

Medicare COVID-19 Hospitalization Trends Report External FAQs

1. What information is included in the Medicare COVID-19 Hospitalization Trends Report?

The Medicare COVID-19 Hospitalization Trends Report data presents information on Medicare beneficiaries who were hospitalized with a COVID-19 diagnosis for the period starting January 1, 2020. The sources for these data are the Medicare Fee-for-Service claims data, Medicare Advantage encounter data, and Medicare enrollment information. All data presented in this report are preliminary and may change as CMS processes additional claims and encounters for the reporting period. A COVID-19 diagnosis is identified using the following International Classification of Diseases (ICD), Tenth Revision (ICD-10), diagnosis codes: B97.29 (from 1/1-3/31/20) and U07.1 (starting 4/1/20).

2. How does the Medicare COVID-19 Hospitalization Trends Report data relate to the Medicare COVID-19 Data Snapshot?

CMS released the snapshot on a monthly basis since June 2020 with the focus on cumulative cases and hospitalizations. This report takes a more focused look at hospitalizations – in addition to providing data by month, it includes much more granular data (over 25K data points) in the data file, allowing for robust analysis of how the pandemic impacted various groups of Medicare beneficiaries at different points in the pandemic.

3. Are there differences between the Medicare COVID-19 Hospitalization Trends Report data and the Medicare COVID-19 Data Snapshot?

Yes, the main difference between the snapshot and the trends report data is that the report data allows for counting of beneficiaries who were re-hospitalized for COVID-19 over the course of the pandemic. The Snapshot counts distinct beneficiaries cumulatively across the entire pandemic period and therefore only counts the first COVID-19 hospitalization for a given beneficiary.

4. How does CMS identify a COVID-19 hospitalization?

A Medicare COVID-19 hospitalization is a Medicare beneficiary with a diagnosis of COVID-19 (B97.29 from 1/1-3/31/20 and U07.1 starting 4/1/20) on an inpatient hospital claim or encounter record. We identify a hospitalization if the COVID-19 diagnosis code is in any of the 25 diagnosis code fields on the claim or encounter record.

5. Why are these data different from the COVID-19 hospitalization data released by the Centers for Disease Control and Prevention (CDC)?

There are a number of methodological differences between the Medicare COVID-19 hospitalization data and [hospitalization data reported by CDC](#). These differences are driven by several factors including different data sources, different populations for data collection, different approaches to identifying a COVID-19 hospitalization, and different time periods for reporting.

6. How does claims lag impact these data?

There will always be a delay between when a service occurs and when the claim/encounter for that service is available in the CMS database – this concept is referred to as claims lag. Claims lag differs across the various types of service (e.g., inpatient vs. physician services) and program (i.e., Original Medicare vs. Medicare Advantage). Due to claims lag, the data presented in this update must be considered preliminary since the data will continue to change as CMS processes additional claims and encounter data for the reporting period. Historically, 90% of Original Medicare claims across all claim types are submitted within 3 months, while 90% of MA encounters across all claim types are submitted within 12 months. We expect timely Original Medicare claims submissions because providers submit claims directly to us for payment. A longer claims lag is expected for Medicare Advantage encounters because Medicare Advantage Organizations: (1) collect encounters before submitting them to us and (2) have more time to submit encounters because there are different programmatic uses for the data, like risk adjustment. For more information on claims lag, please see the disclaimer in the report.

7. Are there differences in reporting and outcomes between Medicare Advantage Plans and Original Medicare?

Claims lag (described above in question #6) differs significantly between Original Medicare (fee-for-service) and Medicare Advantage. The submission of claims in Original Medicare is directly tied to payment and providers submit claims directly to CMS, so we expect them to be submitted in a timely manner. In contrast, Medicare Advantage Organizations collect encounters before submitting this data to CMS, and there are longer timeframes for submission given different programmatic uses of the data (e.g., risk adjustment). As a result, a longer claims lag is expected for Medicare Advantage encounters. Due to the differences in claims lag between Original Medicare and Medicare Advantage, it is not accurate to compare data between the two programs at this time.

8. Where can I find Medicaid data on COVID-19?

CMS has released a Medicaid and Children's Health Insurance Program ([CHIP COVID-19 data snapshot](#)). This snapshot provides a variety of information on COVID-19 related service utilization by Medicaid beneficiaries. Specifically, it provides data on testing, treatment and outcomes; service use among beneficiaries of Medicaid and the Children's Health Insurance Program (CHIP) who are 18 years of age and under; services delivered via telehealth during the COVID-19 PHE; and services for mental health and substance use disorders during COVID-19.

9. Are you going to release additional data on COVID-19 deaths in CMS programs?

No, CMS does not have data on cause of death, so we cannot report on overall COVID-19 mortality in Medicare. Data on the cause of death is available through the National Center for Health Statistics, National Vital Statistics System at the Centers for Disease Control and Prevention (CDC). The CDC has published COVID-19 death data, broken down by

demographic information such as race/ethnicity, age, and geography, at <https://www.cdc.gov/nchs/nvss/covid-19.htm>.

10. Why are the total hospitalizations slightly greater than the sum of corresponding demographic breakouts?

When we combine Medicare claims data with Medicare enrollment data, a small number of beneficiaries who have claims have missing demographic data. Those beneficiaries are included in totals but cannot be included in the demographic breakouts.