New Medicare data available to increase transparency on hospital utilization

As part of the Administration’s efforts to promote better care, smarter spending, and healthier people, CMS is releasing today the third annual update to the Medicare hospital inpatient and outpatient charge data. The data now includes inpatient and outpatient hospital charge data for 2013, as well as data released for years 2011 and 2012, and shows what different hospitals in all 50 states and Washington, D.C. charge for similar services.

The data include information comparing the average hospital charges for services that may be provided in connection with the 100 most common Medicare inpatient stays, such as services provided in connection with certain joint replacements or services provided to treat chest pain. Hospitals determine what they will charge for items and services provided to patients and these “charges” are the amounts the hospital bills for those items or services.

The data also provide average Medicare payment information for the top 100 inpatient discharges to provide a point of comparison against hospital charges for the services. Information on the number of discharges for each service at each hospital is also provided to describe the volume of service utilization. CMS protects beneficiaries’ personal information in all its data releases.

Data Source

CMS used inpatient data from the Medicare Providers Analysis and Review (MedPAR) dataset for fiscal year 2013 to produce the new data. The MedPAR dataset contains Medicare inpatient hospital claims for all Medicare beneficiaries enrolled in Medicare Part A (hospital insurance). Inpatient acute-care services are paid by Medicare based on the Medicare Severity Diagnosis Related Group (MS-DRG) to which the Medicare patient’s case is assigned. The MS-DRG is a classification system that groups similar clinical diagnoses and the procedures the hospital furnished to treat those conditions during the inpatient stay, and these classes were used to describe the services in the data.

Data Analyses

This data enables many different types of comparisons of charges, costs, and service utilization by individual hospitals or within local markets and nationwide. For example, Table 1 below shows the national top ten diagnostic related groups (DRG) based on the number of discharges and describes their associated total Medicare allowed amounts. Major joint replacement (DRG 470) continues to be the most frequently occurring discharge nationally with 446,148 total discharges and total allowed amount cost of $6.6 billion. The majority of these DRGs have been ranked in the top ten across all three years of publicly available data.

<table>
<thead>
<tr>
<th>Diagnostic Related Group Code and Description</th>
<th>Total Discharges</th>
<th>Total Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC</td>
<td>446,148</td>
<td>$6,600,563,136</td>
</tr>
<tr>
<td>871 - SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC</td>
<td>398,004</td>
<td>$5,560,910,280</td>
</tr>
<tr>
<td>592 - ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC</td>
<td>199,292</td>
<td>$1,089,985,661</td>
</tr>
<tr>
<td>292 - HEART FAILURE &amp; SHOCK W CC</td>
<td>198,483</td>
<td>$1,427,000,058</td>
</tr>
<tr>
<td>291 - HEART FAILURE &amp; SHOCK W MCC</td>
<td>194,697</td>
<td>$2,114,205,303</td>
</tr>
<tr>
<td>194 - SIMPLE PNEUMONIA &amp; PLEURISY W CC</td>
<td>182,388</td>
<td>$1,295,140,342</td>
</tr>
<tr>
<td>690 - KIDNEY &amp; URINARY TRACT INFECTIONS W/O MCC</td>
<td>175,529</td>
<td>$982,549,614</td>
</tr>
<tr>
<td>683 - RENAL FAILURE W CC</td>
<td>154,280</td>
<td>$1,098,579,709</td>
</tr>
</tbody>
</table>

With three years of data publicly available, it is now possible to conduct trend analyses of charges, payments, and utilization. Chart 1 below displays the three-year trend in average hospital charges per discharge for several of the top MS-DRGs based on total discharges. In general, charges increased over time at a modest rate. For example, major joint replacement (DRG 470) grew from $50,116 to $52,249 or a rate of 4.3% 2011 to 2012, and grew from $52,249 to $54,239, a rate of 3.8%, from 2012 to 2013.

Chart 1. Trend in Medicare Average Hospital Charges for Top Discharges, FY2013.

Using the address of the hospital facility, it is possible to conduct trend analyses by geography. The map below (Map 1) shows the FY2013 hospital discharge rate per capita for Major Joint Replacement by Hospital Referral Region (HRR). This analysis shows geographic variation around the national average of 12.2 discharges per 1,000 beneficiaries. The highest discharge rates for this procedure were found in the Midwest and Rocky Mountain areas. The lowest discharge rates per 1,000 were seen in the parts of the northeast, New Mexico, and parts of California and Nevada.

Map 1. Medicare Hospital Discharges per Capita for Major Joint Replacement (DRG 470) by Hospital Referral Region, FY2013.

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Map 2 below shows the compound annual growth rate in per capita discharges for major joint replacement (DRG 470) by HRR over the period of 2011 to 2013. This analysis shows that changes in discharges for major joint replacement, in general, grew fastest in parts of the upper Midwest and decreased in the south central region.

Map 2. Hospital Compound Annual Growth Rate in Discharges per Capita for Major Joint Replacement (DRG 470) by Hospital Referral Region, 2011 to 2013.

Data Parameters

Although the Inpatient Public Use File (PUF) has a wealth of payment and utilization information about many Medicare Part A services, the dataset also has some limitations that should be noted.

The data in the Inpatient PUF may not be representative of a hospital’s entire population served. The data in the file only has information for Medicare beneficiaries with Part A fee-for-service coverage, but hospitals typically treat many other patients who do not have that form of coverage. In addition, the data is limited to only the top 100 DRGs and thus does not necessarily include all Medicare discharges from a given hospital.
The file only contains cost and utilization information, and for the reasons described in the preceding paragraph, the volume of procedures presented may not be fully inclusive of all procedures performed by the hospital.

More Information


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