CRISP

Medicare Performance Adjustment (MPA) Year 5 Monitoring Reports User Guide

By HSCRC and CRISP, last updated 6/17/2022

CONTENTS

1. Purpose

The purpose of this document is to define and clarify how to use CRISP's MPA Monitoring Report.

The MPA is an HSCRC adjustment for each hospital based on its performance in improving Medicare total cost of care for attributed Maryland Medicare beneficiaries. The MPA Monitoring Report allows hospital users to track utilization and cost for attributed beneficiaries and understand how their hospital compares to other Maryland hospitals on various metrics for Medicare FFS beneficiaries. For more information on HSCRC's MPA Policy, please visit the following HSCRC website page: http://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx.

Note that HSCRC calculates hospital MPA performance using CCLF data. CRISP built the MPA Monitoring Reports using CCLF data provided to HSCRC by CMS. Tab 1A-1 MPA Monitoring Reports allows hospitals to monitor MPA performance using CCLF and compare at a high level MPA trends in using both CMMI National and CCLF State data. Drill down reports 1A-1, 1A-4 and 1A-5 provide additional information for monitoring performance and a multi-hospital views.

As this report is focused on analysis of attributed beneficiaries, references to hospitals or facilities are typically referring to the attributed beneficiaries of that facility (the MPA Assigned Facility) rather than those beneficiaries directly receiving care at the facility.

2. Timeframe

Current Base Period = CY 2019, with run out through March 2020

Current Performance Period = CY22. CRISP will add additional months of 2022 as the year completes and 3 months of run out is available. Typically, a month will be added in the standard release at the beginning of the month, limited to the latest month with 3 months of run out, i.e., the latest month in the MPA reports will usually be 5 months prior to the current month. For example, CRISP will add May incurred data in early October (3 months completion = August, August data received from CMS in late September for inclusion in October release). In the event that receipt of CCLF data from CMS is delayed, CRISP will update reporting mid-month.

Be advised that CY2020 and CY2021 dates are selectable in certain reports. These dates will not populate any data in the reports. Additionally, whenever a selected date range spans a month in 2019 through a month in 2022, no 2020 or 2021 data are included in the figures.

3. Population

The population for this report is all Maryland Medicare Fee-for-Service (FFS) members who have both Part A and Part B coverage.

4. Exclusions

See exclusions in discussion of the Hospital Attributed Sandbox.

5. HIPAA Protected Health Information (PHI) Warning

In general, all data in these reports is at an aggregate level and does not contain PHI. However, some queries may result in very small cell sizes resulting in the possibility of creating potentially identifiable data. Therefore, access to this tool is restricted to users with full PHI access at their facilities and it is advisable that these users consider all HIPAA requirements, including the "minimum necessary" requirement, if sharing all or part of this report when small cell sizes are generated.

6. MPA Y5 Reports

This reporting suite contains three views to track hospital performance in the MPA over time:

1. All Hospital Sandbox
2. Hospital Attributed Sandbox
3. MPA Monitoring Reports

For MPA Y5 reports, hospital inpatient and outpatient claim payments in 2022 have been adjusted, by hospital, to remove the effective MPA reward or penalty percentage that has been applied by CMS for the specific claim. This neutralized payment is presented for all claims data presented in MADE as well as all other CCLF-based reports in CRISP Reporting Services. Claims in prior periods (2019 through 2021) have not been neutralized.

MPA Monitoring Report Access/Card

The MPA Monitoring Report can be accessed by visiting reports.crisphealth.org and logging-in with a CRS username and password. Once in the CRS Portal, a dashboard of different report 'cards' will appear based on the access of the user. First click the card titled "Medicare Population. Then the "MPA Monitoring Reports Y5 2022/2019" is where users can

click to access the MPA reports for the 2022 performance year from the menu (Year one, two, three, and four reports are available through the respective cards). The tableau icon gives access to the most up to date tableau dashboard reports. The question icon will pull up documentation such as user guides and data dictionaries.

Upon selecting a report, the user will have access to all data they are entitled to in that report. It is not necessary to select a facility in the top right selection box.

The report set options are described in more detail below. **Generally, the MPA Monitoring Reports are intended to meet most user needs**. The remaining reports provide an opportunity to access the data at a much more detailed level in a flexible interface.
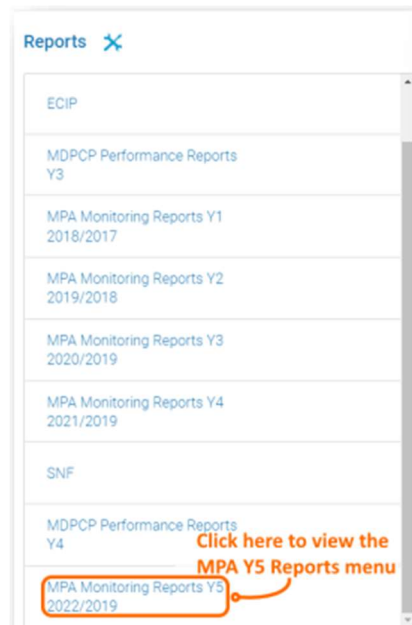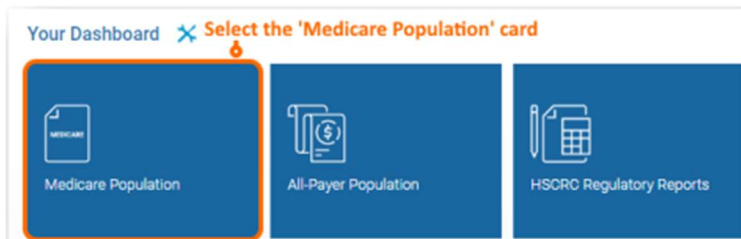
All Hospital Sandbox

This report is a tableau dashboard which allows users to analyze Medicare FFS utilization and costs both in total and on a per beneficiary level across Maryland. All users will have access to all of the Maryland data in this report with the exclusion of certain data fields as discussed below. Key components of this report are as follows:
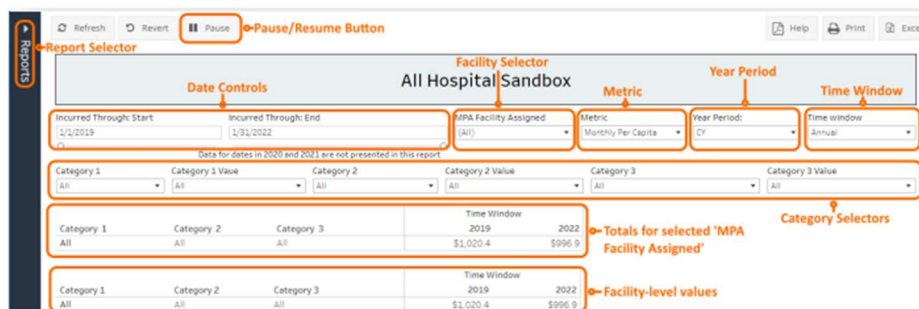
Report Selector: Allows switching to the other reports in the MPA Monitoring Report Card.

Pause Button: Report execution can be paused by pressing this button. If multiple changes are to be made to report parameters it is advisable to press pause first to prevent individual execution of each selection. Once all selections have been, made press this button again to execute the report.

Excel Download: This will trigger a download of the currently executed report to Excel. As column headers will not download it will be necessary to manually label the download.

Time Controls: There are 4 controls that impact what time periods and time slices are displayed:

Incurred Through Start and Incurred Through End Sliders: These sliders establish the period of data displayed in the report. All data is assigned to an incurred month, so selecting any day in the month on one of the sliders will yield the same answer. Reporting is not available at an individual day level. All data is displayed with a minimum of 3 months run out, so the last period available will be limited by the availability of 3 months of run out. Run out is included through March 31st of the following year, if available, so a maximum of 15 months of run out for January and 3 months of run out for December. This run out period matches that used by CMS in the CCW scorekeeping data.

Year Period Drop Down: Year Period controls how periods in the displayed view are defined:

- CY – Periods will match Calendar Years. If the incurred period crosses two calendar years then data will be segmented into two partial calendar years.
- 6/30 FY – Periods will match 6/30 Fiscal Years. If the incurred period crosses two 6/30 Fiscal years then data will be segmented into two partial fiscal years.
- Rolling – Periods will be defined as 12-month periods with the last one ending on the Incurred Through End Date. If more than 12 months but less than 24 months is brought into the view then the earliest year will be incomplete.
- YTD – Performance will reflect data through the latest available month, base year data will be shown through the same month in that year.

Time Window Drop Down: Time Window controls the segmentation within the defined period:

- Monthly – Displays months
- Quarterly – Displays quarters. In CY Year Period, Q1 will contain Jan to March. In 6/30 FY Year Period, Q1 will contain July to Sept. In Rolling Year Period, Q4 will be the last 3 months in the window shown and other quarters will work back from

that. If the months of data pulled into the view is not a multiple of 3 months then the earliest quarter will reflect a partial quarter.

- Annual – Segments as defined by Year Period. Rolling Year Period will show the last 12 months as a year and work backwards from that. If the months of data pulled into the view is not a multiple of 12, the earliest year will be a partial year.

Facility Selector: Limits the report to one or more MPA Assigned Facility(ies). The report will then display only results for the beneficiaries attributed to that facility(ies). If the report is to be limited to one facility, using this field to select that facility first will improve response time. If aggregated reporting for multiple facilities is desired, selecting multiple facilities in this drop down will aggregate those facilities in the report generated. If multiple facilities are to be viewed separately this can be done by selecting MPA Assigned Facility in the Category Selectors described below and selecting the facilities desired in the category value drop down.

Metric: Defines the metric displayed in the report. A list of metrics and their definitions can be found in the PDF available by clicking on the Question Mark icon on the report entry screen. There are special considerations in using the Unique Patient Count metric that are documented in the definitions document.

Category Selectors: Allow for the selection of up to 3 categories that will be arrayed on the left-hand side of the report to slice the data. Each Category has 2 values:

- Category: Determines the data slicer. Categories allow the slicing of data along multiple dimensions. Categories are either 1) Beneficiary based, i.e., related to the attributes of a beneficiary, like age, or 2) Claim based, i.e., related to the attributes of a claim, like provider specialty. A full list of the categories and their definitions is available by clicking on the Question Mark icon on the report entry screen. This document also includes a discussion of the differences in behavior of Claim and Beneficiary based categories. If a report is to be sorted, the category to be used in the sorting should be specified as Category 1.
- Category Value: These drop down boxes can be used to limit the values from that category displayed in the report. After selecting one or more values, the Apply button at the bottom of the drop down should be clicked. The Category must be selected first and the report executed to allow for retrieval of the possible values. For example, if only Inpatient is desired, first the Category "Care Setting" should be selected and retrieved and then "IP" selected in the Category Value drop down to limit the output to Inpatient.

Totals Row: Will always display the aggregate totals for the selections made. Be aware that totals reflect all category options regardless of selections.

Hospital Attributed Sandbox

This report is identical to the All Hospital Sandbox in functionality except that additional data is available that is not available in the All Hospital Sandbox or the MPA Monitoring Reports. Two additional categories are available in the Category Selectors, Professional Provider and MDPCP Supplemental Adj. Affiliated Facility. In addition, the Rendering Provider category in this version includes all Rendering Providers. In the All Hospital Sandbox, only HSCRC regulated Rendering Providers are available. As this additional data contains more detailed hospital specific information, this report is only available to users for the facilities for which they have credentialed access permissions (e.g., a user from Hospital X only has information for these Category Selectors and Rendering Provider for Hospital X).

MPA Monitoring Reports

These reports are intended as the quick reference tool to answer typical questions about the MPA performance of a hospital and how the performance compares to other hospitals. This suite is now a combination of reports that were formerly found within the MPA Monitoring Reports and the Specialized Drill Throughs. Due to the simplified logic of MPA Y5, several other reports have been removed. The time period for each tab is defined on the tab.

All tabs have the Report Selector, Pause, and Excel buttons described above.

Tab 1A-1 High Lvl by Facility Y5: This report shows the CCLF and adjusted CCLF per capita and total spend, and attributed beneficiary months for a selected facility(ies). This report contains the specific adjustments to CCLF data to get the adjusted and risk adjusted Scorekeeping (CCLF) values. The time controls are similar to those found in the Sandbox for a user to evaluate trends over different periods. To replicate the MPA scorekeeping trends, set the incurred period from January of the first year to the last available period and set the year period to CY (these are the default values).

The 'MDPCP Fees' presented in the measure year include Care Management Fees (CMF), CPCP fees, PBIP, and HEART payments paid to MDPCP participating NPIs for beneficiaries in selected hospitals' PSA/PSAPs.

Tab 1A-2 Summary of Trends Y5: This report provides a structured approach to comparing facilities base and performance year measures. Time controls are similar to those in the Sandbox reports. The report includes the national trend as well as hospitals' specific MPA target trend, both of which are updated monthly. Additional metrics include, for base and performance years, attributed beneficiary count, total payments, payment adjustments and total payments.

Tab 1A-3 RA Summary of Trends: This report is identical in structure to Tab 1A-2, but incorporates risk adjustment to figures presented.

Geographic Reward (Penalty) Calculator: This tab shows the inputs and calculates the estimated MPA rewards (penalty) for each hospital using the most recent data available. The source and calculation for all fields in the statewide inputs (lettered variables) and the hospital-specific inputs (numbered columns) are described in the footer of the report, and with additional detail below:

MPA Y5 Calculator Term	Source/Description
Statewide Inputs	
(a) Maximum Revenue at Risk	Equal to 1%. Used in the calculation of '(6) Hospital MPA Reward (Penalty) %, before quality'
(b) Maximum Performance Threshold	Equal to 3%. Used in the calculation of '(6) Hospital MPA Reward (Penalty) %, before quality'
(c) YTD Months Complete	The count of months of data included in the report. Used in the calculation of (11) Annualized Hospital MPA Reward (Penalty) $, before quality
(d) Change in National Trend YTD (2020/2019)	The risk adjusted PMPM trend for YTD2020 relative to YTD 2019. The figure is included in the header of the report
(e) Change in National Trend YTD (2021/2020)	The risk adjusted PMPM trend for YTD2021 relative to YTD2020. The figure is included in the header of the report.
(f) Change in National Trend YTD (2022/2021)	The risk adjusted PMPM trend for YTD2022 relative to YTD2021. The figure is included in the header of the report.
Hospital Specific Inputs	
(1) Adjusted Base Year TCOC, Risk Adjusted	MPA Monitoring Reports - Tab 1A-3 RA Summary of Trends Y5, Adjusted Per Capita Paid Base, YTD.
(2) Performance Year TCOC, Risk Adjusted	MPA Monitoring Reports - Tab 1A-3 RA Summary of Trends Y5, Adjusted Per Capita Paid Performance.
(3) Achieved Trend	$\left(\frac{Column\ 2}{Column\ 1} - 1\right) * 100\%$ MPA Monitoring Reports - Tab 1c, 2nd Graph, Hospital Trend. The year to date Risk Adjusted Performance Year TCOC compared to the Base Year TCOC, presented as a percentage.
(4) TCOC Target Trend	The hospital specific MPA Y4 TCOC trend target, updated monthly.

	$(1 + (d)) * (1 + (e) + Hospital\ Specific\ Adjustment\ Factor)$
(5) Hospital Target TCOC	$(Column(1) * (1 + Column(4))$ The risk adjusted, year to date Base Year TCOC adjusted by the TCOC Trend Target.
(6) Hospital Achieved TCOC	MPA Monitoring Reports - Tab 1A-3 RA Summary of Trends Y5 Adjusted Per Capita Paid Performance.
(7) Reward (Penalty) %, before quality*	Bounded between -1% and +1%, calculated as: $\left(\frac{Column\ 5 - Column\ 6}{Column\ 4} * \frac{a}{b} * 100\%\right)$
(8) FFS Hospital Cost Delivered at Hospital	All Hospital Sandbox – MPA Facility Assigned: All; Category 1: Rendering Facility; Metric: Paid $ Total dollars for services rendered to FFS beneficiaries at the respective hospital during the performance year, year to date.
(9) SAMHSA Cost Delivered at Hospital	Calculated based on the SAMHSA cost delivered at the hospital from the CCW data.
(10) YTD Hospital MPA Reward (Penalty) $, before quality*	$(Column(8) + Column(9)) * Column(7)$
(11) Annualized Hospital MPA Reward (Penalty), before quality*	$\left(\frac{Column\ 10 * 12}{c}\right)$

*Quality adjustments cannot be estimated during the year. However, the impact is expected to be relatively small.

7. Metric and Category Definitions

Category Types

Beneficiary:

These categories are characteristics of the beneficiary. A query using one of these categories will split the beneficiaries into groups and result in comparative per capita or per 1000 values. For example, Beneficiary Age is a beneficiary category, in which arraying the age buckets with the per capita metric will calculate and present the per capita spending for each age category separately. Averaging the values in each bucket, weighted by the beneficiary count in each bucket, will result in the total value

Claim:

These categories are characteristics of the claim. A query using one of these categories will split the claims into groups and result in per capita or per 1000 values that are components of the total per capita or per 1000 value. For example, Regulated and Non-Regulated

provider metric is a claim-level category (Beneficiaries are not directly associated with regulated/non-regulated providers); breaking out the total per capita spend by this field will result in two values that add up to the total spend and reflect the regulated and unregulated spend spread across all beneficiaries. Using these categories and a query using a beneficiary metric (e.g. beneficiary months) will yield the same total beneficiaries in every cell.

Security Status

Restricted:

Restricted Categories will only be available in the Hospital Attributed version of the tool. All other categories will be available in both versions except Rendering Provider for which non-Regulated facilities are Restricted and are only available in the Hospital Attributed version. The Hospital Attributed version will be restricted to beneficiaries (and their claims) of the MPA Attributed Facilities with which the user is affiliated.

Categories

For each category, the category type (Beneficiary or Claim) is noted in parentheses. Restricted categories only available in the Hospital-Attributed Sandbox are also noted.

Age (Beneficiary):

Age bracket of the beneficiary at the end of the year for which data is being summarized. Age is calculated once for each calendar year. Therefore, a member's age bracket will be the same when looking at their data at any point within a calendar year, regardless of their birth date. Possible values:

65-69
70-74
75-79
80-84
85 and Older

Medicare Eligibility Status (Beneficiary):

The category under which a beneficiary is eligible for Medicare. Possible values:

Aged
ESRD Age 65+
ESRD Age <65
Disabled and Age 65+
Disabled and Age <65

MPA Facility Assigned (Beneficiary):

The facility to which a beneficiary is attributed under the MPA methodology. Possible values include all acute care hospitals in the state.

Care Setting (Claim):

The type of physical location in which care was delivered. The Care Setting is defined based on the below definition:

Care Setting	Claim Definition
Short Term Hospital	Claim Type Code = 60 and Provider Type in ("25","19", "01")
SNF	Claim Type Code = 20,30
Physician Office	Physician claim with POS = 11
Physician Non-Office	Physician claim with POS not equal to 11
Outpatient Facility	Claim Type Code = 40, but not in ER bucket
Other Inpatient	Rest of the claims with claim type 60
Long-Term Care	Claim Type Code = 50 and provider_type = "12"
Inpatient Rehabilitation	Claim Type Code = 60 and provider_type in ("17","43") or PRVDR_NUM starts with "R"
Hospice	Claim Type Code = 50
HHA	Claim Type Code = 10
ER	Claim Type Code = 40 and Claim Line HCPCS of ("99281", "99282", "99283", "99284", "99285") or Claim Type Code = 40 and Revenue Center Code = 045x
DME	DME claims
NULL	Beneficiary did not receive any care from any care setting during the specified date range

Regulated or not (Claim):

Whether a claim was for a regulated service or not. Regulated services are defined as those occurring at a Regulated facility. Possible values are:

(i) Regulated. When adding "Rendering Facility" as a Category, user can individually identify the following providers.

HSCRC ID	Hospital Name
210001	Meritus Medical Center
210002	UM Medical Center
210003	UM Prince George's Hospital Center
210004	Holy Cross Hospital
210005	Frederick Health Hospital
210006	UM Harford Memorial
210008	Mercy Medical Center
210009	Johns Hopkins Hospital
210010	UM Shore Medical Center at Dorchester

210011	Ascension Saint Agnes Hospital
210012	Sinai Hospital
210013	Grace Medical Center
210015	Medstar Franklin Square
210016	Adventist Healthcare White Oak Medical Center
210017	Garrett County
210018	Medstar Mongomery
210019	Tidalhealth Peninsula Regional, Inc.
210022	Suburban Hospital
210023	Anne Arundel Medical Center
210024	Medstar Union Memorial
210027	UPMC – Western Maryland
210028	Medstar St. Mary's
210029	Johns Hopkins Bayview
210030	UM Shore Regional Health at Chestertown
210032	Union Hospital of Cecil
210033	Carroll Hospital Center
210034	Medstar Harbor Hospital Center
210035	UM Charles Regional
210037	UM-Shore Regional Health at Easton
210038	UM Midtown
210039	Calvert Health Medical Center
210040	Northwest Hospital
210043	UM Baltimore Washington Medical Center
210044	Greater Baltimore Medical Center
210045	Mccready Health Pavilion
210048	Howard County Hospital
210049	UM Upper Chesapeake Medical Center
210051	Doctors Community Medical Center
210055	UM Laurel Medical Center
210056	Medstar Good Samaritan
210057	Shady Grove Adventist
210058	UM Rehabilitation & Orthopeadic Institute
210060	Adventist Healthcare Fort Washington Medical Center
210061	Atlantic General
210062	Medstar Southern Maryland
210063	UM-St. Joseph Medical Center
210064 **(215033 before 6/1/2013)**	Levindale
210065	Holy Cross Hospital – Germantown

(ii) Unregulated

In the "All Hospital Sandbox, when adding "Rendering Facility" as a Category, all Unregulated providers are grouped as "Other."

In the Hospital Attributed Sandbox, when adding "Rendering Facility" as a Category, user can individually identify the Unregulated providers.

Primary Diagnosis Hierarchy (Claim)

The CSS category into which the primary diagnosis on the relevant claim line maps. Possible values are:

Certain conditions originating in the perinatal period
Complications of pregnancy; childbirth; and the puerperium
Congenital anomalies
Diseases of the circulatory system
Diseases of the digestive system
Diseases of the genitourinary system
Diseases of the musculoskeletal system and connective tissue
Diseases of the nervous system and sense organs
Diseases of the respiratory system
Diseases of the skin and subcutaneous tissue
Endocrine; nutritional; and metabolic diseases and immunity disorders
Infectious and parasitic diseases
Injury and poisoning
Mental Illness
Neoplasms
Residual codes; unclassified; all E codes
Symptoms; sings; and ill-defined conditions and factors influencing health status

Geography – Zip (Beneficiary):

The beneficiary's zip code of residence. Only care for Maryland residents is in scope for MPA, therefore no out of state beneficiaries should be found.

Geographical – Regional Aggregation (Beneficiary):

The Regional Aggregation to which a member is assigned based on attributed provider. The Regional Aggregations are based on the Regional Partnerships provided by CRISP. Possible Regional Partnerships are:

Bay Area Transformation Partnership
Calvert Memorial Hospital (Calvert Hospital)

Community Health Partnership (Johns Hopkins Community Health Partnership)
GBMC
Howard County Regional Partnership (Howard County)
LifeBridge Health (LifeBridge)
Nexus Montgomery
Peninsula Regional
TLC (Three Lower Counties)
Total Eldercare Collaborative
Trivergent Health Alliance
UM St. Joseph
Upper Chesapeake Health (UMUCH-UHCC)
West Baltimore Partnership (West Baltimore Collaborative)

Geography – County (Beneficiary):

The beneficiary's county of residence. Only care for Maryland residents is in scope for MPA, therefore no out of state beneficiaries should be found.

Current hAM score (Beneficiary):

hMetrix Advanced Model (hAM) score assigned to a beneficiary in the most recent period included in the data set, summarized into brackets. Only the most recent hAM score is used so the same value will occur for a beneficiary regardless of the period selected.

Using 24 months of statewide historical health care utilization data, the hAM model uses a machine learning ensemble algorithm to identify patients who are predicted to be of high- or rising- needs in the next 12 months (current year). Utilization flags, impactable costs, and total costs are identified for measures of health care utilization, including but not limited to: diagnostic and procedure codes; revenue centers; places of service; physician specialties; admission counts and length of stay for inpatient hospitalizations; visit counts for emergency departments; and clinical severity measures derived from HCCs.

NULL
0.75 – 1.00
0.50 – 0.75
0.40 – 0.50
0.30 – 0.40
0.20 – 0.30
0.15 – 0.20
0.10 – 0.15
0.05 – 0.10
0 – 0.05

Rendering Facility (Claim) (Partially Restricted):

The facility at which a service was delivered. In the All Hospital Sandbox only Regulated services will be detailed, all other services will return a rendering facility of "Other."

Specialty (Claim):

The specialty of the physician delivering services as reported on the professional claim. For other claim types this field will not be populated. This value is based on the specialty code in the physician claims, but the smallest 30 specialties reflect less than 1% of total claims in the total data set and have been aggregated into "All Other". The specialty description used is from https://www.resdac.org/sites/resdac.umn.edu/files/CMS_PRVDR_SPCLTY_TB.txt. The specialty descriptions used are:

All Other
Allergy/immunology
Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
Ambulatory surgical center (formerly miscellaneous)
Anesthesiology
Audiologist (billing independently)
Cardiology
Chiropractic
Clinical laboratory (billing independently)
Clinical psychologist
Critical care (intensivists) (eff 5/92)
CRNA (eff. 1/87) (Anesthesiologist Assistants were removed from this specialty 4/1/03)
Dermatology
Diagnostic radiology
DME Provider
Emergency medicine (eff 5/92)
Endocrine (eff 5/92)
Family Practice
Gastroenterology
General practice
General surgery
Geriatric medicine
Hand surgery
Hematology (eff 5/92)
Hematology/oncology (eff 5/92)
Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)
Infectious Disease
Internal medicine
Interventional Pain Management (IPM) (eff. 4/1/03)

Interventional radiology (eff 5/92)
Nephrology
Neurology
Neurosurgery
Nurse practitioner
Obstetrics/gynecology
Occupational therapist (private practice added 4/1/03) (independently practicing removed 4/1/03
Ophthalmology
Optometry (revised 10/93 to mean optometrist)
Orthopedic surgery
Otolaryngology
Pain Management (eff. 1/1/02)
Pathologic anatomy, clinical pathology (osteopaths only) (discontinued 5/92 use code 22)
Pathology
Physical medicine and rehabilitation
Physical therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)
Physician assistant (eff 5/92)
Plastic and reconstructive surgery
Podiatry
Portable X-ray supplier
Psychiatry
Pulmonary disease
Radiation oncology (eff 5/92)
Rheumatology (eff 5/92) Note: during 93/94 DMERC also used this to mean medical supply company with
Urology
Vascular surgery (eff 5/92)

Rendering Provider Location – State (Claim):

The State of the rendering provider.

Maryland
District of Columbia
Pennsylvania
Virginia
Delaware
Out of State (aggregates all other states)

Rendering Provider Location – Regional Aggregation (Claim):

The Regional Aggregation of the rendering provider. The Regional Aggregations are based on the Regional Partnerships provided by CRISP similar to the Geographical – Regional Aggregation.

Rendering Provider Location – County (Claim):

The county of the rendering provider. Individual counties in states bordering Maryland are identified by name. All other counties in other states are aggregated into "Out of State." Possible county values are:

Counties in Maryland
Counties in District of Columbia
Counties in Pennsylvania
Counties in Virginia
Counties in Delaware
Out of State (aggregates all other states)

Professional Provider (Claim) (Restricted):

The professional provider associated with a service. For IP stays this will reflect the physician reported on the IP claims – either the operating physician for surgical admissions or the attending physician for medical admissions. Outpatient and ER utilized the provider reported on the facility claim. For other physician services, this field will be the same as the Rendering Facility. For other services it is populated as blank.

Dual Status (Beneficiary):

The indicator for Medicare FFS beneficiaries who were also eligible for Medicaid coverage for at least one month in the 36-month period include in the CCLF data.

MDPCP Supplemental Adj. Affiliated Facility (Beneficiary) (Restricted):

The acute care hospital under which a beneficiary's utilization is incorporated into the MDPCP Supplemental MPA Adjustment.

Metrics

Unique Patient Count:

A count of the number of unique beneficiaries with at least one claim for a service in a period, with the service defined by the Categories selected and period by the Time Window selected. Patients without a claim in the period will return a count of 1 in the NULL value for the Category; therefore, the total row will include patients that did not have a claim.

To get a count of unique beneficiaries excluding those without a claim, a category with a Claim Type of "Claims" must be selected and the NULL value must be de-selected in the filter. As NULL can also be produced in a small number of other cases for each Claim Category the result will differ slightly depending on which Category is selected.

It is recommended that Care Setting be used to eliminate NULL values in the Unique Patient Count, if feasible, as it should not yield a NULL value in any other circumstance. However, other Categories can be used depending on query requirements.

Beneficiary Months:

A beneficiary month is counted for every beneficiary who is attributed to an MPA Attributed Facility in a month. As the attribution is only updated annually, this count will only change month to month in the event that a beneficiary dies.

Average Beneficiaries:

Calculated as Beneficiary Months / (number of months in the period being reported).

Paid $:

Amount paid by CMS for the claims.

Risk-Adjusted Paid $:

Amount paid by CMS for the claims adjusted for the Risk Score. This is the value used in all MPA scorekeeping.

Monthly per Capita:

Paid $/Beneficiary Months. Some MPA reporting is shown in annual per capita which can be derived by Monthly per Capita times 12.

Risk-Adjusted Monthly per Capita:

Risk Adjusted Paid $/Beneficiary Months. Some MPA reporting is shown in Risk Adjusted annual per capita which can be derived by Risk Adjusted Monthly per Capita times 12.

Allowed $:

Reflects the total amount paid for the service including the Medicare payment and beneficiary costsharing. It is derived by summing the claim-level Medicare paid amount and the Beneficiary cost sharing (copayments, deductibles, and coinsurance). Allowed $ will be more similar than Paid $ to a provider's actual charges. For Regulated Facilities, Allowed $ is persistently 6-10% below charges.

Allowed $ Monthly per Capita:

Allowed $/Beneficiary Months

IP Days and IP Days/1000:

Days spent in a short-term acute care facility (based on Claim Type Code = 60 and Provider Type in "25", "19", "01") derived from the claim from and claim through dates.

Inpatient days per 1,000 beneficiaries is also presented to allow for appropriate comparisons across cohorts. IP Days/1000 is calculated as either:

IP Days/(Average Beneficiaries/1000)

Or

IP Days*12,000/Beneficiary Months

ER Visits and ER Visits/1000:

Visits to an emergency department either in a short-term acute facility or stand-alone ED that did not result in an IP admission. Count is based on the number of claims with Claim Type Code = 40 (Outpatient) and either Claim Line HCPCS in ("99281", "99282", "99283", "99284", "99285") or Revenue Center Code = 045x.

Emergency department visits per 1,000 beneficiaries is also presented to allow for appropriate comparisons across cohorts. ED Visits/1000 is calculated as either:

ED Visits/(Average Beneficiaries/1000)

Or

ED Visits*12,000/Beneficiary Months

OP Visits and OP Visits/1000:

Visits to a hospital outpatient facility, defined by CMS Claim Type Code = 40 excluding those classified as ER. Visits are calculated by the unique number of claims.

OP visits per 1,000 beneficiaries is also presented to allow for appropriate comparisons across cohorts. OP Visits/1000 is calculated as either

OP Visits/(Average Beneficiaries/1000)

Or

OP Visits*12,000/Beneficiary Months

Primary Care Visits and Primary Care Visits/1000:

See Appendix A for a detailed definition of Primary Care Visits.

Primary Care Visits per 1,000 beneficiaries is also presented to allow for appropriate comparisons across cohorts. Primary Care Visits/1000 is calculated as either:

Primary Care Visits/(Average Beneficiaries/1000)

Or

Primary Care Visits*12,000/Beneficiary Months

Specialist Visits and Specialist Visits/1000:

See Appendix A for a detailed definition of Specialist Visits.

In the event that there is both a Facility Setting E and M claim and a Primary/Specialty visit for a single encounter, priority is given to the Primary/Specialty claim when determining the classification of the visit.

Specialist Visits per 1,000 beneficiaries is also presented to allow for appropriate comparisons across cohorts. Specialist Visits/1000 is calculated as either:

Specialist Visits/(Average Beneficiaries/1000)

Or

Specialist Visits*12,000/Beneficiary Months

Facility Setting E and M and Facility Setting E and M/1000:

See Appendix A for a detailed definition of Facility Setting E and M.

In the event that there is both a Facility Setting E and M claim and a Primary/Specialty visit for a single encounter, priority is given to the Primary/Specialty claim when determining the classification of the visit.

Facility Setting E and M per 1,000 beneficiaries is also presented to allow for appropriate comparisons across cohorts. Facility Setting E and M/1000 is calculated as either:

Facility Setting E and M/(Average Beneficiaries/1000)

Or

Facility Setting E and M*12,000/Beneficiary Months

Ambulatory Visits and Ambulatory Visits/1000:

Visits to a hospital outpatient department (defined as CMS Claims Type 40 on the claim), excluding visits to an Emergency room (Revenue Codes starting with 045 or CPTs in the range 99281-99285). Visits to a Physician office (CMS POS 11) are additionally included. Physician services in the inpatient hospital are not included in this count. Visit count is based on a count of unique claims.

Ambulatory Visits per 1,000 beneficiaries is also presented it allow for appropriate comparisons across cohorts. Ambulatory Visits/1000 is calculated as either

Ambulatory Visits/(Average Beneficiaries/1000)

Or

Ambulatory Visits*12,000/Beneficiary Months

Risk Score:

Risk Score used for risk adjustment, based on CMS's new enrollee risk scoring approach.

Appendix A: Primary Care, Specialist, Facility E&M

Evaluation and Management (E&M) services are presented across three different measures. The goal of these measures is to illustrate the reliance on primary care physicians providing care and billing under Medicare Part B, specialist physicians providing care and billing under Medicare Part B, or physician care provided in **and billed by** a facility setting (Medicare Part A or B). These categories are identified using a combination of CPT/HCPCS codes grouped into BETOS service category, place of service information, and rendering physician specialty.

Services reflected in these measures are restricted to CPT/HCPCS included in the BETOS Evaluation & Management category. Primary Care and Specialist Visits are identified using both BETOS codes **and** physician specialty. Facility Setting E&M is identified only using the BETOS codes.

Deduplicated BETOS Category	Designation
M1A: Office Visits – New	Primary Care or Specialty, based on physician specialty
M1B: Office Visits – Established	Primary Care or Specialty, based on physician specialty
M2A: Hospital Visits – Initial	Facility Setting E&M
M2B: Home Visit	Facility Setting E&M
M2C: Hospital Visit – Critical Care	Facility Setting E&M
M3: Emergency Room Visit	Facility Setting E&M
M4A: Home Visit	Primary Care or Specialty, based on physician specialty
M4B: Nursing Home Visit	Facility Setting E&M
M5A: Specialist – Pathology	Primary Care or Specialty, based on physician specialty
M5B: Specialist – Psychiatry	Primary Care or Specialty, based on physician specialty
M5C: Specialist: Ophthalmology	Primary Care or Specialty, based on physician specialty
M5D: Specialist – Other	Primary Care or Specialty, based on physician specialty
M6: Consultations	Primary Care or Specialty, based on physician specialty

Physician specialty within the relevant BETOS categories is identified two ways:

1. For Part B physician claims, specialty is identified using the physician specialty code on the claim.
2. For non-Part B physician claims (e.g., hospital outpatient claims) with E&M services that fit within the Primary Care or Specialty BETOS categories (e.g., M1B and M5B), specialty is identified using the National Uniform Claim Committee (NUCC) specialization code for the rendering physician NPI on the claim.

The specialties used to define Primary Care physicians and Specialists are listed below:

Visit Type	Definition
Primary Care Physicians	CMS Provider Specialty and NUCC Codes for: General Practice Family Practice Internal Medicine Pediatric Medicine Geriatric Medicine Nurse Practitioner Physician Assistant
Specialist	All CMS Provider Specialty and NUCC Codes excluding Primary Care Physicians (above)

In many events, there are two claims for a single beneficiary visit, both billed with an E&M service. This most typically occurs when a physician sees a patient and provides services in a facility setting. Both the physician may submit a bill (Part B physician claim) as well as the facility (hospital outpatient bill, for example). In these events, we deduplicated the claims to ensure that the E&M service is only captured one time. Priority is given to the Part B physician claim when determining where the visit is included.

Furthermore, facility settings may bill E&M services that are outside of the "Facility Setting E&M" BETOS categories listed above, such as a M5D – Specialist Other. In this event, as long as there is no accompanying Part B physician claim, the service will be classified as either Primary Care or Specialist based on the NUCC code of the physician on the facility claim. If there is a Part B physician claim, the Primary Care or Specialist designation will be determined from the Part B physician claim specialty