DATA SOURCE AND METHODOLOGY – CMS PROGRAM STATISTICS

SECTION: MEDICARE UTILIZATION AND PAYMENTS

OVERVIEW

The Office of Enterprise Data and Analytics, within the Centers for Medicare & Medicaid Services (CMS), developed the CMS Program Statistics, an information product which replaced the Medicare and Medicaid Statistical Supplement. The CMS Program Statistics is an online statistical report that includes tables describing characteristics of the Medicare-covered populations, use of services, and expenditures under these programs, as well as Medicare providers serving beneficiaries.

The Medicare Utilization and Payments section includes tables with utilization and payment data for the following service types: inpatient hospital, skilled nursing facility, home health agency, hospice, outpatient, and physician/supplier. Additionally, the Medicare Utilization and Payments section includes tables with Part D utilization and drug cost data, as well as tables on Medicare premiums.

This document provides an overview of the data and methods used to develop the various tables in this section and will be updated as needed.

DATA SOURCE

The data reported in the Medicare Utilization and Payments section are based upon calendar year CMS administrative enrollment and claims data for beneficiaries enrolled in Original Medicare (also referred to as fee-for-service). Claims data for Medicare Advantage & Other Health Plan enrollees are currently unavailable for the CMS Program Statistics. The Original Medicare data are available from the CMS Chronic Conditions Data Warehouse (CCW), a database with 100% of Medicare enrollment and fee-for-service claims data. Detailed information on the CCW is available from the CCW website, www.ccwdata.org.

METHODOLOGY

For the Medicare Utilization and Payments section, race code data are based on the Research Triangle Institute (RTI) race codes; this differs from the use of the Social Security Administration (SSA)-supplied race codes in the Medicare and Medicaid Statistical Supplement. The area of residence is determined based on a beneficiary’s residence at the end of the calendar year. Medicare beneficiaries residing in foreign countries are entitled to covered services upon
returning to the United States. Each beneficiary’s age and Medicare status (aged, disabled or ESRD) are determined based on an end-of-year value.

CMS is obligated by the Federal Privacy Act, 5 U.S.C. Section 552a to protect the privacy of individual beneficiaries. Enrollee counts of 1-10 in these tables are suppressed and are denoted with an asterisk (*). Additional counts are cross-suppressed to prevent the recalculation of suppressed counts of 1-10 and are denoted with a plus sign (+).

The following describes the methods for the specific utilization sections:

**Inpatient Hospital**

This section includes utilization and program payments for all inpatient hospitals, including short-stay hospitals, critical access hospitals, long-term care hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, religious nonmedical health care institutions, children’s hospitals, and other hospitals. Tables 5-9 are specific to short-stay hospitals paid under Inpatient Prospective Payment System. Table 10 holds counts and amounts for special-category hospitals: Cancer hospitals, Disproportionate Share hospitals, Medicare Dependent hospitals, and Sole Community hospitals. The data source for these special-category hospitals is the CMS Cost Reports.

All tables in this section are based upon inpatient claims with covered days greater than 0 or Medicare program payment amounts greater than 0. The reported “per enrollee” rates are calculated using Original Medicare Part A enrollment as the denominator.

**Skilled Nursing Facility**

All tables in this section are based upon skilled nursing facility claims with covered days greater than 0. The reported “per enrollee” rates are calculated using Original Medicare Part A enrollment as the denominator.

**Physician/Supplier**

All tables in this section include utilization and program payments for physicians, non-physicians, limited-licensed practitioners, and durable medical equipment, prosthetic, and orthotic (DMEPOS) suppliers. The reported “per enrollee” rates are calculated using Original Medicare Part B enrollment as the denominator.

**Outpatient Facilities**

All tables in this section include utilization and program payments for all outpatient facilities, including outpatient hospitals, critical access hospitals, rural health clinics, community mental health centers, federally qualified health centers, outpatient dialysis facilities, comprehensive
outpatient rehabilitation facilities, and other outpatient facilities. The tables exclude claims from physicians and ambulatory surgical centers. The reported “per enrollee” rates are calculated using Original Medicare Part B enrollment as the denominator.

**Hospice**

All tables in this section include utilization and program payments for hospice. The tables limit the reporting of hospice days to utilization days occurring within the specified calendar year and may not reflect all of a beneficiary’s utilization days for an entire hospice episode of care. The “per enrollee” rates are based on enrollees in Original Medicare and Medicare Advantage/Other Health Plans combined, because once a beneficiary enrolled in Medicare Advantage/Other Health Plan elects the hospice benefit, his or her Medicare benefits revert to fee-for-service.

**Home Health Agency**

All tables in this section include utilization and program payments for home health agencies. The tables report utilization and expenditure data from home health Part A and Part B claims with home health agency services greater than 0, within the specified calendar year. Services provided by home health agencies to beneficiaries who are not under a home health plan of care are excluded in the reporting. The calculated “per enrollee” rates are based on Original Medicare beneficiaries with Part A and/or Part B coverage.

**Medicare Part A and Part B Summary**

The tables in this section are a compilation of utilization and expenditure data reported in tables from the service-specific sections described above. This section includes a breakout of Part A and Part B home health agency services, separately.

**Medicare Part D Utilization**

The tables in this section include utilization and drug cost data for Medicare Part D. The trend tables report Part D utilization data (including utilizers, average prescription drug events, generic dispensing rates, average unique drug products per utilizer, and beneficiaries who entered catastrophic coverage) and Part D drug costs (including brand name and generic) by type of Part D plan (stand-alone prescription drug plan and Medicare Advantage prescription drug plan). The demographic and state tables report utilizers, average prescription drug events (fills), and average Part D gross drug costs by type of Part D plan. Additionally, this section also includes yearly trend, demographic, and state tables that present utilization and expenditure data by Part D coverage phase.
Medicare Premiums

The tables in this section include counts of Medicare Part A and Part B premium beneficiaries, Part A and Part B premium amounts, and counts of Part A and Part B beneficiaries paying a penalty, including the Part A and Part B penalty amounts.