MEDICARE SPENDING PER BENEFICIARY (MSPB)
SPENDING BREAKDOWN BY CLAIM TYPE
Webpage Description

OVERVIEW

This document is intended to assist the public in understanding the data displayed on the "Medicare Hospital Spending by Claim" webpage on this Hospital Compare webpage or this Data.Medicare.Gov webpage. The "Medicare Hospital Spending by Claim" webpage contains detailed information concerning each hospital's average spending levels during a Medicare Spending Per Beneficiary (MSPB) episode for a given period of performance.[1]

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. 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. 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. Medicare payment amounts are price-standardized to remove the effect of geographic payment differences and add-on payments for indirect medical education (IME) and disproportionate share hospitals (DSH).[2] In addition, the MSPB Measure is risk adjusted to account for beneficiary age and severity of illness. The data presented on the Hospital Compare webpages provide non-risk-adjusted values for two reasons: first, so that the public can evaluate service costs based on non-risk-adjusted amounts and determine appropriate next steps; and second, because risk adjustment is done at the episode level rather than at the service category/claim level. The values on the webpage are identical to the values that hospitals received in Table 5 of their Hospital-Specific Reports during the data preview.

WEBPAGE TABLE STRUCTURE

On the "Medicare Hospital Spending by Claim" webpage, each hospital's average MSPB episode spending level is divided into more detailed categories. First, the webpage separates every eligible hospital's MSPB episode spending into three time periods: 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 price-standardized non-risk-adjusted

[1] For further details on the MSPB methodology, please visit this QualityNet webpage.
[2] For further details on price-standardization, please visit this QualityNet webpage.

MSPB 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 spending 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 total 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, the 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.

The table on the "Medicare Hospital Spending by Claim" webpage includes the following columns:

- Column 1: **Hospital Name**.
- Column 2: **Provider Number**. Hospital CMS Certification Number (provider identifier). Note that many provider numbers have leading 0's and thus must be uploaded as character variables.
- 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 contains 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.[3] 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 settings. 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 this ResDAC website. 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 price-standardized non-risk-adjusted spending for each hospitalization episode.

[3] Non-institutional claims (i.e., durable medical equipment and carrier) that begin on an episode's index hospitalization discharge date are included in the "During Index Hospital Admission" category; institutional claims (i.e., home health agency, hospice, inpatient, outpatient, and skilled nursing facility) that begin on an index hospitalization's discharge date, on the other hand, are included in the "1 through 30 days After Discharge from Index Hospital Admission" category.

- Column 6: **Avg Spending Per Episode (Hospital)**.[4] 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)**.[3,5] 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] 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)**.[6] 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] 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] 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.

[4] 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.
[5] 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.
[6] 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.