CRISP

# Multi-Payer Reporting Suite User Guide

User Guide 1.3 – January 15, 2024

# 1 Welcome to the Multi-Payer Reporting Suite

The Multi-payer Reporting Suite includes 8 top-level, Tableau-based reports populated using both Medicare and Medicaid claims data. The goal of the reporting suite is to allow users to view population-health metrics and access care management tools across their entire patient populations, agnostic to payer. The reporting suite provides population-level aggregate views, as well as beneficiary and claim-level details. A Population Navigator allows users to custom curate their own patient lists, within their CRISP patient panels to investigate sub-populations more easily.

This represents the first test release of the Multi-Payer Reporting Suite, which will be enhanced over time as user feedback is provided, as well as the availability of additional data sources.

The reporting suite is powered by CRISP patient panels, also referred to as CEND panels. Patient panels are managed by individual CRISP users outside of this reporting suite. Based on the available patient panels, this reporting suite uses CMS Claim and Claim Line Feed (CCLF) data for Medicare Fee-for-Service (FFS) beneficiaries, as well as Medicaid FFS and encounter data. The most recent 36 months of data are available for both payer populations. The most recent three months of all data sources 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 4.3.

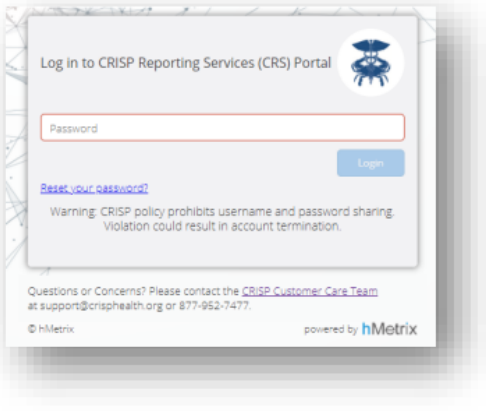
## 1.1 Software Requirements

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

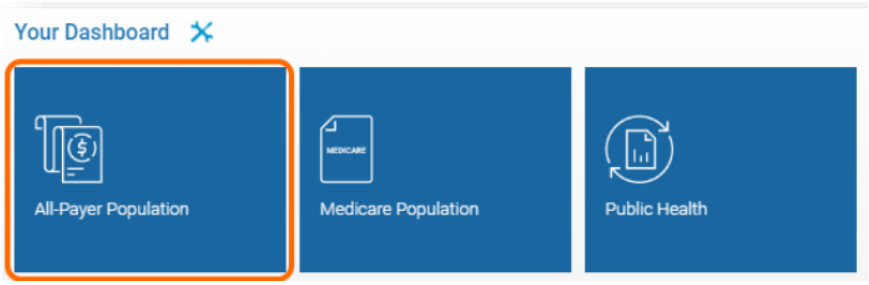
## 1.2 Launching Multi-Payer Reports

To access the Multi-Payer Reports, a user must first login to the CRISP Reporting Portal. Once in the portal, the user shall click the Card labeled “All-Payer Population.” The following screen shots represent the user’s workflow.

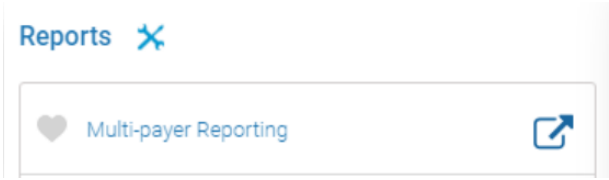
Step 1: Log into the CRISP Reporting Portal using the user id and password provided for the portal - https://reports.crisphealth.org


Step 2: Click the Card named “All-Payer Population” within the Portal




Step 3: After clicking the card, users will see a link for the Multi-Payer Reporting Suite.

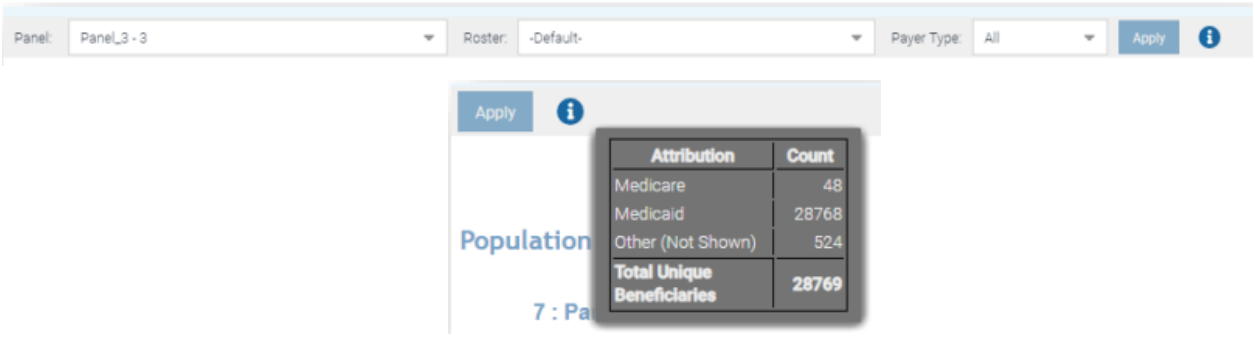



Step 4: Upon clicking the link, you will be directed to the Population Summary report. Use the menu on the left to navigate to other reports.

## 1.3 Global Filters

The navigation bar at the top represents global filters that will be applied to all reports in the Suite. The Panel Filters should be used to select the patient panel to use when populating the reports. Once user-defined patient Roster are created to subset the Panel population in Population Navigator, the Roster Filter can apply the Panel population to that Roster (see Section 2.2.4 for more details). The Payer filter further subsets the selected Panel (and the Roster, if selected) by the indicated payer type identified. Payer options include Medicare and Medicaid. Clicking Help will open this user guide in a new browser tab. Users must click "Apply" for the settings to be implemented in the reports.

Once a Panel is selected, users should view the blue "i" to the right of the selected roster. Hovering the cursor over this icon shows the distribution of beneficiaries by payer type. As the reporting suite only includes Medicare and Medicaid claims data, any beneficiaries within the patient panel that have other insurance coverage will not be available in the reporting suite. These beneficiaries are shown in "Other (not shown)". Users should review this table to better understand which beneficiaries are included and excluded from the reports.

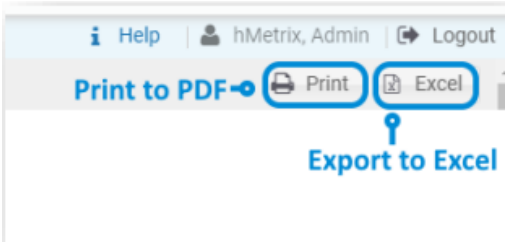



## 1.4 Filter Selection and Claim Lag Indicator

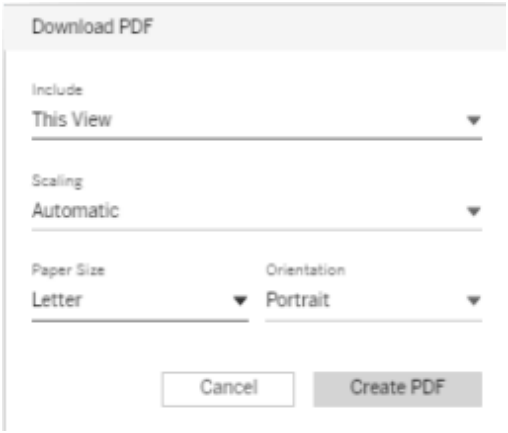
Each report contains filters that may be applied and adjusted. The below image and table describe the functionality of the filters and data consideration text.

| Filter/Data Considerations | Description |
|---|---|
| *Date Selector* | Select the start month and the end month from the data selection slider to limit the data used to populate the reports. The date indicates the date of service, not the date of processing of payment. |
| *Comparison Group Selector* | Select from "Medicare" or "Medicaid" for statewide payer-specific comparison groups. Medicare includes both Part A and B Medicare coverage, while Medicaid includes FFS and encounter data for all Maryland Medicaid enrollees. Comparison figures are presented in the reports in orange. |
| *Lag Indicator* | This text will be present in any report that includes claims more recent than the last three months of claims available in the Suite. This is to advise users that the most recent month(s) are not complete due to the data lag. (see Section 4.3 for detail). |

## 1.5 Print to PDF and Export to Excel




Each report allows for printing in the current view to a PDF document. Clicking the "Excel" button will result in the user being prompted to download an .xlsx file that will include one sheet for each chart included in the report along with an 'About' sheet with information on which report was exported, the date exported, and which user created the file. Users may export from any of the top-level reports as well as from the beneficiary level drill throughs (Beneficiary Details and Claim Details).




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.

## 1.6 Session Timeout

To minimize unauthorized use of Multi-Payer Reports, a user's session is set to time out after 30 minutes of inactivity. A warning message will be displayed 5 minutes before the session times out. If the user clicks Yes to the warning message, then the user's session will be active for another 30 minutes. If the user clicks No or does not respond to the warning message, the user's session will time out and the Session Timeout warning message will be displayed.

# 2 Reports

The Multi-Payer Reporting Suite contains 8 reports that cover metrics of interest for Medicare and/or Medicaid beneficiaries. As available, reports contain metrics for comparison group population to help the user view their trends with an overall perspective within Medicare or Medicaid utilization across the state of Maryland. The Population Navigator also contains beneficiary-level details with functionality to subset and parse the patient panel into more meaningful sub-populations for further evaluation.

## 2.1 Population Summary

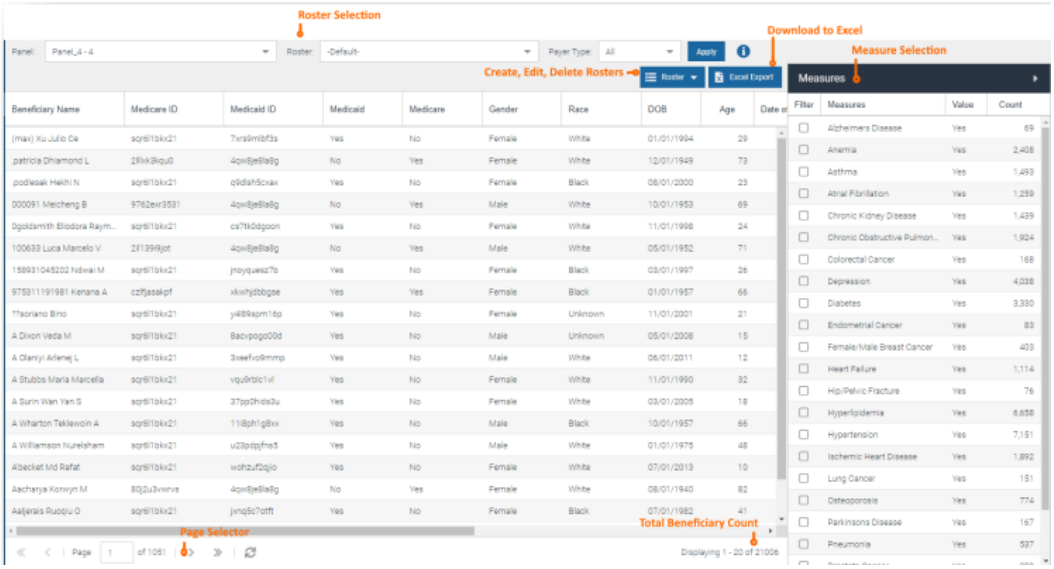
Population Summary serves as an initial dashboard with direct links to all reports and presents metrics of interest. Click the text box in any of the cards to navigate directly to the selected report.

Report icons that contain metrics for the selected panel (and roster if selected) for the 33-month period described at the top of the page, which excludes incomplete data due to claim lag.

| Report Name | Description (Report Section Reference) |
|---|---|
| *Beneficiary Count*<br>*# of Beneficiaries* | Navigates to Beneficiary Details (Section 3.1) See also Patient Navigator (Section 2.2).<br>*The total number of beneficiaries in the panel that are included in the reporting metrics.* |
| *Measure Comparison by Time Period* | Directs to Measure Comparison by Time Period Report, Section 2.3 |
| *Inpatient Admissions*<br>*# IP* | Directs to Acute Care Setting Utilization Report, Section 0.<br>*Annualized IP admissions from the 33-month period.* |
| *ER Visits*<br>*# ED* | Directs to Emergency Room Utilization Report, Section 2.5.<br>*Annualized NED Visits from the 33-month period.* |
| *Readmission Rate*<br>*% Readmits* | Directs to Plan All-Cause Readmission Report, Section 2.6.<br>*The percent of all readmissions that are PCR.* |
| *PQI Utilization Report*<br>*PQI Events* | Directs to PQI Utilization Report, Section 2.7.<br>*The number of PQI events from the 33-month period.* |
| *Follow-Up Rate*<br>*% with Follow-up After Admission* | Directs to Follow-up Post-Acute Setting Discharge Report, Section 0.<br>*The percent of events that received physician follow-up within 7-14 days.* |
| *PMPM Trend*<br>*$#* | Directs to PMPM Trend Report, Section 0.<br>*The total per member per month spending across all settings.* |
| *Health Equity by Demographics Report* | Directs to Health Equity by Demographics Reports, Section 2.10.<br>*Annualized PQI Events per K for the Panel's black beneficiaries.* |
| *Maternal Health Utilization* | Directs to Maternal Health Dashboard, Section 2.11.<br>*Contains a collection of four individual reports spanning prenatal care, delivery, and postpartum care.* |
| *CMS Core Set Measures Dashboard* | Directs to CMS Core Set Measures, Section 2.12.<br>*A subset of the CMS Core Set of Measures.* |


## 2.2 Population Navigator

The Population Navigator provides a list of beneficiaries included in the selected panel and used to populate the aggregate and beneficiary-level reports. Drilldowns throughout the reporting suite direct users to a Population Navigator view (without measures and Roster functionality).



### 2.2.1 Population Navigator Columns

Population Navigator includes columns with pre-populated fields that cannot be edited. Users may reorder columns by clicking and dragging a column header to the desired location. Users can also select which columns to include in the view by hovering over a column header, clicking the resulting arrow to the right of the header, and selecting and deselecting column names.

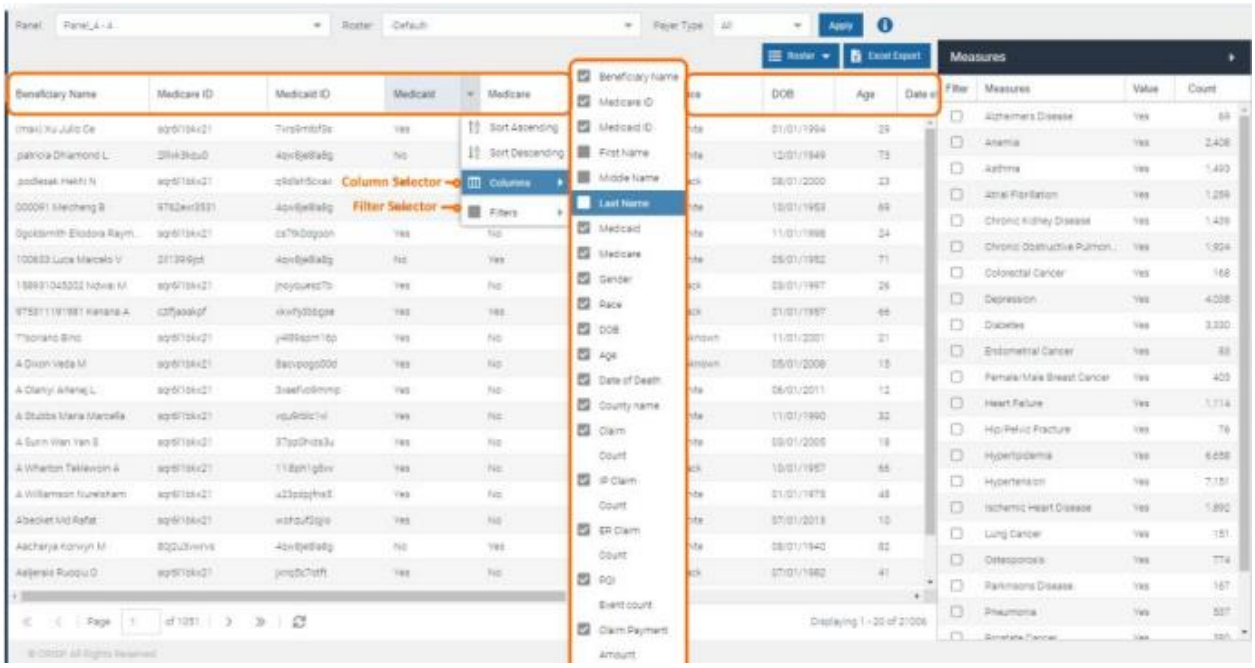
The below table describes each column in Population Navigator that contains beneficiary-level information from the CCLF or Medicaid claims data.

| Column Name | Description |
|---|---|
| *Beneficiary Name* | Concatenated beneficiary name as presented in the claims data; defaulted to the name in the CCLF (Medicare) claims if a patient is dual eligible |
| *Medicare ID* | Medicare Beneficiary Identifier (MBI) contained in the CCLF data |
| *Medicaid ID* | Medicaid ID contained in the Medicaid claims/encounter data |
| *MRN* | Medical Record Number contained on the claim |
| *Medicare* | Yes/No Indicator for beneficiary being enrolled in Medicare FFS for at least one month in the last 36 months |
| *Medicaid* | Yes/No Indicator for beneficiary being enrolled in Medicaid FFS or MCO for at least one month in the last 36 months |
| *Medicaid Plan* | Identifies if beneficiary is in Medicaid FFS or an MCO; if an MCO, identifies the Plan Name. Based on the most recent information for each beneficiary. That is, for beneficiaries with both FFS and MCO plans within the last 36 months, it displays only the current coverage. |
| *Patient First Name* | Patient first name; useful for filtering or sorting in Population Navigator or Excel export. Defaulted to the name in the CCLF (Medicare) claims if a patient is dual eligible. |
| *Patient Middle Name* | Patient middle initial; indicated as "^" when not available. Useful for filtering or sorting in Population Navigator or in Excel export. Defaulted to the name in the CCLF (Medicare) claims if a patient is dual eligible. |
| *Patient Last Name* | Patient last name; useful for filtering or sorting in Population Navigator or in Excel export. Defaulted to the name in the CCLF (Medicare) claims if a patient is dual eligible. |
| *Gender* | Identified as Male or Female |
| *DOB* | Date of birth in MM/DD/YYY format |
| *Date of Death* | Date of death as indicated in the beneficiary demographic files for each dataset. |
| *County* | County of residence according to CMS beneficiary files |
| *Dual Eligibility* | Value is 'Yes' if the Medicare beneficiary also qualified for Medicaid for at least one month in the CCLF. |

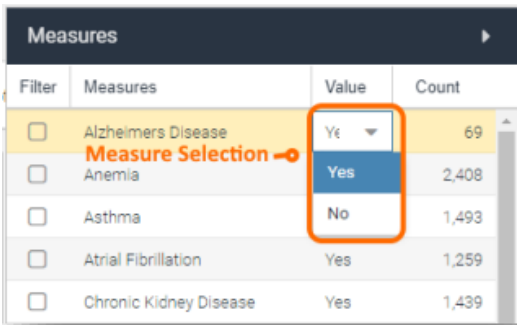
| | |
|---|---|
| | Value is 'No' if the Medicare beneficiary did not also qualify for Medicaid for any month in the CCLF. |
| *Claim Count* | Count of Medicare and/or Medicaid claims in the most recent 36 months. |
| *IP Count* | Number of total IP admissions in most recent 36 months |
| *ER Count* | Number of total ED visits admissions in most recent 36 months. |
| *PQI Count* | Number of total PQI admissions in most recent 36 months. |
| *Claim Payment Amount* | Sum of payments for medical claims in the most recent 33 months; excluding the 3 month claim lag |
| *Individual Chronic Conditions* | Indicator for the presence of 24 individual chronic conditions, based on logic from CMS's Chronic Condition Warehouse (CCW). |

## 2.2.2 Population Navigator Column Selection and Filters

All column headers can be rearranged or changed by clicking on the column header. Each column header can be filtered using pre-set filters and sorted by ascending or descending order. Move your cursor over a column header and click the triangle to the right on the column name to view the different filter options. To change the sequence of the table column headers, hold and drag the columns to the desired location.



## 2.2.3 Measures




The Population Navigator roster can be refined using the Measures filter. These measures include chronic conditions based on the Chronic Condition Warehouse (CCW) chronic condition algorithm. These conditions are defined according to diagnosis and procedure code algorithms found here: https://www2.ccwdata.org/web/guest/condition-categories-chronic

One or more measures can be added to or removed from the Population Navigator view by clicking the checkbox. For each measure, select the value to filter on by clicking on the Value dropdown options. The number to the right of the measure is the count of patients that will remain after applying the filter.

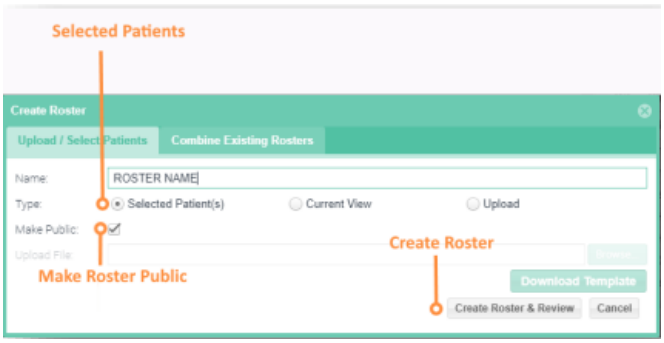
## 2.2.4 Create/Edit/Delete Roster

You can create, edit and delete a Roster easily from the Population Navigator page. Note that rosters are fixed. While they are based on logic at the time they are created, they are not dynamically updated as new patients are added to patient panels or as patient clinical and demographic characteristics change. Users may need to periodically update their rosters to ensure they include all beneficiaries they were intended to capture.

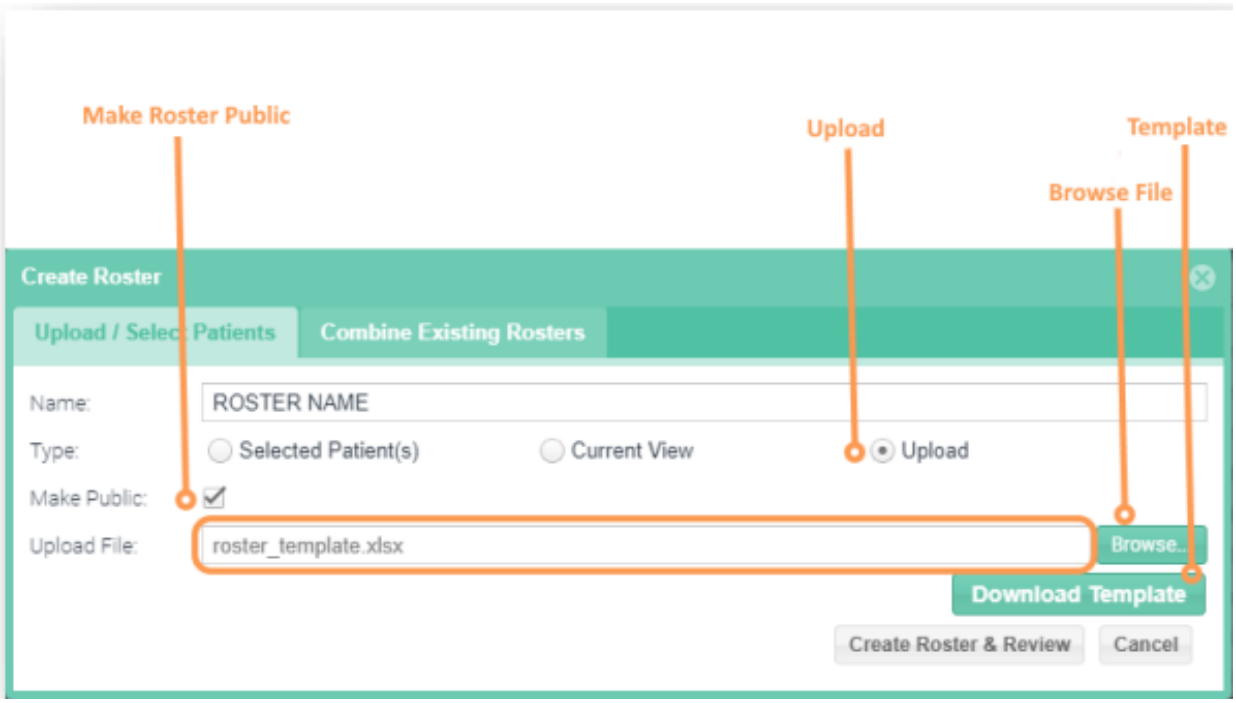
### *2.2.4.1 Create a Roster*

You can create a new roster by clicking on the Roster >> Create button. There are four options to create and save a Roster:

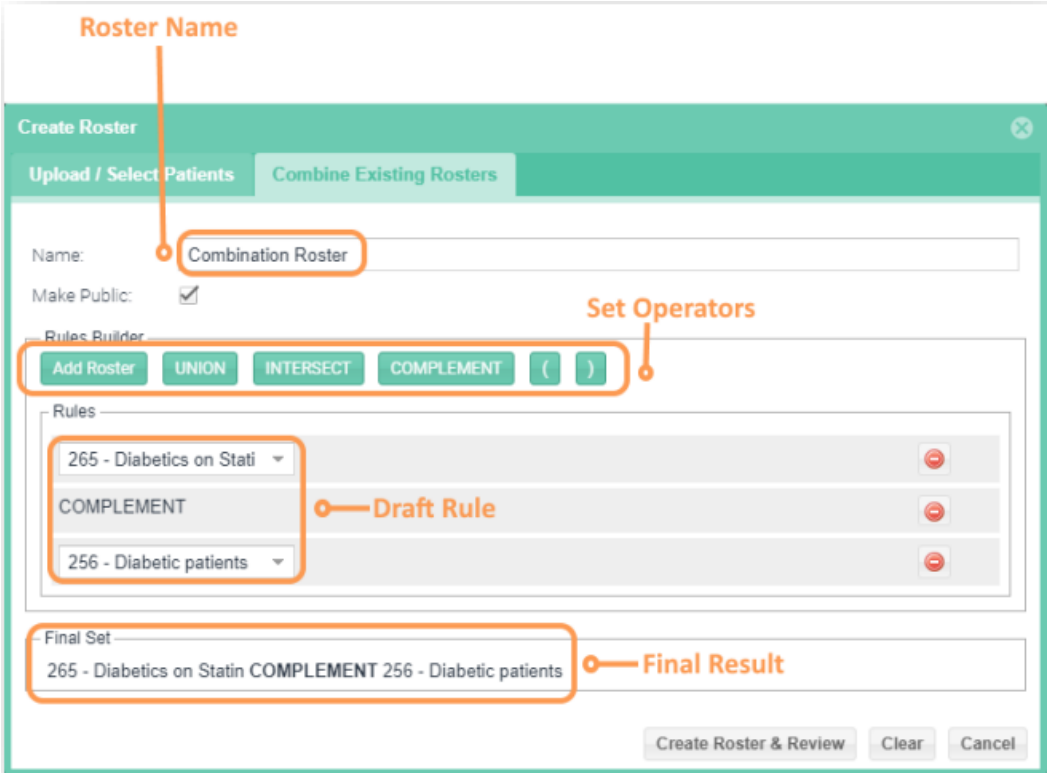
1. Roster based on measures
    a. Filter the Patient list by selecting your measures
    b. Click on Roster >> Create Roster
    c. Create a name for your roster
    d. On the Type, select Current View
    e. Click on Create button
2. Roster for individual patients from the patient list
    a. From the patient list, you can select on or more patients at a time. To select a group of patients, click on patients while holding the SHIFT key on a PC (or CMD or MAC). Patients can be selected individually by clicking on them while holding the CTRL key on a PC (or CMD on MAC). The selected patient names will be highlighted in green.
    b. Click on Create Roster
    c. Enter a name for your roster
    d. For Type, select Selected Patients(s)
    e. Click on Create button



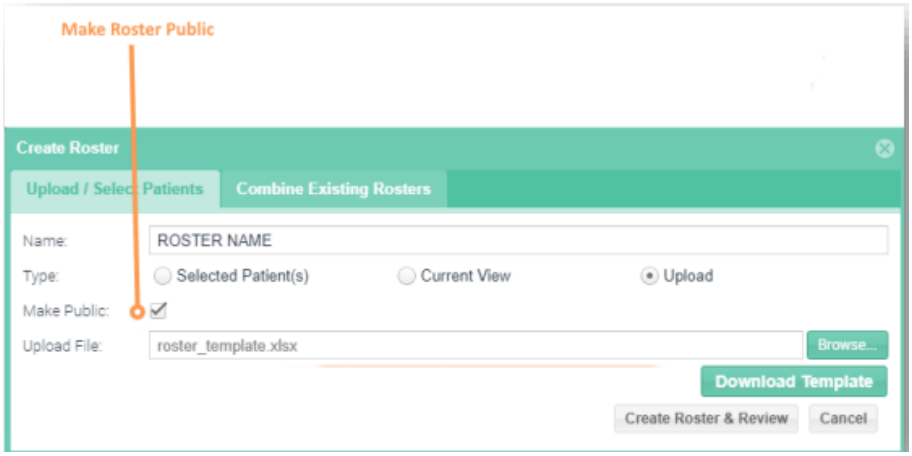

3. Upload a roster
    a. Click on Create Roster button from the Population Navigator window, and the Create Roster window will be displayed.
    b. Enter the Roster name
    c. Select Upload from the Type options
    d. Click on Download the Roster Template
    e. The file will be saved to your computer
    f. Open the template, enter the required values for First Name, Last Name, DOB, and Gender (written out as “Female” or “Male”), and any other optional fields
    g. In the Create Roster dialogue, click on the Browse button and select the template file to upload
    h. Click on Create to save the roster
    i. The new roster will be displayed in Population Navigator



4. Create a Roster Based on Other Existing Rosters
    a. Click on Create Roster button from the Population Navigator window, and the Create Roster window will be displayed.
    b. Click on the Combine Existing Rosters tab.
    c. Enter the Roster name
    d. Select the Rosters and Set Operations needed from the options. Examples of set operators are:
        i. Union – the combination of all patients across both rosters. For example, if Roster A contains patients X & Y and Roster B contains patients Y & Z, then Roster A Union Roster contains patients X, Y & Z
        ii. Intersect – the common patients across both rosters. For example, if Roster A contains patients X & Y and Roster B contains patients Y & Z, then Roster A Intersect Roster B contains patients Y
        iii. Complement – the patients in one roster that are not represented in other rosters. For example, if Roster A contains patients X & Y and Roster B contains patients Y & Z, then Roster A Complement Roster B contains patients X. If the algorithm were reversed (Roster B Complement Roster A), the resulting roster would contain patients Z
        iv. Brackets / Parenthesis are used to specify the order of operations
    e. Click on Create Roster & Review to view and save the roster
    f. The new roster will be displayed in the Population Navigator



5. Making the Roster public
    a. Check the Make Public checkbox when creating a Roster
    b. The Roster will be available to all other users with access to data for the same panel.




### *2.2.4.2 Edit a Roster*

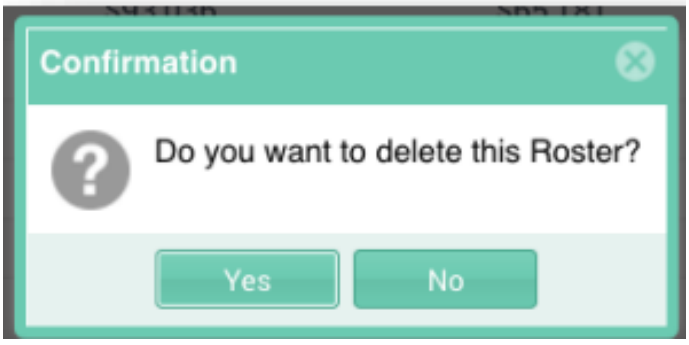
Only the author of a roster may edit it. To edit a roster not created by the present user, create a copy of the roster of interest before editing.

1. On the Population Navigator select the Roster name you wish to edit from the dropdown.
2. Click on the Roster button and select Edit from the options displayed.
3. Edit the name and click Edit Roster and Review button to view the patients and save your changes.

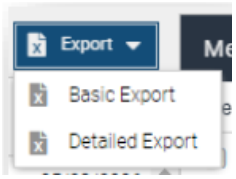
### *2.2.4.3 Delete a Roster*

Only the author of a roster may delete it.

1. On the Population Navigator select the Roster name you wish to delete from the dropdown.
2. Click on the Roster button and select Delete from the options displayed.
3. Delete the name and click Yes button to save your changes.



### *2.2.4.4 Excel Export*



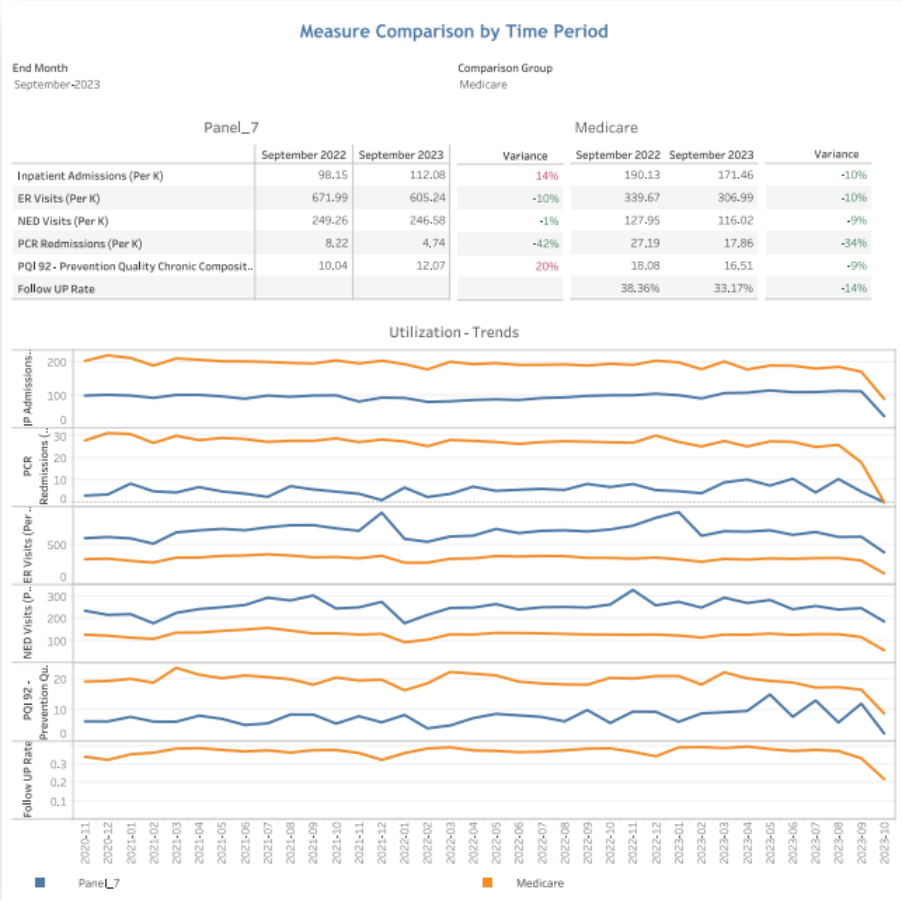

You can create an Excel export of the Population Navigator in two ways:

1. *Basic View:* This view will create an Excel export for all selected patients identical to the columns seen in the User Interface
2. *Detailed View:* This view will create an Excel export for all selected patients with all the available measures included as columns, and all data columns (including those not selected) will be included.

## 2.3 Measure Comparison by Time Period

The Measure Comparison by Time Period Report allows users to view several of their key utilization measures over time. This report contains summary utilization rates and trend lines that compare the panel population to the selected comparison group.

The top section presents the utilization measures with a year-over-year comparison, as well as a variance indicator. The variance indicator is conditionally formatted to indicate positive (green) change or negative (red) changes from the prior year. The data are presented separately for the panel and the selected comparison group. The line charts shows the data month by month for the most recent 12 months.




| | Panel_7 | | | Medicare | | |
|---|---|---|---|---|---|---|
| | September 2022 | September 2023 | Variance | September 2022 | September 2023 | Variance |
| Inpatient Admissions (Per K) | 98.15 | 112.08 | 14% | 190.13 | 171.46 | -10% |
| ER Visits (Per K) | 671.99 | 605.24 | -10% | 339.67 | 306.99 | -10% |
| NED Visits (Per K) | 249.26 | 246.58 | -1% | 127.95 | 116.02 | -9% |
| PCR Redmissions (Per K) | 8.22 | 4.74 | -42% | 27.19 | 17.86 | -34% |
| PQI 92 - Prevention Quality Chronic Composit.. | 10.04 | 12.07 | 20% | 18.08 | 16.51 | -9% |
| Follow UP Rate | | | | 38.36% | 33.17% | -14% |

All data are fictitious – for demonstration purposes only.

The rates measures available in the report include: Inpatient admissions (per K), ER Visits (per K), NED Visits (per K), PCR readmissions (Per K), PQI-92 events (per K) and follow-up rate (%) following inpatient or ED discharge. All measures correspond to the measures in their own specific report, explained further in the sections below.

## 2.4 Acute Care Setting Utilization Report

The Acute Care Setting Report dashboard allows users to view their patients' use of acute care settings, including inpatient hospital admissions and readmissions. Additionally, per hospital metrics are presented including avoidable hospital utilization, total admissions, average length of stay, readmission rate.

| Chart Name | Description |
|---|---|
| *Monthly Trend of Total Inpatient Admissions and Readmissions* | Monthly counts of inpatient and readmission hospital stays. Readmissions include all readmissions within 30-days, without exclusion criteria |
| *Monthly Trend of Average Payments for Total Inpatient Admissions and Readmissions* | Monthly payment totals for inpatient and readmission hospital stays |
| *Monthly Trend of Total Impatient Admissions and Readmissions for [Comparison Group]* | For the selected comparison group, the monthly count of inpatient and readmission hospital stays. Readmissions include all readmissions within 30-days, without exclusion criteria. |
| *Monthly Trend of Average Payments for Total Inpatient and Readmissions for [Comparison Group]* | For the selected comparison group, the monthly average payment per inpatient and readmission hospital stay. |
| *Avoidable and Unavoidable Total Inpatient Admissions by Hospital* | Stacked bar chart presenting the count of admissions that qualify as Prevention Quality Indicator (PQI) admissions and those that do not (Non PQI).<br>This chart changes based on the filter selection of 'Total Inpatient Admissions' or 'Readmission.' |
| *Avoidable and Unavoidable Total Inpatient Admissions by Primary Diagnosis* | Counts of hospital utilization according to the primary diagnosis code on the claim.<br>This chart changes based on the filter selection of 'Total Inpatient Admissions' or 'Readmission.' |
| *Utilization Summary by Patient* | Table including patients' individual average length of stay, total inpatient admissions, readmissions, and readmission rate. |
| *Utilization Summary by Hospital* | Table including several metrics that can be used to understand which hospitals patients on the panel utilize, and to view differences on metrics among those hospitals. |

The Acute Care Setting Report links to drilldowns to access Beneficiary Details.

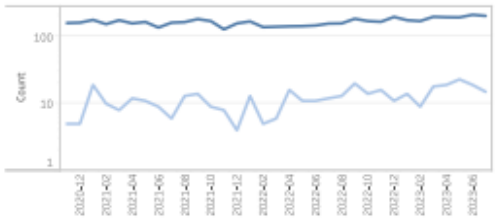
# Acute Care Setting Report

*The Acute Care Setting Report allows you to view inpatient utilization (including index admissions and readmissions) for your beneficiaries over a selected time period, alongside a comparison group of all Medicare or Medicaid beneficiaries in the State of Maryland. This report can help your organization identify the provider associated with these services and the diagnoses specific to these events.*

**Service Date**
November 2020 to July 2023

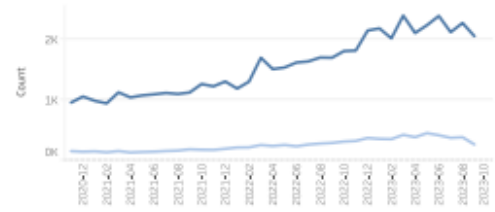
**Comparison Group**
Medicare

## Monthly Trend of Total Inpatient Admissions and Readmissions

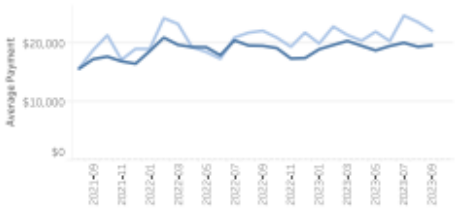



## Monthly Trend of Average Payments for Total Inpatient Admissions and Readmissions


## Monthly Trend of Total Inpatient Admissions and Readmissions for Medicare



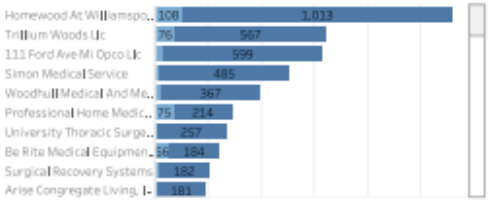

## Monthly Trend of Average Payments for Inpatient Admissions and Readmissions for Medicare




Readmissions  Total Inpatient Admissions

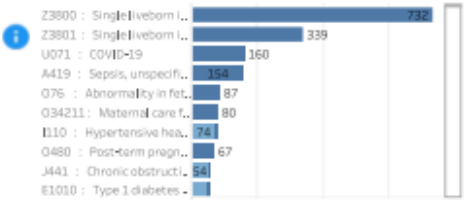
## Avoidable and Unavoidable Total Inpatient Admissions by Hospital

Total Inpatient Admissions




PCI (Avoidable)  Non-PCI (Unavoidable)

## Avoidable and Unavoidable Total Inpatient Admissions by Primary Diagnosis




## Utilization Summary by Patient

| Beneficiary Name | Avg. LOS in Days | Total Inpatient Admissions | Readmissions | Readmission Rate |
|---|---|---|---|---|
| Canton-rodriguez Cheyt | 10 | 22 | 19 | 86.4% |
| Wampole Giking | 2 | 17 | 9 | 52.9% |
| Alcawayii Ashlyn D L | 4 | 13 | 6 | 46.2% |
| Munoz-acevedo Cesario A | 23 | 13 | 5 | 38.5% |
| Huniak Eileani | 9 | 13 | 9 | 69.2% |
| Palermo Jeramya C | 6 | 13 | 2 | 15.4% |

## Utilization Summary by Hospital

| Provider Name | Beneficiary Count | Total Inpatient Admissions | Avg. LOS in Days | Readmissions | Readmission Rate | Total Amount Paid | Amount Paid Per Patient | Amount Paid Per Visit |
|---|---|---|---|---|---|---|---|---|
| Homewood At Williamsport Md, Inc. | 860 | 1,121 | 6 | 81 | 7.2% | $1,166,618 | $1,349 | $1,041 |
| Trillium Woods Llc | 529 | 643 | 7 | 45 | 7.0% | $970,734 | $1,828 | $1,510 |
| 111 Ford Ave Mi Opco Llc | 523 | 631 | 6 | 42 | 6.7% | $998,691 | $1,895 | $1,583 |
| Simon Medical Service | 458 | 502 | 5 | 28 | 5.6% | $204,569 | $447 | $408 |
| Woodhull Medical And Mental Health Center | 348 | 393 | 6 | 19 | 4.8% | $569,745 | $1,637 | $1,450 |
| University Thoracic Surgeons | 257 | 265 | 4 | 2 | 0.8% | $49,938 | $194 | $188 |
| Professional Home Medical Supplies, Inc | 217 | 289 | 5 | 45 | 15.6% | $203,943 | $940 | $706 |

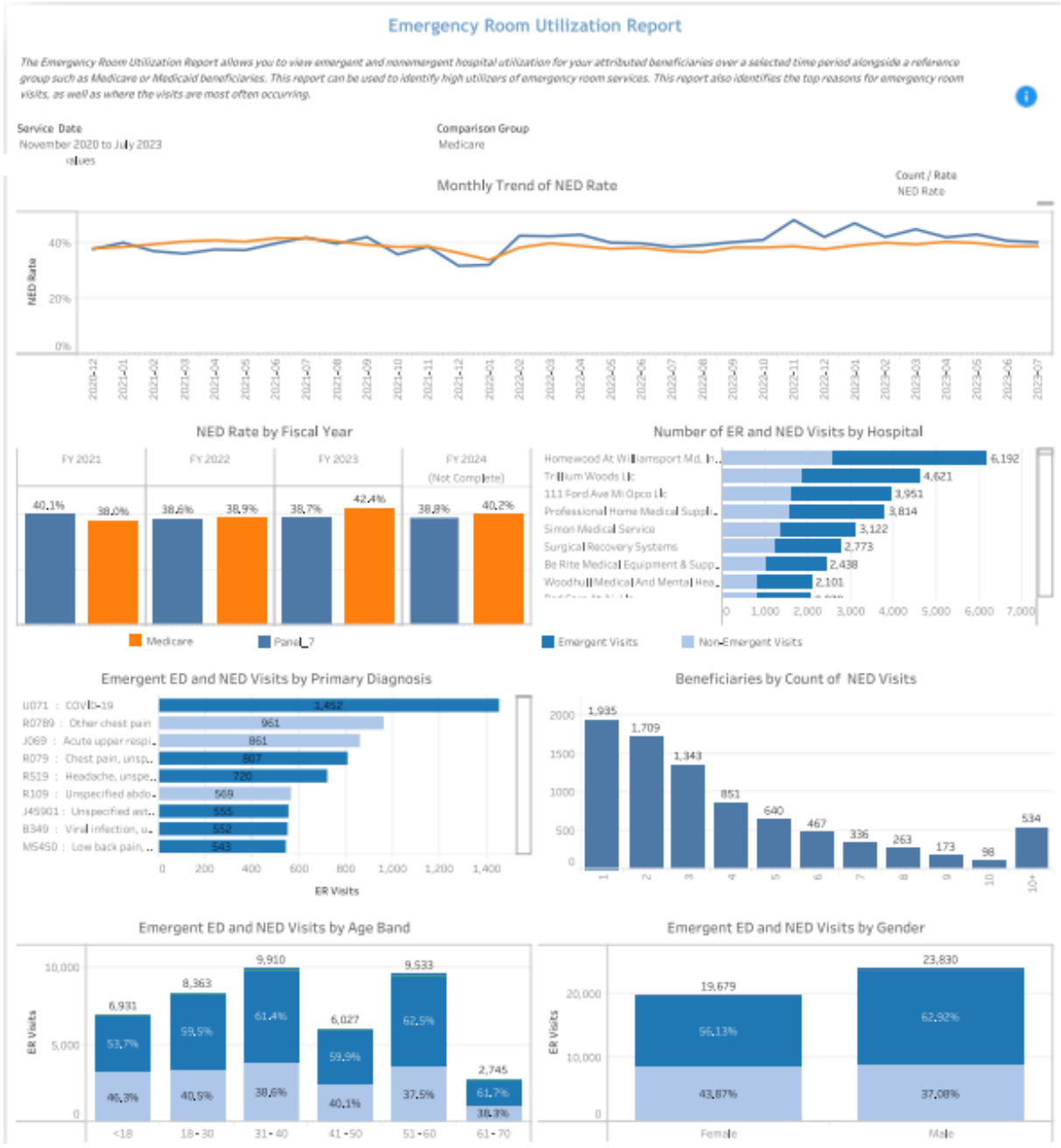
All data are fictitious – for demonstration purposes only.

## 2.5 Emergency Room Utilization Report

The Emergency Room Utilization Report allows users to view emergent and non-emergent hospital utilization for their attributed beneficiaries. This dashboard can be used to identify high utilizers by number of NED visits by beneficiary, primary diagnosis, and hospital.

The NED measure identifies ED visits according to ICD-10 diagnosis codes for which immediate medical care was not required within 12 hours. NYU Center for Health and Public Service Research provides the algorithm that classifies ED visits into Non-emergent and three other groups. The NED measure counts Non-emergent as a percentage of total ED visits. More details can be found at: https://wagner.nyu.edu/faculty/billings/nyued-background

| Chart Name | Description |
|---|---|
| *Monthly Trend of {Selected Measure}* | Presents either the monthly rate of NED ED Utilization or the total count of all ED Utilization depending on the filter 'Count/Rate' selection. Includes the corresponding measure for the selected Comparison Group. |
| *NED Rate by Fiscal Year* | For each Fiscal Year (July through June), the overall count of non-emergent ED visits divided by the overall ED visits for the panel and selected Comparison Group. |
| *Number of ED and NED Visits by Hospital* | For each hospital, a stacked bar chart with respective counts of emergent ED and NED utilization. |
| *Emergent ED and NED Visits by Primary Diagnosis* | Count of visits (classified as emergent or NED) by primary diagnosis |
| *Beneficiaries by Count of NED Visits* | The count beneficiaries with NED visits and associated NED rate for those beneficiaries |
| *Emergent ED and NED Visits by Age Band* | The count of emergent ED and NED visits, grouped by the age band of the beneficiary who encountered the service. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as visits. Stacked bar shows the percent of visits within that age band that are Emergent ED and NED. |
| *Emergent ED and NED Visits by Gender* | The count of emergent ED and NED visits, grouped by the gender of the beneficiary who encountered the service. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as visits. Stacked bar shows the percent of visits within that age band that are Emergent ED and NED. |



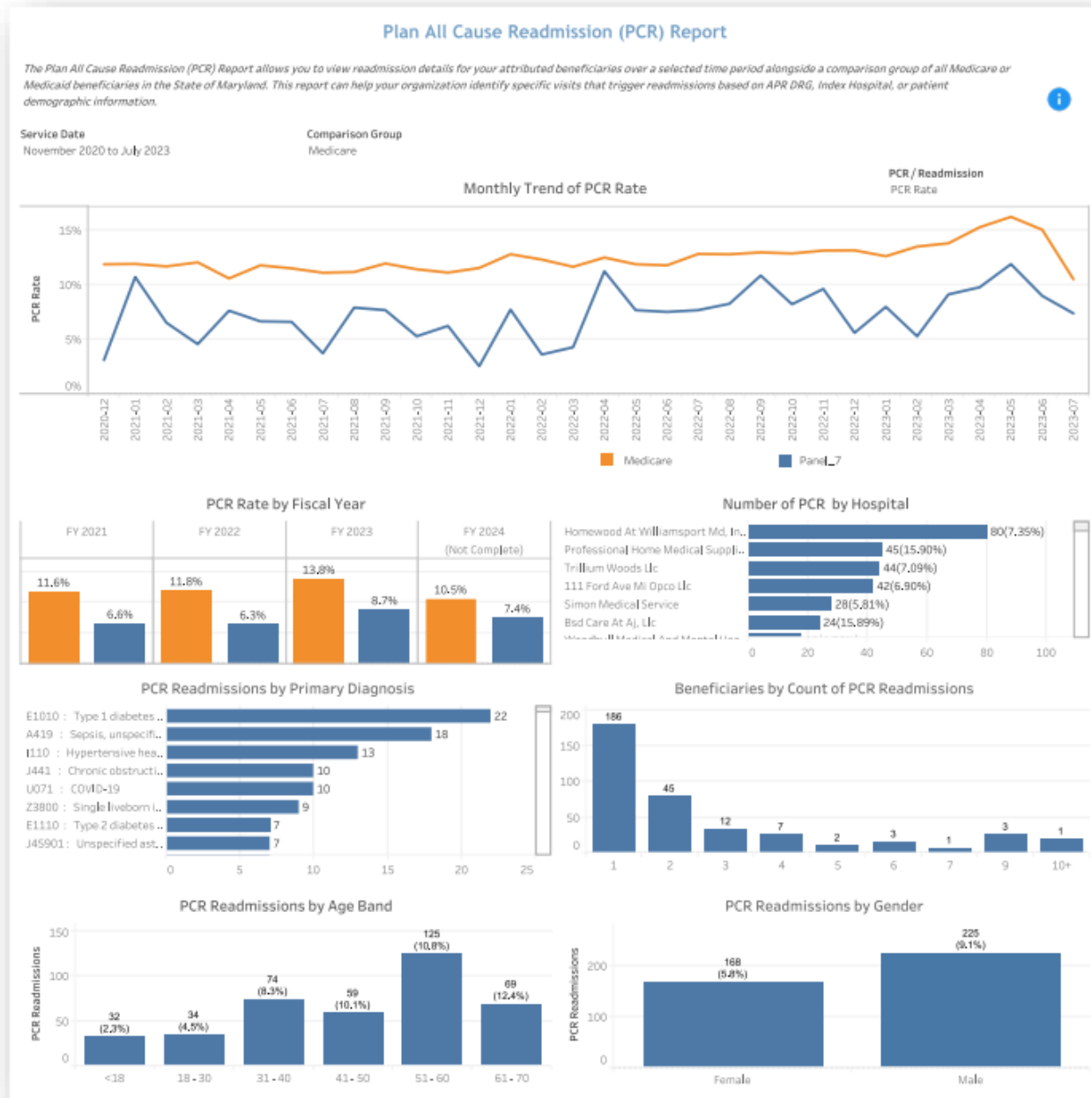

All data are fictitious – for demonstration purposes only.

## 2.6 Plan All-Cause Readmissions (PCR) Report

The PCR Dashboard allows users to view the readmission details for their attributed beneficiaries. This dashboard can help identify discharges that trigger readmissions by diagnosis, Index Hospital, or patient demographic information.

PCR measure is defined as the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

| Chart Name | Description |
|---|---|
| *Monthly Trend of {Selected Measure}* | The monthly PCR readmission rate or count of PCR defined readmissions, depending on the 'PCR vs Readmission' filter selection for the panel and selected Comparison Group |
| *PCR Rate by Fiscal Year* | For each fiscal year (July through June), the panel's and selected comparison group's overall PCR rate. |
| *Number of PCR by Hospital* | The total count of PCR defined readmissions by hospital. |
| *PCR Readmissions by Primary Diagnosis* | Count of PCR Readmissions by primary diagnosis |
| *Beneficiary by Count of PCR Readmission* | The count and percentage of beneficiaries according to the number of PCR Readmissions |
| *PCR Readmissions by Age Band* | The count of PCR Readmissions, grouped by the age band of the beneficiary who encountered the event. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as visits. |
| *PCR Readmissions by Gender* | The count of PCR Readmissions, grouped by the gender of the beneficiary who encountered the event. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as visits. |



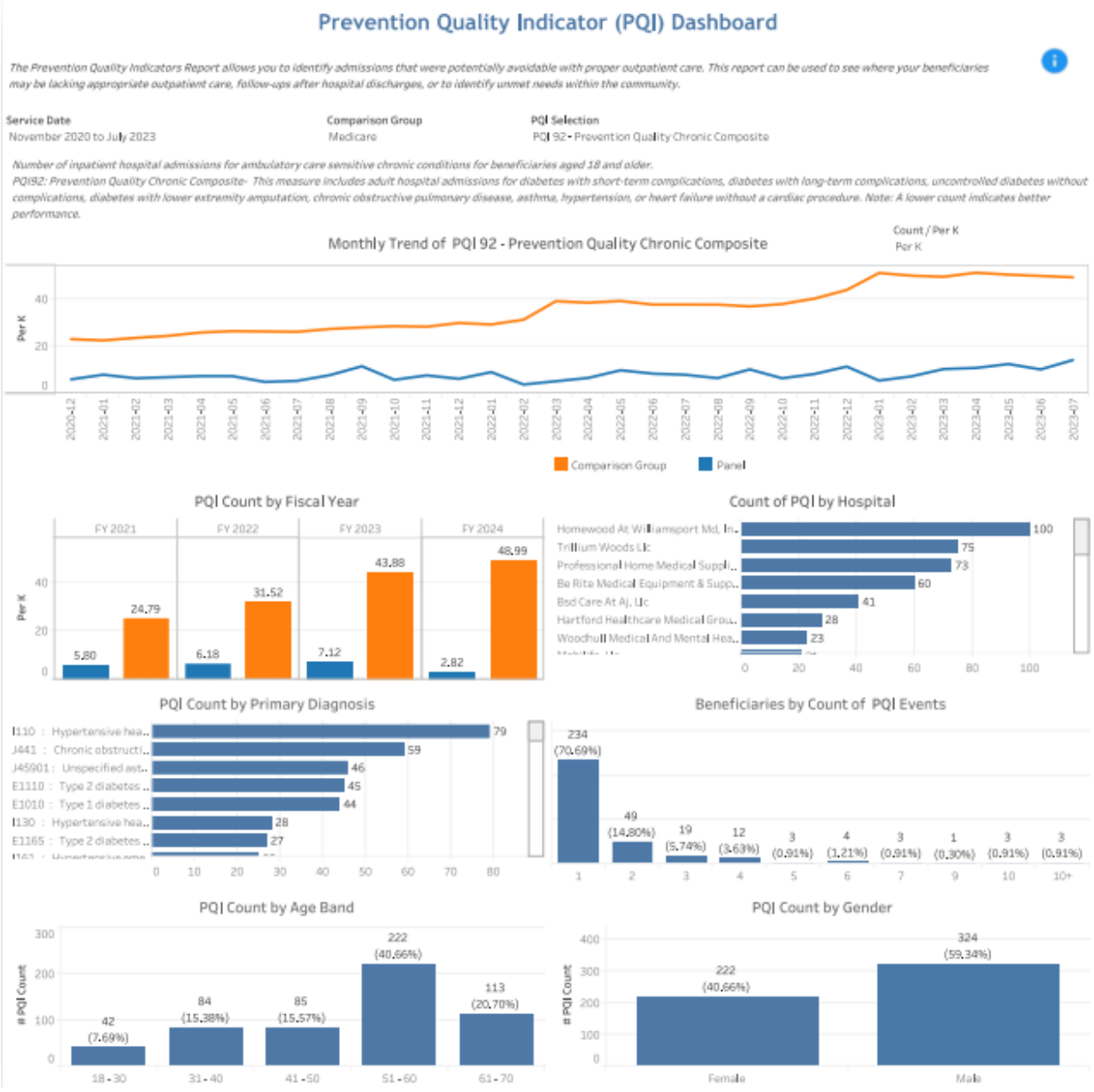

All data are fictitious – for demonstration purposes only.

# 2.7 PQI Utilization Report

The PQI Utilization Report allows users to view the details for the preventable quality indicators (PQIs) experienced by their attributed beneficiaries. This dashboard can help identify the most prevalent PQIs and help isolate beneficiaries (by demographic characteristic) who experience these events.

The Prevention Quality Indicators (PQIs) identify issues of access to outpatient care, including appropriate follow-up care after hospital discharge. More specifically, the PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality outpatient care. The PQIs are population-based indicators that capture all cases of the potentially preventable complications that occur in a given population (in a community or region) either during a hospitalization or in a subsequent hospitalization. The PQIs are a key tool for community health needs assessments. More details can be found at:
https://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx

| Chart Name | Description |
|---|---|
| *Monthly Trend of {Selected Measure}* | The monthly PQI rate or count depending on the PQI filter selection for the panel and selected Comparison Group. |
| *PQI Count by Fiscal Year* | For each fiscal year (July through June), the panel's and selected comparison group's overall PQI count per K for the selected PQI |
| *Count of PQI by Hospital* | The total count of PQI events by hospital. |
| *PQI Count by Primary Diagnosis* | Count of PQI admissions by primary diagnosis |
| *Beneficiary by Count of PQI Events* | The count and percentage of beneficiaries according to the number of PQI events |
| *PQI Count by Age Band* | The count of PQI events, grouped by the age band of the beneficiary who encountered the event. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as events. |
| *PQI Count by Gender* | The count of PQI events, grouped by the gender of the beneficiary who encountered the event. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as events. |

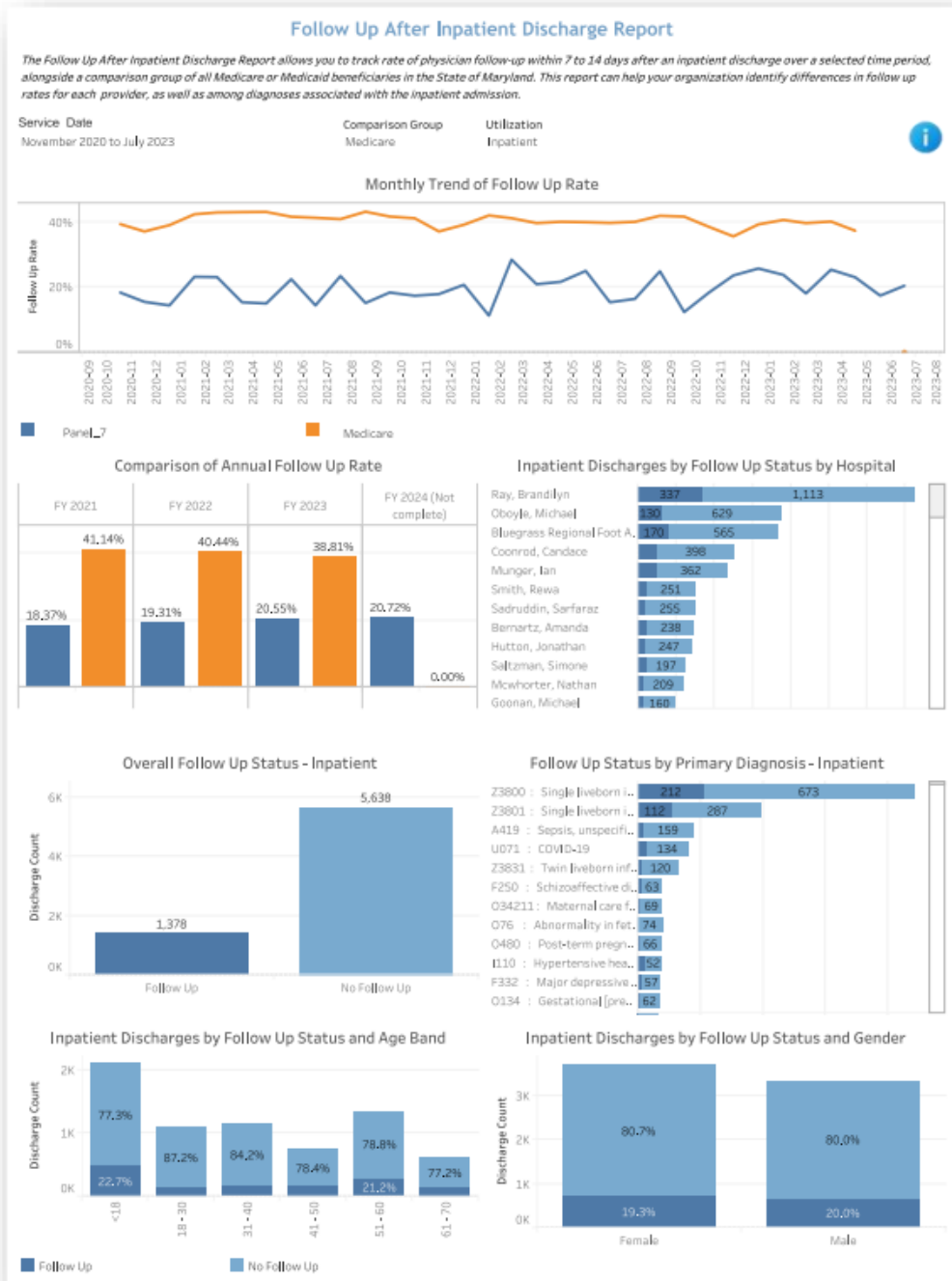



All data are fictitious – for demonstration purposes only.

## 2.8 Follow Up Post-Acute Setting Discharge Report

The Follow Up Post-Acute Setting Discharge Report dashboard allows users to track physician follow-up visits that were provided within 7-14 days after patient discharge from an acute care hospital admission or emergency room visit. Users have the flexibility to toggle between the Inpatient (IP) Hospital or Emergency Room (ER) views to analyze follow up visits related to these settings.

| Chart Name | Description |
|---|---|
| *Monthly Trend of Follow Up Rate* | The monthly follow up rate for inpatient or Emergency Room utilization. |
| *Comparison of Annual Follow Up Rate* | For each fiscal year (July through June), the panel's and selected comparison group's overall follow up rate. |
| *{Selected Measure} by Follow Up Status by Hospital* | Count of inpatient or emergency room services, as selected by the filter, with and without follow up, by hospital |
| *Overall Follow Up Status* | The total count of events, with and without follow up, based on the utilization service selected. |
| *Follow Up Status by Primary Diagnosis* | For each primary diagnosis code, the count of visits with and without follow up, based on the utilization service selected |
| *Beneficiaries by Follow-Up Status and Age Band* | The count of inpatient discharges or emergency room visits (based on selection), grouped by the follow up status of the event, and the age band of the beneficiary who encountered the service. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as visits. Stacked bar shows the percent of visits within that age band with and without follow up. |
| *Beneficiaries by Follow Up Status and Gender* | The count of inpatient discharges or emergency room visits (based on selection), grouped by the follow up status of the event, and the gender of the beneficiary who encountered the service. The drill through will produce a different number of beneficiaries than shown, as the data element in the chart is shown in as visits. Stacked bar shows the percent of visits within that age band with and without follow up. |




All data are fictitious – for demonstration purposes only.

## 2.9 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 Comparison Group.

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.

The PMPM Trend Report is limited to claim payments for Medicare FFS and Medicaid FFS beneficiaries only. For Medicaid MCO beneficiaries, all payments - including those for services rendered under capitated payment arrangements and those carved-out and paid at FFS rates - are excluded.

| 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 panel and Comparison Group for the selected time horizon. |
| *Providers by Payment Amount – All (or selected Provider Type)* | Table 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 hovering over a column header and clicking the 'sort by' icon.<br>When filtering to "Physician" claim type, additional detail is available in order to filter results by physician specialty, place of service, or individual physician.<br>** This functionality is not yet available. ** |

# PMPM Trend Report

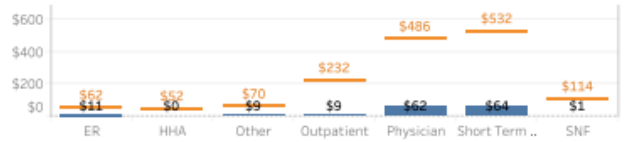
*The PMPM Trend Report allows you to identify per-member-per-month spending across care settings over a selected time period, alongside a comparison group of all Medicare or Medicaid beneficiaries in the State of Maryland. This report can help your organization identify drivers of health care spending.*

*The PMPM Trend Report is limited to claim payments for Medicare FFS and Medicaid FFS beneficiaries only. For Medicaid MCO beneficiaries, all payments - including those for services rendered under capitated payment arrangements and those carved-out and paid at FFS rates - are excluded.*

**Service Date**
November 2020 to July 2023

**Comparison Group**
Medicare

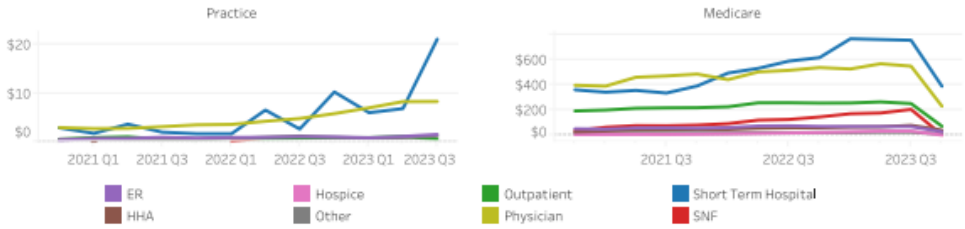
## PMPM by Claim Type




## PMPM by Part A/B


*Legend: Orange amounts indicate the average for the selected Comparsion Grourp*

## PMPM Trend




## Providers by Payment Amount - All

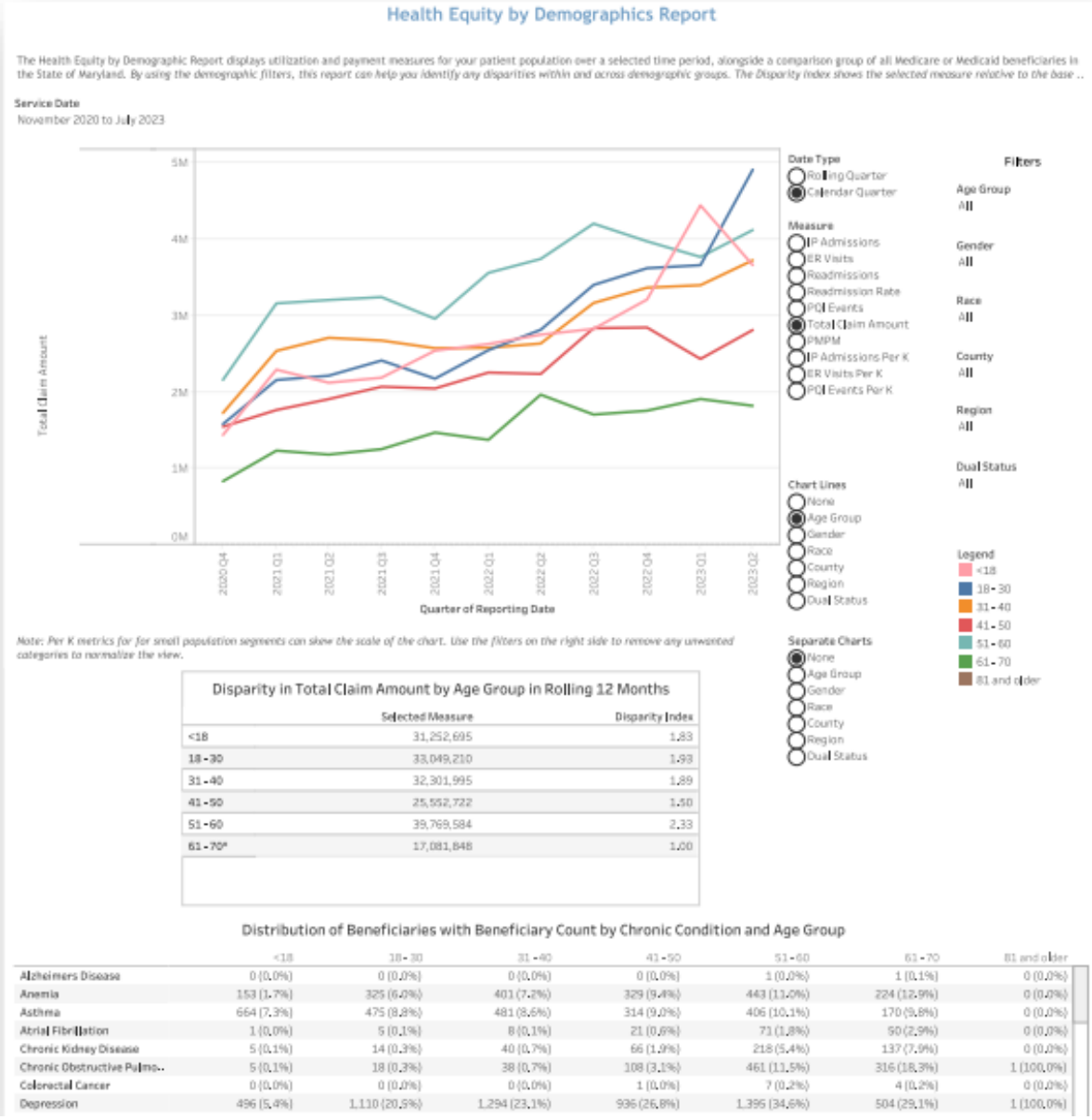
| Provider Name | Beneficiary Count | Claim Payment Amount | Avg. Claim Payment Amount |
|---|---|---|---|
| Homewood At Williamsport Md, Inc. | 5,715 | $948,402 | $1,252.84 |
| 111 Ford Ave Mi Opco Llc | 2,743 | $766,544 | $2,903.58 |
| Trillium Woods Llc | 3,764 | $596,190 | $1,461.25 |
| Slp Overton Llc | 8 | $393,305 | $393,305.00 |
| Surgical Recovery Systems | 1,678 | $381,566 | $2,826.41 |
| Complete Home Care Medical Equipment, Llc. | 1 | $270,198 | $6,004.40 |
| Woodhull Medical And Mental Health Center | 2,359 | $257,208 | $774.72 |
| Heartland Of Paxton Ii Llc | 18,366 | $232,288 | $94.16 |
| Bsd Care At Aj, Llc | 1,705 | $200,175 | $1,906.43 |
| Ds Best Care, Llc | 1 | $156,575 | $2,408.85 |
| Simon Medical Service | 2,279 | $154,409 | $913.66 |
| Elite Advantage Dm, Llc | 8 | $137,726 | $3,722.32 |
| Knasas City Vamed Ctr | 1 | $135,042 | $634.00 |
| Clarksburg Vamc | 1 | $130,390 | $6,519.50 |
| Arise Congregate Living, Inc | 1,241 | $122,848 | $789.93 |

Click and drag over multiple categories in the 'PMPM by Claim Type' bar chart to populate the PMPM Trend charts and Providers by Payment Amount table accordingly.

All data are fictitious – for demonstration purposes only.

# 2.10 Health Equity by Demographics Report

This report allows users to view select one of eleven measures to view utilization over time. Additionally, users may also restrict the population according to five demographic filters and on Medicare/Medicaid Dual Eligibility status.




All data are fictitious – for demonstration purposes only.

| Measure | Description |
|---|---|
| *IP Admissions* | The count of admissions to short term acute-care hospitals |
| *ER Visits* | The count of emergency room claims. |
| *Readmission* | The count of admissions to an acute care hospital following discharge from an acute care hospital. See Section 4.4 for additional detail. |
| *Readmission Rate* | The total readmissions divided by the number of admissions eligible for a readmission. See Section 4.4 for additional detail. |
| *PQI-Events* | IP admissions with diagnosis codes included in the Prevention Quality Indicator taxonomy. |
| *Total Claim Amount* | Sum of all Medicare Part A and Part B claims for attributed beneficiaries. |
| *PMPM* | Per Member Per Month; Total Claim Amount divided by the number of eligible and attributed beneficiaries in a month. |
| *IP Admissions Per K* | IP Admissions divided by the count eligible and attributed beneficiaries in a given month multiplied by 1,000. |
| *ER Visits Per K* | Emergency room claims divided by the count of eligible beneficiaries in a given month multiplied by 1,000. |
| *PQI Events Per K* | PQI Events divided by the count of eligible beneficiaries in a given month multiplied by 1,000. |

The *Chart Lines menu* allows a user to break out the metrics according to the selection. The *Separate Charts menu* allows a user to create separate charts according to the selection.

| Chart Lines/Separate Chart | Description |
|---|---|
| *None* | |
| *Age Group* | Age bands; <18, 18-30, 10 year age bands up to 80, 85 and older |
| *Gender* | Gender of the beneficiaries; Female, Male |
| *Race* | Race of beneficiary; Asian, Black, Native American, Other, Unknown, White |
| *County* | Maryland county of beneficiary residence. |
| *Region* | Maryland Department of Health region; Capital, Central, Eastern Shore, Outside MD, Southern, Western. |
| *Dual Status* | Indicator of whether a beneficiary was eligible for both Medicare and Medicaid for at least one month in the 36-month period included in the CCLF. |
| *Medicare Status* | How the beneficiary qualifies for Medicare; Aged or Disabled. |

## 2.10.1 Disparity by Measure in Selected Demographic

This report calculates a disparity index to better understand the differences in utilization per K across demographic populations. Each demographic category has a base category from which each other category is compared. A disparity index of 1.0 indicates that the given population has utilization per K that is comparable to the base population. A disparity index less than 1.0 indicates that utilization per K for the demographic category is lower than the base population, whereas a disparity index above 1.0 indicates rates higher than the base population. Disparity indices are calculated by dividing the respective population's measure by the base population measure value. Drill through to Beneficiary Details from a selection in the disparity table.

The base populations are indicated with an asterisk (*) in the report and listed in the table below:

| Chart Line | Base Population |
|---|---|
| *Age Group* | 61-70 |
| *Gender* | Female |
| *Race* | White |
| *County* | Base county is the one in which the most beneficiaries reside for the selected practice(s) |
| *Region* | Base region is the one in which the most beneficiaries reside for the selected practice(s) |
| *Dual Status* | No |

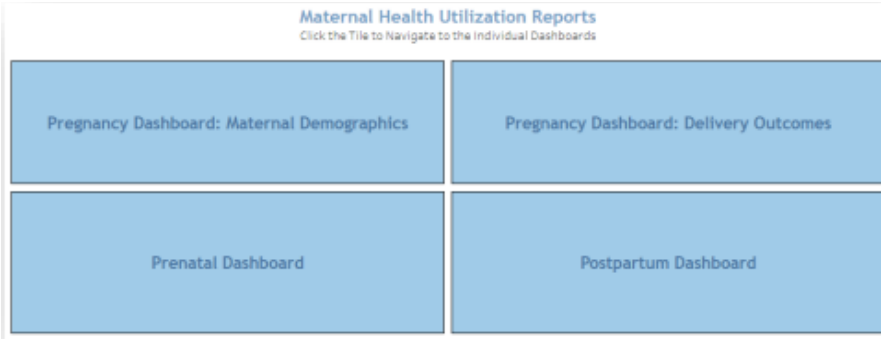
## 2.10.2 Distribution of Beneficiaries with Selected Measure by Chronic Condition and Chart Line

This table identifies the proportion of beneficiaries, by chronic condition, who have utilization of the measure selected (see section 2.2.3 for more information on chronic conditions). The table will include all Chart Line categories as the columns in the table. For example, in the image of the report above, the columns are the age groups and the beneficiaries included are those with any IP utilization. Only beneficiaries with the specified utilization metric are included in the table. The percent indicates the percent of beneficiaries within the column with the chronic condition of interest.

Note that drill throughs to Beneficiary Details from a cell in this table will include all beneficiaries in that row/with the corresponding chronic condition. For example, with Chart Lines set to Gender, this table will have columns for Female and Male. Accessing the drill through from the Hypertension row will produce Beneficiary Details with both female and male beneficiaries with a chronic condition of Hypertension. Beneficiary Details filters for Gender will help users identify the specific population of interest.

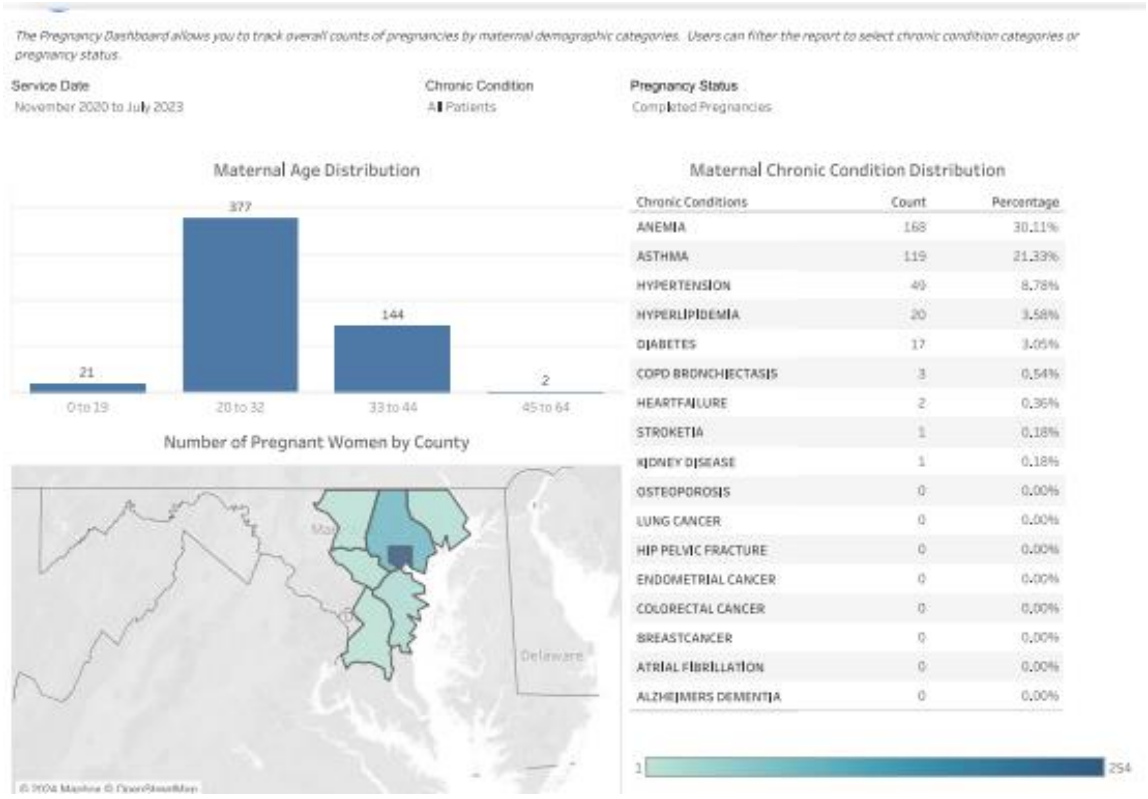
## 2.11 Maternal Health Utilization Report

Maternal Health Report consists of four dashboards that span prenatal care, delivery, and postpartum care.




### 2.11.1 Pregnancy Dashboard: Maternal Demographics Dashboard

Pregnancy Dashboard: Maternal Demographics allows users to view the distribution of beneficiaries by maternal age, maternal chronic condition, and the number of pregnant women by neighborhood.

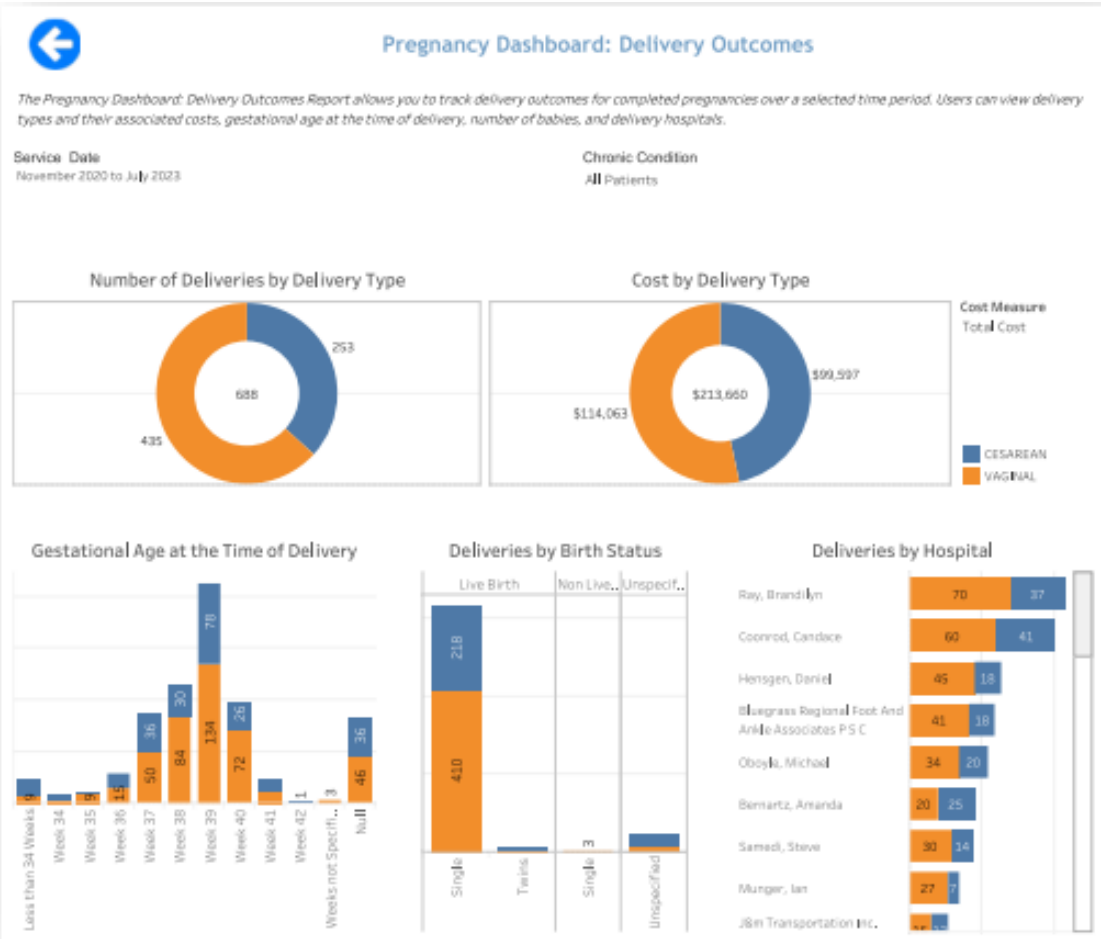



All data are fictitious – for demonstration purposes only.

| Chart Name | Description |
|---|---|
| *Maternal Age Distribution* | Count of beneficiaries with ongoing or completed pregnancies by age band. |
| *Maternal Chronic Condition Distribution* | Count and percentage of chronic conditions among beneficiaries with ongoing or completed pregnancies. |
| *Number of Pregnant Women by County* | Map with color indicating the number of beneficiaries with ongoing or completed pregnancy. Darker blue indicates a higher number. |

## 2.11.2 Pregnancy Dashboard: Delivery Outcomes Dashboard

The Pregnancy Dashboard: Delivery Details allows users to view the distribution of deliveries and delivery costs by delivery type - cesarean or vaginal. The dashboard also includes the gestational age at the time of delivery, number of babies by birth status, and number of deliveries by hospital.

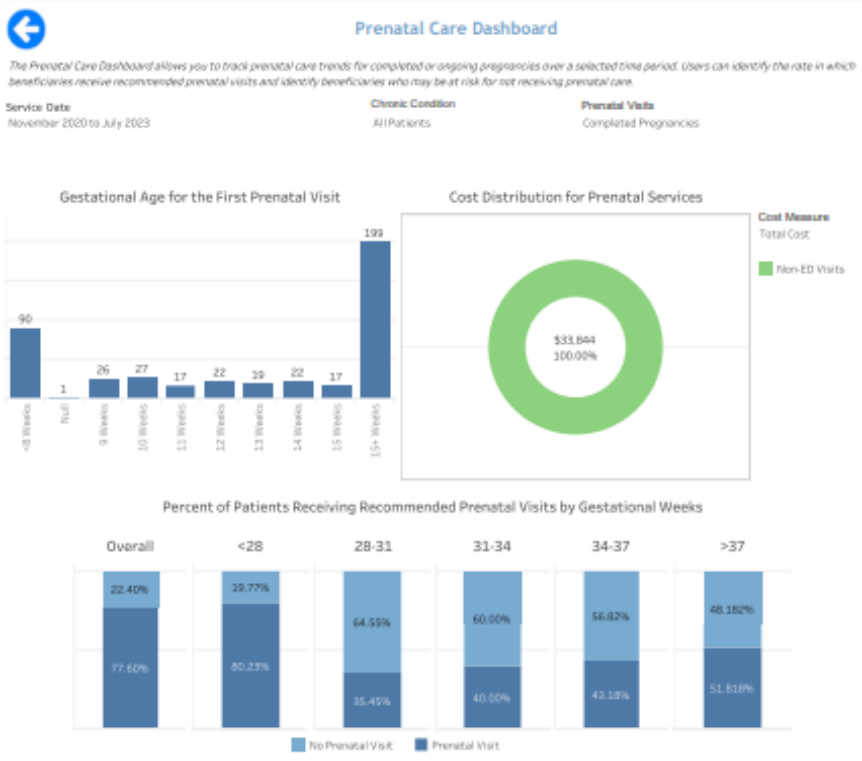



All data are fictitious – for demonstration purposes only.

| Chart Name | Description |
|---|---|
| *Number of Deliveries by Type* | Count of deliveries by type, vaginal and cesarean, with the total in the middle. |
| *Cost by Delivery Type* | The total claim payments for each delivery type, with the total in the middle. |
| *Gestational Age at the Time of Delivery* | Count of deliveries by gestational age in weeks. |
| *Deliveries by Birth Status* | Count of deliveries with indication for live births and number of births per delivery - single births, twin births, 3 or more babies delivered, or unspecified. |
| *Deliveries by Hospital Name* | Count of deliveries for each hospital. |

## 2.11.3 Prenatal Care Dashboard

The Prenatal Care dashboard allows users to view the distribution of the gestational age for the patient's first prenatal visit, cost distribution for the prenatal service categories, and distribution of patients receiving prenatal visits according to recommended guidelines.[1] The dashboard allows users to view these metrics for ongoing and completed pregnancies and includes beneficiary- level and claim-level drill-throughs.



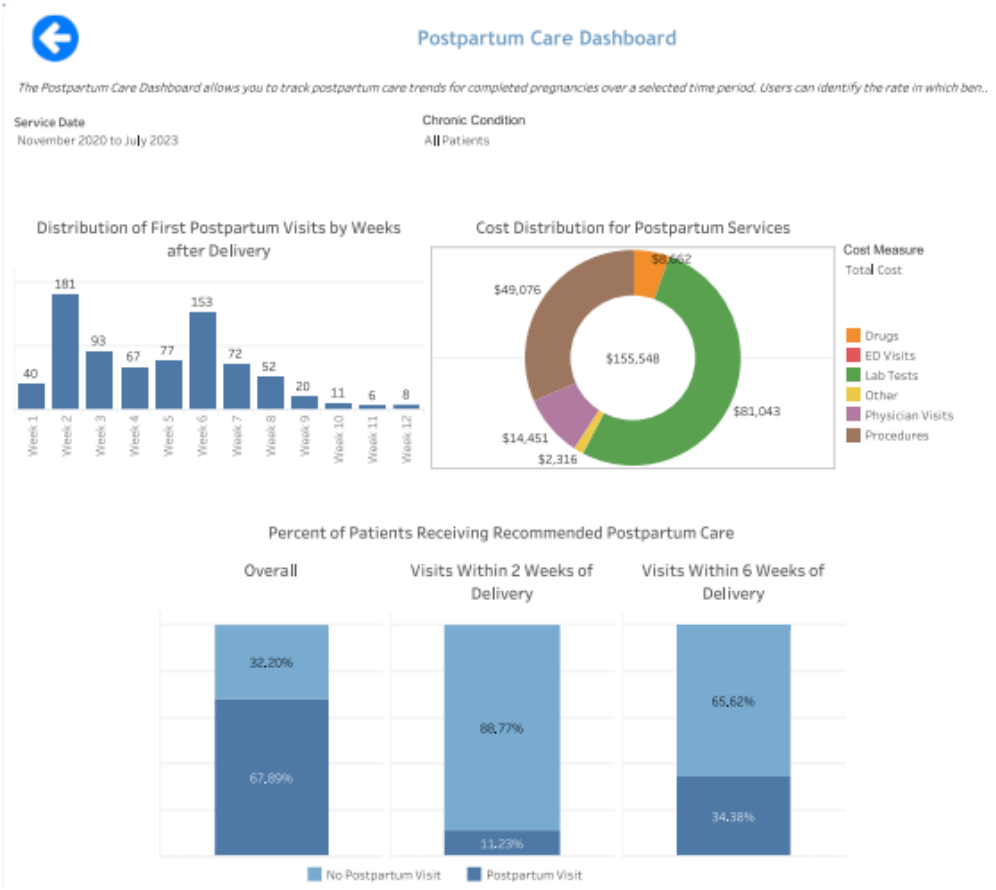

All data are fictitious – for demonstration purposes only.

[1] https://health.maryland.gov/phpa/mch/pages/prenatal.aspx#:~:text=your%20future%20baby.-,PRENATAL%20VISITS,seen%20every%20week%20until%20delivery

| Chart Name | Description |
|---|---|
| *Gestational Age for the First Prenatal Visit* | For ongoing or completed pregnancies, gestational age in weeks when the first prenatal visit occurred. |
| *Cost Distribution for Prenatal Services* | Total Cost or Average Cost and service type of all prenatal services for ongoing or completed pregnancies. |
| *Percent of Patients Receiving Recommended Prenatal Visits by Gestational Age* | Of all ongoing or completed pregnancies identified, percentage of beneficiaries who received a recommended prenatal visit during gestational weeks 37. |

## 2.11.4 Postpartum Care Dashboard

The Postpartum Care Dashboard allows users to view the distribution of the first postpartum visit by weeks after delivery, cost distribution for the postpartum service categories, and distribution of patients receiving postpartum care according to recommended guidelines. The dashboard includes beneficiary-level and claim level drill-throughs.



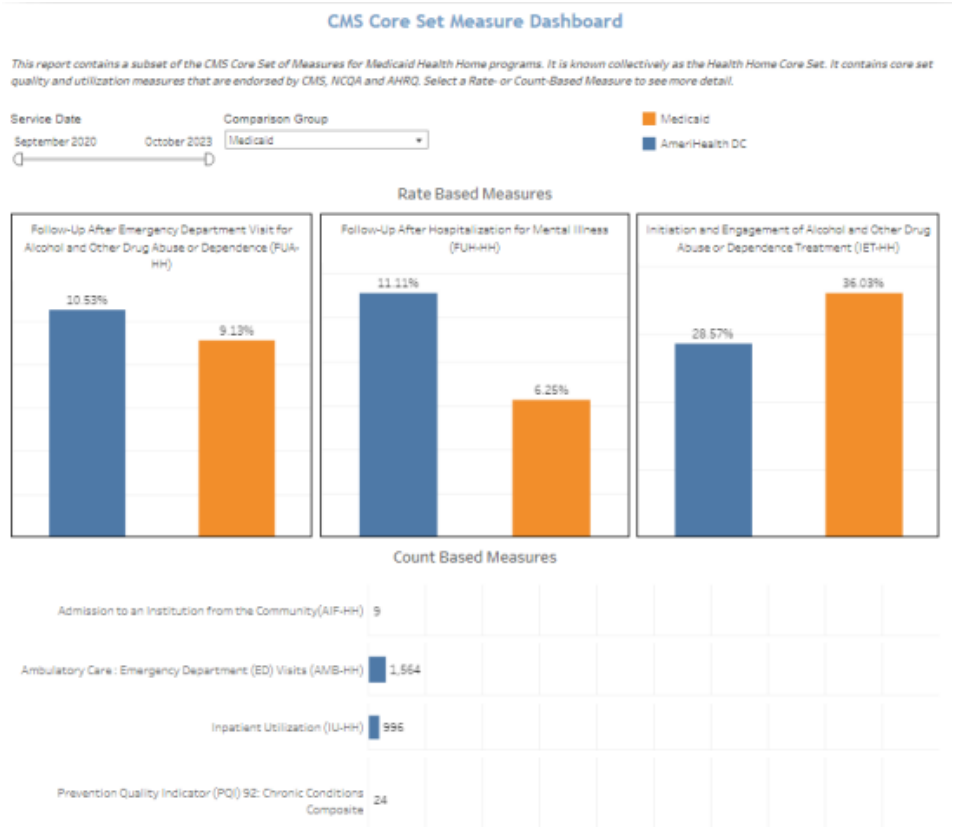

All data are fictitious – for demonstration purposes only.

| Chart Name | Description |
|---|---|
| *Distribution of First Postpartum Visits by Weeks After Delivery* | Count of beneficiaries by postpartum weeks indicating when the first postpartum visit(s) occurred. |
| *Cost Distribution for Postpartum Services* | Total Cost or Average Cost and service type of all postpartum services. |
| *Percent of Patients Receiving Recommended Postpartum Care* | Percentage of beneficiaries receiving recommended postpartum care within two weeks of delivery, within six weeks of delivery, and overall. |

## 2.12 CMS Core Set Measures Reports

The Summary Dashboard contains a subset of the CMS Core Set of Health Care Quality Measures for Medicaid Health Home Programs. It includes select core set quality and utilization measures endorsed by CMS, NCQA, and AHRQ.

To access a specific report, click within any measures' chart in the CMS Core Set Measure Dashboard.




All data are fictitious – for demonstration purposes only.

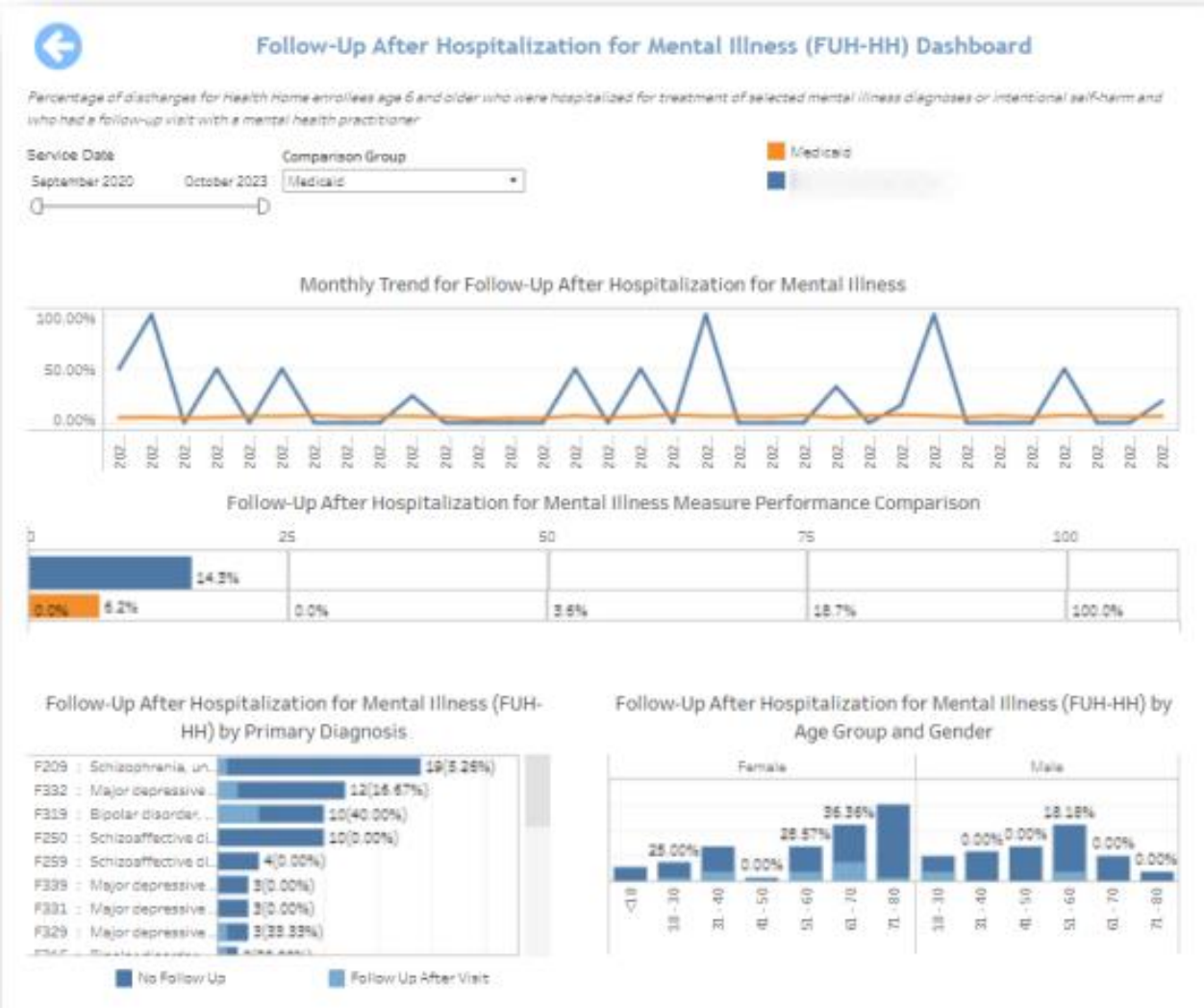
The Core Set Measure reports include the following measures:

1. *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH) Dashboard:* The FUA-HH dashboard allows users to view the percentage of emergency department (ED) visits for beneficiaries aged 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence.
2. *Follow-up After Hospitalization for Mental Illness (FUH-HH) Dashboard:* The FUH-HH dashboard allows users to view the percentage of discharges for beneficiaries aged 6 and older hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who have a follow-up visit with a mental health practitioner.
3. *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH) Dashboard:* The IET-HH dashboard allows the users to view the percentage of beneficiaries aged 13 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the Initiation Engagement of AOD Treatment. The dashboard also includes the monthly trend of the IET measure.
4. *Admission to an Institution from the Community (AIF-HH) Dashboard:* The AIF-HH dashboard allows users to view the number of admissions to an institution among beneficiaries aged 18 and older residing in the community for at least one month. The dashboard includes the monthly trend of institution visits and the top diagnosis by the number of visits.
5. *Ambulatory Care: Emergency Department (ED) Visits (AMB-HH) Dashboard:* The AMB-HH dashboard allows users to view the number of admissions to an institution among beneficiaries aged 18 and older residing in the community for at least one month. The dashboard includes a monthly trend by ED visits.
6. *Inpatient Utilization (IU-HH) Dashboard:* The IU-HH dashboard allows users to view the rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) among Medicaid beneficiaries. The dashboard includes the monthly trend of inpatient visits, top IP diagnosis by the number of visits, and the amount paid.
7. *Prevention Quality Indicator (PQI) 92:* Chronic Conditions Composite (PQI92-HH) Dashboard: The PQI92-HH dashboard allows users to identify potentially avoidable admissions with proper outpatient care. The dashboard can be used to see where the beneficiaries may lack appropriate outpatient care, follow-ups after hospital discharges, or to identify unmet needs within the community.

## 2.12.1 Report Formats

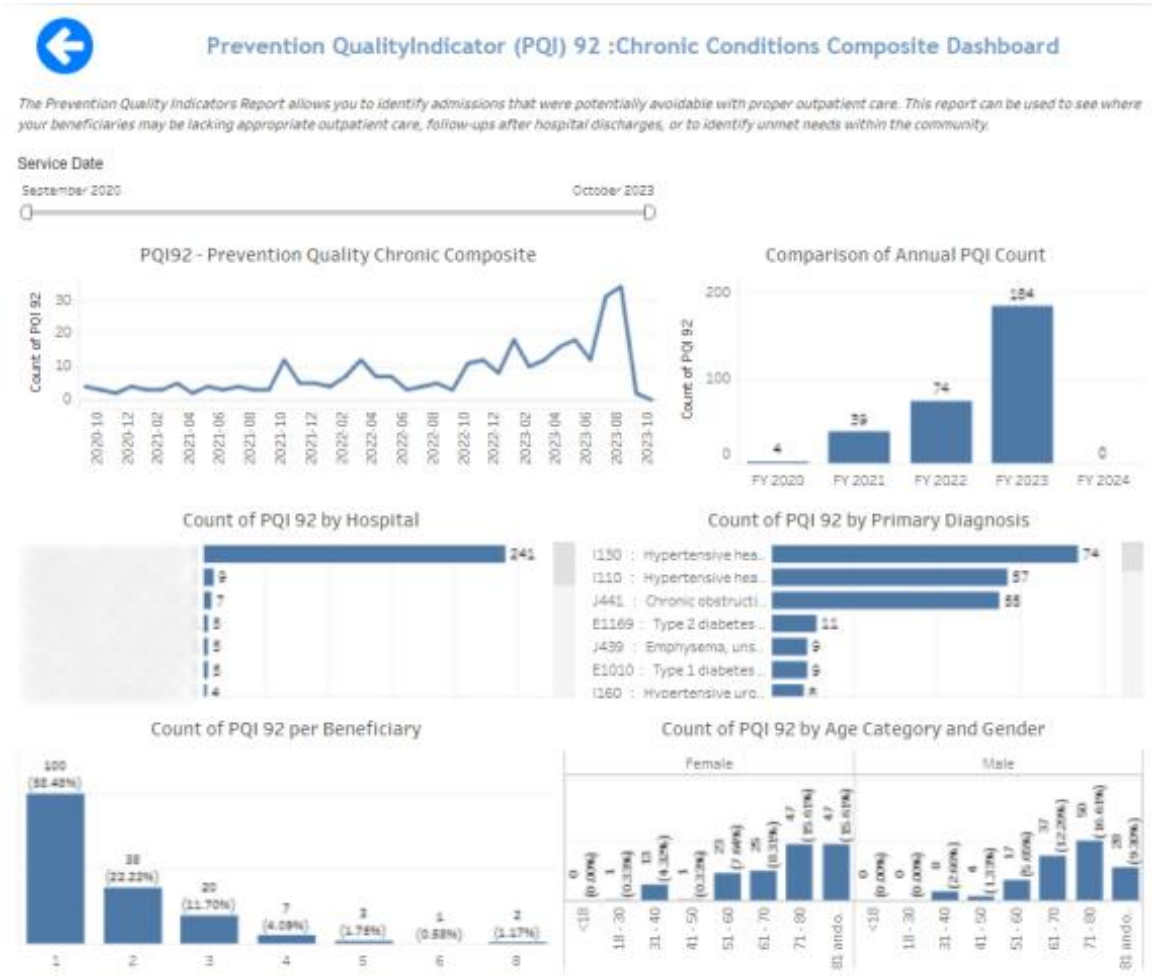
The Core Set Measures reports are presented in one of the three different formats.

The FUA-HH, FUH-HH, and IET-HH measures are presented in the following manner.



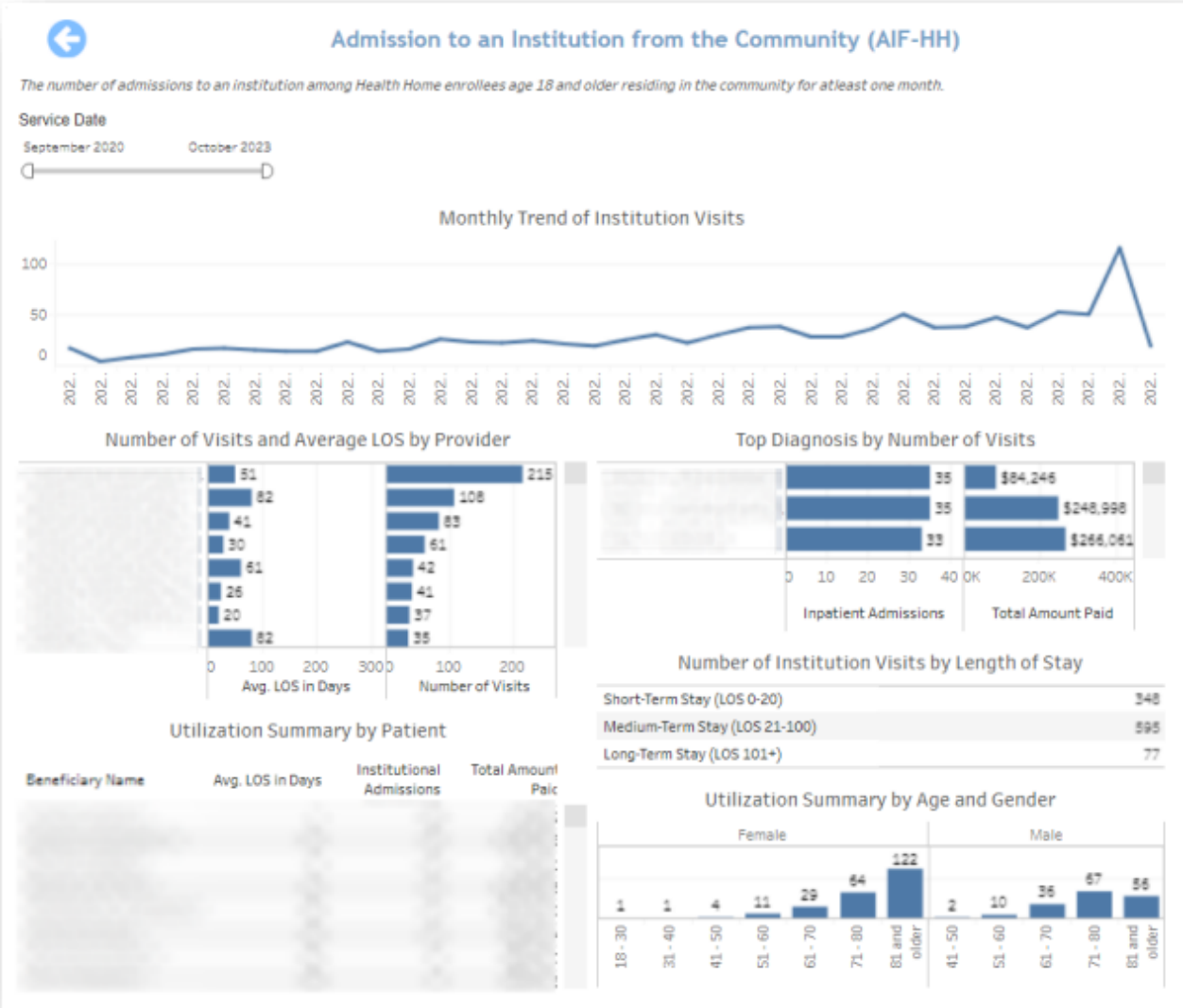

| Chart Name | Description |
|---|---|
| *Monthly Trend for [Measure]* | The monthly measure performance by month. |
| *[Measure] Performance Comparison* | Measure's performance for the panel compared to the selected comparison group. |
| *[Measure] by Primary Diagnosis* | The count and measure performance by primary diagnosis of the beneficiary. |
| *[Measure] by Age Category and Gender* | Measure performance by age category and gender. |

PQI92-HH measure is presented in the following format.




| Chart Name | Description |
|---|---|
| *Monthly Trend of [Selected Measure]* | The monthly measure rate or count for the panel and selected Comparison Group. |
| *Number of [Measure] by Hospital* | The total count of measures by hospital. |
| *Comparison of Annual [Measure]* | For each fiscal year (July through June), the panel's and selected comparison group's overall measure rate. |
| *Number of [Measure] by Primary Diagnosis* | Count of beneficiaries with a given number of measure events |
| *Beneficiary Count by [Selected Measure]* | The count and percentage of beneficiaries according to the number of measure events. |
| *Count of Beneficiaries with [Measure] by Age Category and Gender* | The count and percentage of measure events grouped by age band and gender. |

AIF-HH, AMB-HH, and IU-HH measures are presented in the following format.




| Chart Name | Description |
|---|---|
| *Monthly Trend of [Selected Measure]* | The monthly measure rate or count for the panel and selected Comparison Group. |
| *Number of [Measure] by Provider* | The total count of measures by provider. |
| *Top Diagnosis by Number of Visits* | Count of measure visits by primary diagnosis. |
| *Utilization Summary by Patient* | Beneficiary-level details including count of events and total payments. |
| *Utilization Summary by Age and Gender* | Measure performance by age category and gender. |

# 3 Drilldown Reports

## 3.1 Beneficiary Details

Beneficiary Details may be accessed directly through the Population Summary, as well as through drill throughs in all reports except the Core Set Measure reports. Beneficiary Details presents the same columns and sort/filter functionality as available in Population Navigator but does not include the Measure selection or Roster functionality. See section 2.2.1 for the complete list of columns available in Beneficiary Details.

Beneficiary Details includes information limited to any filters or selections through which the user accessed the view. For example, when drilling through from Beneficiary Count, in a report with date filters the Service Start Month and Service End Month filter selections will constrain utilization measures to experiences in that period in Beneficiary Details.

## 3.2 Claims Details

Claims details may be accessed through Beneficiary Details, either from Population Summary or any report drill through. Drilling through Beneficiary Details by selecting a beneficiary will show claims for that beneficiary consistent with any filters applied or selections in the parent report (e.g. date ranges).

The report includes the beneficiary unique identifiers, Name, Claim From and Claim Through dates, Claim Type Group, Primary Diagnosis, Provider Name, Claim Count, and Claim Payment Amount.

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

To access Claim Details from Beneficiary Details for an individual, click on any beneficiary’s blue unique identifier, and Claim Details will open in a new window within the application. Use the Excel button in the top right to export Claims Detail as an Excel file and close the window using the “X” icon above the Excel export button to return to Beneficiary Details.

# 4 Help

## 4.1 Glossary

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

| Term | Definition |
|---|---|
| *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. |
| *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 Beneficiaries* | 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 beneficiaries. |
| *Physician* | Type of service; includes all physician Part B services regardless of site of service. |
| *Planned All Cause Readmission (PCR)* | The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. The risk adjustment is not used. More Information. |
| *PMPM* | Per Member Per Month (PMPM) is a common measure for analyzing a population. This measure factors in the number of beneficiaries (or "member" – in this case Part A and Part B beneficiaries) as well as the time each beneficiary was enrolled (i.e. beneficiary months). The most common usage is for payments, where the PMPM measure is the average payments for a beneficiary over one month. |
| *PQI* | The Prevention Quality Indicators (PQIs) identify issues of access to outpatient care, including appropriate follow-up care after hospital discharge. More specifically, the PQIs use data from hospital discharges to identify admissions that might have been avoided through access to highquality outpatient care. The PQIs are population-based indicators that capture all cases of the potentially preventable complications that occur in a given population (in a community or region) either during a hospitalization or in a subsequent hospitalization. More Information. |
| *Non-Emergent ED* | NYU Center for Health and Public Service Research algorithm that classifies ED visits into Nonemergent and three other groups. The NED measure counts Non-emergent as a percentage of total ED visits. https://wagner.nyu.edu/faculty/billings/nyued-background. NED is used as a proxy for LANE. LANE is the official DHCF algorithm for measuring ED use. |
| *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. |

## 4.2 Data Basics

### 4.2.1 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 Multi-Payer Reporting Suite is powered by the latest 36 months of data for 100% of the Maryland Medicare beneficiaries.[2] 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.

### 4.2.2 Medicaid

The Medicaid datasets used in this reporting suite are the Medicaid FFS claims and encounter data. The Medicaid claims data contains all claims for all Medicaid covered services across care settings, including institutional, medical, and pharmacy claims. The datasets include beneficiary claim level data including Medicaid payment amounts, diagnoses, procedures, dates of service, and provider identifiers. Provider cost information is not included in the data.

The Medicare encounter data reflects health care services received for beneficiaries who are enrolled in a Medicaid Managed Care organization (MCO). As Maryland Medicaid agency does not process the claim nor pay the provider directly, for services rendered for MCO beneficiaries, the administrative record available for these services differ from those

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

for FFS beneficiaries. Specifically, the encounter data does not always contain a payment amount. When a payment value is present, it does not always reflect the full payment the provider received.

*Effective December 2023, all payment rates for encounter claims for MCO beneficiaries will be removed from the reporting suite to prevent the inaccurate interpretation of the health care utilization. Payments for claims for services carved-out of capitated payment arrangements (services paid under Medicaid FFS) are still included. In a subsequent release, services provided to MCO beneficiaries will be re-priced according to the Maryland Medicaid Fee Schedule (and prevailing GBR rates). This will enable the appropriate comparison or aggregation of populations that include MCO beneficiaries.*

The Multi-Payer Reporting Suite is powered by the latest 36 months of data for 100% of the Maryland Medicaid beneficiaries. Use of this data is governed by a data use agreement 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.

The Medicare and Medicaid claims data are linked together (in the case of dual eligibles) using CRISP Enterprise Identifier (EID).

## 4.3 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 Multi-Payer 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 three months are considered incomplete. Therefore, the more reliable months are displayed by default with the option to include the more recent three "lag" months.

## 4.4 Readmission

A readmission is defined as an 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.

Readmissions can only occur following a discharge from an acute care hospital with a subsequent admission to the same or other acute care hospital within the measured period. In order to be counted as a readmission, the readmission must not be planned. Generally, planned readmissions are limited to:

1. Specific types of care that are always considered planned (transplant surgery, maintenance chemotherapy/immunotherapy, rehabilitation);

2. A non-acute readmission for a scheduled procedure.

In order for a hospitalization to be eligible for a readmission, the index admission must:

1. Not be for rehabilitation.
2. Not be for a number of psychiatric disorders, according to CCS Diagnosis category.

In the often cited 30-day readmission rate, transfers from one short-term acute care facility directly to another short-term acute care facility are excluded. In Multi-payer reporting, transfers are defined according to the CRISP Standard Acute-to-Acute Transfer logic as an admission to an acute care hospital on either the same or next day following discharge from an acute care hospital. Of note, in the event of a transfer, the admission at the hospital to which the beneficiary is transferred is eligible for a readmission but not the admission at the transferring hospital.