Spending per Hospital Patient with Medicare
Also Known as Medicare Spending per Beneficiary (MSPB)

Spending Breakdowns by Claim Type
Webpage Description

July 2012

OVERVIEW

This document is intended to assist the public in understanding the data displayed on the "Spending per Hospital Patient with Medicare: Spending Breakdowns by Claim Type" webpage. The webpage is located on *Hospital Compare*. To access it, go to: http://hospitalcompare.hhs.gov/staticpages/for-consumers/value-based-purchasing.aspx. Next, click on "Spending per Hospital Patient with Medicare (also known as Medicare Spending per Beneficiary)" and then click on "view data."

The "Spending per Hospital Patient with Medicare: Spending Breakdowns by Claim Type" webpage contains detailed information concerning each hospital's average spending levels during a Medicare Spending per Beneficiary (MSPB) episode for the period of performance from May 15, 2010 through February 14, 2011. These average Medicare payment amounts have been price-standardized to remove the effect of geographic payment differences and add-on payments for indirect medical education (IME) and disproportionate share hospitals (DSH).[1] CMS uses the information on this webpage to calculate a hospital's MSPB Measure value, which is reported on *Hospital Compare*.

This webpage provides price-standardized, non-risk-adjusted values to help the public understand the MSPB Measure and its composition. An MSPB episode includes all Medicare Part A and Part B claims paid during the period from 3 days prior to a hospital admission (i.e., index admission) through 30 days after discharge from the hospital. The values on the webpage are identical to the values that hospitals received in Table 5 of their Hospital-Specific Reports during the February 2012 data preview. In order to calculate the MSPB measure rates displayed on *Hospital Compare*, these numbers would be risk adjusted, to account for beneficiary age and severity of illness.

On the "Spending per Hospital Patient with Medicare: Spending Breakdowns by Claim Type" webpage, each hospital's average episode spending level is divided into more detailed categories. First, the webpage separates every eligible hospital's episode spending into three time periods:

[1] For further details on price-standardization, please visit: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350

during the 3 days prior to the index admission, during the index admission, and during the 30 days after hospital discharge. Within these three time periods, the average episode spending levels are further broken down into seven claim types (e.g., inpatient, outpatient). The result is a display of 21 rows for each hospital which contain average Medicare payment amounts during the 3 time periods, each broken down into 7 claim types. The sum of a hospital's spending across these 21 rows equals the average price-standardized, non-risk-adjusted spending for an average MSPB episode for each hospital; this value is presented in an additional 22nd row for each hospital entry. For comparison, this webpage also presents the average and percent of spending for these 21 categories for the average hospital at the state and national levels. These state and national averages are provided for informational purposes and are *not* used in the calculation of the MSPB Measure rate for hospitals.

WEBPAGE TABLE STRUCTURE

The table on the "Spending per Hospital Patient with Medicare: Spending Breakdowns by Claim Type" webpage is divided into 11 columns:

- Column 1: **Hospital Name**.
- Column 2: **Provider Number**.
- Column 3: **State**. The state in which the hospital is located.
- Column 4: **Period**. This column indicates the relevant time period during the MSPB episode. This column can contain one of the three episode time periods discussed above: (i) 1 to 3 days Prior to Index Hospital Admission, (ii) During Index Hospital Admission, and (iii) 1 through 30 days After Discharge from Index Hospital Admission.[2] In addition, when a row contains a value that represents the totals from these three episode time periods, this column contains the label "Complete Episode."
- Column 5: **Claim Type**. Episode spending is broken down by seven claim types (as discussed in more detail below). As a result, each hospital entry has 21 rows (i.e., 3 episode time periods multiplied by 7 claim types per time period). The sum of these 21 rows equals the total average spending per episode. The "Total" claim type, which is presented in the 22nd row for each hospital entry, contains the total average spending for each hospitalization episode.

[2] The "During Index Hospital Admission" category includes all services that fall between an episode's initial hospital admission date and discharge date. Any service that begins on the date the patient is discharged from their initial hospital stay is included in the "During Index Hospital Admission" time period. For example, if a patient is admitted to a skilled nursing facility (SNF) on the same day that he or she is discharged from the initial hospitalization, then the cost associated with this SNF claim is included in the "During Index Hospital Admission" time period.

- Column 6: **Avg Spending Per Episode (Hospital)**.[3] This column presents the average spending across each of the 21 time period/claim type combinations for each hospital. The sum of the average spending per episode across these 21 time period/claim type combinations is presented in an additional 22nd row for each hospital entry.
- Column 7: **Avg Spending Per Episode (State)**.[3,4] This column presents the average spending across each of the 21 time period/claim type combinations for the state in which the hospital is located. The sum of the average spending per episode across these 21 time period/claim type combinations is presented in an additional 22nd row for each state.
- Column 8: **Avg Spending Per Episode (Nation)**.[3] This column presents the average spending across each of the 21 time period/claim type combinations for the nation. The sum of the average spending per episode across these 21 time period/claim type combinations is presented in an additional 22nd row for the nation.
- Column 9: **Percent of Spending (Hospital)**.[5] This column presents the portion of the total average episode spending amount that each of a hospital's 21 time period/claim type average episode spending amounts contributes to the total.
- Column 10: **Percent of Spending (State)**.[4,5] This column presents the portion of the total average episode spending amount that each of a state's 21 time period/claim type average episode spending amounts contributes to the total.
- Column 11: **Percent of Spending (Nation)**.[5] This column presents the portion of the total average episode spending amount that each of the nation's 21 time period/claim type average episode spending amounts contributes to the total.

CLAIM TYPES

In each of the three time periods, spending is divided into one of seven claim types. These include: (i) home health agency, (ii) hospice, (iii) inpatient, (iv) outpatient, (v) skilled nursing facility, (vi) durable medical equipment, and (vii) carrier. The carrier file is also known as the Physician/Supplier Part B file.

Additional information describing the types of claims included in each claim type is available on the ResDAC website: http://www.resdac.org/medicare/file_descriptions.asp.

[3] The sum of the average spending per episode across the 21 time period/claim type combinations may not equal the value presented in the 22nd row (i.e., claim type "Total") for each hospital entry due to rounding.
[4] If a hospital is located in a state or territory with fewer than 10 hospitals, the state's results are combined with other small or nearby states or territories to protect confidentiality. Specifically, results are combined as follows: (1) the District of Columbia and Delaware are combined; (2) Alaska is combined with Washington; (3) North Dakota is grouped with South Dakota; and (4) Vermont is combined with New Hampshire.
[5] The sum of the percentages across the 21 time period/claim type combinations may not equal 100% (i.e., the value presented in the 22nd row for each hospital entry) due to rounding.

MSPB METHODOLOGY

The MSPB Measure evaluates hospitals' efficiency, as reflected by Medicare payments made during an MSPB episode, relative to the efficiency of the median hospital. Specifically, a hospital's MSPB Measure is calculated as the hospital's average MSPB Amount divided by the median MSPB Amount across all hospitals, where a hospital's MSPB Amount is the hospital's average price-standardized, risk-adjusted spending for an MSPB episode.

A detailed description of how CMS uses standardized payments presented on the "Spending per Hospital Patient with Medicare: Spending Breakdowns by Claim Type" webpage to calculate the MSPB Amount is available on the QualityNet website: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350.

Note: The values presented in the 22nd row of column 6 for each hospital entry, are *not* equivalent to hospitals' MSPB Amounts. To calculate the MSPB Amount, the values reported on the "Spending per Hospital Patient with Medicare: Spending Breakdowns by Claim Type" webpage are risk-adjusted to account for beneficiary age and severity of illness. The values on this webpage are for informational purposes only.