MARYLAND PRIMARY CARE PROGRAM (MDPCP): REPORTING SUITE

User Guide 1.1.0.5

October 11, 2019

hMetrix

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1 WELCOME TO THE MDPCP REPORTING SUITE

The MDPCP Reporting Suite includes 8 top-level, Tableau-based reports populated using CMS Claim and Claim Line Feed (CCLF) data. hMetrix and CRISP receive the latest 36 months of data for 100% of the Maryland Medicare Fee for Service (FFS) beneficiaries attributed to physician practices participating in the MDPCP program as well as aggregate Statewide data. Both are updated on a monthly basis. Using a beneficiary's unique identifier, the beneficiary's claim payments, types of service, procedures, diagnoses and eligibility are tracked throughout the 36 months. This allows for analyses across CTOs' and practices' attributed populations.

The latest two months of CCLF data are considered incomplete due to lag in claims submission and processing and are not presented in the default views of reports but are available to view by adjusting the selected time horizon. For more information on claim lag see section 3.2.2 CCLF Data Lag.

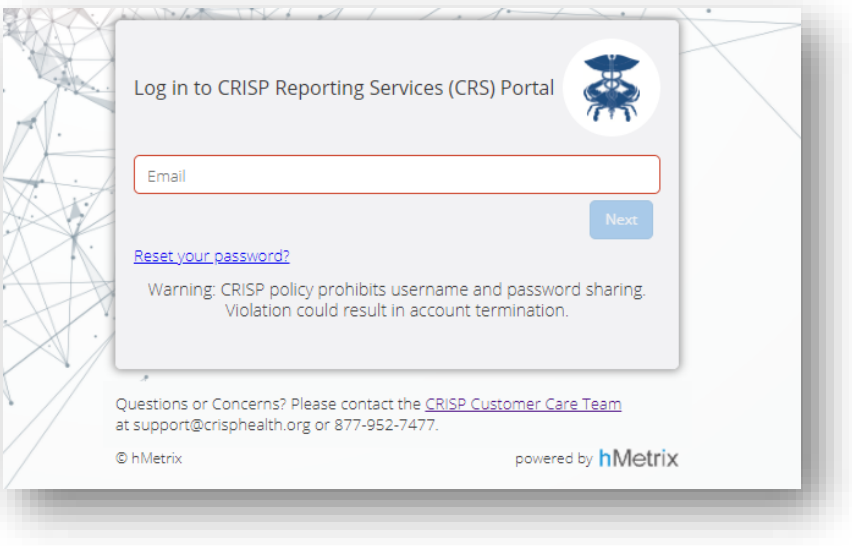
1.1 Software Requirements

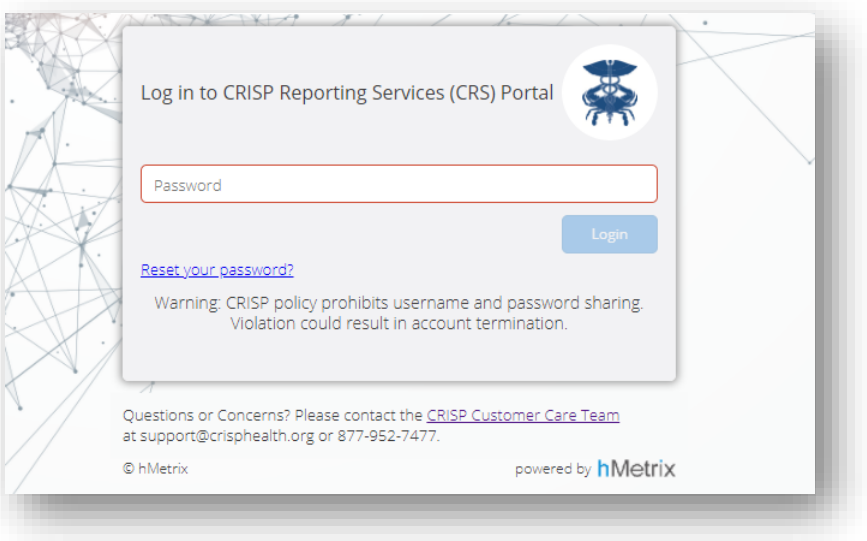
The MDPCP reports are available through a web-based application accessible using a modern browser: Google Chrome 57 or higher, Internet Explorer 11 or higher, Firefox 52 or higher, and Safari 9 or higher.

1.2 Launching MDPCP Reports

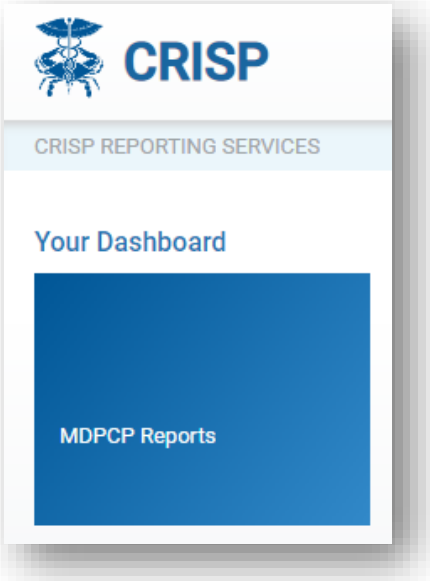
To access the MDPCP Reports, a user must first login to the CRISP Hospital Reporting Portal. Once in the portal, the user shall click the Card named "MDPCP Reports." The following screen shots represent the user's workflow.

Step 1: Log into the CRISP Hospital Reporting Portal using the user id and password provided for the portal - https://reports.crisphealth.org/

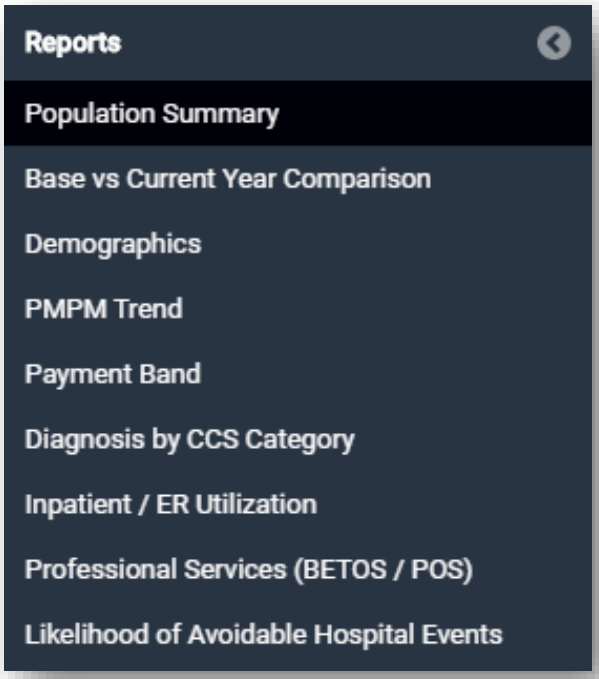




Step 2: Click the Card named “MDPCP Reports” within the Portal

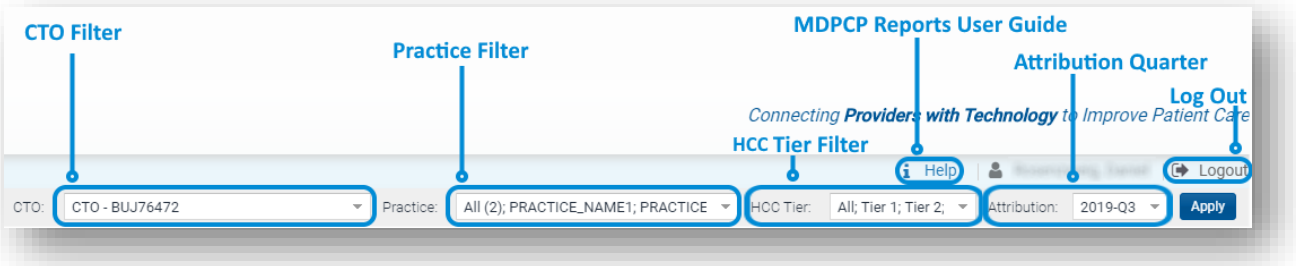


Step 3: Upon clicking the card, you will be directed to the Population Summary report. Use the menu on the left to navigate to other reports.



1.3 Navigation

Use the CTO and Practice Filters to select which practice you would like to see when running reports. Use the HCC Tier Filter to select one or more HCC tiers to view and the Attribution Quarter Filter to view the latest or an historic quarter's attributed beneficiaries. After making any filter selections in the top row, click the Apply button. CTO users may select "All" in the Practice Filter to view all associated practices' data at once. Select which HCC Tier(s) to include in reports with the HCC Tier filter and which attribution quarter to use to populate reports with the Attribution Quarter Filter. Clicking Help will open this user guide in a new browser tab. These are global filters that will persist across all reports in the suite.



1.4 Filter Selection and Claim Lag Indicator

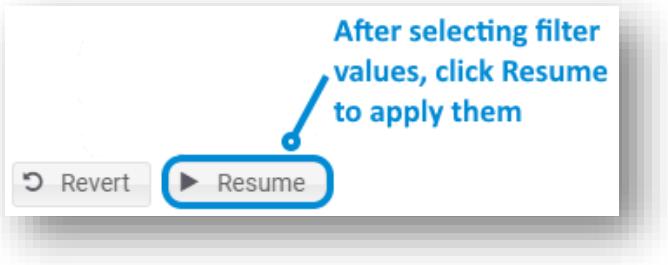
Each report contains filters that may be applied and adjusted. The below image and table describe the functionality of the filters and data consideration text.

Filter/Data Considerations	DESCRIPTION
State Comparison Filter	Select from "State – MDPCP" or "State" for statewide comparison. "State – MDPCP" represents all beneficiaries attributed to MDPCP participating practices while "State" represents the entire State's Medicare fee-for-service beneficiary population regardless of MDPCP participation. State comparison figures are presented in the reports as red.
Service Start Month Filter	Select the start month from the dropdown list to indicate the start of the date range used to populate the reports. The date indicates the date of service, not the date of processing of payment.
Service End Month Filter	Select the end month from the dropdown list to indicate the end of the date range used to populate the reports. The date indicates the date of service, not the date of processing of payment.
Claims Through	The date of the latest available claims in the data.
Lag Indicator	The date after which the presented CCLF are considered incomplete due to lag time in claims processing (see Section 3.2.2 for detail on CCLF Claim Lag).
Claim Lag Warning	This text will be present in any report that includes claims after the date indicated in the Lag Indicator. This is to advise users that the most recent month(s) are not complete due to the CCLF data lag

1.5 Pause/Resume Filter Functionality

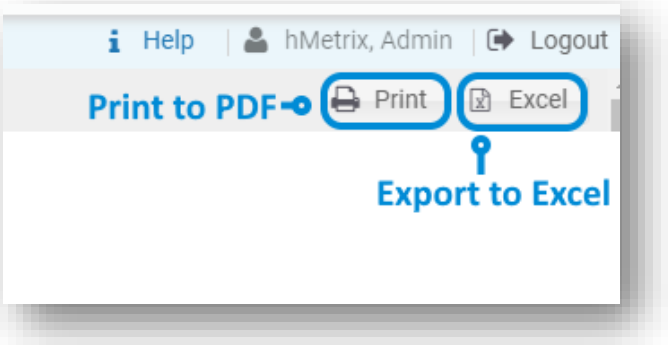
By default, each time a filter value from Section 1.4 is changed, the loaded report will refresh to reflect that selection. In order to apply multiple filters, without waiting for each to load completely prior to making another selection, use the Pause/Resume functionality located at the top left of each report.

The Revert button will change all filter values back to their default values.

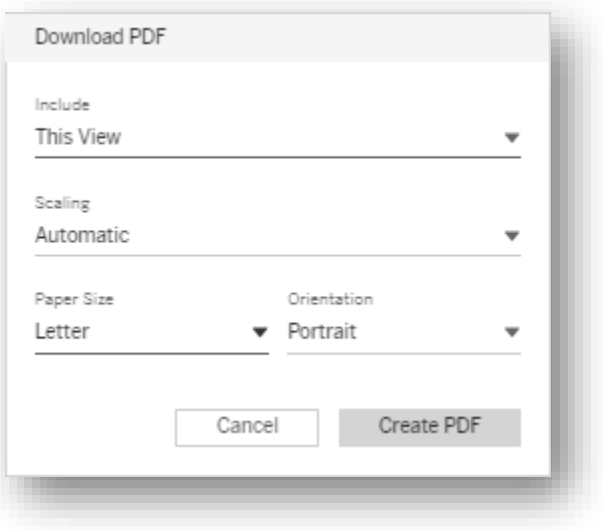


1.6 Print to PDF and Export to Excel

Each report allows for printing in the current view to a PDF document. Users can also export the data in a tabular Microsoft Excel spreadsheet for further analysis.



Clicking Print will result in the below prompt. The default settings will create a PDF will all of the graphs and tables presented in the currently viewed report. Click Create PDF to download the file.

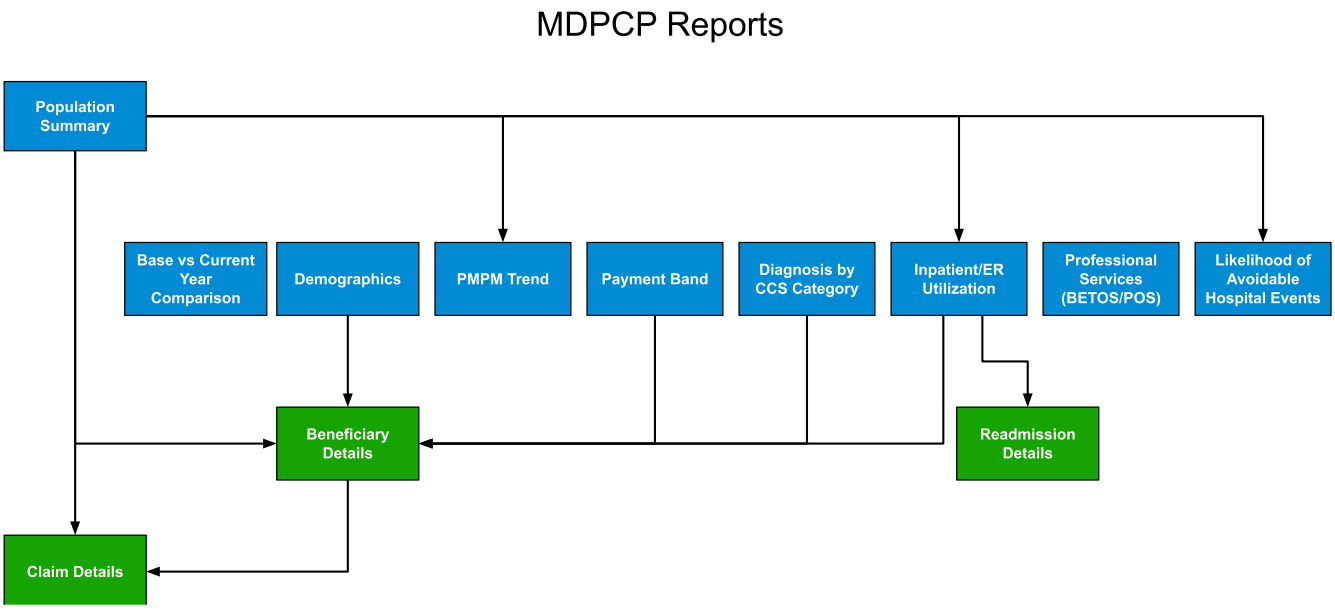


1.7 Workflow

The workflow of the MDPCP Reports is shown below. All reports indicated in blue boxes may be accessed directly from the MDPCP Reports side menu within the reporting suite. “Beneficiary Details,” “Claims Details,” and “Readmission Details” may be accessed via the reports with drill downs – these are indicated by arrows pointing from them to the green detail reports.

With a report loaded, any underlined text may be selected and will then provide the option to drill down to another report by hovering the cursor over the selection, and then clicking the hyperlink text with the drilldown report name.

Whenever drilling through a report, the path will be indicated at the top left of the loaded screen. This shows how you got to the current view as well as which report will load when you click the back arrow in the loaded report.

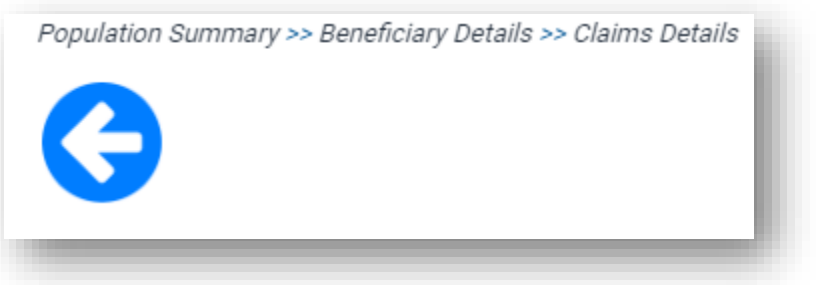


1.8 Drill Through Navigation and Indicators

As indicated in section 1.7, many of the reports include an ability to drill through to additional views with increased detail. To show how a user navigated to a particular drill through view, there is an indication at the top left of any drill through report.

Use the blue back button in the report to navigate to the report(s) through which you drilled. Using your web browser's back button will not work.

For example, the image below indicates the user has drilled through to Claims Details from Beneficiary Details, having drilled to Beneficiary Details from Population Summary.



2 REPORTS

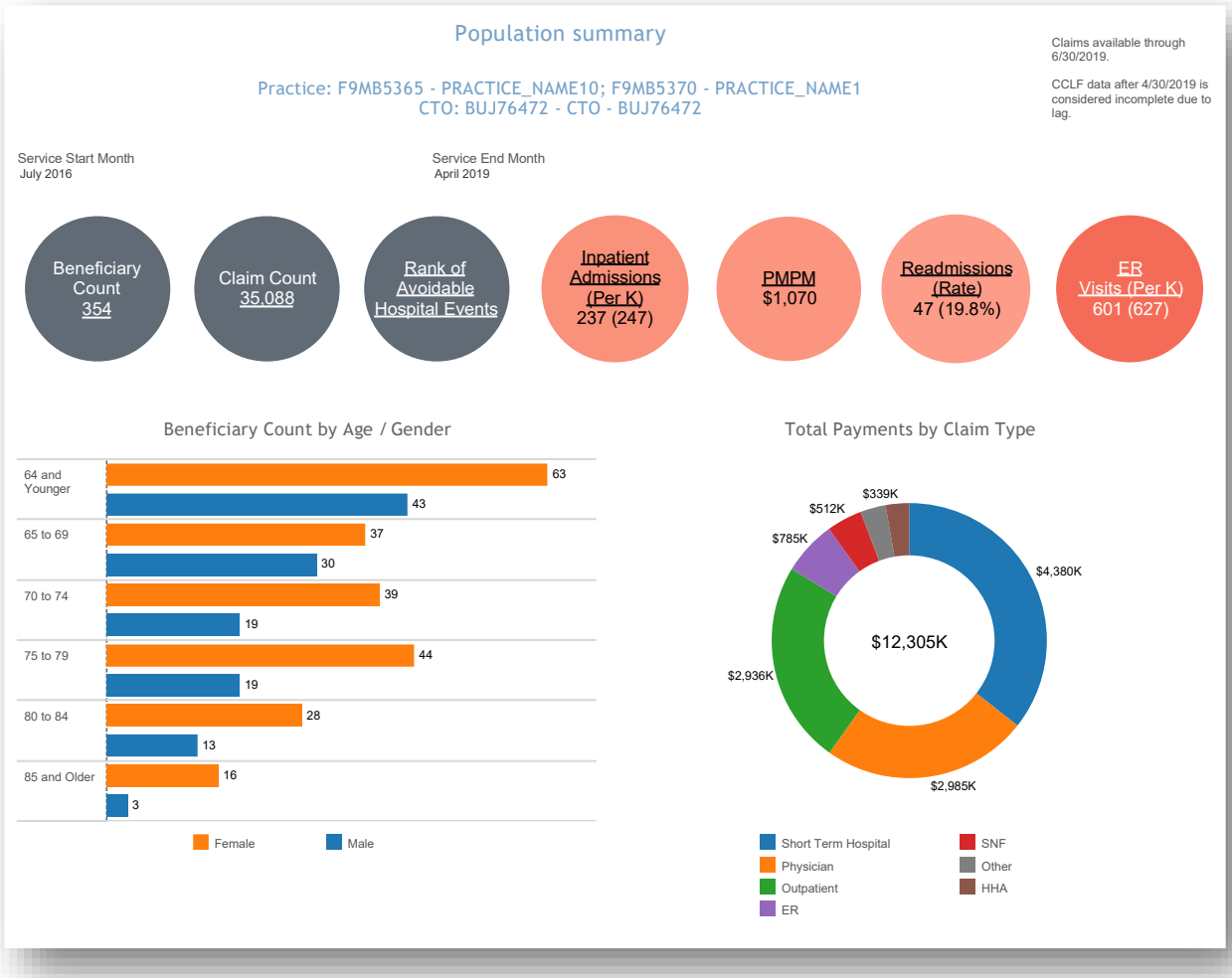
The MDPCP reports include filters for CTO selection, Practice selection, HCC Tier, and date selection that limits reports to include only claims within selected months. Some reports also include a filter for "State – Comparison" that allows the user to compare the attributed population to either the MDPCP population across the entire state of Maryland or to the entire Maryland Medicare FFS population regardless of MDPCP participation.

2.1 Population Summary Report

The Population Summary Report serves as an initial dashboard summarizing data from the remaining reports. The report includes high level breakdowns of a CTO's and/or practice's beneficiaries' claims. The report shows the total attributed beneficiaries according to 5-year age bands and gender, and a doughnut chart indicates the total claims in dollars in aggregate and by claim type. Each bubble in the report allows for drill down to either Beneficiary Details, Claims Details, or directly to another report in the suite.

This report links to the Demographics, PMPM Trend and Inpatient/ER Utilization reports as well as drilldowns to Claim Details and Beneficiary Details.

CHART NAME	DESCRIPTION
Beneficiary Count	Total number of beneficiaries attributed to a CTO/practice. Drill down to Beneficiary Details.
Claim Count	Total number of Medicare Part A and B claims for the attributed population. Drill down to Claim Details for all attributed beneficiaries.
Rank of Avoidable Hospital Events	Direct link to the "Likelihood of Avoidable Hospital Events" report.
Inpatient Admissions (Per K Per Year)	The count of actual inpatient admissions. In parentheses, for the duration of the selected time period, the annualized number of inpatient admissions per beneficiary months per 1,000 beneficiaries. Drill through to Inpatient/ED Utilization Report. Details on the per 1,000 per year calculation can be found in Section 3.4.
PMPM	Per Member Per Month; for the duration of the selected time period, the total payments for all beneficiaries divided by the total number of beneficiary months (YTD or Rolling 12-months). Drill through to PMPM Trend Report.
Readmissions (Rate)	The count of all readmissions (planned or unplanned) to a short-term hospital and in parentheses, the readmission rate (readmissions/total inpatient admissions). Drill through to Inpatient/ED Utilization Report.
ER Visits (Per K Per Year)	The count of actual emergency room visits. In parentheses, for the duration of the selected time period, the annualized number of ER visits per beneficiary months per 1,000 beneficiaries. Drill through to Inpatient/ED Utilization Report. Details on the per 1,000 per year calculation can be found in Section 3.4.
Beneficiary Count by Age / Gender	CTO/Practice attributed beneficiaries by 5-year age band broken down by gender including "64 and Younger" and "85 and Older."
Total Payment by Claim Type	Doughnut chart with the summed total Medicare fee-for-service payments grouped by care settings associated with the claims.



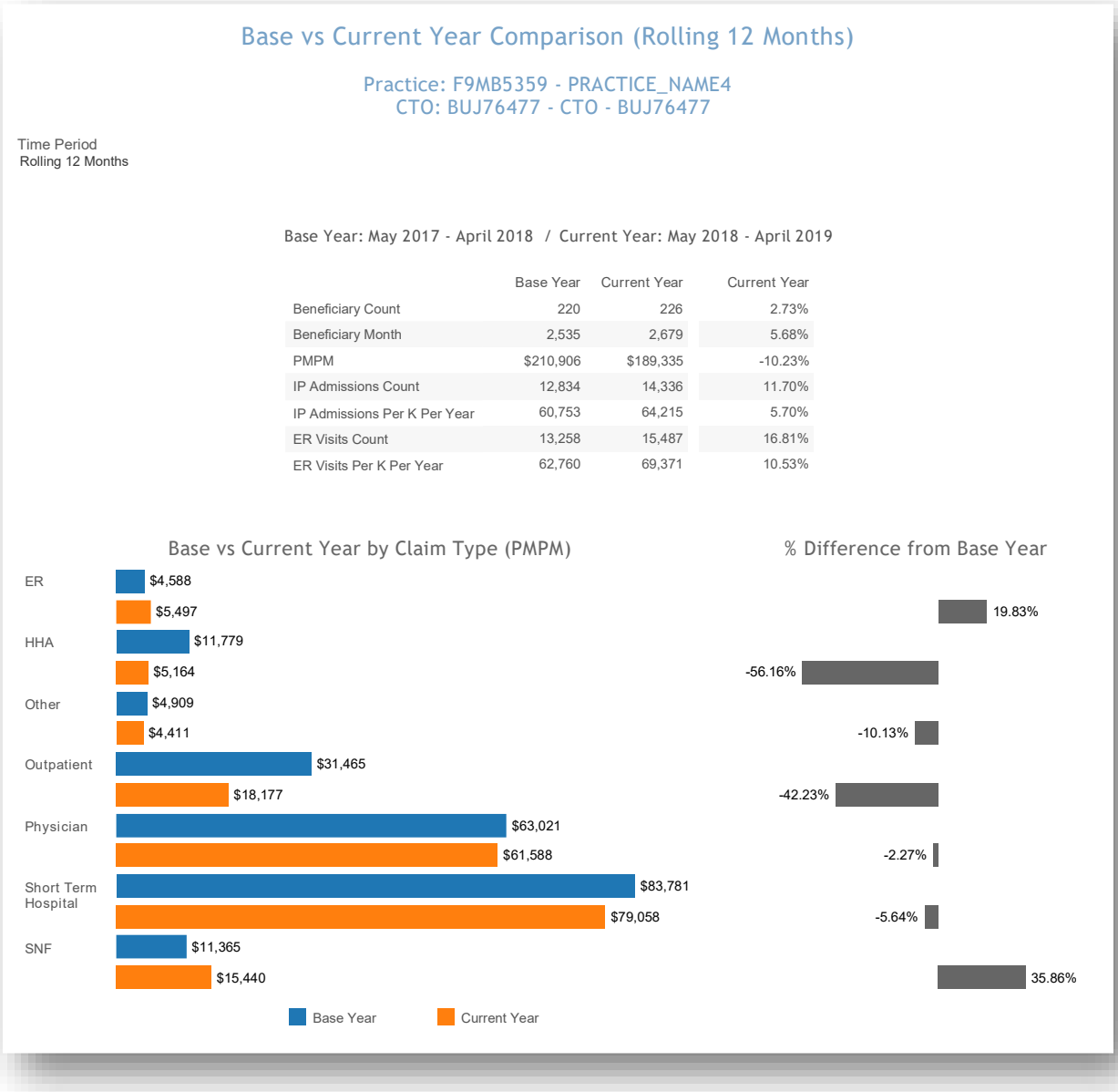
All data are fictitious – for example purposes only.

2.2 Base vs Current Year Comparison Report

The Base Comparison Report shows various measures for the current calendar year (Year to Date) or rolling 12 months as well as the same figures for the respective previous year period. The "Base vs Current Year Comparison" report includes a filter for time period with options for YTD (Year to Date) or the rolling 12 months and presents metrics for the selected time period alongside figures from the respective historic months. The difference from base to current year is presented in percentage change.

n.b. The Base vs Current Year Comparison Report does not allow for inclusion of the lag months.

METRIC NAME	DESCRIPTION
Time Period	Time period used to populate the reports. Year to Date (YTD) or Rolling 12 Months comparison period.
Beneficiary Count	The number of beneficiaries attributed to the practice(s) for the selected time period.
Beneficiary Month	The total count of months in which beneficiaries attributed to the practice(s) were enrolled in Medicare Part A and Part B.
PMPM	Per Member Per Month; the total payments for all beneficiaries divided by the number of member months during the selected period (YTD or Rolling 12-months).
IP Admissions Count	The number of attributed beneficiary admissions to short term acute-care hospitals.
IP Admissions Per K Per Year	For the duration of the selected time period, the annualized number of inpatient admissions per beneficiary months per 1,000 beneficiaries. Details on the per 1,000 per year calculation can be found in Section 3.4.
ER Visits Count	The count of emergency room claims.
ER Visits Per K Per Year	For the duration of the selected time period, the annualized number of ER Visits per beneficiary months per 1,000 beneficiaries. Details on the per 1,000 per year calculation can be found in Section 3.4.



All data are fictitious – for example purposes only.

2.3 Demographics Report

The Demographics report shows the distribution of attributed beneficiaries by HCC tier, age group, average HCC by HCC tier, race/ethnicity as well as gender and dual eligibility. Additionally, state levels for each distribution are presented in red, and there is a filter to compare to statewide MDPCP beneficiaries or to statewide beneficiaries regardless of MDPCP participation.

The Demographics report is based on attribution files that are updated quarterly and not each month as the CCLF data are. Beneficiary attribution to practices are revised annually. However, each quarter beneficiaries not attributed elsewhere may be added, and deceased beneficiaries are removed from the attribution file.

The Demographics report links to drilldowns to Beneficiary Details.

n.b. Statewide data for HCC Score and Average HCC Score by HCC Tier are only available for State – MDPCP.

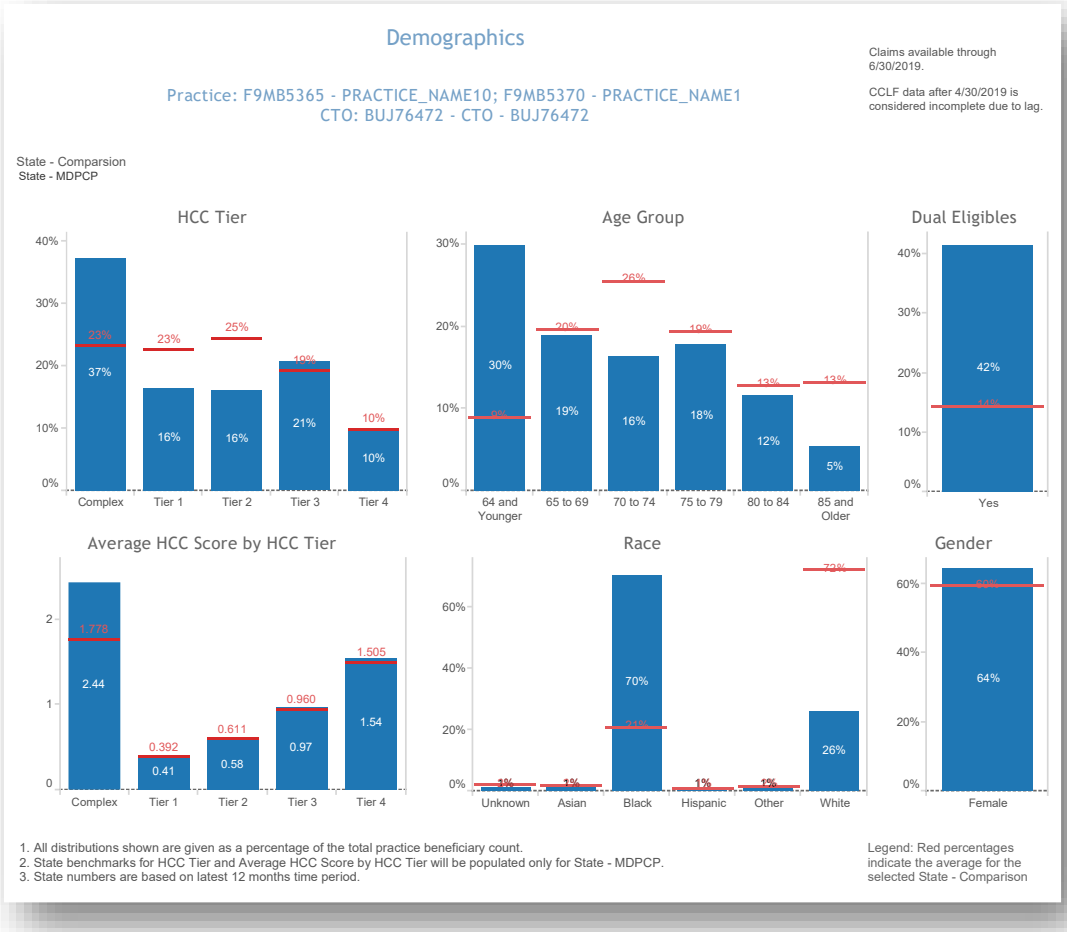
CHART NAME	DESCRIPTION
HCC Tier	Distribution of beneficiaries by the 5 HCC tiers. Details of the tiers are presented in the table below.
Age Group	Distribution of beneficiaries by 5-year age bands including "64 and Younger" and "85 and Older."
Dual Eligibles	The percentage of attributed beneficiaries who are enrolled in Medicaid in addition to Medicare.
Average HCC Score by HCC Tier	The average HCC score of beneficiaries within each of the 5 HCC tiers.
Race / Ethnicity	The distribution of beneficiaries by race.
Gender	The overall percentage of female beneficiaries is shown.

2.3.1 Distribution of HCC Tier

CMS assigns all participating beneficiaries in the MDPCP program an HCC Score and an HCC Tier. The HCC Score is based on the HCC community risk model to reflect the beneficiary's clinical profile and care needs. The HCC Tier is assigned to each beneficiary generally based on the distribution of HCC Scores across the Maryland Reference Population. Select factors such as evidence of select mental illness diagnoses or substance use disorder are factored into the HCC Tier placement, as well as logic for new beneficiaries without enough historical data to calculate an HCC score.

The table below contains the distribution of HCC Scores contained within each HCC Tier. Note that beneficiaries with "evidence of dementia, substance use disorder, or severe and persistent mental illness" are included in the "Complex" tier. These beneficiaries often have relatively lower HCC Scores than others within the tier. Additionally, new Medicare beneficiaries with no HCC Score are included in HCC Tier 2 by default.

HCC TIER	HCC TIER CRITERIA
Tier 1	HCC score < 25th percentile of Maryland Reference Population
Tier 2	25th percentile <= HCC score < 50th percentile of Maryland Reference Population
Tier 3	50th percentile <= HCC score < 75th percentile of Maryland Reference Population
Tier 4	75th percentile <= HCC score < 90th percentile of Maryland Reference Population
Complex	HCC score >= 90th percentile of Maryland Reference Population or evidence of dementia, substance use disorder, or severe and persistent mental illness



All data are fictitious – for example purposes only.

2.4 PMPM Trend Report

The Per Member Per Month (PMPM) Trend Report presents PMPM claim payment amounts by claim type (ER, hospice, outpatient, short term hospital, home health agency, physician, SNF, and other) and an overall summary by Part A and Part B claims. This report also shows quarterly trends in PMPM amounts by claim type for the practice and selected state reference.

The PMPM Trend graphs and table and Top Providers by Payment Amount will by default show all claim types and may be filtered to a specific claim type by clicking on the respective bar in the PMPM by Claim Type chart.

CHART NAME	DESCRIPTION
PMPM by Claim Type	The Per Member per Month dollar amount for each of the 8 claim types.
PMPM by Part A/B	The PMPM for Medicare Part A and Part B claims, separately and combined.
PMPM Trend	Average PMPM per quarter for the practice and state comparison for the selected time horizon.
Top Providers by Payment Amount – All (or selected Provider Type)	Table(s) showing providers (physicians or facilities) with the highest total payments. Filter to a claim type by clicking a bar in the PMPM by Claim Type chart. Sort the table(s) by mousing over a column header and clicking the 'sort by' icon. When filtering to "Physician" claim type, additional detail is available in order to filter results by physician specialty, place of service, or individual physician.

PMPM Trend

Practice: F9MB5370 - PRACTICE_NAME1
CTO: BUJ76472 - CTO - BUJ76472

Claims available through 6/30/2019.

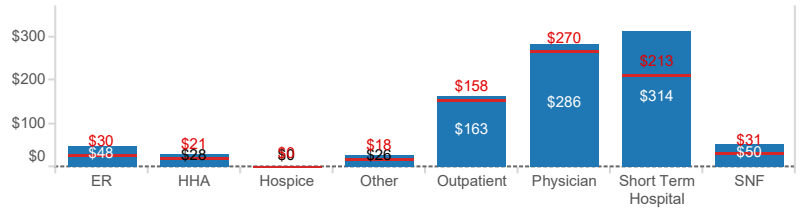
CCLF data after 4/30/2019 is considered incomplete due to lag.

State - Comparsion
State - MDPCP

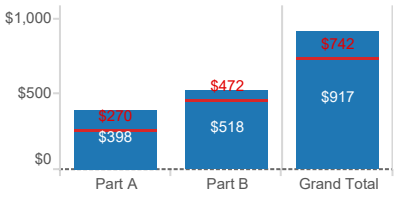
Service Start Month
July 2016

Service End Month
April 2019

PMPM by Claim Type

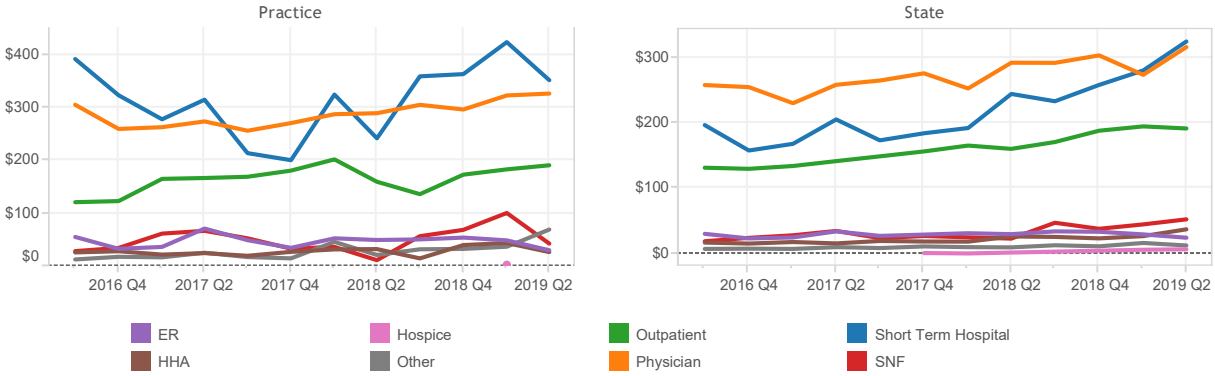


PMPM by Part A/B



Legend: Red amounts indicate the average for the selected State - Comparison

PMPM Trend



Top Providers by Payment Amount - None

Provider Name	Beneficiary Count	Claim Payment Amount	Avg. Claim Payment Amount
Pitman Place, Llc	1	$44,154	$44,154
Lifecare Center Of Americia	1	$34,249	$34,249
The Montefiore Housing Corporation	1	$31,588	$31,588
Sebring Health Services, Llc	1	$31,350	$31,350
St Mary Medical Center	1	$29,318	$29,318
Sebastopol Convalescent Hospital	2	$46,572	$23,286
Mekendree Village, Inc.			

Provider Specialty	Beneficiary Count - Practice	Claim Payment Amount - Practice	Avg. Claim Payment Amount - Practice
Family practice	97	$66,993	$70
Vascular surgery	41	$46,223	$294
Clinical laboratory (b..	95	$41,435	$24
Diagnostic radiology	68	$25,394	$63
Cardiology	43	$17,370	$69
Neurology	9	$16,600	$227

Provider Name	Provider Specialty	Beneficiary Count - Practice	Claim Payment Amount - Practice	Avg. Claim Payment Amount - Practice
Demeritte, Da..	Family practice	91	$61,781	$71
Olivo, Brenda	Vascular surgery	18	$31,860	$590
Solari, Kimbe..	Clinical laboratory (billi..	78	$16,415	$19
Reilly, Richard	Neurology	2	$15,041	$289
Zagoria, Molly	Rheumatology	4	$11,119	$134
Studnicka, M..	Vascular surgery	15	$10,980	$183

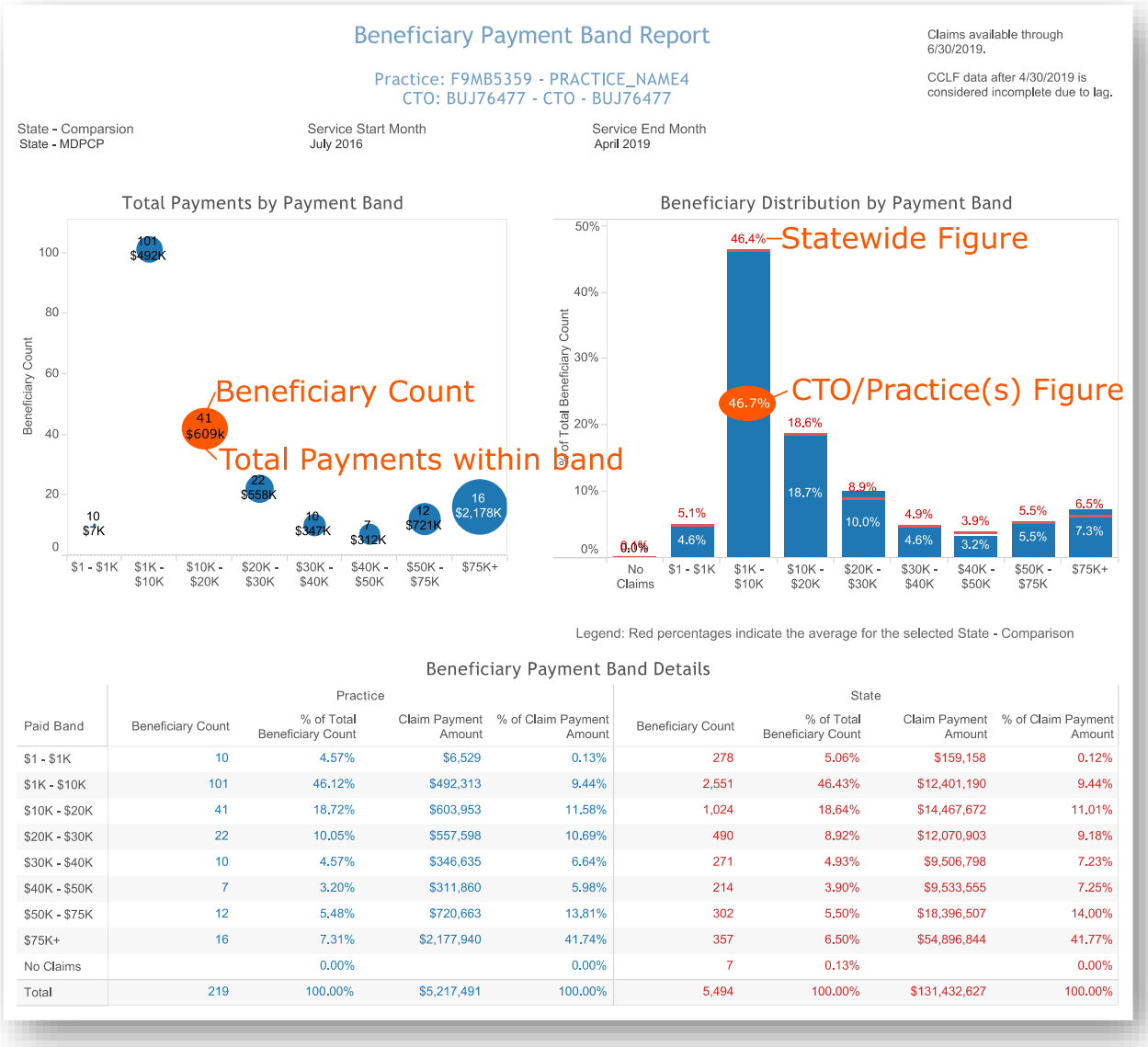
All data are fictitious – for example purposes only.

2.5 Payment Band Report

The Beneficiary Payment Band Report presents the distribution of the total paid claims amount graphically and in tabular form. In the Total Payments by Payment Band bubble chart, the size of the bubble reflects the summed total of claims paid for beneficiaries with total claim payments within that band. The Beneficiary Distribution by Payment Band histogram shows the percentage of beneficiaries within each band along with the selected state comparison. The Beneficiary payment Band Details table includes the data presented in the charts above and additional detail. Clicking and then hovering over any payment band in either chart or the table allows the user to drill through to Beneficiary Details for those beneficiaries.

The Payment Band report links to drilldowns to Beneficiary Details.

CHART NAME	DESCRIPTION
Total Payment by Payment Band	Chart showing the total payments for beneficiaries within the indicated band. The size of the bubble reflects the total payments across all beneficiaries within that payment band.
Beneficiary Distribution by Payment Band	The percent of all beneficiaries within the respective payment band.
Beneficiary Payment Band Details	Table showing the Beneficiary Count, % of Total Beneficiary Count – Practice, Total Payment Amount, and % of Total Claim Payment Amount – Practice for beneficiaries within each payment band both for the practice and the selected State comparison population.



Paid Band	Practice Beneficiary Count	Practice % of Total Beneficiary Count	Practice Claim Payment Amount	Practice % of Claim Payment Amount	State Beneficiary Count	State % of Total Beneficiary Count	State Claim Payment Amount	State % of Claim Payment Amount
$1 - $1K	10	4.57%	$6,529	0.13%	278	5.06%	$159,158	0.12%
$1K - $10K	101	46.12%	$492,313	9.44%	2,551	46.43%	$12,401,190	9.44%
$10K - $20K	41	18.72%	$603,953	11.58%	1,024	18.64%	$14,467,672	11.01%
$20K - $30K	22	10.05%	$557,598	10.69%	490	8.92%	$12,070,903	9.18%
$30K - $40K	10	4.57%	$346,635	6.64%	271	4.93%	$9,506,798	7.23%
$40K - $50K	7	3.20%	$311,860	5.98%	214	3.90%	$9,533,555	7.25%
$50K - $75K	12	5.48%	$720,663	13.81%	302	5.50%	$18,396,507	14.00%
$75K+	16	7.31%	$2,177,940	41.74%	357	6.50%	$54,896,844	41.77%
No Claims		0.00%		0.00%	7	0.13%		0.00%
Total	219	100.00%	$5,217,491	100.00%	5,494	100.00%	$131,432,627	100.00%

All data are fictitious – for example purposes only.

2.6 Diagnosis by CCS Category Report

The Diagnosis by CCS Category Report presents the total claim payments and the beneficiary distribution of CCS Categories for beneficiaries in the practice and state comparison. The Total Payments by Diagnosis Category bubble cluster indicates the highest total payments by the size of the bubble and the count of beneficiaries within the CCS Category according by the bubble color (darker colors indicate a higher beneficiary count). Mouse over any bubble for additional detail or select a bubble for the option to drill through to Beneficiary Details. The Diagnosis Category Distribution chart indicates the percent of attributed beneficiaries with at least one claim during the time period selected with a primary diagnosis of the CCS category. The selected state comparison is also provided. The Diagnosis Category Summary table presents data included in the above charts as well as beneficiary counts and average claim per beneficiary per Diagnosis Category.

The Diagnosis by CCS Category report allows drilldowns to Beneficiary Details.

CHART NAME	DESCRIPTION
Total Payment by Diagnosis Category	Bubble cluster with the size representing the total claim amount and the color representing the beneficiary count (more beneficiaries will have a darker color). A beneficiary is represented in the bubble if they have at least one claim (Part A or B) with a primary diagnosis of a condition represented in the respective CCS category.
Diagnosis Category Distribution	The percent of beneficiaries attributed to the practice and selected state comparison population with a primary diagnosis related to the CCS categories. These bars are not mutually exclusive, as beneficiaries may have claims with primary diagnoses that fit into several CCS categories.
Diagnosis Category Summary	Table showing the Beneficiary Count, Claim Count – Practice, Claim Payment Amount - Practice, Claim Paid Per Beneficiary for beneficiaries within each CCS Category both for the practice and the selected State comparison population.

Diagnosis Report (by CCS Category)

Practice: All - None
CTO: BUJ76482 - None

Claims available through 6/30/2019.

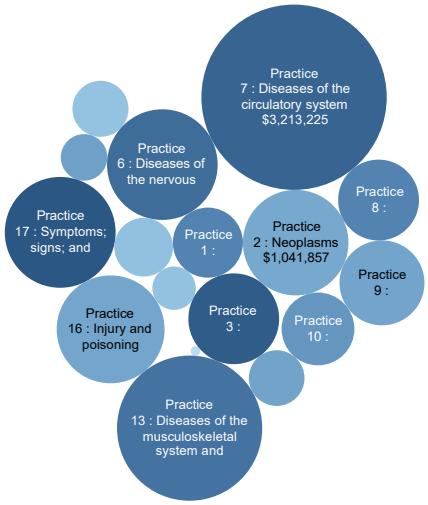
CCLF data after 4/30/2019 is considered incomplete due to lag.

State - Comparsion
State - MDPCP

Service Start Month
July 2016

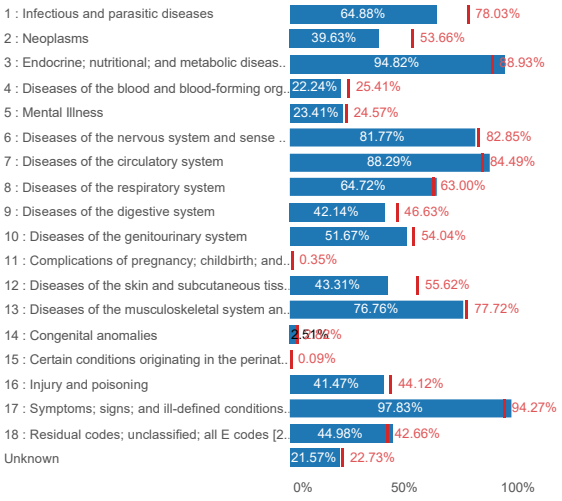
Service End Month
April 2019

Total Payments by Diagnosis Category



Bubble size represents Total Claim Payment Amount and Color represents Beneficiary Count

Diagnosis Category Distribution



Legend: Red percentages indicate the average for the selected State - Comparison

Diagnosis Category Summary

CCS Category	Practice				State - MDPCP			
	Beneficiary Count	Claim Count	Claim Payment Amount	Claim Paid Per Beneficiary	Beneficiary Count	Claim Count	Claim Payment Amount	Claim Paid Per Beneficiary
1 : Infectious and parasitic diseases	388	1,385	$459,452	$768	4,287	14,482	$4,093,164	$745
10 : Diseases of the genitourinary system	309	2,389	$495,483	$829	2,969	24,058	$5,579,705	$1,016
11 : Complications of pregnancy; childbirth; and the p..					19	211	$138,890	$25
12 : Diseases of the skin and subcutaneous tissue	259	1,212	$289,999	$485	3,056	14,121	$2,733,252	$497
13 : Diseases of the musculoskeletal system and con..	459	7,130	$1,971,883	$3,297	4,270	74,817	$19,072,247	$3,471
14 : Congenital anomalies	15	51	$8,439	$14	155	457	$229,978	$42
15 : Certain conditions originating in the perinatal peri..					5	7	$962	$0
16 : Injury and poisoning	248	1,624	$1,088,249	$1,820	2,424	14,681	$8,810,379	$1,604
17 : Symptoms; signs; and ill-defined conditions and f..	585	5,336	$1,149,041	$1,921	5,179	47,497	$9,460,402	$1,722
18 : Residual codes; unclassified; all E codes [259. a..	269	1,476	$202,678	$339	2,344	12,326	$1,619,385	$295
2 : Neoplasms	237	2,337	$1,041,857	$1,742	2,948	30,030	$16,053,242	$2,922
3 : Endocrine; nutritional; and metabolic diseases and..	567	6,290	$770,882	$1,289	4,886	57,050	$10,015,275	$1,823
4 : Diseases of the blood and blood-forming organs	133	1,233	$176,176	$295	1,396	6,521	$1,401,876	$255
5 : Mental Illness	140	1,434	$322,316	$539	1,350	13,893	$2,791,545	$508
6 : Diseases of the nervous system and sense organs	489	4,690	$1,145,129	$1,915	4,552	42,797	$11,504,005	$2,094
7 : Diseases of the circulatory system	528	7,866	$3,213,225	$5,373	4,642	63,427	$23,011,531	$4,188
8 : Diseases of the respiratory system	387	2,505	$611,923	$1,023	3,461	27,446	$6,394,840	$1,164
9 : Diseases of the digestive system	252	1,748	$674,945	$1,129	2,562	15,370	$5,801,300	$1,056
Unknown	129	466	$294,006	$492	1,249	4,323	$2,720,650	$495

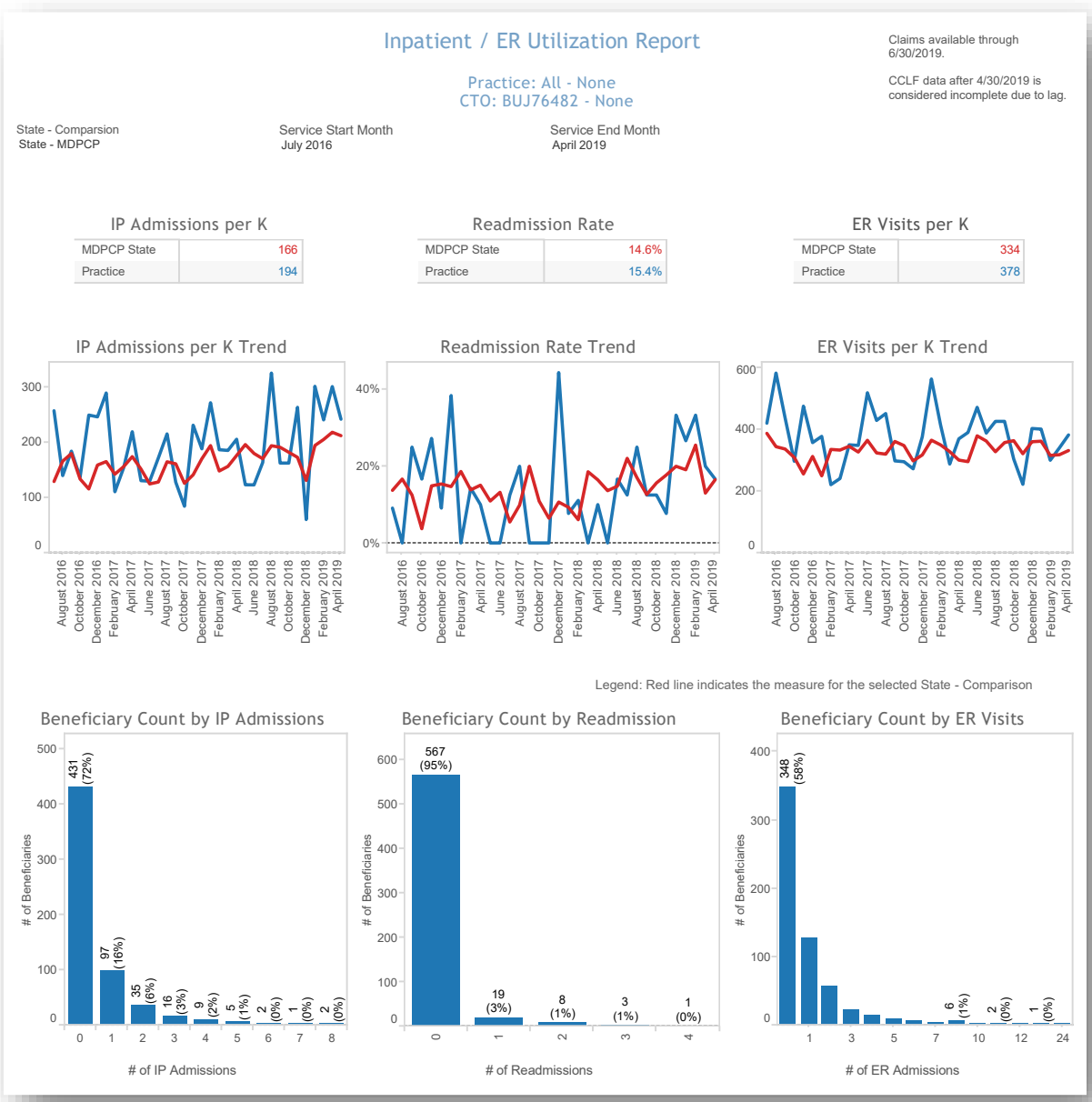
All data are fictitious – for example purposes only.

2.7 Inpatient / ER Utilization Report

The Inpatient / ER Utilization Report presents annualized inpatient admissions, 30-day readmissions, and ER visits per 1,000 beneficiaries. It also presents trend graphs by month. Below each trend graph is a histogram showing the count and percent of beneficiaries with IP admissions, readmissions, and ER visits by the number of events by month during the time period.

The Inpatient/ER Utilization report links to drilldowns to Beneficiary Details.

CHART NAME	DESCRIPTION
IP Admissions per K Trend	For a given month, the number of IP admissions per beneficiary month during the given month, per 1,000 beneficiaries. Details on the per 1,000 calculation can be found in Section 3.4.
Inpatient Admissions per K per Year	For the duration of the selected time period, the annualized number of inpatient admissions per beneficiary month per 1,000 beneficiaries. Details on the per 1,000 per year calculation can be found in Section 3.4.
Readmission Rate	Total planned or unplanned readmissions divided by the total admissions for the presented time period.
Readmission Rate Trend	30-day planned or unplanned readmission rates (readmissions/total inpatient admissions) per month.
ER Visits per K per Year	For the duration of the selected time period, the annualized number of ER visits per beneficiary month per 1,000 beneficiaries. Details on the per 1,000 per year calculation can be found in Section 3.4.
ER Visits per K Trend	For a given month, the number of ER visits per beneficiary month during the given month per 1,000 beneficiaries. Details on the per 1,000 calculation can be found in Section 3.4.
Beneficiary Count by IP Admission	Count and distribution of beneficiaries by count of inpatient admissions.
Beneficiary Count by Readmission	Count and distribution of beneficiaries by count of readmissions to a short-term acute care hospital.
Beneficiary Count by ER Visits	Count and distribution of beneficiaries by count of emergency room visits.



All data are fictitious – for example purposes only.

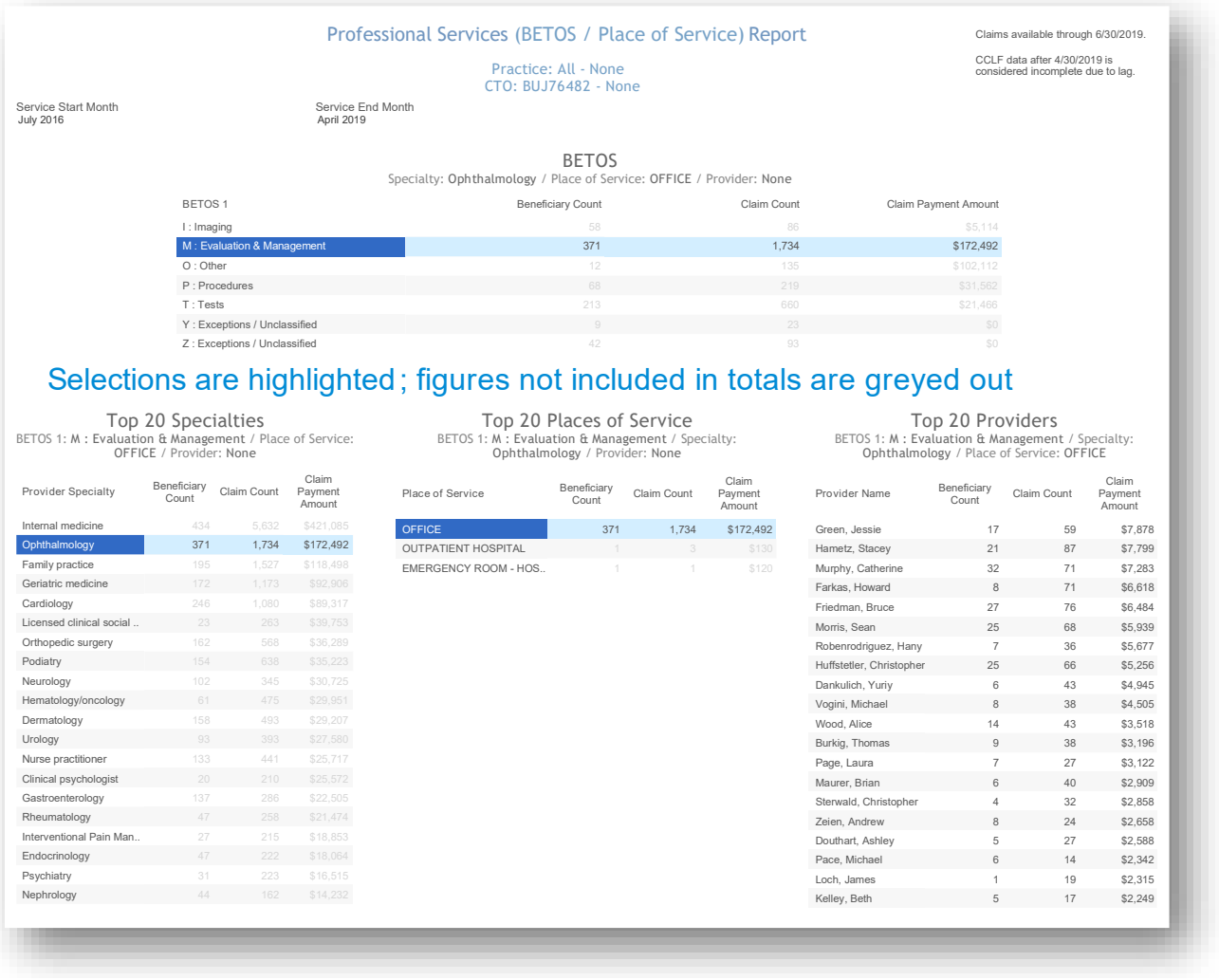
2.8 Professional Services (BETOS/Place of Service) Report

The Professional Services Report presents beneficiary counts, claim counts and claim payment amount by BETOS code. Professional services in this report are Part B covered services regardless of site of service that may occur in a physician's office, SNF, hospital, or other settings. The Berenson-Eggers Type of Service (BETOS) coding system groups Health Care Financing Administration Common Procedure Coding System (HCPCS) codes into 7 clinical categories. The goal of this report is to isolate physician services to help users identify services provided to beneficiaries by physician specialty, place of service, and specific physician.

This report may be filtered by selecting any row(s) in any table. Selecting a BETOS code from the BETOS table will filter the Top 20 Specialties, Top 20 Places of Service, and Top 20 Providers to represent only claims related to that BETOS code. Similarly, adding the specialty filter within the BETOS table will further show only claims related to that BETOS and specialty, as well as limit the Top 20 Places of Service and Top 20 Providers accordingly.

When applying multiple filters, they are applied sequentially; all affected tables are updated after each selection.

CHART NAME	DESCRIPTION
BETOS	The beneficiary, claim count and claim payment amount for each BETOS code.
Top 20 Specialties	By default, shows the overall top 20 specialties by claim payment amount for all claims across all BETOS. After selecting a row from one or more tables, the Top 20 Specialties table will refresh and show physician specialties associated only with the selected rows.
Top 20 Places of Service	By default, shows the overall top 20 places of service by claim payment amount for all claims across all BETOS. After selecting a row from one or more tables, the table will refresh and show the Top 20 places of services associated only with the selected rows.
Top 20 Providers	By default, shows the overall top 20 providers (physicians) by claim payment amount for all claims across all BETOS. After selecting a row from one or more tables, the Top 20 Providers table will refresh and show providers associated only with the selected rows.



Professional Services (BETOS / Place of Service) Report

Practice: All - None
CTO: BUJ76482 - None

Claims available through 6/30/2019.

CCLF data after 4/30/2019 is considered incomplete due to lag.

Service Start Month
July 2016

Service End Month
April 2019

BETOS

Specialty: Ophthalmology / Place of Service: OFFICE / Provider: None

BETOS 1	Beneficiary Count	Claim Count	Claim Payment Amount
I : Imaging	58	86	$5,114
M : Evaluation & Management	371	1,734	$172,492
O : Other	12	135	$102,112
P : Procedures	68	219	$31,562
T : Tests	213	660	$21,466
Y : Exceptions / Unclassified	9	23	$0
Z : Exceptions / Unclassified	42	93	$0

Selections are highlighted; figures not included in totals are greyed out

Top 20 Specialties

BETOS 1: M : Evaluation & Management / Place of Service: OFFICE / Provider: None

Provider Specialty	Beneficiary Count	Claim Count	Claim Payment Amount
Internal medicine	434	5,632	$421,085
Ophthalmology	371	1,734	$172,492
Family practice	195	1,527	$118,498
Geriatric medicine	172	1,173	$92,906
Cardiology	246	1,080	$89,317
Licensed clinical social ..	23	263	$39,753
Orthopedic surgery	162	568	$36,289
Podiatry	154	638	$35,223
Neurology	102	345	$30,725
Hematology/oncology	61	475	$29,951
Dermatology	158	493	$29,207
Urology	93	393	$27,580
Nurse practitioner	133	441	$25,717
Clinical psychologist	20	210	$25,572
Gastroenterology	137	286	$22,505
Rheumatology	47	258	$21,474
Interventional Pain Man..	27	215	$18,853
Endocrinology	47	222	$18,064
Psychiatry	31	223	$16,515
Nephrology	44	162	$14,232

Top 20 Places of Service

BETOS 1: M : Evaluation & Management / Specialty: Ophthalmology / Provider: None

Place of Service	Beneficiary Count	Claim Count	Claim Payment Amount
OFFICE	371	1,734	$172,492
OUTPATIENT HOSPITAL	1	3	$130
EMERGENCY ROOM - HOS..	1	1	$120

Top 20 Providers

BETOS 1: M : Evaluation & Management / Specialty: Ophthalmology / Place of Service: OFFICE

Provider Name	Beneficiary Count	Claim Count	Claim Payment Amount
Green, Jessie	17	59	$7,878
Hametz, Stacey	21	87	$7,799
Murphy, Catherine	32	71	$7,283
Farkas, Howard	8	71	$6,618
Friedman, Bruce	27	76	$6,484
Morris, Sean	25	68	$5,939
Robenrodriguez, Hany	7	36	$5,677
Huffstetler, Christopher	25	66	$5,256
Dankulich, Yuriy	6	43	$4,945
Vogini, Michael	8	38	$4,505
Wood, Alice	14	43	$3,518
Burkig, Thomas	9	38	$3,196
Page, Laura	7	27	$3,122
Maurer, Brian	6	40	$2,909
Sterwald, Christopher	4	32	$2,858
Zeien, Andrew	8	24	$2,658
Douthart, Ashley	5	27	$2,588
Pace, Michael	6	14	$2,342
Loch, James	1	19	$2,315
Kelley, Beth	5	17	$2,249

2.9 Likelihood of Avoidable Hospital Events

The Likelihood of Avoidable Hospital Events report shows the probability that a beneficiary will experience an avoidable hospital event (inpatient or emergency room stay) within the next 30 days. This report is static in that it does not contain any drill through capabilities, at this time. For each beneficiary, this report shows the beneficiaries' MBI, name, gender, date of birth, age, Medicare status, Medicare/Medicaid dual eligibility flag, MDPCP Practice ID, HCC Tier, likelihood of avoidable hospital event, and total claim payment amount.

The Likelihood of Avoidable Hospital Events score is calculated and refreshed monthly. This score is based on The Hilltop Institute's Prevent-Avoidable Hospital Events tool (Pre-AH Model™) that draws from socio-demographic, biologic/diagnostic, and health care utilization-related data elements from the administrative (CCLF) claims data.

The score is presented as a probability; the higher the probability, the higher the risk of having an avoidable hospital event within the next 30 days. The score can be used by practices to identify beneficiaries most at risk of these avoidable hospital events in the next month, allowing practices to target their care management and interventions. As the model is updated each month, beneficiaries who are deceased will not have a score presented (shown as a blank value).

The Likelihood of Avoidable Hospital Events score is conditionally color formatting according to the percentile distribution ***within a single practice***. Therefore, the risk score that corresponds with each percentile risk band will differ by practice. When multiple practices are selected, these inconsistencies may be noticeable. Furthermore, the percentile distribution is not recalculated when subpopulations are selected.

The MDPCP Report's global filters (see Section1.3 – Navigation) can be applied to this report, as well as a search function by beneficiary name or MBI.

For more information on the technical specifications of the Pre-AH Model™, refer to The Hilltop Institute's user documentation, available in the Help section of the MDPCP Reports.

Likelihood of Avoidable Hospital Events

Claims available through
6/30/2019

Practice: F9MB5365 - PRACTICE_NAME10
CTO: BUJ76472 - CTO - BUJ76472

Risk Score Key
- Top 1st Percentile
- Between 2nd and 5th Percentile
- Between 6th and 10th Percentile
- Between 11th and 20th Percentile
- Between 21st and 100th Percentile

The percentiles are determined at a single practice-level and do not vary when selecting more than one practice or sub-populations within a practice.

Search By
Member ID

Key
All

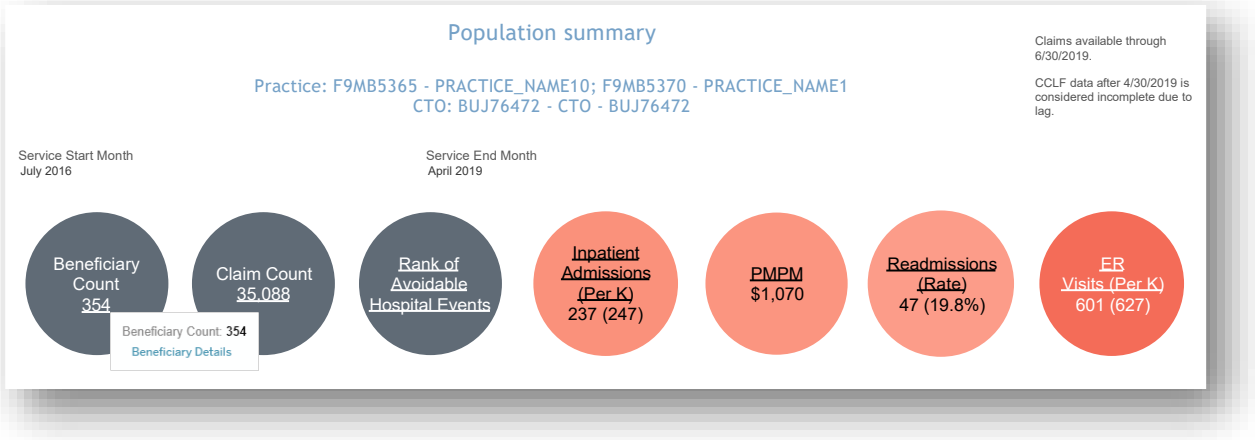
MBI	Beneficiary Name	Gender	DOB	Age	Medicare Status	Dual Status	PracticeID	HCC Tier	Likelihood of Avoidable Hospital Events	Claim Payment Amount
3FE4L31XW34	Hazlett, Egesta R	Male	6/1/1943	76	Aged without ESRD	Yes	F9MB5365	Complex	12.32%	$349,486
3W41FF5BO35	Martin, Joseph M	Female	10/1/1946	72	Aged without ESRD	Yes	F9MB5365	Complex	6.94%	$289,170
8UL7NM9YJ61	Coursey, Sarah P	Female	3/1/1951	68	Aged without ESRD	No	F9MB5365	Complex	5.44%	$78,876
6HG2L77KI56	Allen, Kimberly R	Female	11/1/1933	85	Aged without ESRD	Yes	F9MB5365	Complex	4.40%	$114,266
9DT3WB0NF04	Bernstein, Anna	Female	4/1/1936	83	Aged without ESRD	Yes	F9MB5365	Complex	3.74%	$117,220
2C61OZ9YE50	Leavey, Anna G	Female	7/1/1981	37	Disabled without ESRD	Yes	F9MB5365	Complex	3.38%	$235,716
6XR4W06US01	Gould, Johanna	Female	12/1/1932	86	Aged without ESRD	Yes	F9MB5365	Tier 4	2.89%	$77,506
8HS2QY8XV45	Crowell, Richard M	Female	10/1/1938	80	Aged without ESRD	No	F9MB5365	Tier 4	2.71%	$37,822
8RW8UZ6MQ57	Sharrieff, Annmarie	Female	1/1/1947	72	Aged without ESRD	Yes	F9MB5365	Complex	2.48%	$197,236
3L69HU7SM86	Butler, Janelle G	Male	12/1/1943	75	Aged without ESRD	No	F9MB5365	Complex	2.33%	$66,454
7Q94VW7WI25	Kirpan, Reni P	Male	12/1/1952	66	Aged without ESRD	No	F9MB5365	Tier 2	2.14%	$46,749
2XR1QJ6US41	Chong, Juliana D	Female	5/1/1959	60	Disabled without ESRD	Yes	F9MB5365	Tier 4	1.96%	$161,402
2T00IK9IJ58	Horn, Timothy A	Male	12/1/1942	76	Aged without ESRD	No	F9MB5365	Complex	1.76%	$39,148
8QC8S03NC58	Smith, Harrison G	Female	7/1/1954	64	Disabled without ESRD	Yes	F9MB5365	Complex	1.68%	$15,739
0HC1FU6KM56	Poulin, Sonja	Male	5/1/1944	75	Aged without ESRD	Yes	F9MB5365	Tier 4	1.58%	$72,414
2Q83UR8NO39	Badzinski, Arisrodel T	Female	11/1/1948	70	Aged without ESRD	No	F9MB5365	Tier 2	1.52%	$33,625
9TZ2N48KF39	Leslie, Alex A	Female	5/1/1939	80	Aged without ESRD	No	F9MB5365	Complex	1.47%	$23,923
5RZ2JY8QL23	Perrone-Sheets, Mykayla A	Female	10/1/1940	78	Aged without ESRD	No	F9MB5365	Tier 2	1.42%	$24,095
8HM4E07BF19	Patel, Wei	Female	12/1/1943	75	Aged without ESRD	Yes	F9MB5365	Complex	1.42%	$47,299
0JT8S68TF84	Budny, Antoinette J	Female	10/1/1941	77	Aged without ESRD	No	F9MB5365	Tier 3	1.40%	$162,987
7C28Q57UV88	Badzinski, Craig W	Female	8/1/1936	82	Aged without ESRD	No	F9MB5365	Tier 3	1.24%	$150,450
3NY7E01UW61	Fey, Lettitia W	Female	11/1/1946	72	Aged without ESRD	Yes	F9MB5365	Tier 4	1.19%	$108,908
8YC1Q46BC38	Welter, Joseph O	Female	1/1/1947	72	Aged without ESRD	No	F9MB5365	Complex	1.18%	$32,945
9JB6N27FW73	Poulin, Theresa A	Female	2/1/1963	56	Disabled without ESRD	No	F9MB5365	Complex	1.12%	$265,514
5A84VZ8MV97	Maurer, Devyn A	Male	9/1/1936	82	Aged without ESRD	No	F9MB5365	Complex	1.03%	$31,291
3TS3YV1DI24	Kakkar, Christa K	Female	1/1/1955	64	Disabled without ESRD	Yes	F9MB5365	Complex	1.01%	$151,536
7QV7MB1PX60	Weyand, Yvette	Female	3/1/1941	78	Aged without ESRD	Yes	F9MB5365	Tier 4	1.00%	$20,058
8L20Q49QP44	Poulin, Allah E	Female	6/1/1934	85	Aged without ESRD	No	F9MB5365	Tier 3	0.94%	$29,490
1E72LB1SW17	Adams, Sreenivas L	Male	1/1/1957	62	Disabled without ESRD	Yes	F9MB5365	Complex	0.94%	$228,734
0Y81CB9SQ21	Worley, Seth	Female	7/1/1968	50	Disabled without ESRD	Yes	F9MB5365	Complex	0.88%	$22,185

All data are fictitious – for example purposes only.

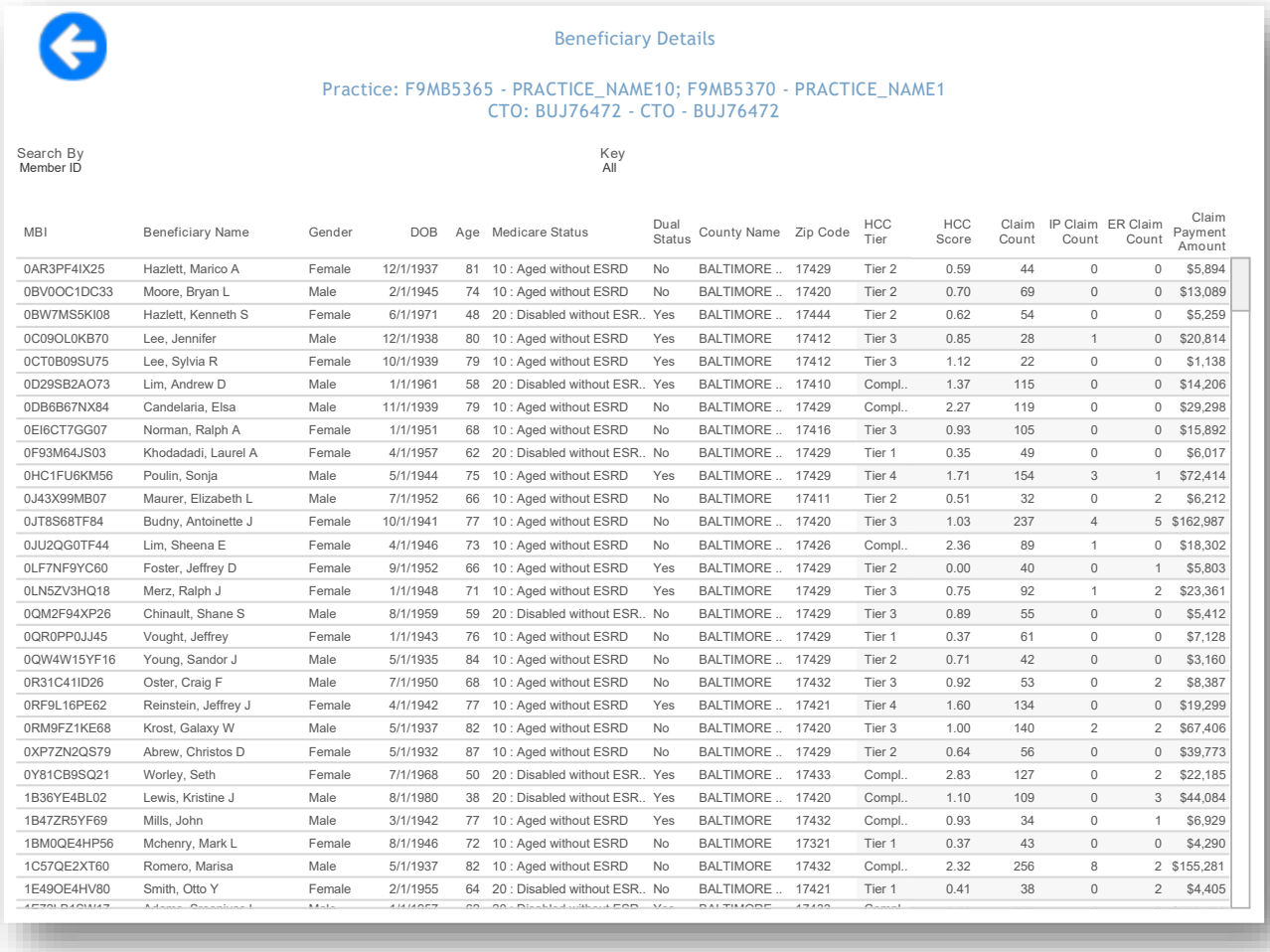
2.10 Drilldown Reports

2.10.1 Beneficiary Details

Beneficiary Details may be accessed through the Population Summary, Demographics, Payment Band, Diagnosis by CCS Category, and Inpatient/ER Utilization reports. The report includes beneficiaries' Medicare Beneficiary Identifier (MBI), Name, Gender, Age, County Name, Zip Code, HCC Tier, HCC Score, Claim Count, IP Claim Count, ER Claim Count, and Claim Payment amount for the time period specified in the report through which was drilled to access Beneficiary Details.



You may search for individuals by Member ID (MBI) or Member Name using the “Search By” menu and then using the “Key” filter to search. To filter from the “Key” options, first deselect “(All)”, enter your search parameter (i.e. MBI or name), make your selection(s), and click “Apply” when your selections are complete.



Beneficiary Details

Practice: F9MB5365 - PRACTICE_NAME10; F9MB5370 - PRACTICE_NAME1
CTO: BUJ76472 - CTO - BUJ76472

Search By: Member ID Key: All

MBI	Beneficiary Name	Gender	DOB	Age	Medicare Status	Dual Status	County Name	Zip Code	HCC Tier	HCC Score	Claim Count	IP Claim Count	ER Claim Count	Claim Payment Amount
0AR3PF4IX25	Hazlett, Marico A	Female	12/1/1937	81	10 : Aged without ESRD	No	BALTIMORE ..	17429	Tier 2	0.59	44	0	0	$5,894
0BV0OC1DC33	Moore, Bryan L	Male	2/1/1945	74	10 : Aged without ESRD	No	BALTIMORE ..	17420	Tier 2	0.70	69	0	0	$13,089
0BW7MS5KI08	Hazlett, Kenneth S	Female	6/1/1971	48	20 : Disabled without ESR..	Yes	BALTIMORE ..	17444	Tier 2	0.62	54	0	0	$5,259
0C09OL0KB70	Lee, Jennifer	Male	12/1/1938	80	10 : Aged without ESRD	Yes	BALTIMORE	17412	Tier 3	0.85	28	1	0	$20,814
0CT0B09SU75	Lee, Sylvia R	Female	10/1/1939	79	10 : Aged without ESRD	Yes	BALTIMORE	17412	Tier 3	1.12	22	0	0	$1,138
0D29SB2AO73	Lim, Andrew D	Male	1/1/1961	58	20 : Disabled without ESR..	Yes	BALTIMORE ..	17410	Compl..	1.37	115	0	0	$14,206
0DB6B67NX84	Candelaria, Elsa	Male	11/1/1939	79	10 : Aged without ESRD	No	BALTIMORE ..	17429	Compl..	2.27	119	0	0	$29,298
0EI6CT7GG07	Norman, Ralph A	Female	1/1/1951	68	10 : Aged without ESRD	No	BALTIMORE ..	17416	Tier 3	0.93	105	0	0	$15,892
0F93M64JS03	Khodadadi, Laurel A	Female	4/1/1957	62	20 : Disabled without ESR..	No	BALTIMORE ..	17429	Tier 1	0.35	49	0	0	$6,017
0HC1FU6KM56	Poulin, Sonja	Male	5/1/1944	75	10 : Aged without ESRD	Yes	BALTIMORE ..	17429	Tier 4	1.71	154	3	1	$72,414
0J43X99MB07	Maurer, Elizabeth L	Male	7/1/1952	66	10 : Aged without ESRD	No	BALTIMORE	17411	Tier 2	0.51	32	0	2	$6,212
0JT8S68TF84	Budny, Antoinette J	Female	10/1/1941	77	10 : Aged without ESRD	No	BALTIMORE ..	17420	Tier 3	1.03	237	4	5	$162,987
0JU2QG0TF44	Lim, Sheena E	Female	4/1/1946	73	10 : Aged without ESRD	No	BALTIMORE ..	17426	Compl..	2.36	89	1	0	$18,302
0LF7NF9YC60	Foster, Jeffrey D	Female	9/1/1952	66	10 : Aged without ESRD	Yes	BALTIMORE ..	17429	Tier 2	0.00	40	0	1	$5,803
0LN5ZV3HQ18	Merz, Ralph J	Female	1/1/1948	71	10 : Aged without ESRD	Yes	BALTIMORE	17429	Tier 3	0.75	92	1	2	$23,361
0QM2F94XP26	Chinault, Shane S	Male	8/1/1959	59	20 : Disabled without ESR..	No	BALTIMORE ..	17429	Tier 3	0.89	55	0	0	$5,412
0QR0PP0JJ45	Vought, Jeffrey	Female	1/1/1943	76	10 : Aged without ESRD	No	BALTIMORE ..	17429	Tier 1	0.37	61	0	0	$7,128
0QW4W15YF16	Young, Sandor J	Male	5/1/1935	84	10 : Aged without ESRD	No	BALTIMORE ..	17429	Tier 2	0.71	42	0	0	$3,160
0R31C41ID26	Oster, Craig F	Male	7/1/1950	68	10 : Aged without ESRD	No	BALTIMORE	17432	Tier 3	0.92	53	0	2	$8,387
0RF9L16PE62	Reinstein, Jeffrey J	Female	4/1/1942	77	10 : Aged without ESRD	Yes	BALTIMORE ..	17421	Tier 4	1.60	134	0	0	$19,299
0RM9FZ1KE68	Krost, Galaxy W	Male	5/1/1937	82	10 : Aged without ESRD	No	BALTIMORE ..	17420	Tier 3	1.00	140	2	2	$67,406
0XP7ZN2QS79	Abrew, Christos D	Female	5/1/1932	87	10 : Aged without ESRD	No	BALTIMORE ..	17429	Tier 2	0.64	56	0	0	$39,773
0Y81CB9SQ21	Worley, Seth	Female	7/1/1968	50	20 : Disabled without ESR..	Yes	BALTIMORE ..	17433	Compl..	2.83	127	0	2	$22,185
1B36YE4BL02	Lewis, Kristine J	Male	8/1/1980	38	20 : Disabled without ESR..	Yes	BALTIMORE ..	17420	Compl..	1.10	109	0	3	$44,084
1B47ZR5YF69	Mills, John	Male	3/1/1942	77	10 : Aged without ESRD	Yes	BALTIMORE	17432	Compl..	0.93	34	0	1	$6,929
1BM0QE4HP56	Mchenry, Mark L	Female	8/1/1946	72	10 : Aged without ESRD	No	BALTIMORE	17321	Tier 1	0.37	43	0	0	$4,290
1C57QE2XT60	Romero, Marisa	Male	5/1/1937	82	10 : Aged without ESRD	No	BALTIMORE	17432	Compl..	2.32	256	8	2	$155,281
1E49OE4HV80	Smith, Otto Y	Female	2/1/1955	64	20 : Disabled without ESR..	No	BALTIMORE ..	17421	Tier 1	0.41	38	0	2	$4,405

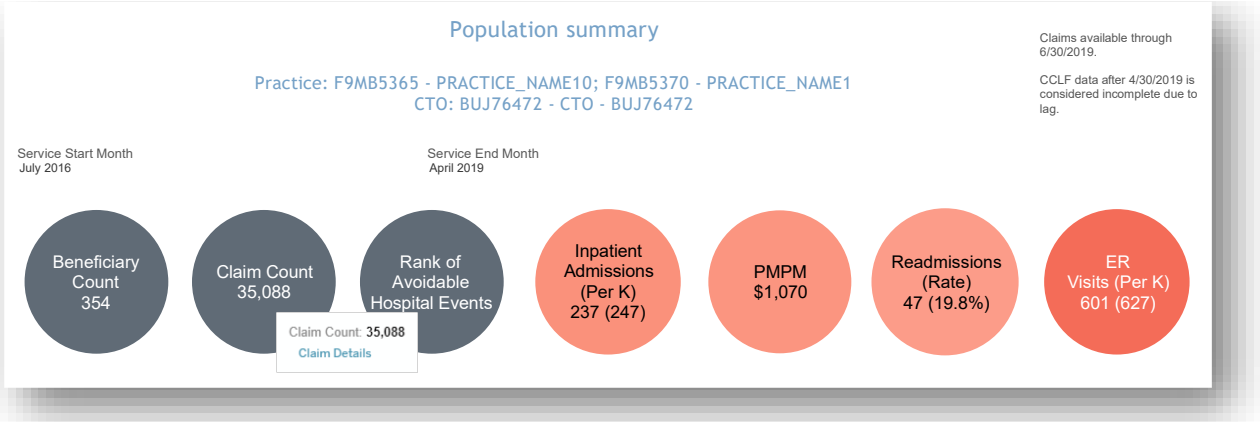
All data are fictitious – for example purposes only.

2.10.2 Claims Details

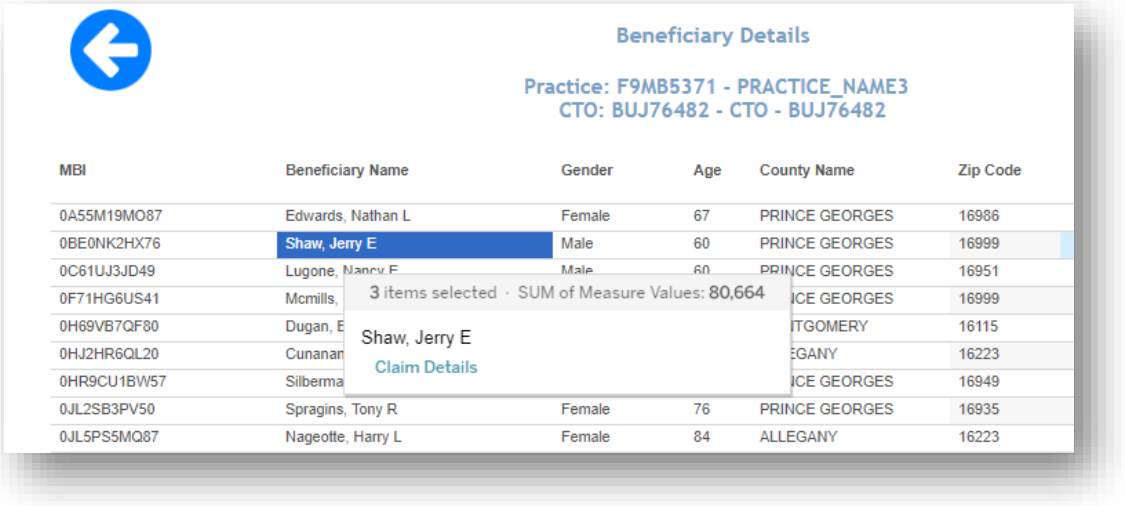
Claims details may be accessed through Population Summary or through Beneficiary Details. Having drilled through Population Summary, this report includes all claims for each beneficiary attributed to a practice or CTO. Drilling through Beneficiary Details by selecting a beneficiary will show all claims for that beneficiary.

The report includes the Medicare Beneficiary Identifier (MBI), Name, Claim From and Claim Through dates, Claim Type Group, Primary Diagnosis, Provider Name, Claim Count, and Claim Payment Amount.

To access Claim Details through Population Summary, first select the "Claim Count" bubble, hover your mouse cursor over the bubble, and then click the link to Claim Details. You can also access Claims Details from Beneficiary Details.

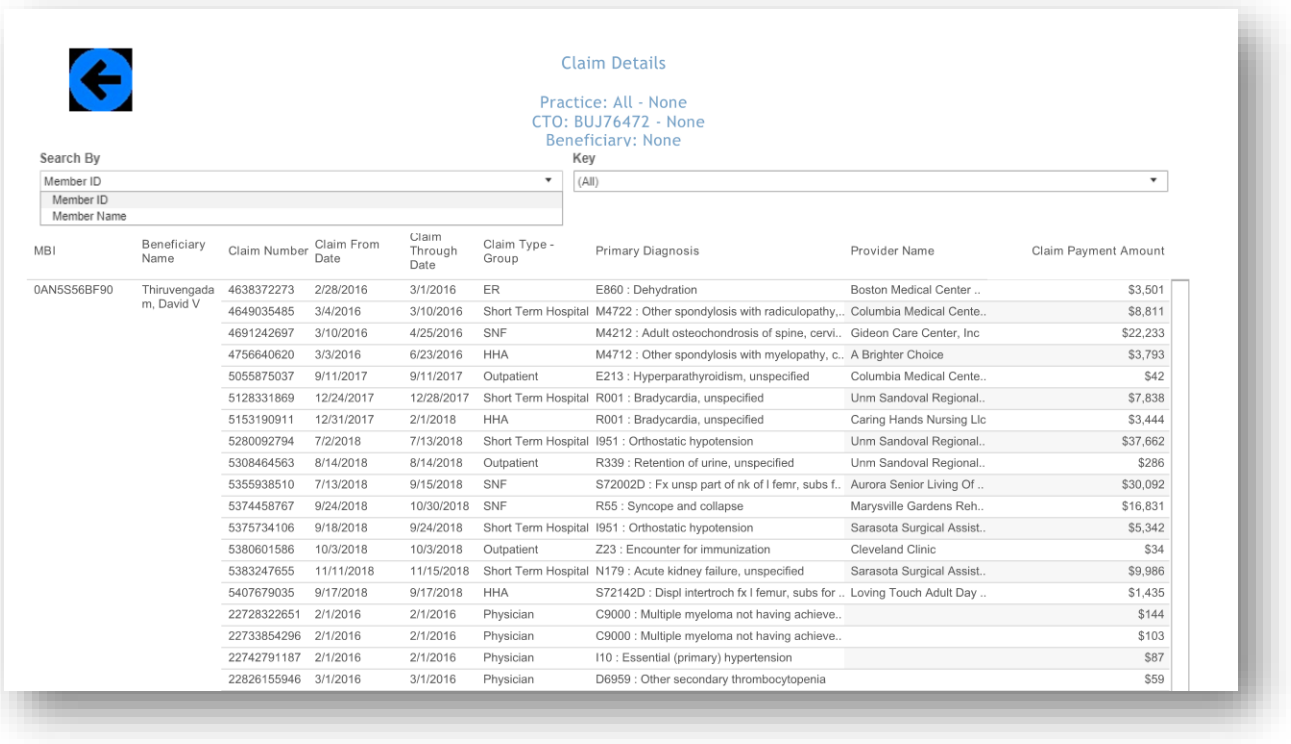


To access Claim Details for an individual beneficiary, first select any cell in the Beneficiary Details report, hover your cursor over the selected cell, and then click the link to Claim Details.



All data are fictitious – for example purposes only.

You may search for individuals by Member ID (MBI) or Member Name using the “Search By” menu and then using the “Key” filter to search. To filter from the “Key” options, first deselect “(All)”, enter your search parameter (i.e. MBI or name), make your selection(s), and click “Apply” when your selections are complete.



Claim Details

Practice: All - None
CTO: BUJ76472 - None
Beneficiary: None

Search By: Member ID (Member ID, Member Name)

Key: (All)

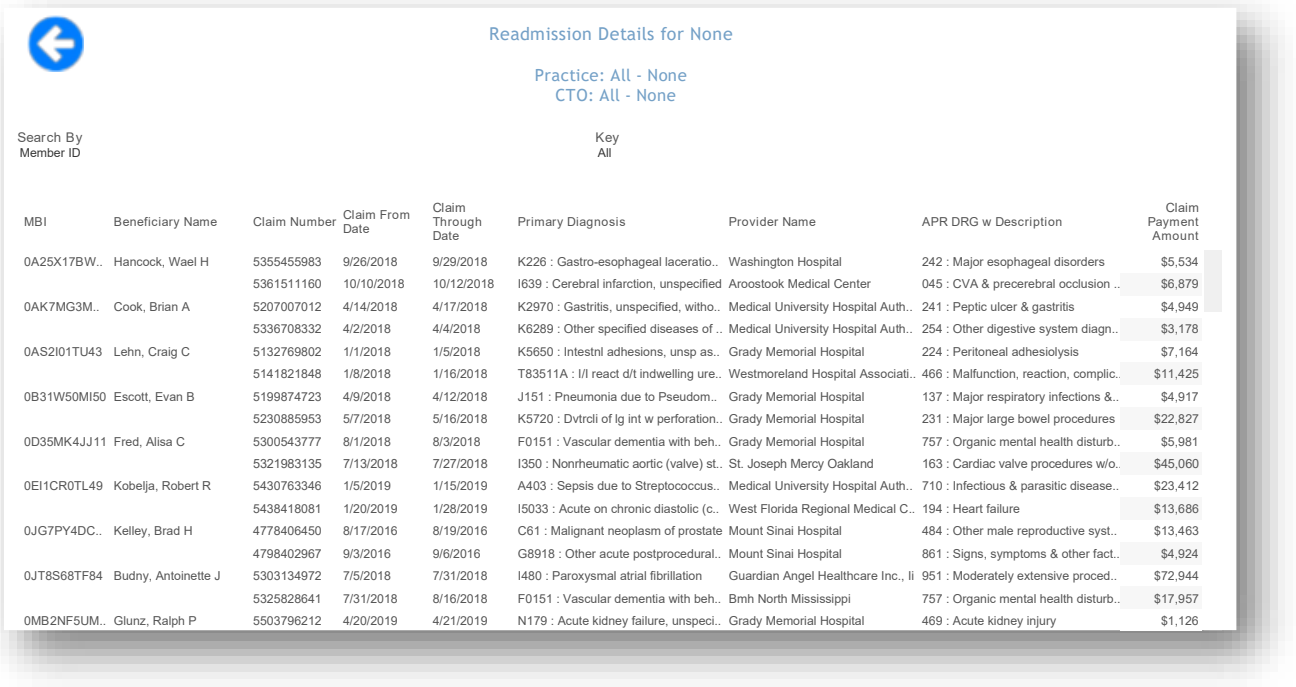
MBI	Beneficiary Name	Claim Number	Claim From Date	Claim Through Date	Claim Type - Group	Primary Diagnosis	Provider Name	Claim Payment Amount
0AN5S56BF90	Thiruvengadam, David V	4638372273	2/28/2016	3/1/2016	ER	E860 : Dehydration	Boston Medical Center ..	$3,501
		4649035485	3/4/2016	3/10/2016	Short Term Hospital	M4722 : Other spondylosis with radiculopathy,..	Columbia Medical Cente..	$8,811
		4691242697	3/10/2016	4/25/2016	SNF	M4212 : Adult osteochondrosis of spine, cervi..	Gideon Care Center, Inc	$22,233
		4756640620	3/3/2016	6/23/2016	HHA	M4712 : Other spondylosis with myelopathy, c..	A Brighter Choice	$3,793
		5055875037	9/11/2017	9/11/2017	Outpatient	E213 : Hyperparathyroidism, unspecified	Columbia Medical Cente..	$42
		5128331869	12/24/2017	12/28/2017	Short Term Hospital	R001 : Bradycardia, unspecified	Unm Sandoval Regional..	$7,838
		5153190911	12/31/2017	2/1/2018	HHA	R001 : Bradycardia, unspecified	Caring Hands Nursing Llc	$3,444
		5280092794	7/2/2018	7/13/2018	Short Term Hospital	I951 : Orthostatic hypotension	Unm Sandoval Regional..	$37,662
		5308464563	8/14/2018	8/14/2018	Outpatient	R339 : Retention of urine, unspecified	Unm Sandoval Regional..	$286
		5355938510	7/13/2018	9/15/2018	SNF	S72002D : Fx unsp part of nk of l femr, subs f..	Aurora Senior Living Of ..	$30,092
		5374458767	9/24/2018	10/30/2018	SNF	R55 : Syncope and collapse	Marysville Gardens Reh..	$16,831
		5375734106	9/18/2018	9/24/2018	Short Term Hospital	I951 : Orthostatic hypotension	Sarasota Surgical Assist..	$5,342
		5380601586	10/3/2018	10/3/2018	Outpatient	Z23 : Encounter for immunization	Cleveland Clinic	$34
		5383247655	11/11/2018	11/15/2018	Short Term Hospital	N179 : Acute kidney failure, unspecified	Sarasota Surgical Assist..	$9,986
		5407679035	9/17/2018	9/17/2018	HHA	S72142D : Displ intertroch fx l femur, subs for ..	Loving Touch Adult Day ..	$1,435
		22728322651	2/1/2016	2/1/2016	Physician	C9000 : Multiple myeloma not having achieve..		$144
		22733854296	2/1/2016	2/1/2016	Physician	C9000 : Multiple myeloma not having achieve..		$103
		22742791187	2/1/2016	2/1/2016	Physician	I10 : Essential (primary) hypertension		$87
		22826155946	3/1/2016	3/1/2016	Physician	D6959 : Other secondary thrombocytopenia		$59

All data are fictitious – for example purposes only.

2.10.3 Readmission Details

The Inpatient/ER Utilization report includes a drilldown to Readmission Details. This report includes beneficiaries' Name, Claim From Date, Claim Through Date, Primary Diagnosis, Provider Name, APR DRG code with Description, and Claim Payment Amount for the time period specified in the Inpatient/ER Utilization report.

You may search for individuals by Member ID (MBI) or Member Name using the "Search By" menu and then using the "Key" filter to search. To filter from the "Key" options, first deselect "(All)", enter your search parameter (i.e. MBI or name), make your selection(s), and click "Apply" when your selections are complete.



Readmission Details for None

Practice: All - None
CTO: All - None

Search By
Member ID

Key
All

MBI	Beneficiary Name	Claim Number	Claim From Date	Claim Through Date	Primary Diagnosis	Provider Name	APR DRG w Description	Claim Payment Amount
0A25X17BW..	Hancock, Wael H	5355455983	9/26/2018	9/29/2018	K226 : Gastro-esophageal laceratio..	Washington Hospital	242 : Major esophageal disorders	$5,534
		5361511160	10/10/2018	10/12/2018	I639 : Cerebral infarction, unspecified	Aroostook Medical Center	045 : CVA & precerebral occlusion ..	$6,879
0AK7MG3M..	Cook, Brian A	5207007012	4/14/2018	4/17/2018	K2970 : Gastritis, unspecified, witho..	Medical University Hospital Auth..	241 : Peptic ulcer & gastritis	$4,949
		5336708332	4/2/2018	4/4/2018	K6289 : Other specified diseases of ..	Medical University Hospital Auth..	254 : Other digestive system diagn..	$3,178
0AS2I01TU43	Lehn, Craig C	5132769802	1/1/2018	1/5/2018	K5650 : Intestnl adhesions, unsp as..	Grady Memorial Hospital	224 : Peritoneal adhesiolysis	$7,164
		5141821848	1/8/2018	1/16/2018	T83511A : I/I react d/t indwelling ure..	Westmoreland Hospital Associati..	466 : Malfunction, reaction, complic..	$11,425
0B31W50MI50	Escott, Evan B	5199874723	4/9/2018	4/12/2018	J151 : Pneumonia due to Pseudom..	Grady Memorial Hospital	137 : Major respiratory infections &..	$4,917
		5230885953	5/7/2018	5/16/2018	K5720 : Dvtrcli of lg int w perforation..	Grady Memorial Hospital	231 : Major large bowel procedures	$22,827
0D35MK4JJ11	Fred, Alisa C	5300543777	8/1/2018	8/3/2018	F0151 : Vascular dementia with beh..	Grady Memorial Hospital	757 : Organic mental health disturb..	$5,981
		5321983135	7/13/2018	7/27/2018	I350 : Nonrheumatic aortic (valve) st..	St. Joseph Mercy Oakland	163 : Cardiac valve procedures w/o..	$45,060
0EI1CR0TL49	Kobelja, Robert R	5430763346	1/5/2019	1/15/2019	A403 : Sepsis due to Streptococcus..	Medical University Hospital Auth..	710 : Infectious & parasitic disease..	$23,412
		5438418081	1/20/2019	1/28/2019	I5033 : Acute on chronic diastolic (c..	West Florida Regional Medical C..	194 : Heart failure	$13,686
0JG7PY4DC..	Kelley, Brad H	4778406450	8/17/2016	8/19/2016	C61 : Malignant neoplasm of prostate	Mount Sinai Hospital	484 : Other male reproductive syst..	$13,463
		4798402967	9/3/2016	9/6/2016	G8918 : Other acute postprocedural..	Mount Sinai Hospital	861 : Signs, symptoms & other fact..	$4,924
0JT8S68TF84	Budny, Antoinette J	5303134972	7/5/2018	7/31/2018	I480 : Paroxysmal atrial fibrillation	Guardian Angel Healthcare Inc., li	951 : Moderately extensive proced..	$72,944
		5325828641	7/31/2018	8/16/2018	F0151 : Vascular dementia with beh..	Bmh North Mississippi	757 : Organic mental health disturb..	$17,957
0MB2NF5UM..	Glunz, Ralph P	5503796212	4/20/2019	4/21/2019	N179 : Acute kidney failure, unspeci..	Grady Memorial Hospital	469 : Acute kidney injury	$1,126

All data are fictitious – for example purposes only.

3 HELP

3.1 Glossary

Glossary provides quick reference to the terms used in the CRISP CCLF application:

Term	Definition
Avoidable Hospital Event	According to The Hilltop Institute's Pre-AH Model™, these are inpatient admissions and emergency department visits that can be avoided through proactive management in the primary care practice setting.
Beneficiary Months	For a given month, the number of beneficiaries enrolled in Medicare Part A and Part B. Because enrollment is not necessarily continuous and beneficiaries may enroll in Medicare FFS midway through an attribution quarter, the Beneficiary Months used in calculations may be less than the number of beneficiaries times the number of months shown in a report.
BETOS	Berenson-Eggers Type of Service (BETOS) codes are a classification of CPT and HCPCS codes into broad categories of like services that allow for easy review and analysis of data.
CCS Category	The Clinical Classifications Software (CCS) is a diagnosis and procedure categorization system developed by AHRQ' HCUP project to aggregate diagnosis and procedure codes into a smaller number of clinically meaningful categories.
Dual Eligible	A beneficiary is indicated as Dual Eligible when he/she has at least one month during the available claims window when he/she was eligible for and enrolled in both Medicaid and Medicare benefits.
ER	Emergency Room; type of service.
HCC Tier	CMS-assigned tier for each MDPCP beneficiary based on the distribution of HCC scores across the program. Newly enrolled Medicare beneficiaries without adequate claims data to calculate an HCC tier are defaulted into Tier 2. The Complex tier includes those beneficiaries in the top 10 decile of HCC scores as well as those with "persistent and severe mental illness, substance use disorder or dementia." For a description of the HCC Tier distribution, see Section 2.3.1: Distribution of HCC Tier.
HCC Score	Hierarchical Condition Categories are a risk score coding system used by Medicare to predict utilization and weight reimbursement.
HHA	Home Health Agency; type of service.
Other (Setting)	Includes care provided in long-term care hospitals, other inpatient facilities such as psychiatric hospitals, DME, inpatient rehabilitation, hospice; type of service.
Outpatient	Type of service; includes all Part B services provided in an outpatient hospital setting, including dialysis center.
Part A + Part B Members	Traditional/Original Medicare beneficiaries. These beneficiaries are also known as fee-for-service (FFS) beneficiaries. This tool only reports on these Part A and Part B members.
Physician	Type of service; includes all physician Part B services regardless of site of service.
PMPM	Per Member Per Month (PMPM) is a common measure for analyzing a population. This measure factors in the number of members as well as the time each member was enrolled (i.e. beneficiary months). The most common usage is for payments, where the PMPM measure is the average payments for a member over one month.

Term	Definition
Readmission	An admission for any reason following discharge from a short-term acute care hospital within 30 days.
SNF	Skilled Nursing Facility; type of service.
Short Term Hospital	Short-Term Acute Care Hospital.

3.2 CCLF Data Basics

3.2.1 CCLF

The CCLF (Claim and Claim Line Feed) data files are a set of Medicare claims files incorporating all Medicare Part A and B claims from Inpatient Facility, Outpatient Facility, Skilled Nursing Facility, Home Health Agency, Hospice, Professional, Durable Medical Equipment, and Part B Prescription Drug services. These files contain beneficiary claim level data including Medicare payment amounts, diagnoses, procedures, dates of service, provider identifiers, and beneficiary copayment amounts. Provider cost information is not included in the data. Drugs paid for under Part A or Part B (such as drugs administered in the hospital) are included in the MDPCP Reports.

The CCLF data also include information regarding beneficiaries' Medicare eligibility, such as the reason for Medicare eligibility (aged, disabled, ESRD), entitlement status, and months of eligibility for all Medicare beneficiaries enrolled during the year of the data set. These data sets contain a unique identifier for each beneficiary, allowing the linkage of beneficiary claims across the various claims' files. CMS provides additional attribution files linking individual beneficiaries to participating primary care practices.

The CCLF data files only contain Medicare fee-for-service (FFS) claims (Part A and Part B) and does not contain any claims for beneficiaries enrolled in Medicare Advantage (Part C) or non-Medicare (private) insurance plans.

The MDPCP reports are powered by the latest 36 months of data for 100% of the Maryland Medicare beneficiaries.[1] Use of this data is governed by a Data Use Agreement (DUA) from the Centers for Medicare & Medicaid Services (CMS) between CMS and CRISP. Using the beneficiary's unique identifier, all health care information is tracked across the available data.

3.2.2 CCLF Data Lag

Due to the nature of claims processing, not all claims are submitted and/or processed by the time the CCLF data are made available. The default view in the MDPCP reports will exclude the most recent three months of CCLF data because the month prior to the data load is not included in the CCLF data and the preceding two months are considered incomplete. Therefore, the more reliable months are displayed by default with the option to include the more recent two "lag" months.

3.2.3 Readmission

A readmission is defined as a planned or unplanned admission to a short-term acute care facility that occurs within 30 days of a discharge from the same or a different short-term acute care facility. Such readmissions are often, but not always, related to a problem inadequately resolved in the prior hospitalization.

[1] Due to CMS lags in claim processing, the latest two months of the data are incomplete.

In the 30-day readmission rate, transfers from one short-term acute care facility directly to another short-term acute care facility are excluded from the rate. Such transfers may occur in order to provide the beneficiary services that the discharging or transferring short-term acute care facility may not offer.

3.3 Practice Attribution

Each calendar year has one attribution file that defines to which practices beneficiaries are attributed. Each quarter, an incremental attribution file is provided that captures new beneficiaries who have not been previously attributed to any primary care practice as well as the removal of beneficiaries due to eligibility changes such as beneficiary death, relocation, or other qualifying change.

3.4 IP Admissions and ER Visits Per K Calculations

IP admissions and ER visits per 1,000 beneficiaries are shown two different ways: per year or for a given month when presenting trends over time. The equation below shows how IP admissions per 1,000 beneficiaries and per 1,000 beneficiaries per year are calculated. This calculation also applies for the comparable ER visit metrics. When calculated for a single month, as presented in the Inpatient/ED Utilization Report, the figure and equation exclude the bracketed terms.

$$IP\ Admissions\ Per\ K\ [Per\ Year] = \frac{\text{Count of IP Admissions}}{\text{Beneficiary Months}} \text{ x } 1{,}000 \text{ x } [12 \text{ months}]$$

COMPONENT	DESCRIPTION
Count of IP Admissions	The number of IP admissions for all beneficiaries during the presented time period or individual month.
Beneficiary Months	The number of months during which beneficiaries were enrolled in Medicare Part A and Part B during the presented time period. When calculated for a single month, this figure is equal to the number of beneficiaries enrolled that month.
1,000	Multiplying by 1,000 adjusts the figure to present a rate per 1,000 beneficiaries from a per beneficiary rate.
12 months	Multiplying by 12 adjusts the figure to present an annualized rate instead of a monthly one.

n.b. Beneficiary months will not always be equal to the number of beneficiaries multiplied by the number of selected months due to new and interrupted enrollment.

3.5 MDPCP Report Training Webinar

To view the recording of the MDPCP Report training webinar conducted on February 26th, 2019, please click the below link or copy and paste the URL into your browser. The webinar covers credentialing for access and how to use the reports.

Link to MDPCP Webinar Recording