Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care: Calendar Year 2005

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
14 Days	153,420	1.2	2,147,880	2.9	14.0	$1,961,360	1.8	$12,850	$913
15 Days	118,450	0.9	1,776,750	2.4	15.0	1,612,374	1.5	13,701	907
16 Days	91,970	0.7	1,471,520	2.0	16.0	1,311,867	1.2	14,366	892
17 Days	75,495	0.6	1,283,415	1.7	17.0	1,122,946	1.0	14,968	875
18 Days	64,275	0.5	1,156,950	1.6	18.0	991,155	0.9	15,518	857
19 Days	53,335	0.4	1,013,365	1.4	19.0	893,865	0.8	16,883	882
20 Days	48,990	0.4	979,800	1.3	20.0	867,310	0.8	17,815	885
21-30 Days	240,615	1.9	5,853,370	7.9	24.3	5,471,006	5.1	22,936	935
31-40 Days	67,085	0.5	2,324,375	3.1	34.6	2,630,370	2.4	39,641	1,132
41-50 Days	25,890	0.2	1,158,375	1.6	44.7	1,444,793	1.3	56,614	1,247
51-60 Days	11,845	0.1	650,795	0.9	54.9	823,949	0.8	71,061	1,266
61-90 Days	11,685	0.1	839,220	1.1	71.8	1,056,653	1.0	92,043	1,259
91 Days or More	4,810	(3)	612,475	0.8	127.3	630,297	0.6	138,679	1,029

[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 5.9

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care: Calendar Year 2006

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	12,384,100	100.0	70,301,460	100.0	5.7	$106,757,631	100.0	$8,669	$1,519
1 Day	1,739,685	14.0	1,739,685	2.5	1.0	11,471,588	10.7	6,647	6,594
2 Days	1,788,935	14.4	3,577,870	5.1	2.0	10,165,678	9.5	5,710	2,841
3 Days	1,959,220	15.8	5,877,660	8.4	3.0	12,493,674	11.7	6,404	2,126
4 Days	1,534,255	12.4	6,137,020	8.7	4.0	10,772,603	10.1	7,051	1,755
5 Days	1,131,165	9.1	5,655,825	8.0	5.0	8,615,811	8.1	7,651	1,523
6 Days	866,145	7.0	5,196,870	7.4	6.0	7,199,254	6.7	8,354	1,385
7 Days	693,270	5.6	4,852,890	6.9	7.0	6,245,443	5.9	9,053	1,287
8 Days	513,055	4.1	4,104,440	5.8	8.0	4,970,832	4.7	9,741	1,211
9 Days	375,825	3.0	3,382,425	4.8	9.0	3,900,610	3.7	10,436	1,153
10 Days	292,695	2.4	2,926,950	4.2	10.0	3,195,672	3.0	10,986	1,092
11 Days	235,870	1.9	2,594,570	3.7	11.0	2,714,626	2.5	11,580	1,046
12 Days	184,810	1.5	2,217,720	3.2	12.0	2,252,430	2.1	12,278	1,016
13 Days	158,920	1.3	2,065,960	2.9	13.0	2,049,194	1.9	12,981	992

See footnotes at end of table.

Table 5.9—Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care: Calendar Year 2006

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
14 Days	145,725	1.2	2,040,150	2.9	14.0	$1,961,958	1.8	$13,556	$962
15 Days	112,610	0.9	1,689,150	2.4	15.0	1,592,075	1.5	14,245	943
16 Days	85,930	0.7	1,374,880	2.0	16.0	1,319,233	1.2	15,458	960
17 Days	71,550	0.6	1,216,350	1.7	17.0	1,127,069	1.1	15,872	927
18 Days	60,960	0.5	1,097,280	1.6	18.0	1,031,942	1.0	17,060	940
19 Days	50,140	0.4	952,660	1.4	19.0	910,877	0.9	18,339	956
20 Days	45,035	0.4	900,700	1.3	20.0	837,351	0.8	18,722	930
21-30 Days	225,215	1.8	5,486,795	7.8	24.4	5,567,901	5.2	24,956	1,015
31-40 Days	62,205	0.5	2,156,315	3.1	34.7	2,570,570	2.4	41,883	1,192
41-50 Days	24,575	0.2	1,101,585	1.6	44.8	1,400,459	1.3	58,134	1,271
51-60 Days	11,015	0.1	604,825	0.9	54.9	805,430	0.8	74,336	1,332
61-90 Days	10,895	0.1	777,060	1.1	71.3	1,008,821	0.9	95,262	1,298
91 Days or More	4,395	(3)	573,825	0.8	130.6	576,532	0.5	139,596	1,005

[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 2005

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]	3,732	100.0	12,788,715	100.0	5.7	$107,195,221	100.0	$8,424
1-99 Beds	1,343	36.0	1,369,930	10.7	4.6	7,948,596	7.4	5,820
100-299 Beds	1,460	39.1	4,596,315	35.9	5.5	33,413,665	31.2	7,301
300-499 Beds	586	15.7	3,558,125	27.8	5.9	30,856,709	28.8	8,717
500 Beds or More	343	9.2	3,264,345	25.5	6.3	34,976,250	32.6	10,784
Total Urban Hospitals	2,427	100.0	10,802,735	100.0	5.9	95,351,279	100.0	8,874
1-99 Beds	521	21.5	615,870	5.7	4.9	4,114,207	4.3	6,705
100-299 Beds	1,026	42.3	3,559,715	33.0	5.6	26,975,040	28.3	7,615
300-499 Beds	545	22.5	3,405,045	31.5	5.9	29,694,967	31.1	8,766
500 Beds or More	335	13.8	3,222,105	29.8	6.3	34,567,065	36.3	10,798
Total Rural Hospitals	1,305	100.0	1,985,980	100.0	5.0	11,843,942	100.0	5,979
1-99 Beds	822	63.0	754,060	38.0	4.5	3,834,389	32.4	5,098
100-299 Beds	434	33.3	1,036,600	52.2	5.2	6,438,626	54.4	6,228
300-499 Beds	41	3.1	153,080	7.7	5.7	1,161,742	9.8	7,609
500 Beds or More	8	0.6	42,240	2.1	6.3	409,185	3.5	9,714

See footnotes at end of table.

Table 5.10–Continued

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 2005

MSA and Type of Control	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]	3,732	100.0	12,788,715	100.0	5.7	$107,195,221	100.0	$8,424
Voluntary	2,253	60.4	9,400,870	73.5	5.7	80,115,847	74.7	8,565
Proprietary	744	19.9	1,705,335	13.3	5.7	12,922,634	12.1	7,613
Government	735	19.7	1,682,510	13.2	5.7	14,156,739	13.2	8,457
Total Teaching Hospitals[4]	1,064	100.0	5,845,575	100.0	6.0	57,448,368	100.0	9,887
Voluntary	792	74.4	4,840,925	82.8	6.0	47,165,472	82.1	9,800
Proprietary	87	8.2	295,195	5.0	5.9	2,523,466	4.4	8,602
Government	185	17.4	709,455	12.1	6.3	7,759,430	13.5	11,016
Total Non-Teaching Hospitals	2,668	100.0	6,943,140	100.0	5.5	49,746,853	100.0	7,194
Voluntary	1,461	54.8	4,559,945	65.7	5.5	32,950,376	66.2	7,256
Proprietary	657	24.6	1,410,140	20.3	5.6	10,399,168	20.9	7,406
Government	550	20.6	973,055	14.0	5.3	6,397,309	12.9	6,597

[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 5.10

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 2006

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]	3,644	100.0	12,317,105	100.0	5.7	$106,502,303	100.0	$8,694
1-99 Beds	1,273	34.9	1,243,970	10.1	4.7	7,622,091	7.2	6,151
100-299 Beds	1,458	40.0	4,480,855	36.4	5.5	33,762,795	31.7	7,571
300-499 Beds	575	15.8	3,432,215	27.9	5.8	30,661,280	28.8	8,983
500 Beds or More	338	9.3	3,160,065	25.7	6.2	34,456,136	32.4	10,978
Total Urban Hospitals	2,408	100.0	10,488,500	100.0	5.8	95,101,400	100.0	9,120
1-99 Beds	517	21.5	587,970	5.6	4.8	4,095,448	4.3	6,996
100-299 Beds	1,025	42.6	3,485,940	33.2	5.5	27,319,599	28.7	7,878
300-499 Beds	534	22.2	3,281,680	31.3	5.8	29,469,353	31.0	9,031
500 Beds or More	332	13.8	3,132,910	29.9	6.2	34,216,999	36.0	10,996
Total Rural Hospitals	1,236	100.0	1,828,605	100.0	5.0	11,400,903	100.0	6,255
1-99 Beds	756	61.2	656,000	35.9	4.5	3,526,643	30.9	5,395
100-299 Beds	433	35.0	994,915	54.4	5.1	6,443,196	56.5	6,496
300-499 Beds	41	3.3	150,535	8.2	5.6	1,191,928	10.5	7,944
500 Beds or More	6	0.5	27,155	1.5	5.5	239,136	2.1	8,823

See footnotes at end of table.

Table 5.10—Continued

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 2006

MSA and Type of Control	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]	3,644	100.0	12,317,105	100.0	5.7	$106,502,303	100.0	$8,694
Voluntary	2,185	60.0	8,939,130	72.6	5.7	78,214,648	73.4	8,798
Proprietary	744	20.4	1,728,225	14.0	5.6	13,876,545	13.0	8,068
Government	715	19.6	1,649,750	13.4	5.7	14,411,110	13.5	8,782
Total Teaching Hospitals[4]	1,062	100.0	5,681,940	100.0	5.9	56,959,549	100.0	10,090
Voluntary	772	72.7	4,621,665	81.3	5.9	45,847,776	80.5	9,984
Proprietary	101	9.5	370,505	6.5	6.0	3,411,811	6.0	9,272
Government	189	17.8	689,770	12.1	6.2	7,699,963	13.5	11,245
Total Non-Teaching Hospitals	2,582	100.0	6,635,165	100.0	5.4	49,542,753	100.0	7,500
Voluntary	1,413	54.7	4,317,465	65.1	5.4	32,366,873	65.3	7,531
Proprietary	643	24.9	1,357,720	20.5	5.6	10,464,734	21.1	7,741
Government	526	20.4	959,980	14.5	5.3	6,711,147	13.5	7,019

[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 2005

Type of Hospital	Hospitals		Discharges		Covered Days of Care		
	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals[2]	6,333	100.0	13,726,980	100.0	80,794,860	100.0	5.9
Short-Stay Hospitals	3,928	62.0	12,903,875	94.0	71,656,035	88.7	5.6
Hospitals	3,928	62.0	12,238,700	89.2	64,145,200	79.4	5.2
Psychiatric Hospital Units[3]	NA	----	372,505	2.7	3,931,230	4.9	10.6
Rehabilitation Hospital Units[3]	NA	----	292,670	2.1	3,579,605	4.4	12.2
Specialty Hospitals	2,405	38.0	823,105	6.0	9,138,825	11.3	11.1
Childrens	81	1.3	2,920	(4)	19,585	(4)	6.7
Psychiatric	476	7.5	130,300	0.9	1,830,780	2.3	14.1
Rehabilitation	226	3.6	154,985	1.1	2,202,870	2.7	14.2
Long Term	385	6.1	135,880	1.0	3,648,010	4.5	26.8
Critical Access (formerly Short-Stay)	1,221	19.3	398,565	2.9	1,422,855	1.8	3.6
Religious Non-Medical	16	0.3	455	(4)	14,725	(4)	32.4

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 2005

	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]	$386,160,485	100.0	$28,131	$4,780	$116,772,270	100.0	$8,548	$1,445
Short-Stay Hospitals	366,758,455	95.0	28,422	5,118	107,615,220	92.2	8,383	1,502
Hospitals	351,914,326	91.1	28,754	5,486	100,953,898	86.5	8,249	1,574
Psychiatric Hospital Units[3]	6,759,410	1.8	18,146	1,719	2,603,030	2.2	7,076	662
Rehabilitation Hospital Units[3]	8,084,720	2.1	27,624	2,259	4,058,292	3.5	13,945	1,134
Specialty Hospitals	19,402,030	5.0	23,572	2,123	9,157,050	7.8	11,125	1,002
Childrens	135,233	(4)	46,313	6,905	39,225	(4)	13,433	2,003
Psychiatric	1,882,228	0.5	14,445	1,028	832,053	0.7	6,386	454
Rehabilitation	3,557,264	0.9	22,952	1,615	2,247,980	1.9	14,505	1,020
Long Term	10,668,438	2.8	78,514	2,924	4,310,739	3.7	31,725	1,182
Critical Access (formerly Short-Stay)	3,152,302	0.8	7,909	2,215	1,722,134	1.5	4,321	1,210
Religious Non-Medical	6,565	(4)	14,428	446	4,919	(4)	10,811	334

[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 1,368 distinct-part psychiatric units and 922 rehabilitation units participating in the Medicare Program during 2005.

[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 5.11

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2006

Type of Hospital	Hospitals		Discharges		Covered Days of Care		
	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals[2]	6,226	100.0	13,245,345	100.0	77,118,235	100.0	5.8
Short-Stay Hospitals	3,729	59.9	12,384,100	93.5	68,079,250	88.3	5.5
Hospitals	3,729	59.9	11,774,915	88.9	61,175,540	79.3	5.2
Psychiatric Hospital Units[3]	NA	----	347,380	2.6	3,704,590	4.8	10.7
Rehabilitation Hospital Units[3]	NA	----	261,805	2.0	3,199,120	4.1	12.2
Specialty Hospitals	2,497	40.1	861,245	6.5	9,038,985	11.7	10.5
Childrens	81	1.3	3,020	(4)	19,940	(4)	6.6
Psychiatric	487	7.8	129,315	1.0	1,804,505	2.3	14.1
Rehabilitation	224	3.6	140,295	1.1	1,940,125	2.5	13.8
Long Term	402	6.5	135,095	1.0	3,652,325	4.7	27.0
Critical Access (formerly Short-Stay)	1,287	20.7	453,135	3.4	1,611,690	2.1	3.6
Religious Non-Medical	16	0.3	385	(4)	10,400	(4)	27.0

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 2006

	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]	$400,625,067	100.0	$30,246	$5,195	$116,232,618	100.0	$8,821	$1,507
Short-Stay Hospitals	379,507,534	94.7	30,645	5,574	106,757,631	91.8	8,669	1,568
Hospitals	364,995,246	91.1	30,998	5,966	100,363,555	86.3	8,524	1,641
Psychiatric Hospital Units[3]	6,747,500	1.7	19,424	1,821	2,453,883	2.1	7,151	662
Rehabilitation Hospital Units[3]	7,764,788	1.9	29,659	2,427	3,940,193	3.4	15,166	1,232
Specialty Hospitals	21,117,533	5.3	24,520	2,336	9,474,987	8.2	11,003	1,048
Childrens	133,169	(4)	44,096	6,678	43,688	(4)	14,466	2,191
Psychiatric	1,958,458	0.5	15,145	1,085	907,794	0.8	7,021	503
Rehabilitation	3,325,378	0.8	23,703	1,714	2,122,567	1.8	15,131	1,094
Long Term	11,841,029	3.0	87,650	3,242	4,378,973	3.8	32,415	1,199
Critical Access (formerly Short-Stay)	3,854,351	1.0	8,506	2,391	2,017,950	1.7	4,454	1,252
Religious Non-Medical	5,148	(4)	13,373	495	4,015	(4)	10,429	386

[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 1,313 distinct-part psychiatric units and 912 rehabilitation units participating in the Medicare Program during 2006.

[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 Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2005

Location and Bedsize of Hospital	Discharges	Hospital Case-Mix Index[1]
Total All Hospitals[2]	12,787,805	1.4674
1-99 Beds	1,369,415	1.2265
100-299 Beds	4,595,920	1.3612
300-499 Beds	3,558,125	1.5175
500 Beds or More	3,264,345	1.6633
Total Urban Hospitals	10,802,185	1.5106
1-99 Beds	615,715	1.3583
100-299 Beds	3,559,320	1.3899
300-499 Beds	3,405,045	1.5206
500 Beds or More	3,222,105	1.6624
Total Rural Hospitals	1,985,620	1.2323
1-99 Beds	753,700	1.1189
100-299 Beds	1,036,600	1.2626
300-499 Beds	153,080	1.4486
500 Beds or More	42,240	1.7304

[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 short-stay hospitals in the 50 States and District of Columbia; excludes discharges from short-stay hospitals 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.

Table 5.12–Continued

Short-Stay Hospital Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2005

Location and Bedsize of Hospital	Total	Percent of Discharges			
		With Procedures			Without
		Total	Surgical	Non-Surgical	Procedure
Total All Hospitals[2]	100.0	57.8	47.4	10.4	42.3
1-99 Beds	100.0	41.1	32.1	9.0	58.9
100-299 Beds	100.0	54.0	43.9	10.1	46.1
300-499 Beds	100.0	61.0	50.6	10.4	39.0
500 Beds or More	100.0	66.5	55.2	11.3	33.5
Total Urban Hospitals	100.0	60.3	49.8	10.5	39.7
1-99 Beds	100.0	50.2	41.1	9.1	49.8
100-299 Beds	100.0	55.6	45.6	10.0	44.4
300-499 Beds	100.0	61.2	50.7	10.5	38.8
500 Beds or More	100.0	66.5	55.1	11.4	33.5
Total Rural Hospitals	100.0	43.7	34.2	9.5	56.3
1-99 Beds	100.0	33.7	24.8	8.9	66.3
100-299 Beds	100.0	48.2	38.0	10.2	51.8
300-499 Beds	100.0	56.5	48.2	8.3	43.6
500 Beds or More	100.0	66.9	57.8	9.1	33.1

Table 5.12

Short-Stay Hospital (SSH) Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2006

Location and Bedsize of Hospital	Discharges	Hospital Case-Mix Index[1]
Total All Hospitals[2]	12,312,200	1.4783
1-99 Beds	1,240,415	1.2436
100-299 Beds	4,479,505	1.3746
300-499 Beds	3,432,215	1.5240
500 Beds or More	3,160,065	1.6677
Total Urban Hospitals	10,484,640	1.5189
1-99 Beds	585,460	1.3726
100-299 Beds	3,484,590	1.4026
300-499 Beds	3,281,680	1.5266
500 Beds or More	3,132,910	1.6675
Total Rural Hospitals	1,827,560	1.2452
1-99 Beds	654,955	1.1283
100-299 Beds	994,915	1.2766
300-499 Beds	150,535	1.4670
500 Beds or More	27,155	1.6895

[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.

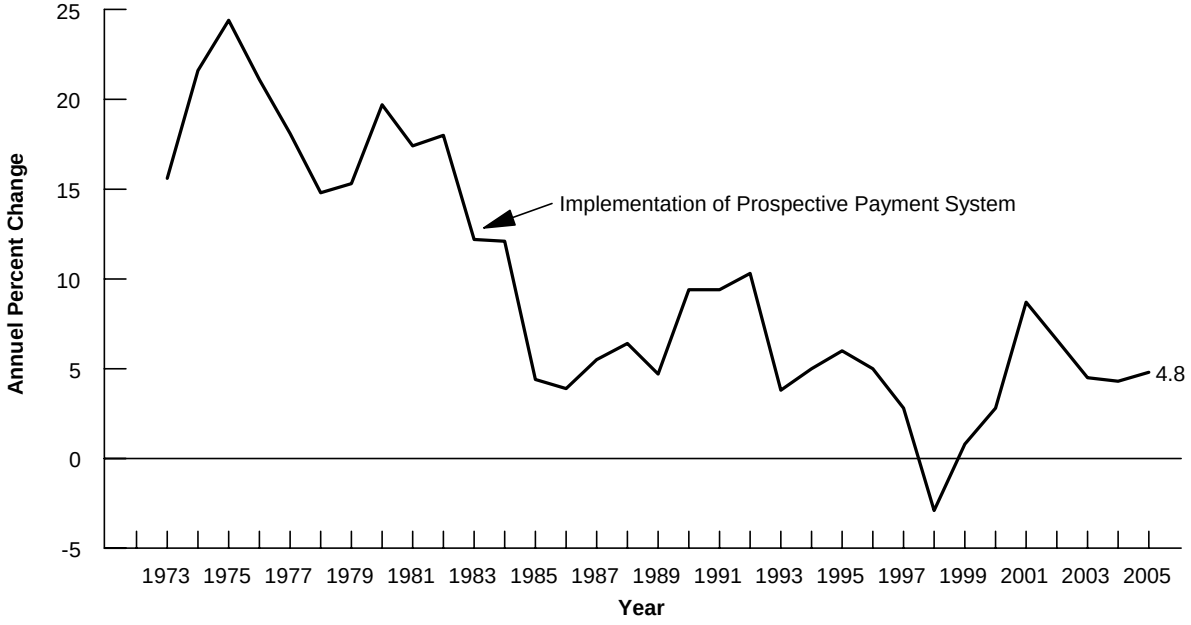
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

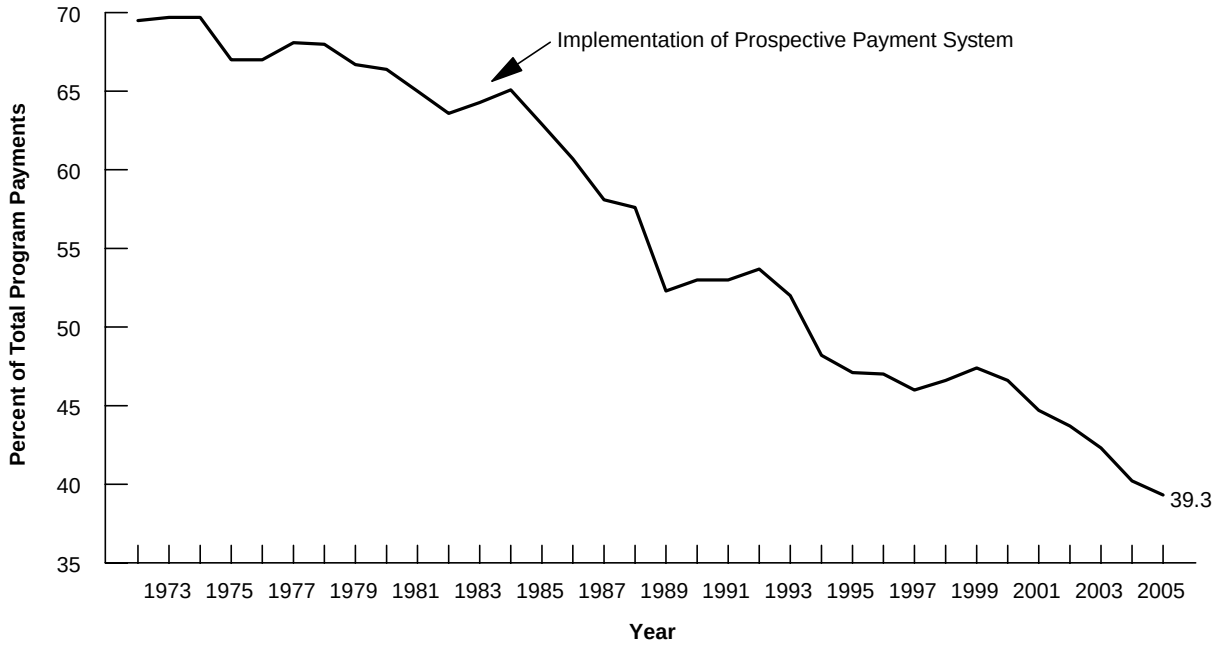
Table 5.12—Continued

Short-Stay Hospital (SSH) Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2006

Location and Bedsize of Hospital	Total	Percent of Discharges			
		With Procedures			Without Procedure
		Total	Surgical	Non-Surgical	
Total All Hospitals[2]	100.0	58.5	47.9	10.6	41.5
1-99 Beds	100.0	43.0	33.5	9.5	57.0
100-299 Beds	100.0	54.6	44.3	10.3	45.4
300-499 Beds	100.0	61.4	50.9	10.5	38.6
500 Beds or More	100.0	67.0	55.3	11.7	32.9
Total Urban Hospitals	100.0	60.8	50.1	10.7	39.1
1-99 Beds	100.0	51.7	42.5	9.2	48.3
100-299 Beds	100.0	56.2	46.0	10.2	43.8
300-499 Beds	100.0	61.6	51.0	10.6	38.4
500 Beds or More	100.0	67.1	55.3	11.8	32.9
Total Rural Hospitals	100.0	45.1	35.1	10.0	54.9
1-99 Beds	100.0	35.2	25.5	9.7	64.8
100-299 Beds	100.0	49.3	38.7	10.6	50.7
300-499 Beds	100.0	57.1	49.1	8.0	43.0
500 Beds or More	100.0	61.7	56.9	4.8	38.3

Figure 5.1
Changes in Medicare Short-Stay Hospital Program Payments: Calendar Years 1972-2005

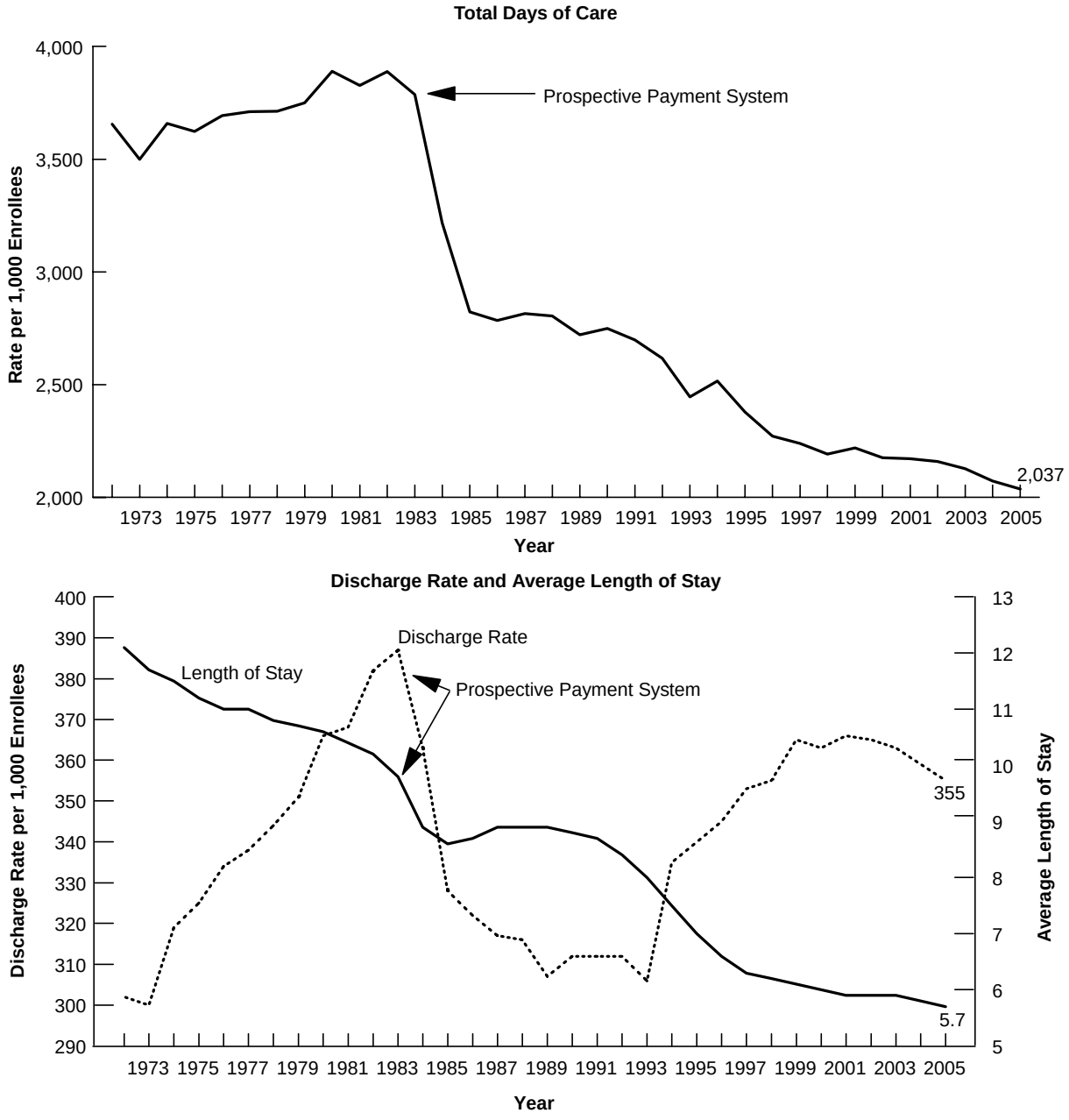




NOTE: The Medicare short-stay hospital prospective payment system was phased in by providers' fiscal years beginning on or after October 1, 1983.

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.

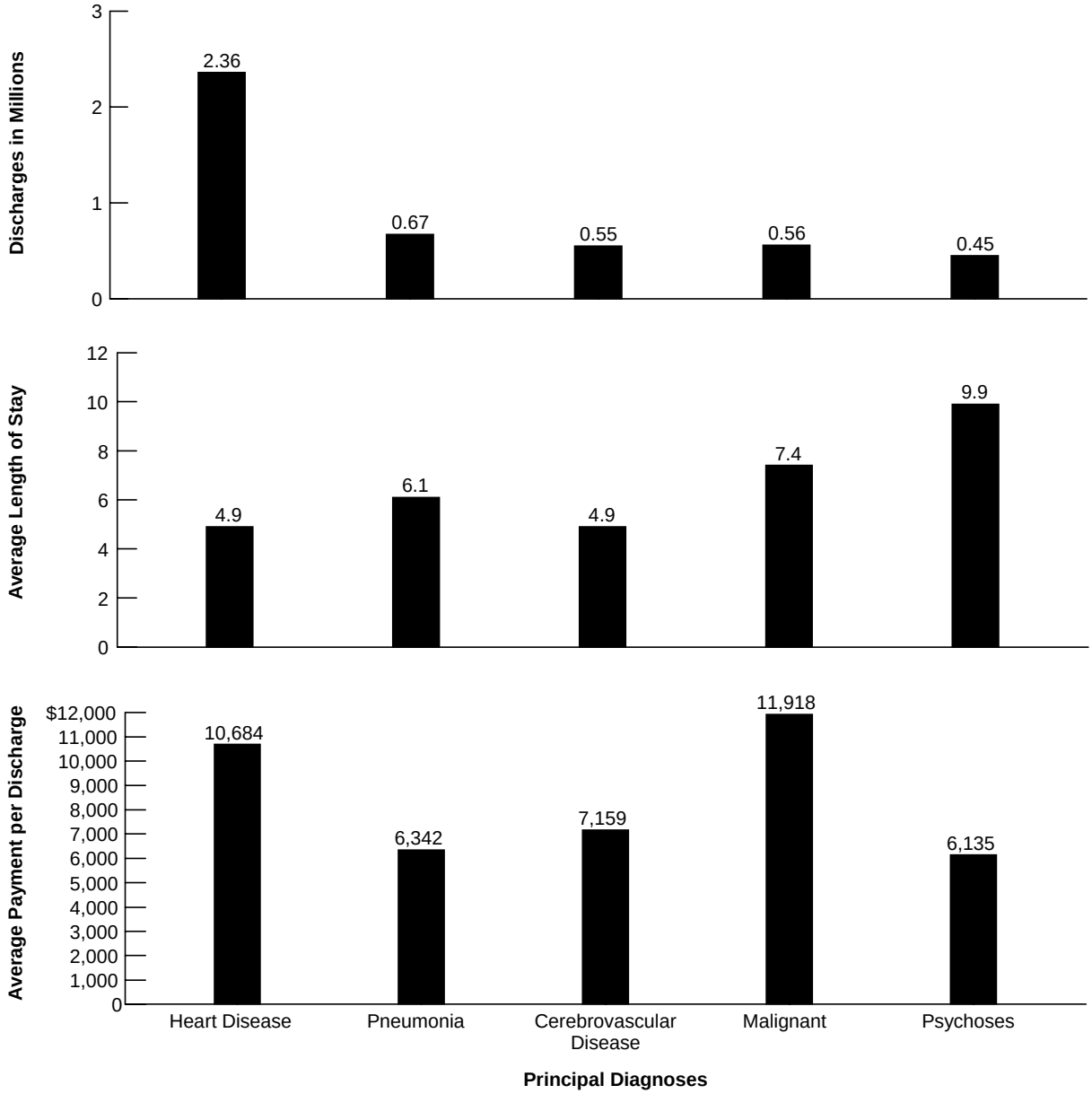
Figure 5.2
Trends in Parameters of Medicare Beneficiary Stays in Short-Stay Hospitals: Calendar Years 1972-2005



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.

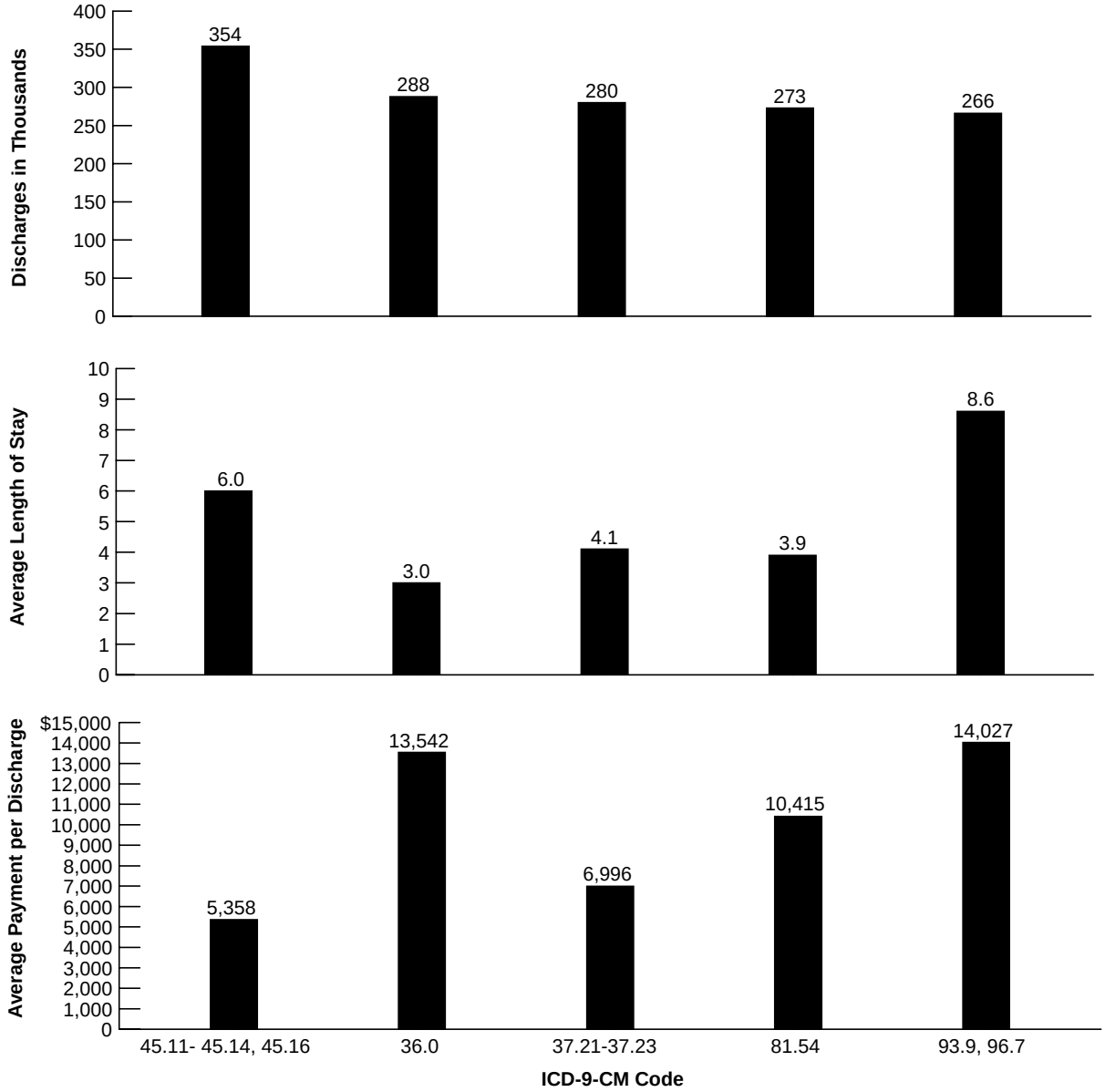
Figure 5.3
Leading Principal Diagnostic Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2005



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; psychoses, 290-299.

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.

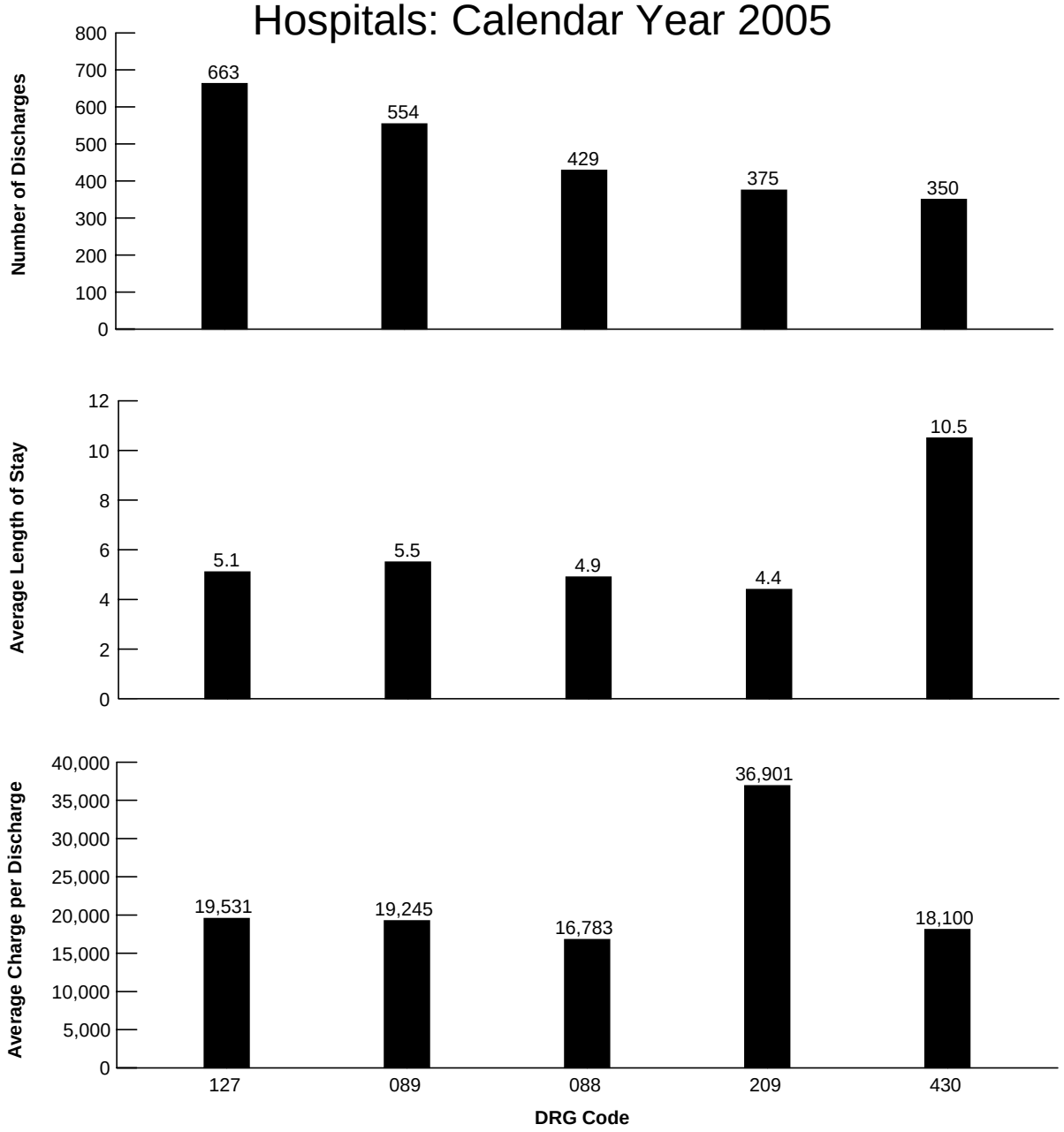
Figure 5.4
Medicare Principal Procedure Classifications for Medicare Beneficiaries Discharged from Short-Stay Hospitals, Based on Frequency: Calendar Year 2005



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; removal of coronary artery obstruction, 36.0; cardiac catheterization, 37.21-37.23; total knee replacement, 81.54; respiratory therapy, 93.9, 96.7.

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.

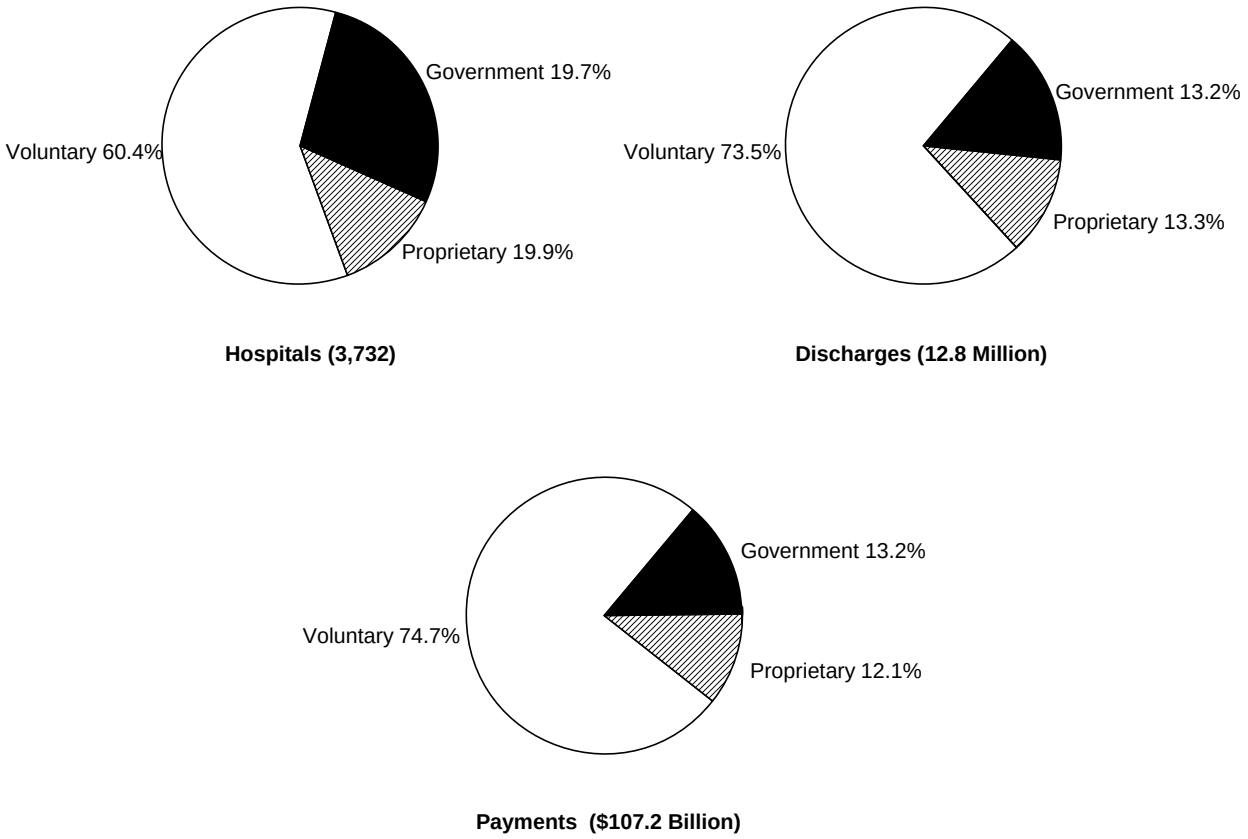
Figure 5.5
Five Most Frequent Medicare Diagnosis-Related Groups (DRGs) for Beneficiaries Discharged from Short-Stay Hospitals: Calendar Year 2005



NOTE: DRG codes are as follows: heart failure & shock, 127; simple pneumonia & pleurisy, 089; chronic obstructive pulmonary disease, 088; major joint & limb reattachment procedures of lower extremity, 209; 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.

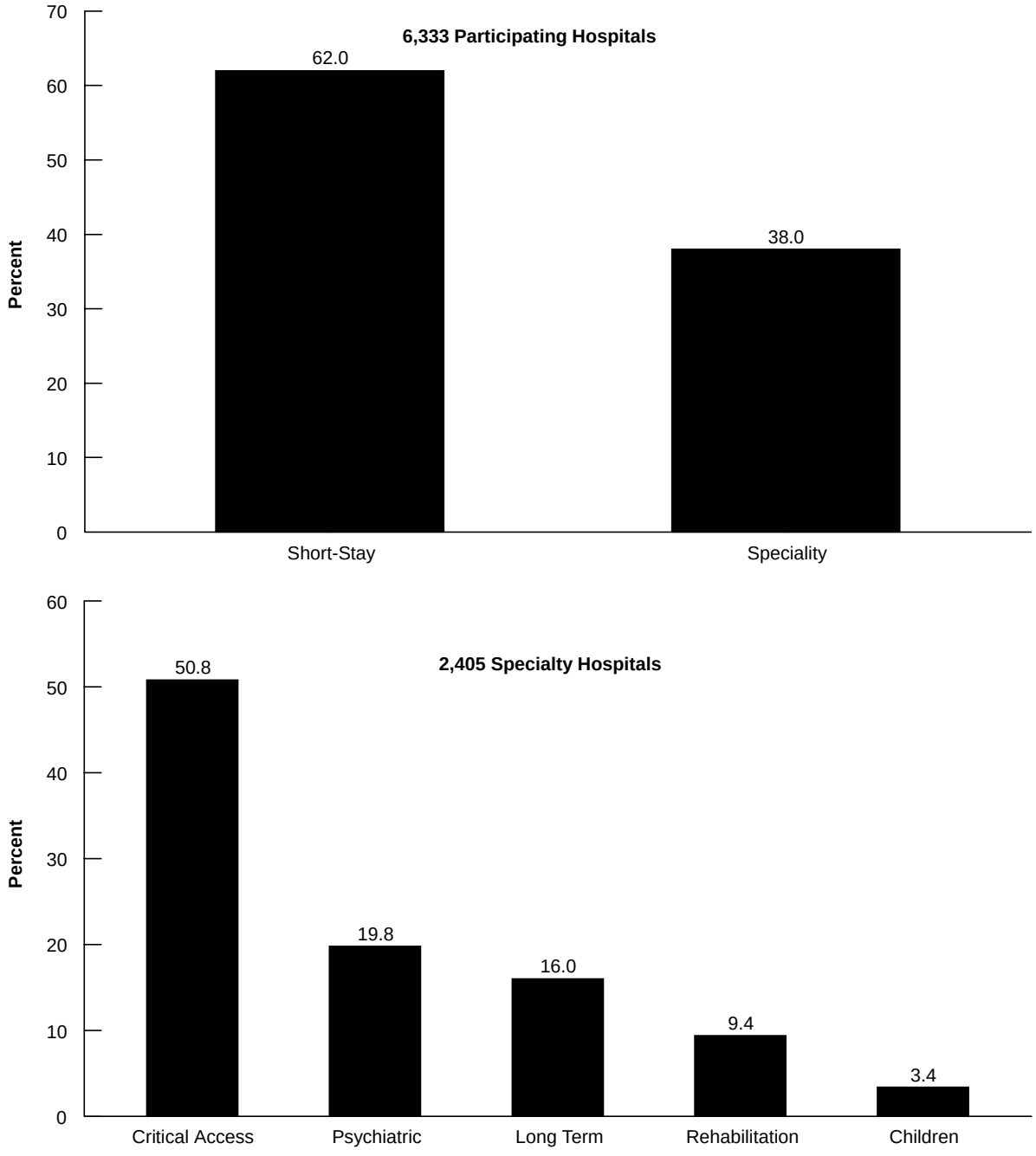
Figure 5.6
Distribution of Medicare Short-Stay Hospitals, Discharges, and Payments, by Type of Control: Calendar Year 2005



NOTE: Short-stay hospital payments excludes outlying areas.

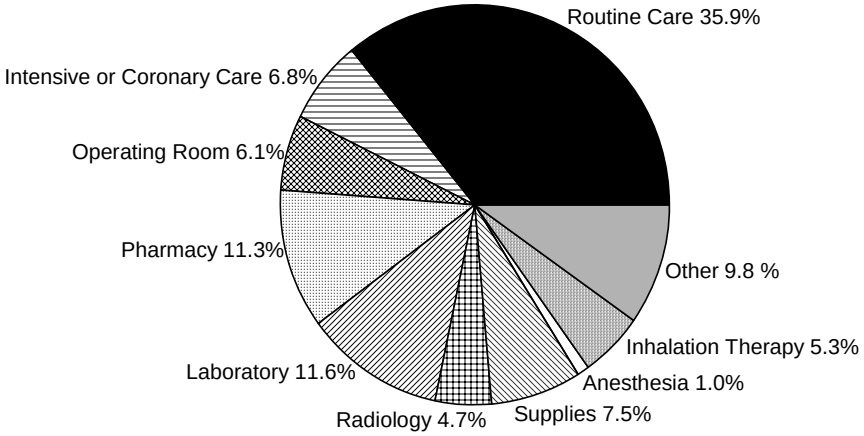
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 5.7
Medicare Participating Hospitals, by Type of Hospital: Calendar Year 2005



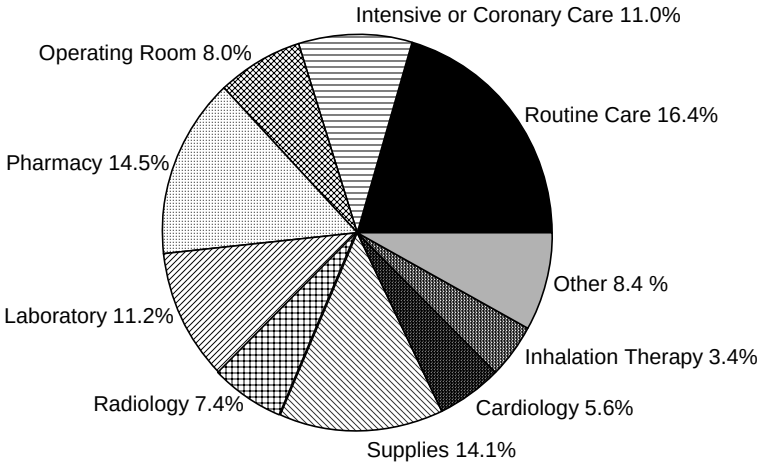
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Data Extract System; data development by the Office of Research, Development, and Information.

Figure 5.8
Percent Distribution of Medicare Short-Stay Hospital Charges, by Type of Service: Calendar Years 1983 and 2005



1983

(Total Charges = $54.8 Billion)



2005

(Total Charges = $369.8 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.