



Medicare CCLF Analytics: Medicare Analytics Data Engine (MADE)

Frequently Asked Questions v1.6

March 8, 2019

hMetrix

This document contains frequently asked questions regarding the utility, functionality, and technical specifications of MADE. These questions were gathered during a series of questions and answers during MADE introductory webinars and follow-up with individual MADE users. This document is organized by theme.

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Access to CCLF Data & Reports

Where do I go to access the CCLF reports?

A user that wishes to access MADE must first login to the CRISP Hospital Reporting Portal. Once in the portal, the user shall click the Card named “CCLF Medicare Analytics & Data Explorer.” The following screen shots represent the user’s workflow.

Step 1: User logs in to the CRISP Hospital Reporting Portal using the user ID and password provided for the portal - <https://reports.crisphealth.org/>



Log in to CRISP Reporting Services (CRS) Portal

Email

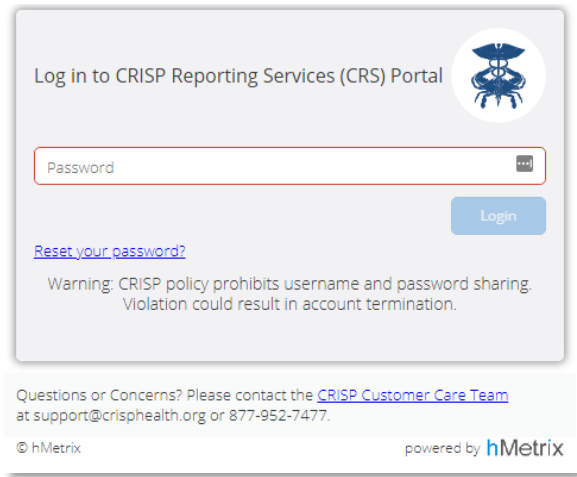
Next

[Reset your password?](#)

Warning: CRISP policy prohibits username and password sharing. Violation could result in account termination.

Questions or Concerns? Please contact the [CRISP Customer Care Team](#) at support@crisphealth.org or 877-952-7477.

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Log in to CRISP Reporting Services (CRS) Portal

Password

Login

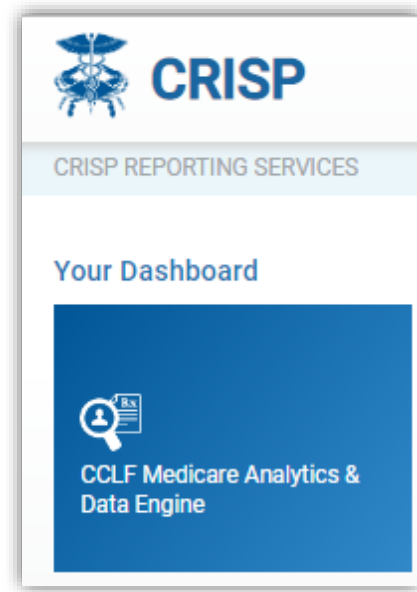
[Reset your password?](#)

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Step 2: User clicks the Card named “CCLF Medicare Analytics & Data Engine” within the Portal (shown at right).



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Step 3: Upon clicking on the card user is directed to the MADE site in a new tab.



Are there different access levels across users within my hospital/organization?

Yes. Each user will be credentialed based on their ability to access protected health information (PHI). Users with access to PHI data will be able to access all CCLF reports and drill down to patient-level details. Users without PHI-level access will be able to see summary reports only. Within an organization, there may be both users with access to PHI and users without access to PHI. To gain access to CCLF reports – non-PHI reports and / or PHI-level data – contact the point of contact within your hospital or the CRISP administrator.

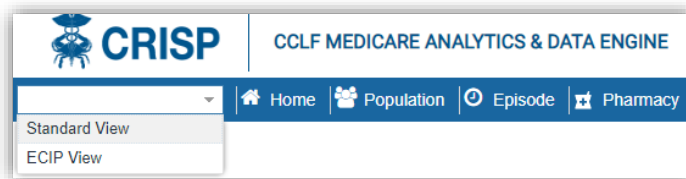
Who has access to CCLF reports? Will access be given to non-hospital entities (e.g., local health departments)?

CCLF reports are currently only available to hospitals in the state of Maryland affiliated with CRISP. No MADE reports, even in the aggregate, will be made available to non-hospital entities.

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What are the differences between Standard and ECIP View in MADE?

Users can toggle between the new ECIP View and Standard View in MADE by using the toggle in the upper left-hand corner of the application.



ECIP View contains a different set of reports (dashboards) and applies a different set of analysis and filtering logic than Standard view to facilitate management and review of ECIP episodes. As a result of these two differences, different patient panels will appear in these two views. Specifically:

1. Only patients with an ECIP defined clinical episode triggered at the respective hospital are visible in ECIP View. Patients that appear in Standard View are all those attributed by the hospital “touch” methodology (see sections 2.2.3 and 8.2 of the MADE User Guide for additional detail). As a result, all patients visible in ECIP View are visible in Standard View, but not all patients from Standard View will appear in ECIP View.
2. ECIP View and Standard View have many overlapping reports, but ECIP View excludes some Standard View reports that deal specifically with inpatient care and incorporates six new ECIP-specific reports not available in Standard View. The reports specific to ECIP View are:
 - a. ECIP Summary Report
 - b. Reconciliation Report
 - c. Financial Trends
 - d. Part B Services Detail
 - e. Post-Acute Care Trends
 - f. Path Flow Diagram
3. Major definition differences:
 - a. ECIP View episodes exclude all inpatient payments including readmission payments from calculations related to episode payments, following the logic for ECIP episode definitions.
 - b. Standard View includes 12 Clinical Episode Categories (previously APR DRG Families) not available in ECIP View as they are not currently episodes offered under the ECIP model.
 - c. Target Price calculations for Standard View and ECIP view are not equivalent, using CMS BPCI and ECIP-specific methodologies, respectively.
 - d. The underlying CCLF may not be updated simultaneously for each view in order to provide the most MADE utility for ECIP users managing care redesign episodes. Mouse over the info button to the right of the Attribution Selector for information on the currently loaded data window.



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CCLF Source Data

Which patients are included in MADE? Is it only for fee-for-service (FFS) beneficiaries?

MADE is generated using CMS' Claim and Claim Line Feed (CCLF) data, which includes all beneficiaries with Medicare FFS enrollment anytime within the last 36 months. Medicare beneficiaries only enrolled in Medicare Advantage and those with third party/commercial insurance during the 36-month window are not included in MADE. Medicare FFS claims are included for those beneficiaries with Medicare Advantage enrollment for only a portion of the CCLF claim window.

Are out-of-state beneficiaries included in the data? What about out-of-state claims for Maryland residents?

Yes, beneficiaries who reside outside of Maryland and have an inpatient or ED admission at a Maryland hospital are included in MADE. MADE includes all claims for Maryland hospital attributed patients, including those from out of state providers.

How recent are the data used to generate MADE reports? Is there a data lag?

The data used in MADE are for the most recent three years (36 months) of available Medicare FFS claims. However, the date range reported varies by MADE module, with no module including data for the month prior to the update. For example, the CCLF data uploaded into MADE in January 2019 does not include any claims data for December 2018. Similarly, pharmacy information (Parts A, B, and D) does not include any claims for the most recent two months preceding the month of the update. The available data by MADE module is presented below.

Population Module

The Population Module includes all data available for the 36-month period. Due to the nature of medical claims processing, claims for services delivered in previous months are backfilled in new data releases as claims are received and processed by CMS. Reports in this module, including patient-level tracking, include all available claims.

Episode Module

Episodes within the Episode Module include the most recent claims data available, in line with the data windows for the modules described above. However, for an episode to be included in the episode module, the 90-day global period for that episode must be complete at least one month prior to the end of the reporting period. This is to avoid variation and missing claims due to claims processing timelines, particularly for post-acute care providers, for episodes ending in the most recent data period. According to data presented in a CMS White Paper¹ on Chronic Condition Warehouse Claims Maturity, which are closely related to CMS CCLF, on average, more than 83% of the services across care settings are paid and final by the month following the service date.

¹ CCW White Paper: Medicare Claims Maturity. <https://www.ccwdata.org/documents/10280/19002256/medicare-claims-maturity.pdf>

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Pharmacy Module

Unlike the other modules, pharmaceutical reports (Parts A, B and D) present data for the most recent 12 months of data, excluding the most recent month due to data incompleteness.

Monitoring Module

To appropriately evaluate programs using only complete data, the default view of the Key Utilization Metrics Report and both Key Performance Metrics Reports exclude the most recent two months of data lag by default. A filter is available for users to include these incomplete claims in the reports.

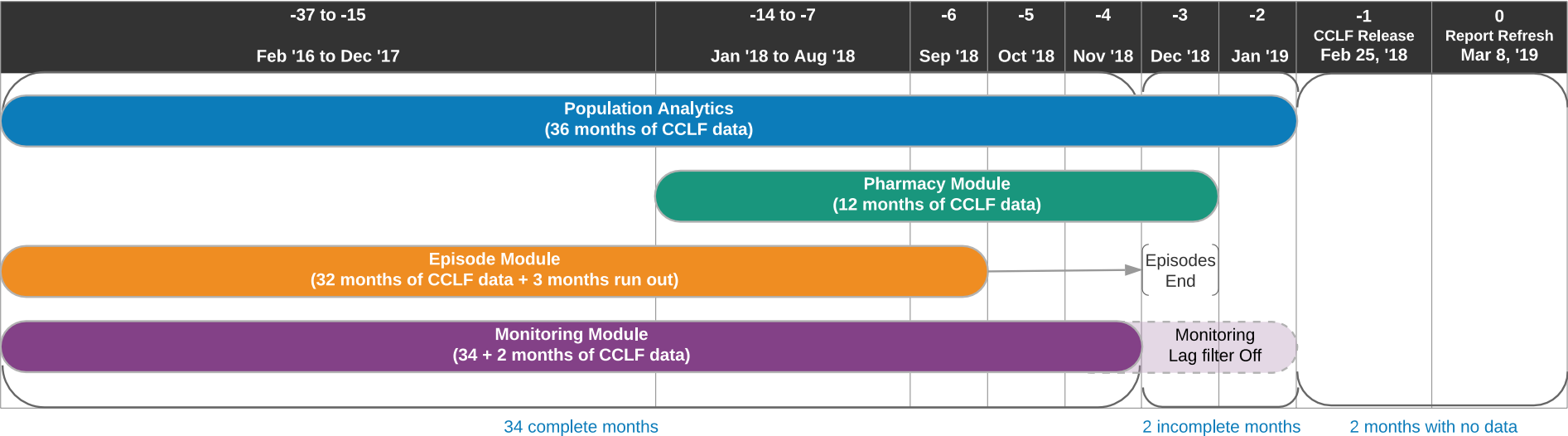
Summary of CCLF Data Availability in MADE

The following infographic (Figure 1) shows data availability for each MADE Module using the February 8th, 2019 update as an example. January 2019 claims are not available, indicated as month “-1.” Due to the incompleteness of December claims, they are omitted from the Episode Module. December is not available in the Pharmacy Module due to incompleteness. November and December are omitted from the Monitoring Module (when the lag filter is turned off).

FIGURE 1

Data in MADE by Module and Month

Calendar months are illustrative



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How often will the data in MADE be updated?

MADE will be updated every month with the most recent CCLF data. Users can expect updated data to be loaded by the 15th of every month.

How are patients assigned to my hospital? What is the attribution methodology?

Each beneficiary in the Population Analytics Module is attributed to one or more of the 47 CRISP hospitals. Attributed beneficiaries must be enrolled in Medicare Part A and Part B (no Medicare Advantage beneficiaries) at some point in the most recent 36 months. All beneficiaries with a “touch” (an inpatient admission claim or a visit to the emergency department) during the last 36 months will be assigned to each hospital to which they have been admitted. Users can elect to show only patients attributed to their hospital or hospital system through an inpatient admission by selecting “IP” using the dropdown “Attribution Type” menu in the top right of the user interface, or can see all beneficiaries by selecting “IP+ED” attribution. All hospitals to which a beneficiary is attributed are able to see the full patient claims for that beneficiary.

CCLF Report Functionality

Can I select more than one hospital at a time to see the combined data, representing a health system or regional partnership?

If you are provisioned to access data for more than one hospital, you can view data for either all hospitals for which you are provisioned, or each hospital individually. Currently, you cannot select a subset of your hospitals to combine data within a health system or regional partnership.

My hospital currently defines high needs patients as those with three or more bedded visits. Can I easily filter patients in Population Navigator to identify these patients by hospital?

To filter a population based on three or more bedded visits, a user may apply a filter in Population Navigator to the column "Current Year Inpatient Admission Count," and set the filter to show only patients with values > 2 in that column. You can then create a roster to save this list of patients for future queries.

Are patient rosters available only to the person who created them?

When creating or editing an existing patient roster, the user may select "Make Public," which will allow any user with access to MADE for that hospital to view that roster and run reports using it, including non-PHI users. Only the user who created a roster may modify or delete that roster.

For roster creation, do names have to match exactly (e.g., Patrick vs Pat) and conform to a specific format such as Last Name, First Name?

The roster upload requires exact matches based on separate fields for Last Name, First Name, Gender and Date of Birth. Missing data fields will result in upload errors. The roster upload template, which contains the required order and headings for the columns, can be downloaded from MADE in the roster creation menu.

Can I load a panel of patients using Medical Record Numbers (MRNs) into this tool?

You can create a roster for a specific panel of patients by uploading a completed Roster Template. The roster must include patient name, gender and date of birth. However, hMetrix does backend processing to cross-reference the CaseMix data and include MRN in Population Navigator. Using a "Current View" or "Detailed View" Excel Export, a hospital may export MRNs and use that field to develop a list of patients. That list can be subsequently uploaded with the required elements (First & Last names, date of birth, gender) to create a roster using the roster template.

In the pharmacy reports, can I create my own filter (roster) to apply to all reports (e.g., antibiotics of a certain class)? If so, how?

The Therapeutic Classifications are not customizable; however, you can create rosters of patients with drugs of interest and use that as a filter for other reports.

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Starting with the “Top 10 Therapeutic Categories-Rolling 12 Months” Report, you can first select a therapeutic category of interest and click on the drill through report for “Therapeutic Category Details.” Then, click on the “sub category,” “subcategory 2” or “drug name” of interest and drill through to “Top 10 Therapeutic Categories- Drug Details” report. Once the list of patients is visible, click on the “Create Roster” button on the top of the report. Enter a roster name to define the roster. Check “selected patients” in order to create a roster from all patients contained in the report. When creating a patient roster, the user may select “Make Public,” which will allow any user with access to MADE for that hospital to view that roster (PHI users) and run reports using it (PHI and Non-PHI users).

Can we create a roster for our hospitalists?

Rosters are only for grouping patients. However, you can create a roster for the panel of patients treated or cared for by each hospitalist. MADE includes numerous User Defined Fields that may be populated and/or edited in Population Navigator or through the roster upload template. The User Defined Field for “Physician” can be populated with a hospitalist and filtered by in MADE to create a roster.

Can the reports in MADE be exported?

Reports and contents displayed in MADE can be exported to PDF and Excel using the Print button and the Excel button, respectively, located in the top right of each report.

What are the dates of service contained in the Opportunity Summary report?

The Opportunity Summary presents data consistent with the rest of the Episode Module (see Figure 1, pg. 7). With each subsequent data update, the report will change, without the ability to change the time period. Consider downloading and storing the report if you are interested in trending results over time.

Is there a report that shows the performance of a PAC setting across multiple DRGs?

In the “Inpatient Rehab Report,” “Skilled Nursing Facility Report,” and “Home Health Report” within the Episode module, a user can select “(All)” Index Admission DRG Families and select a PAC provider of interest to see the drill through report of “Post-Discharge Provider Details.” This report will contain all episodes that contained an admission to this PAC provider (across all DRGs) at any point in the episode’s 90-day duration. Additionally, a user may select only APR DRGs of interest using the filter at the top of the report.

The “SNF Utilization Report” in the Monitoring Module provides risk adjusted LOS, Average Payment, and Readmissions for all SNFs in a hospital’s network for all APR DRGs.

Is there a report that summarizes physician practice patterns by physician by cost efficiency and readmission rates?

Within the “Physician Discharge Pattern” report in the Episode Module, you can compare discharge patterns across physicians and access episode details for each physician through the “Physician Detail” drill throughs.

In the PAVE Savings Opportunity report within the Episode module, physicians are compared based on episode payments and post-discharge payments in order to determine the highest performing cluster of physicians with respect to episode payments. While this does not directly consider readmission rates, a physician with high readmission rates will likely have higher post-discharge payments, which are considered in the clustering algorithm.

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This report will allow you to see which discharge patterns are likely to lead to lower readmission rates and smaller episode payments.

What is the process for prioritizing future enhancements to MADE?

We plan to continually improve upon the reports presented in MADE. Priorities will be determined based on discussions with CRISP and the user community. Users will be notified of the enhancements through CRISP communications and updated User Manuals.

What tool is used to generate the reports in MADE?

MADE is based on Tableau visualizations housed within a .NET web application framework.

Data Definitions

How is the “Master Patient ID” determined? Is it the same as the “CRISP EID”?

The Patient Master ID is Medicare Beneficiary Identifier (MBI). It is not equivalent to the CRISP EID. The Master Patient ID is consistent across hospitals when patients are attributed to multiple settings. Previously, the Master Patient ID was an encrypted HICN, which is still available to users through the column selection menu in Population Navigator, now labeled, “Encrypted Patient ID.” The “Encrypted Patient ID” is not linked to Medical Record Numbers (MRNs), CRISP EIDs, or other hospital-specific beneficiary identifiers.

How are the diagnoses within the Population Module identified?

Diagnoses are coded according to three sets of definitions, each with available filters in the ‘Measures’ menu within Population Navigator. The first are chronic conditions defined according to the CMS Chronic Conditions Warehouse (CCW) criteria. The second are based on other utilization measures including pharmaceutical claims. The third are diagnoses that are defined to align with common quality reporting metrics.

How are readmissions defined? Are they all-cause or do they align with Maryland or CMS’ methodologies?

As an episode of care captures all health care utilization, readmissions are based on all causes over the 90-days. In the Key Utilization and Key Performance Metrics Reports, 30-day readmission rates are available on an all-cause basis and according to the Maryland Readmission Reduction Incentive Program.

How is the Responsible Physician identified?

Each episode in the Episode Module is assigned to a physician. The assigned physician is the one most responsible for the index acute care hospitalization. For a surgical discharge, the responsible physician is the operating physician or the surgeon, if available on the claims. For a medical discharge or a surgical discharge without an operating physician identified, the responsible physician is the attending physician.

How are the first post-acute care settings defined within the Episode Module?

The first post-acute care setting represents the first care setting the beneficiary enters upon discharge from the index acute care hospitalization. The first post-acute care settings are as follows:

- Short term hospital: Patient is discharged to the community (presumably home) and before having any claim with a physician or other care setting, they are readmitted to a hospital. This does not include transfers across hospitals during the index hospitalization.
- Inpatient rehab: Patient is admitted to an inpatient rehabilitation facility for rehabilitation, defined as an MS-DRG 945 (Rehabilitation with CC/MCC) or 946 (Rehabilitation w/o CC/MCC).
- Skilled Nursing Facility: Patient is admitted to a skilled nursing facility within 3 days of discharge.
- Home Health: Patient is discharge home to receive skilled home health care with an HHA claim within 14 days of discharge.
- Ambulatory: Patient is discharged home for follow-up with their physician or to receive outpatient therapy or other outpatient surgical procedures.
- Other: Patient is admitted to another inpatient facility including a long-term care hospital, psychiatric facility or hospice.

How is “High-Risk Medication” defined?

A high-risk medication is defined according to the American Geriatrics Society (AGS) Beers Criteria for Potentially Inappropriate Medication Use in Older Adults list. This list contains drugs that are best avoided in older adults and those with certain diseases or syndromes. Patients on these medications should be prescribed reduced doses or prescribed with caution and carefully monitored as these medications have been found to be associated with poor health outcomes, including confusion, falls, and mortality.

How is the Therapeutic Class defined in the Pharmacy Module?

The Therapeutic Class presented in the Pharmacy Module is obtained from the Multum Vantage Rx reference database. The Therapeutic Categories themselves are defined by the Food and Drug Administration. This data is not contained the CCLF data.

Episode Structure and ECIP View

Can I filter the MADE reports to a specific time period?

In the Episode and Monitoring Modules, reports can be filtered to specific months and years, the default being the most recent 12 months. In the Population module, reports can be filtered by calendar year. The Pharmacy Module does not allow for filtering by date and shows the most recent 12 months.

How is the episode start date determined? Is the admission time period based on admission date or discharge date?

The Episode Module presents 90-day episodes of care. An episode is triggered by an acute care hospitalization. The “Admission Time Period” drop down menu allows users to filter episodes based on the date of the index hospitalization. The admission time period is based on the **date of discharge**. That is, episodes included within a given month were discharged in that month but may have been admitted in the previous month. Consistent with

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DRG payment methodology, the three days prior to the episode start are included in the episode payment amount in Standard View. All inpatient payments are excluded in ECIP View.

When does the 90-day episode start?

In both Standard and ECIP View, the 90-day episode period starts at discharge from the index acute care hospitalization for an included APR DRG. As noted above, in Standard View, payments for services rendered from three days before index admission up until discharge are also included in the episode. These payments are not included in episodes in ECIP View.

What is included in the 90-day episode of care?

An episode is only triggered by an acute care hospital admission for an APR DRG included in the filter options for the loaded view.

In Standard View, the 90-day episode of care includes all care across all Part A and Part B sites of services and represents the total cost of care. Claims during the index admission stay and during any readmissions are included in the episode cost calculation. Episodes in Standard View and ECIP View do not include Part D claims.

In ECIP View, episodes follow the specifications for ECIP episode construction. Most notably and different from Standard view, all claims associated with STACH stays (including episode index admissions and any readmissions) are excluded from the episode payment calculations.

How are differences in severity of illness (SOI) accounted for within the Episode Module?

Across the Episode Module, users can filter by one or more APR DRGs. The APR DRG coding process involves inclusion of numerical SOI indicators (1 – Minor, 2 – Moderate, 3 – Major, 4 – Extreme). Reports in the Episode Module that present APR DRGs by SOI are:

1. Acute Care Management
2. Readmission Overview
3. Readmission Details
4. Physician Readmissions
5. Sequence of Care
6. Physician Details
7. Patient Level Details

How does the Episode Module in Standard View align with ECIP?

In Standard View, the Index Admission DRG Family filter includes the 23 clinical episode categories available in ECIP, with APR DRGs grouped and labeled as they are in ECIP. However, the episode construction presented in the Standard View Episode Module does not align with ECIP. For example, Standard View includes index admission and readmission claims in episode payment calculations, which are both excluded in episode payment calculations for ECIP.

For reports entirely consistent with ECIP policy and definitions as well as a handful of ECIP-specific reports not available in Standard View, please use ECIP View.

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Do I need to participate in ECIP to access the ECIP View of MADE?

No. All hospitals with access to MADE have access to ECIP View, including data on all 23 potential clinical episode categories, to evaluate potential participation in future performance years, regardless of ECIP participation status.

Requests for Additional Information

Will there be additional educational sessions?

Hospitals may contact CRISP to request training for new and existing users via support@crisphealth.org.

If we have additional questions or suggestions for enhancements, who do we contact?

Please contact support@crisphealth.org if you have additional questions and suggestions regarding MADE and the CCLF data.