MARYLAND PRIMARY CARE PROGRAM (MDPCP): REPORTING SUITE

User Guide 1.5.13.40

February 9th, 2024

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1 WELCOME TO THE MDPCP REPORTING SUITE

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

The latest three months of CCLF data are considered incomplete due to lag in claims submission and processing and are not presented in the default views of reports but are available to view by adjusting the selected time horizon. For more information on claim lag see section 4.2.2 CCLF Data Lag.

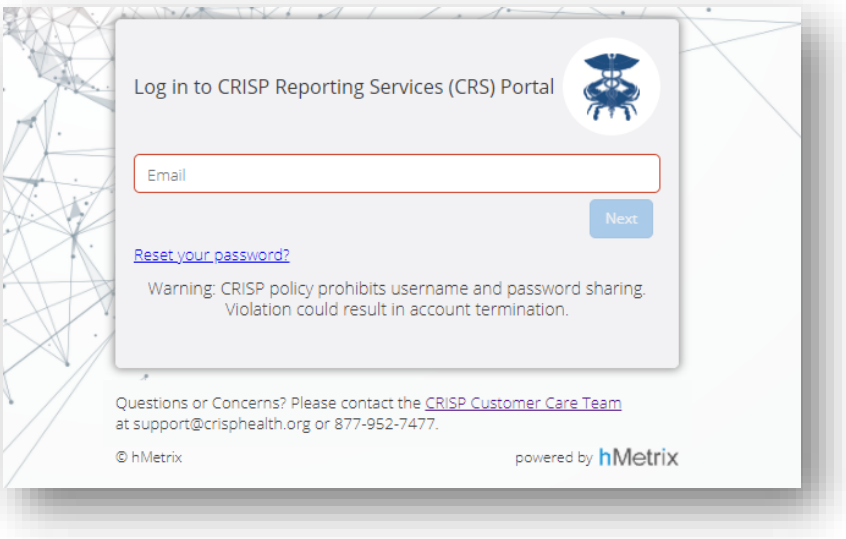
1.1 Software Requirements

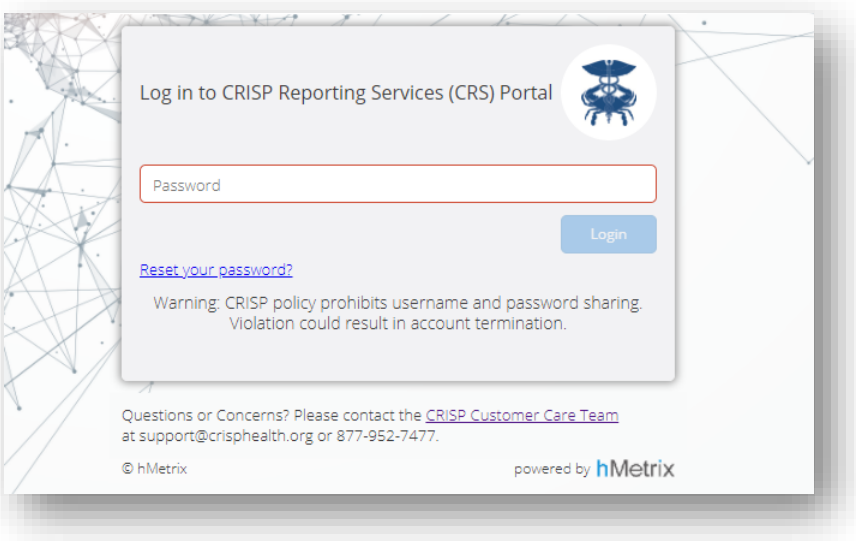
The MDPCP reports are available through a web-based application accessible using a modern browser: Google Chrome 57 or higher, Internet Explorer 11 or higher, Firefox 52 or higher, and Safari 9 or higher.

1.2 Launching MDPCP Reports

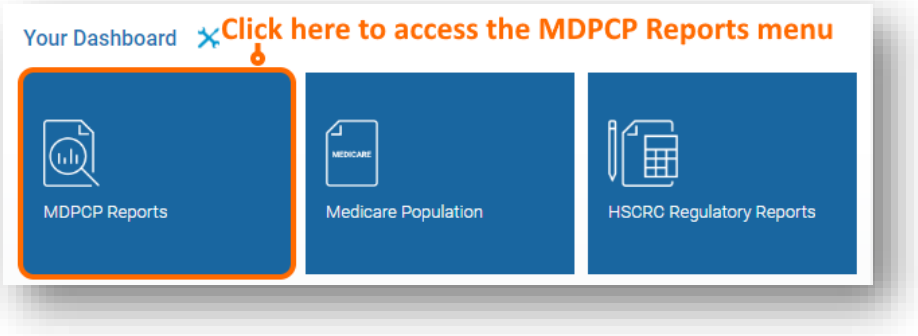
To access the MDPCP Reports, a user must first login to the CRISP Hospital Reporting Portal. Once in the portal, the user shall click the Card labeled "MDPCP Reports." The following screen shots represent the user's workflow.

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



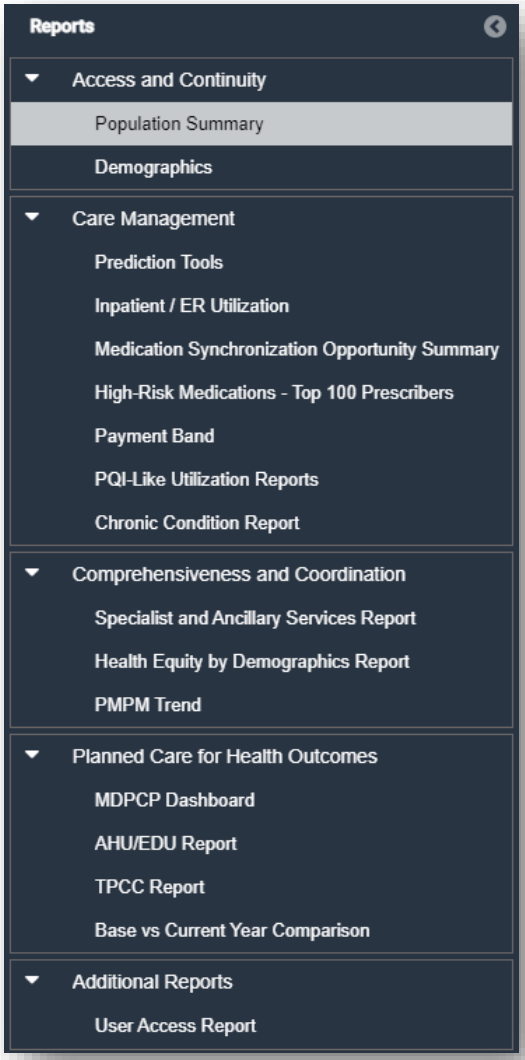


Step 2: Click the Card named “MDPCP Reports” within the Portal



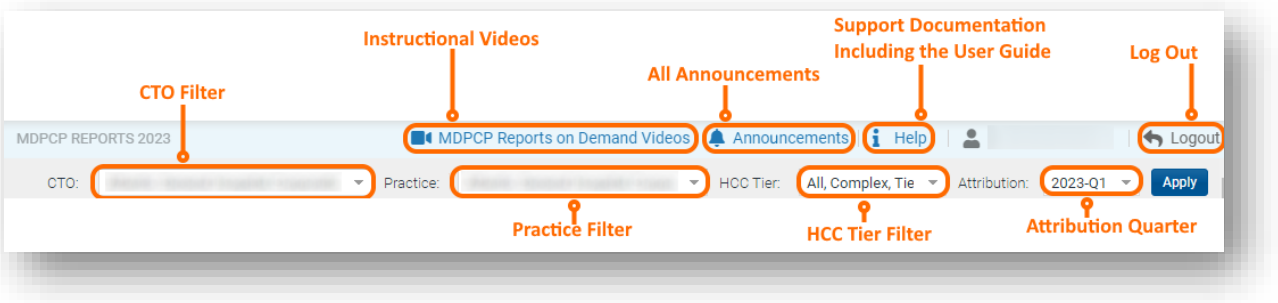
Step 3: After clicking the card, users will see a menu with links to up to five separate reporting suites, , if the user's practice(s) participated in the respective year – 2019 through 2024. The primary differences in the data underlying the three suits are the participating practices, practice to CTO linkages, and the beneficiary attribution quarters. For example, in the MDPCP Reports 2019, users can view the Q1 2019 through Q4 2019 beneficiary attributions for practices that participated in 2019. Attribution quarters for 2024 are only shown in the 2024 reports.

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. The reports are grouped thematically, differently from previous years.



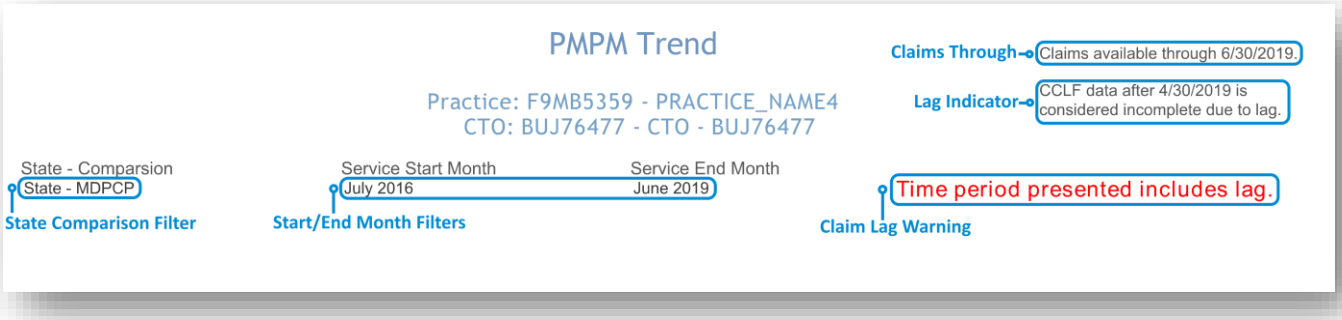
1.3 Navigation

Use the CTO and Practice Filters to select which practice you would like to see when running reports. Use the HCC Tier Filter to select one or more HCC tiers to view and the Attribution Quarter Filter to view the latest or an historic quarter's attributed beneficiaries. After making any filter selections in the top row, click the Apply button. CTO users may select "All" in the Practice Filter to view all associated practices' data at once. Select which HCC Tier(s) to include in reports with the HCC Tier filter and which attribution quarter to use to populate reports with the Attribution Quarter Filter. The 8-character code ('T#MD####') in parentheses following a practice name is the unique Practice ID for MDPCP. Please note that the number following the 'T' reflects only the track with which the practice began participation in MDPCP and not necessarily its current track. Clicking Help will open this user guide in a new browser tab. These are global filters that will persist across all reports in the suite.



1.4 Filter Selection and Claim Lag Indicator

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



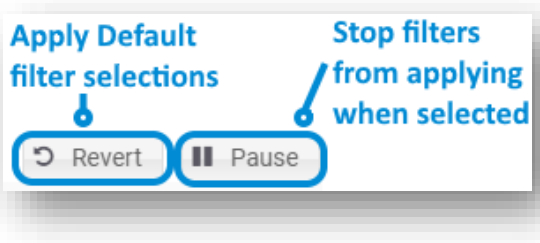
Filter/Data Considerations	DESCRIPTION
State - Comparison Filter	Select from "State – MDPCP" or "State" for statewide comparison. "State – MDPCP" represents all beneficiaries attributed to MDPCP participating practices. "State" represents the entire State's Medicare fee-for-service beneficiary population with both Part A and B coverage regardless of MDPCP participation. "Equ Non-Participating" (Equivalent Non-Participating) represents a non-participating MDPCP population that is matched to the participating MDPCP population in a selected attribution quarter. This population is matched to the MDPCP statewide participating population based on the distribution of age band, race, sex, dual eligibility, and county of residence. "MDPCP FQHC" includes all beneficiaries attributed to MDPCP participating FQHCs in the latest MDPCP Attribution quarter. Comparison figures are presented in the reports in red.
Service Start Month Filter	Select the start month from the dropdown list to indicate the start of the date range used to populate the reports. The date indicates the date of service, not the date of processing of payment.
Service End Month Filter	Select the end month from the dropdown list to indicate the end of the date range used to populate the reports. The date indicates the date of service, not the date of processing of payment.
Claims Through	The date of the latest available claims in the data.
Lag Indicator	The date after which the presented CCLF are considered incomplete due to lag time in claims processing (see Section 4.2.2 CCLF Data Lag for detail).

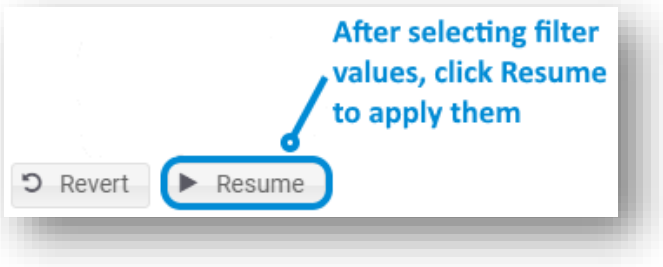
Claim Lag Warning	This text will be present in any report that includes claims after the date indicated in the Lag Indicator. This is to advise users that the most recent month(s) are not complete due to the CCLF data lag.

1.5 Pause/Resume Filter Functionality

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

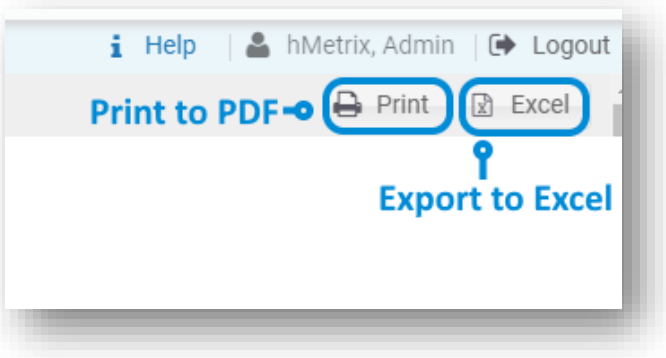
The Revert button will change all filter values back to their default values.



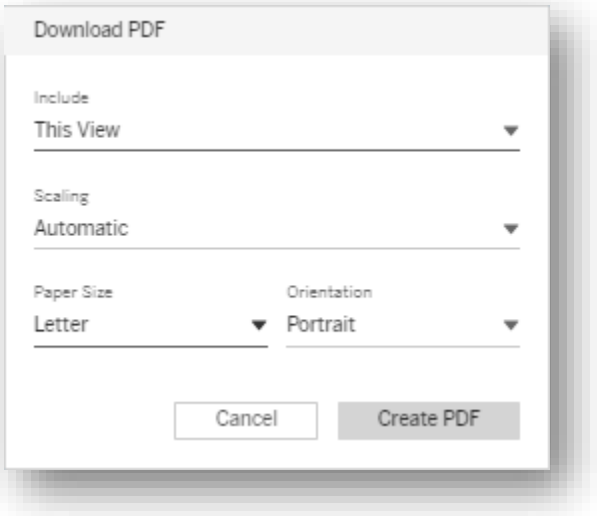


1.6 Print to PDF and Export to Excel

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



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

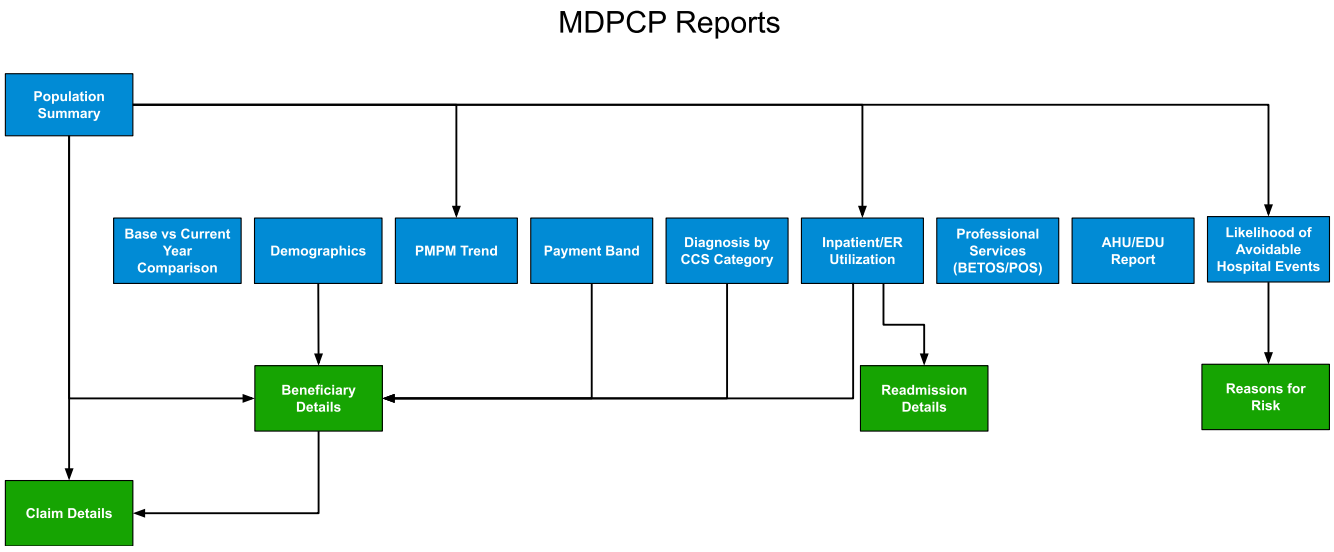


1.7 Workflow

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

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

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

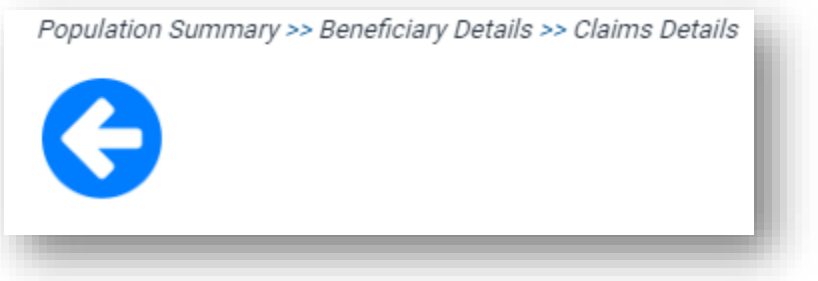


1.8 Drill Through Navigation and Indicators

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

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

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



2 REPORTS

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

2.1 Access and Continuity

2.1.1 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 are color coded to indicate performance relative to the overall MDPCP. Colors range from green to red, with green indicating favorable performance relative to the overall MCPCP. A darker color represents further distance from the overall program's value. Please note that with the exceptions of Medication Synchronization Opportunity Summary and AHU/EDU, the icons with color coding, the figures represent the 33-month period described at the top of the page.

GROUP	REPORT NAME	DESCRIPTION (Report Section Reference)
Access and Continuity	Beneficiary Count *# Beneficiaries*	Navigates to Beneficiary Details. Section 3.1. The number is the total number of beneficiaries attributed to the selected practice(s).
	Claim Count *#*	Navigates to Claim Details for all attributed beneficiaries. Section 3.2. The number is the total number of Medicare Part A and B claims for the attributed population.
	Demographics Report	Section 2.1.2
Care Management	Prediction Tools	Section 2.2.1
	Inpatient | ED Utilization *# IP per K | # ED per K*	Section 2.2.2 The per K figures are annualized from the 33-month period.
	Medication Synchronization Opportunity Summary	Section 2.2.3 The percentage Out of Sync reflects those out of sync as of the month indicated in this report, which is the 35th of the 36 months in the current CCLF period.
	High-Risk Medications: Top 100 Prescribers	Section 2.2.4
	Payment Band	Section 2.2.5
	PQI-Like Utilization Report *# per K*	See Section 2.2.6 The PQI-Like per K figure is annualized from the 33-month period.

GROUP	REPORT NAME	DESCRIPTION (Report Section Reference)
	Chronic Condition Report	Section 2.2.7
Comprehensiveness and Coordination	Specialist and Ancillary Services *# Beneficiaries*	Section 2.3.1 The number is the total number of beneficiaries attributed to the selected practice(s).
	Health Equity by Demographics *# PQI-Like Events per K*	Section 2.3.2 The PQI-Like Events per K figure represents the annualized rated PQI-Like utilization for the practice(s)'s black attributed beneficiaries.
	PMPM Trend *$#*	Section 2.3.3 The dollar amount is the per member per month figure for the 33-month period.
Planned Care for Health Outcomes	AHU EDU *# | #*	Section 2.4.2 The left figure is the Observed to Expected ratio (O:E) of AHU utilization. The right figure is the O:E for EDU utilization. The ratios reflect the average over the latest 4 quarters of data.
	TPCC *#*	Section 2.4.3 The figure is the Observed to Expected ratio (O:E) of TPCC. The ratio reflects the average over the latest 4 quarters of data.
	Base vs Current Year	Section 2.4.4
	MDPCP Dashboard	Visible to those with access to it, see Section 2.4.1

Population Summary

Practice: [redacted]

CTO: [redacted]

Claims available through 7/31/2023.

The top quintile cutoff for National ADI for Q3 2023 is an **ADI greater than 49**.
Note that this cutoff may change each quarter.

Access and Continuity

- Beneficiary Details — 1,604 Beneficiaries
- Claim Count — 131,815
- Demographics Report

Care Management

- Prediction Tools
- Inpatient | ED Utilization — 157 IP per k | 259 ED per k
- Medication Synchronization Opportunity Summary — 62% Out of Sync
- High-Risk Medications: Top 100 Prescribers
- Payment Band
- PQI-Like Utilization Report — 40 per K
- Chronic Condition Report

Comprehensiveness and Coordination

- Specialist and Ancillary Services — 1,604 Beneficiaries
- Health Equity by Demographics — 40 PQI-Like Events per K
- PMPM Trend — $848

Planned Care for Health Outcomes

- AHU EDU — 1.137 | 0.63
- TPCC — 0.919
- Base vs Current Year
- MDPCP Dashboard

Metrics on the Landing Page reflect the 33-month period from 8/1/2020 through 4/30/2023

2.1.2 Demographics Report

Click here to watch a short MDPCP Basics video explaining how to use this report:

https://www.gotostage.com/channel/6218fe0614ce4de48cb53d75ada41b87/recording/f8d7e6c8a6514f938d72b50c7705f3b4/watch

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

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

The Demographics report links to drilldowns to Beneficiary Details.

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

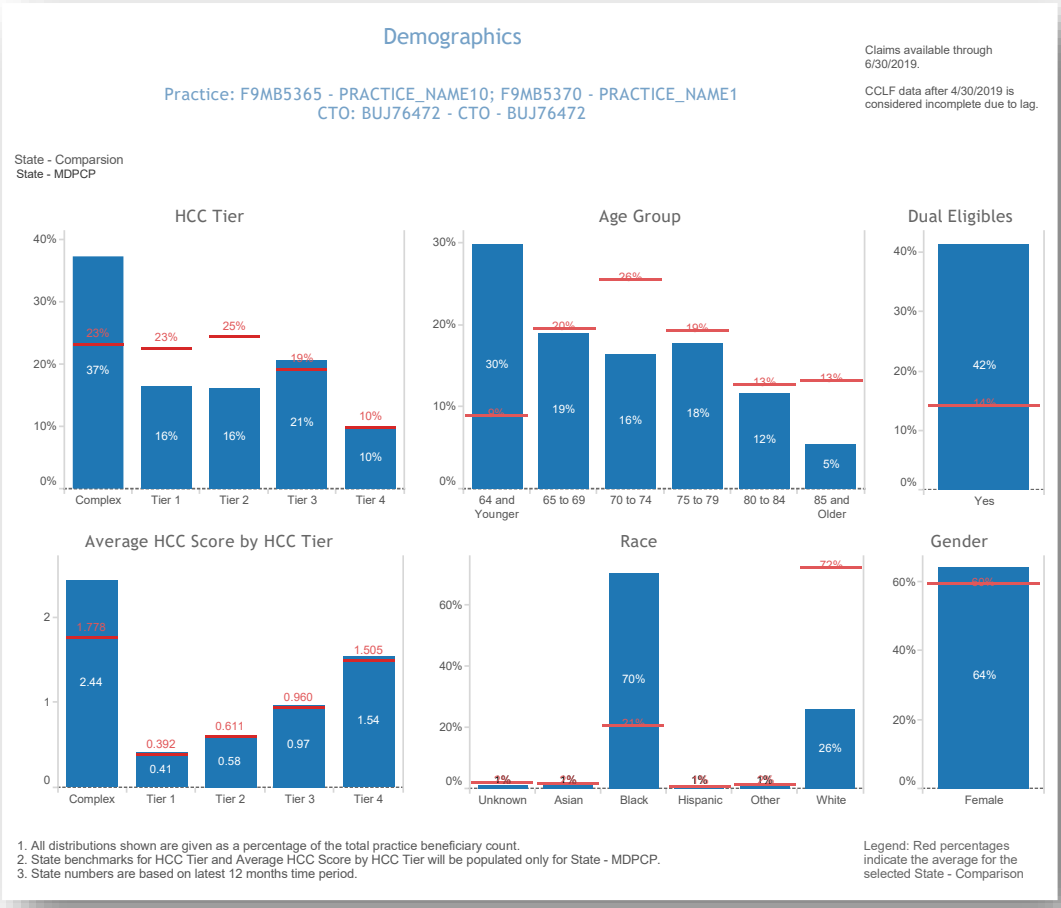
CHART NAME	DESCRIPTION
HCC Tier	Distribution of beneficiaries by the 5 HCC tiers. Details of the tiers are presented in the table below.
Age Group	Distribution of beneficiaries by 5-year age bands including “64 and Younger” and “85 and Older.”
Dual Eligibles	The percentage of attributed beneficiaries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

2.1.2.1 Distribution of HCC Tier

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

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

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



All data are fictitious – for example purposes only.

2.2 Care Management

2.2.1 Prediction Tools

Click here to watch a short MDPCP Basics video explaining how to use this report (Please note this video covers the previous version of this report, which only included the Avoidable Hospital Events model):

https://www.gotostage.com/channel/6218fe0614ce4de48cb53d75ada41b87/recording/4768e6cb4fec40b69b59185b6619d842/watch

2.2.1.1 Prediction Tools Models:

Pre-AH:

The Avoidable Hospital Events (Pre-AH) Model™ score reflects a probability that a beneficiary will experience an avoidable hospital event (inpatient or emergency room stay) within the next 30 days. The events included in the Pre-AH Model™ are PQI-Like Events; see section 2.2.6 for more information on PQI-Like Events.

Pre-DC

The Hilltop Severe Diabetes Complications (Pre-DC) Model™ score reflects a probability that a beneficiary will experience an inpatient hospitalization or ED visit due to severe complications of type-2 diabetes in the next month across six domains of complications: ophthalmic/retinopathy; nephropathy; cerebrovascular; cardiovascular; peripheral vascular; metabolic.

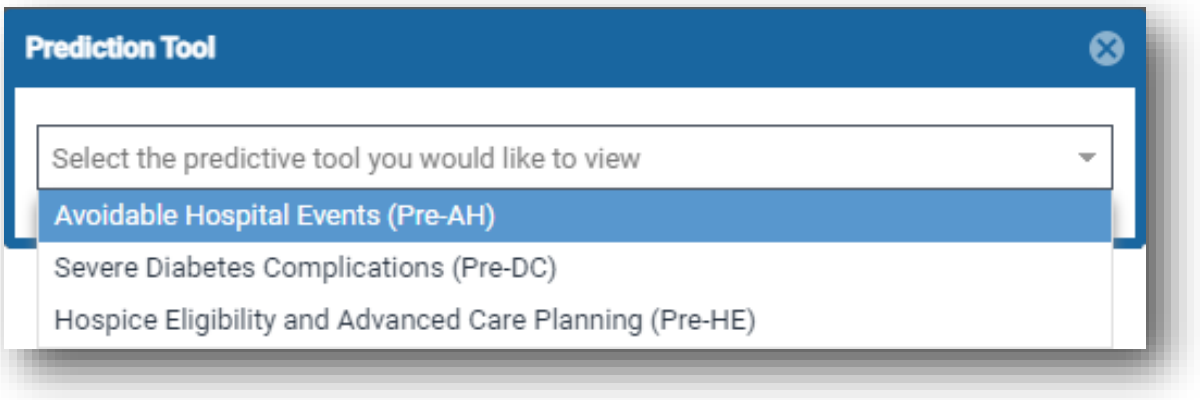
Please note that the Pre-DC prediction tool provides risk scores and reasons for risk for all attributed beneficiaries regardless of having been diagnosed as having Diabetes. Specifically, this tool indicates the risk of inpatient hospitalization or ED visit due to ophthalmic/retinopathic, nephropathic, cerebrovascular, cardiovascular, peripheral vascular, or metabolic complications. While these are typically complications of Type 2 diabetes, they can also have other causes.

Pre-HE

The Hilltop Hospice Eligibility and Advanced Care Planning (Pre-HE) Model™ score predicts risk of eligibility for hospice. It is designed to support proactive advanced care planning discussions by estimating a patient's probability of death within the next six months.

2.2.1.2 Navigating Prediction Tools

When first navigating to Prediction Tools, users are prompted to select which model with which to load the report. Once in the report, there is a filter to switch between models.



The report shows beneficiaries' MBI, name, gender, date of birth, age, ZIP code, Medicare status, Medicare/Medicaid dual eligibility flag, MDPCP Practice ID, HCC Tier, HEART payment indicator, PQI-Like Events, prediction score, total claim payment amount. Each score is calculated and refreshed monthly.

A score can be used by practices to identify beneficiaries with a probability of avoidable hospital events, severe diabetes complications in the next month, or all-cause mortality in the next 6 months, allowing practices to target their care management and interventions. As the models are updated each month, beneficiaries who are deceased will not have a score presented (shown as a blank value).

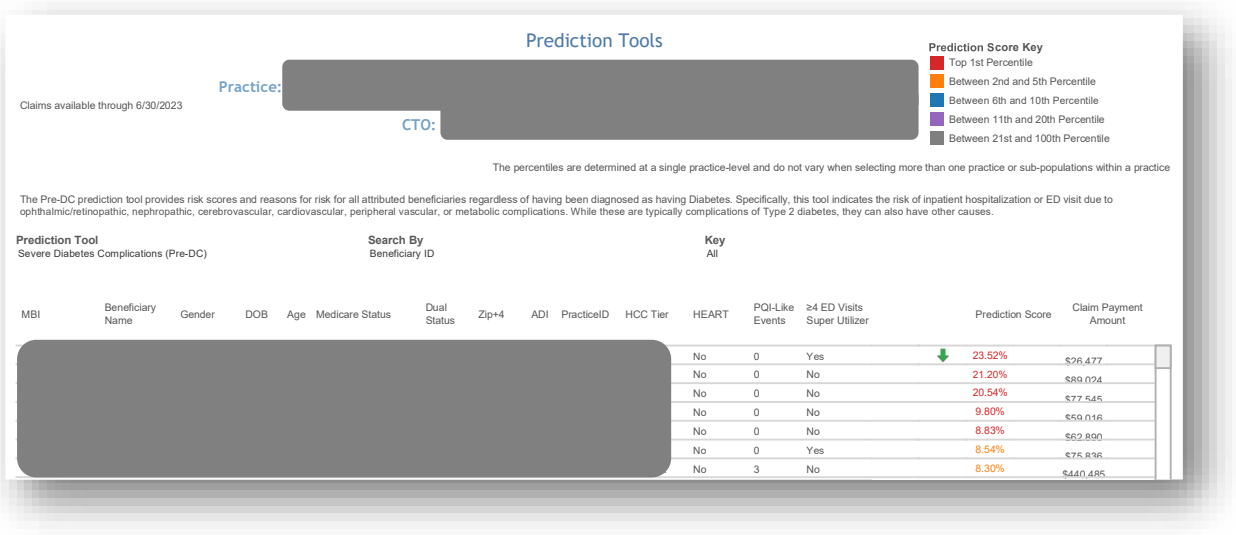
Each score is based on The Hilltop Institute's respective tool (Pre-AH Model™, Pre-DC Model™, and Pre-HE Model™), each of which draws from socio-demographic, biologic/diagnostic, and health care utilization-related data elements from the administrative (CCLF) claims data. The Pre-DC and Pre-HE Models™ each also include 18 factors specific to either model that are not incorporated into the Pre-AH Model™.

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

The MDPCP Report's global filters (see Section 1.3 – Navigation) can be applied to this report, as well as a search function by beneficiary name or MBI.

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

Prediction Score change indicators (green down arrow or red up arrow) may be applied to beneficiaries with a score in the current or previous month's top twenty percent of scores within a practice. Beneficiaries in the top decile of change from the previous month are flagged with the direction that their score changed.



All PHI is redacted – for example purposes only. Please note that the text disclaiming the Pre-DC tool in the screenshot above is present only when Severe Diabetes Complications (Pre-DC) is selected.

COLUMN	DESCRIPTION
Medicare Status	The beneficiary's qualification for Medicare.
Dual Status	Flag indicating whether the beneficiary has at least one month of eligibility for and coverage by Medicaid in the 36 months of claims data.
Zip+4	Beneficiary's 10-digit ZIP code of residence according to CMS demographic data.
ADI	National Area Deprivation Index Percentile; the 2019 ranking of socioeconomic disadvantage by 9-digit ZIP code. Beneficiaries' ADIs are presented as percentiles, 1 through 100. The most disadvantaged percentile is 100. Those without a percentile ADI are presented with blank entries (i.e. the beneficiary ZIP code is present but is not assigned an ADI).
HEART	Indicates whether the beneficiary qualified for HEART payments to the practice for the selected attributed quarter.
PQI-Like Events	The count of PQI-Like events in the latest 12 months of claims data, inclusive of the lag period.
≥ 4 ED Visits Super Utilizer	Yes/No flag indicating whether the beneficiary has at least four ED visits in the latest 12 months of claims data, inclusive of the lag period.
Prediction Score	The output of the selected model reflecting the predicted risk of event/eligibility.
Claim Payment Amount	Sum of all claims paid for the latest 12 months of claims data, inclusive of the lag period.

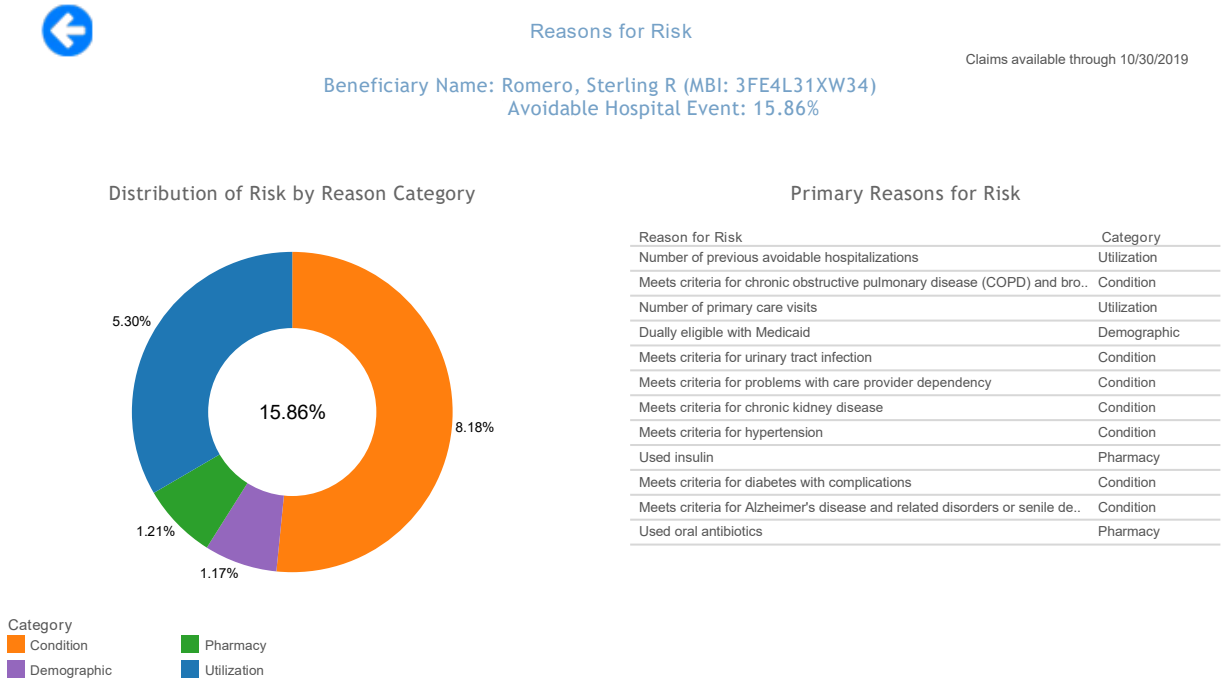
2.2.1.3 Reasons for Risk

Details on the factors contributing to a beneficiary's score are available in this report. The Distribution of Risk by Reason Category shows the contribution of the four risk categories to a given beneficiary's risk score. It is important to note that this report excludes a number of reasons that contribute to the risk score that stakeholders have deemed to be non-impactable through care coordination or management (e.g. geography, age). The relative contributions of the categories of risk presented are re-based to sum to the total risk score in this report.

When unfiltered, the Primary Reasons for Risk table shows up to 12 of the top specific factors contributing to the beneficiary's risk score, regardless of category. Factors are presented in descending order of contribution.

When selecting a category within the Distribution of Risk by Reason Category chart, the Primary Reasons for Risk table will update to show only reasons for risk within the selected category. Selections will show additional contributing reasons for risk when available if not included in the top 12 displayed by default.

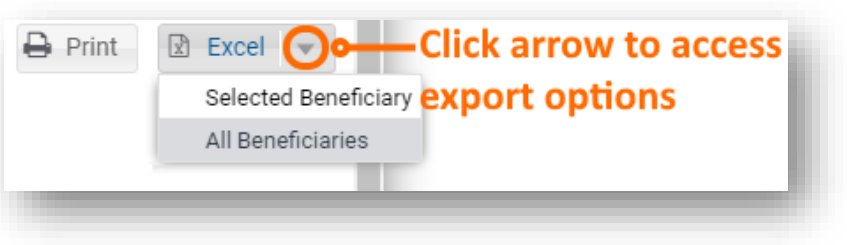
For more information on the reasons for risk, please refer to the Pre-AH Risk Score Specifications document available in the Help section of the MDPCP Reports.



All data are fictitious – for example purposes only.

2.2.1.4 Reasons for Risk Bulk Export

Having navigated to the Reasons for Risk report for an individual beneficiary, the user is able to export that report in an .xlsx file for a single beneficiary or for all beneficiaries within the selected practice(s) from the base Likelihood of Avoidable Hospital Events Report.



The resulting file includes three sheets, the first two of which include beneficiary level information.

SHEET NAME	DESCRIPTION
Summary	Corresponds to the "Distribution of Risk by Reason Category" (doughnut) chart in the Reasons for Risk report and includes the AH Score and relative contributions by category.
Report	Corresponds to the "Primary Reasons for Risk" table in the report and includes the AH Score with the relative contribution of each reason for risk.
About	Audit information regarding the selected practice(s), CTO, selected attribution quarter, selected HCC Tier(s), Prediction Model, export date and username.

2.2.2 Inpatient / ER Utilization Report

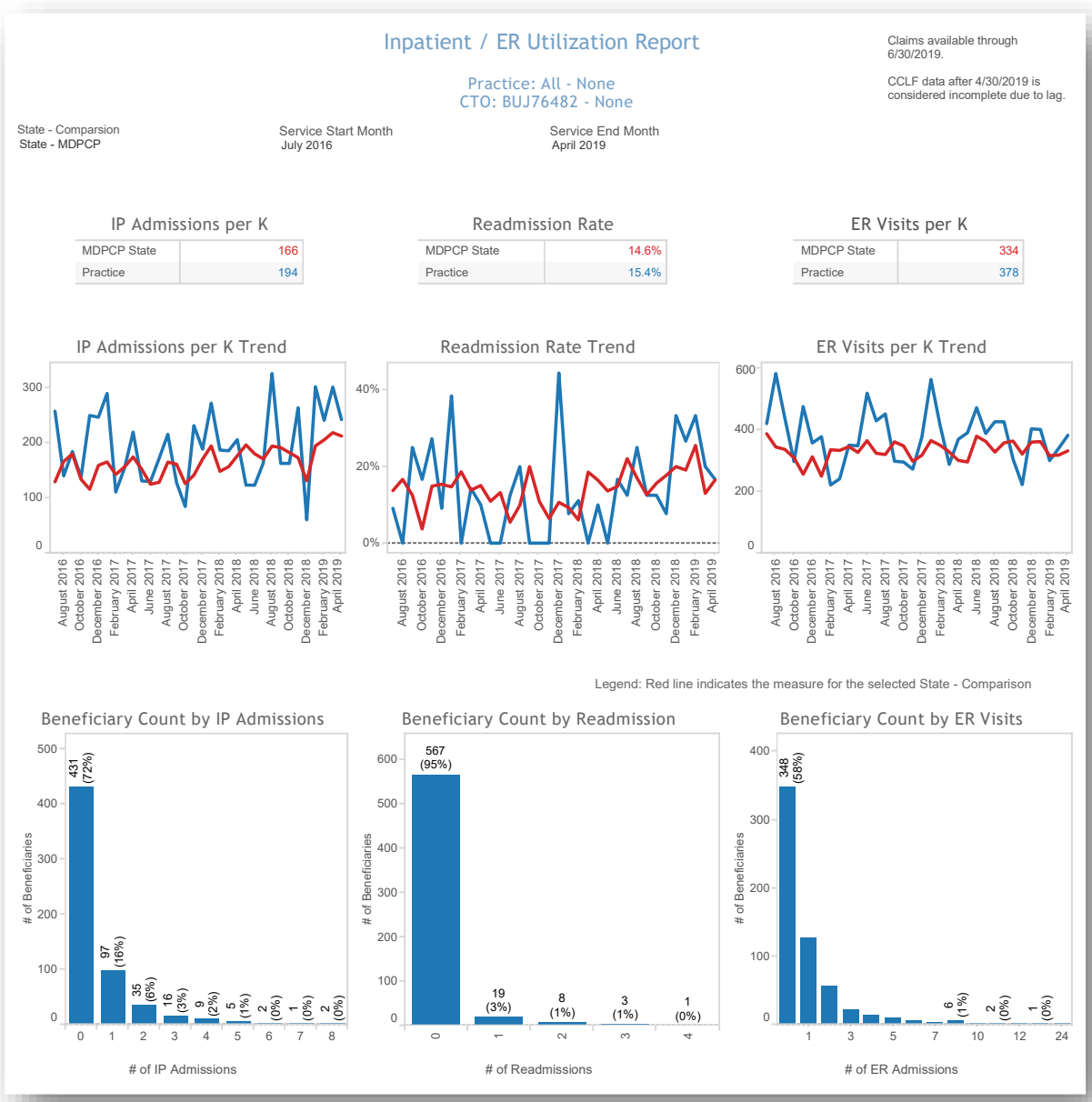
Click here to watch a short MDPCP Basics video explaining how to use this report:

https://www.gotostage.com/channel/6218fe0614ce4de48cb53d75ada41b87/recording/627401a80be44cff89460b88bb831995/watch

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

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

CHART NAME	DESCRIPTION
IP Admissions per K Trend	For a given month, the number of IP admissions per beneficiary month during the given month, per 1,000 beneficiaries. Details on the per 1,000 calculation can be found in Section 4.4.
Inpatient Admissions per K per Year	For the duration of the selected time period, the annualized number of inpatient admissions per beneficiary month per 1,000 beneficiaries. Details on the per 1,000 per year calculation can be found in Section 4.4.
Readmission Rate	Total unplanned readmissions divided by the total admissions for the presented time period.
Readmission Rate Trend	30-day unplanned readmission rates (readmissions/total inpatient admissions) per month.
ER Visits per K per Year	For the duration of the selected time period, the annualized number of ER visits per beneficiary month per 1,000 beneficiaries. Details on the per 1,000 per year calculation can be found in Section 4.4.
ER Visits per K Trend	For a given month, the number of ER visits per beneficiary month during the given month per 1,000 beneficiaries. Details on the per 1,000 calculation can be found in Section 4.4.
Beneficiary Count by IP Admission	Count and distribution of beneficiaries by count of inpatient admissions.
Beneficiary Count by Readmission	Count and distribution of beneficiaries by count of readmissions to a short-term acute care hospital.
Beneficiary Count by ER Visits	Count and distribution of beneficiaries by count of emergency room visits.

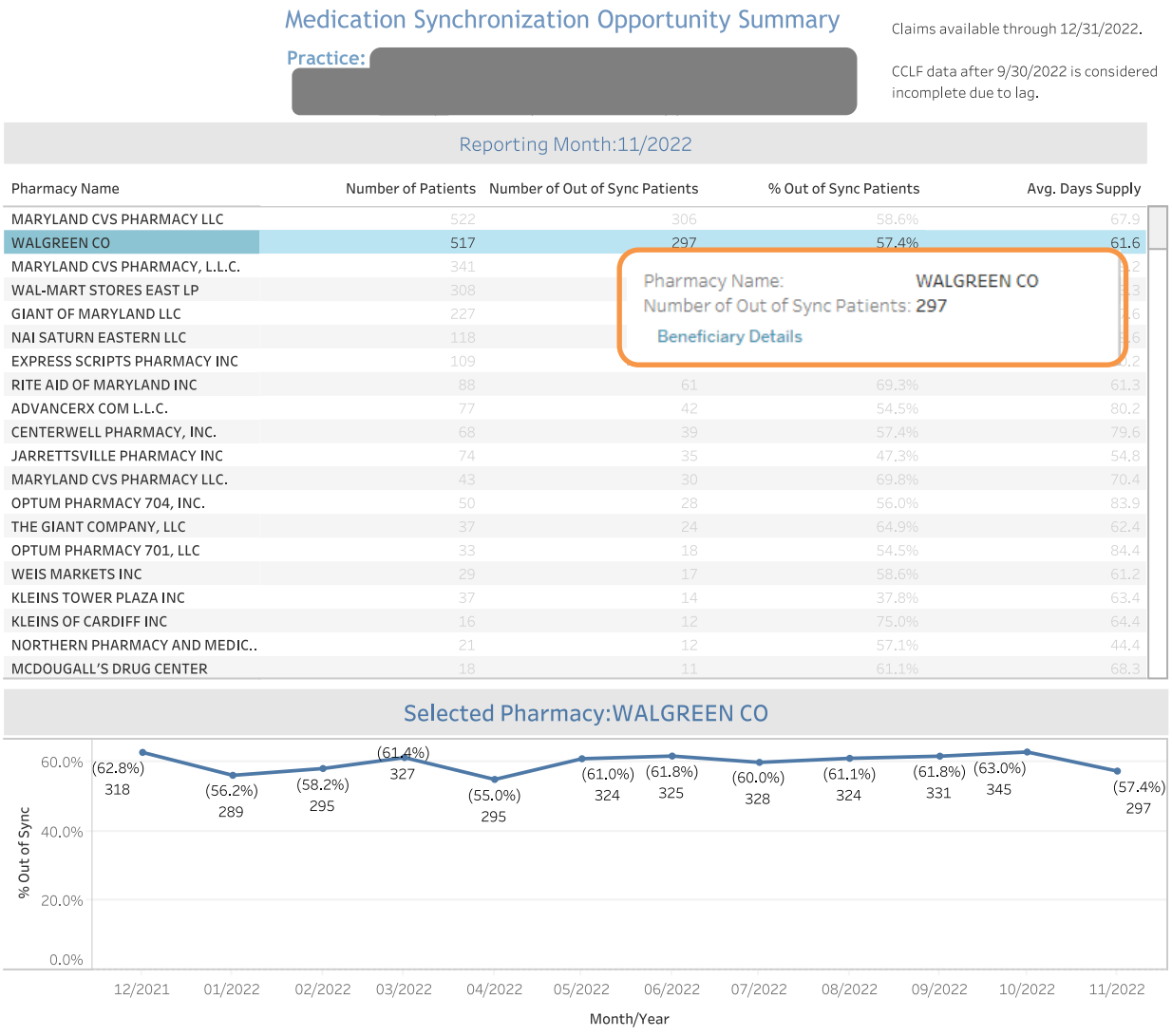


All data are fictitious – for example purposes only.

2.2.3 Medication Synchronization Opportunity Summary

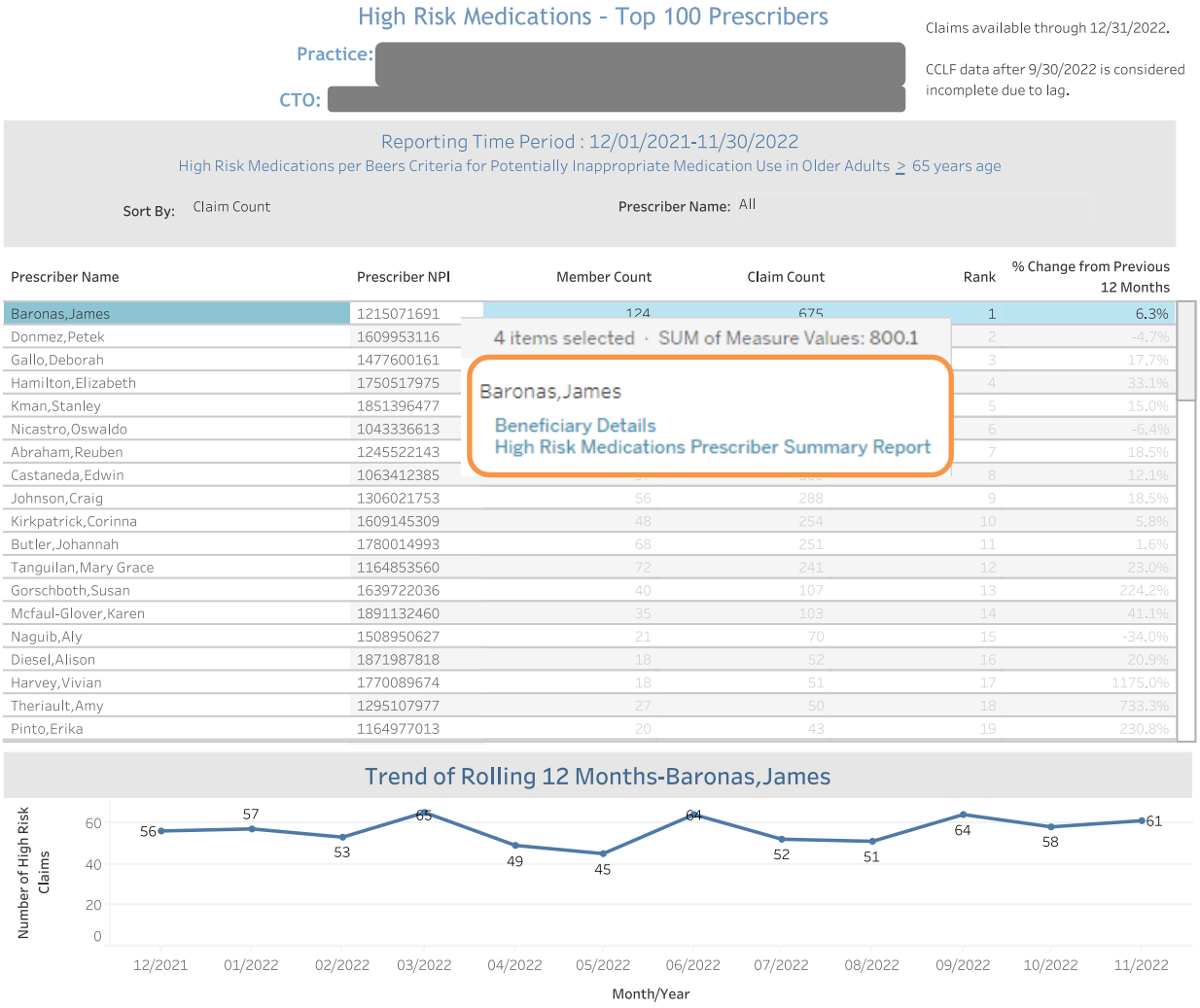
Medication Synchronization Opportunity Summary ranks the pharmacies by number and proportion of patients whose prescriptions are not synchronized. Medication synchronization refers to the extent to which a patient fills their prescriptions on a single day from a single pharmacy. Patients who fill prescriptions on multiple days in a single month and/or fill prescriptions at multiple pharmacies are considered not synchronized.

Select a pharmacy to populate the chart at the bottom of the report. Select the Number of Out of Sync Patients to access the drill through to Beneficiary Details. Selecting any of the other three columns will allow for access to beneficiary details for all those who fill scripts at the highlighted pharmacy.



2.2.4 High Risk Medications – Top 100 Prescribers

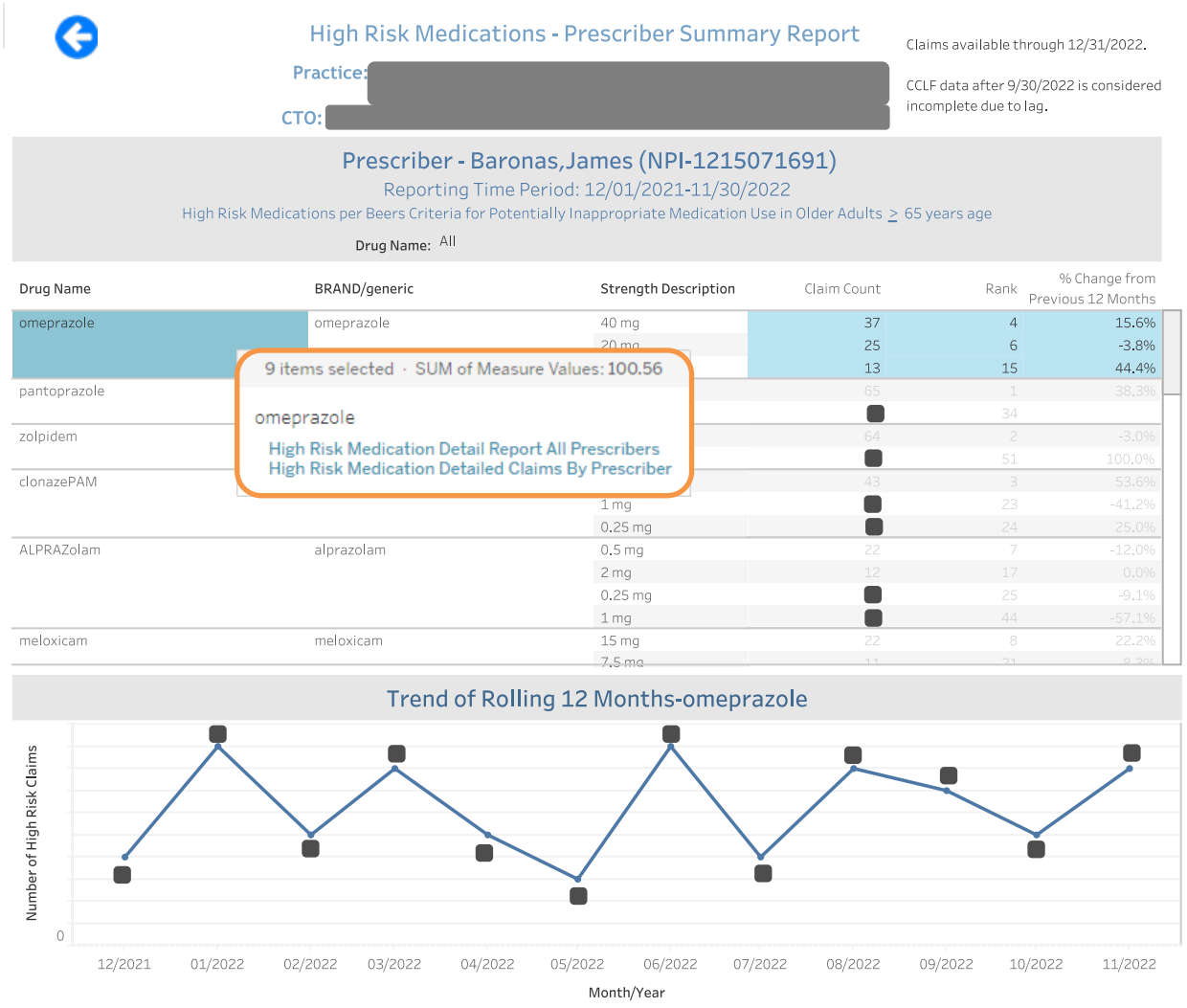
High Risk Medications Top 100 Prescribers identifies the top 100 prescribers – not limited to MDPCP participating physicians – who prescribed medications identified as potentially high risk according to Beers criteria for potentially inappropriate medication use in older adults (> 65 years of age or older). The report displays the number of high risk medication claims by prescriber and the change from the previous 12 months. Click on Prescriber Name or Prescriber NPI to view detailed reports.



Prescriber Name	Prescriber NPI	Member Count	Claim Count	Rank	% Change from Previous 12 Months
Baronas,James	1215071691	124	675	1	6.3%
Donmez,Petek	1609953116	120	645	2	-4.7%
Gallo,Deborah	1477600161	114	636	3	17.7%
Hamilton,Elizabeth	1750517975	110	624	4	33.1%
Kman,Stanley	1851396477	107	615	5	15.0%
Nicastro,Oswaldo	1043336613	104	611	6	-6.4%
Abraham,Reuben	1245522143	101	608	7	18.5%
Castaneda,Edwin	1063412385	97	588	8	12.1%
Johnson,Craig	1306021753	56	288	9	18.5%
Kirkpatrick,Corinna	1609145309	48	254	10	5.8%
Butler,Johannah	1780014993	68	251	11	1.6%
Tanguilan,Mary Grace	1164853560	72	241	12	23.0%
Gorschboth,Susan	1639722036	40	107	13	224.2%
Mcfaul-Glover,Karen	1891132460	35	103	14	41.1%
Naguib,Aly	1508950627	21	70	15	-34.0%
Diesel,Alison	1871987818	18	52	16	20.9%
Harvey,Vivian	1770089674	18	51	17	1175.0%
Theriault,Amy	1295107977	27	50	18	733.3%
Pinto,Erika	1164977013	20	43	19	230.8%

2.2.4.1 High Risk Medications Prescriber Summary

High Risk Medication Prescriber Summary lists the medications identified as potentially high risk according to Beers criteria for potentially inappropriate medication use in older adults (> 65 years of age or older) by selected Prescriber. The report lists the medication prescribed and corresponding claim count. To access this report, select the High Risk Medication Top 100 Prescribers and click on the Provider Name. Click on the Drug Name or BRAND/generic to view the High Risk Medication Detail Report by Prescriber and High Risk Medication Detail Claims Report.

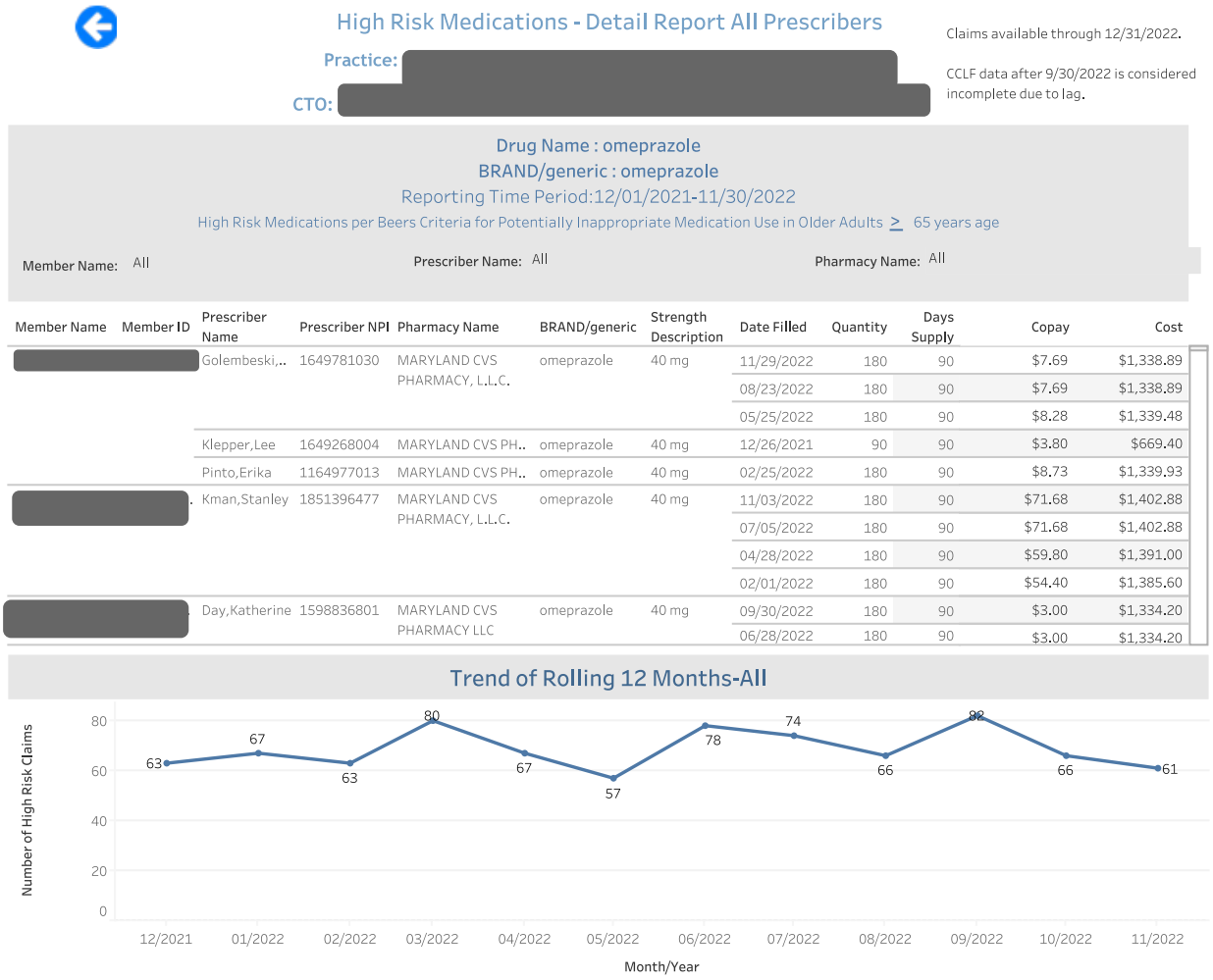


n.b. Small cell sizes (<11) are masked. No PHI is disclosed.

2.2.4.1.1 HIGH RISK MEDICATION DETAIL REPORT ALL PRESCRIBERS

High Risk Medication Detail Report All Prescribers report provides detailed claims information for all prescribers for the selected high risk medication. The report can be sorted by member name, prescriber name, pharmacy name, among other fields. The trend graph illustrates the number of claims for a specified drug across all prescribers by month.

To access this report, select a drug name from the High Risk Medications Prescriber Summary report and click on the High Risk Medication Detail Report All Prescribers. Patient-level claims information is available by clicking on Patient Summary and Patient Timeline. Click the back button to return the previous report.



High Risk Medications - Detail Report All Prescribers

Practice: [redacted]

CTO: [redacted]

Claims available through 12/31/2022.

CCLF data after 9/30/2022 is considered incomplete due to lag.

Drug Name : omeprazole
BRAND/generic : omeprazole
Reporting Time Period:12/01/2021-11/30/2022
High Risk Medications per Beers Criteria for Potentially Inappropriate Medication Use in Older Adults ≥ 65 years age

Member Name: All Prescriber Name: All Pharmacy Name: All

Member Name	Member ID	Prescriber Name	Prescriber NPI	Pharmacy Name	BRAND/generic	Strength Description	Date Filled	Quantity	Days Supply	Copay	Cost
[redacted]		Golembeski,..	1649781030	MARYLAND CVS PHARMACY, L.L.C.	omeprazole	40 mg	11/29/2022	180	90	$7.69	$1,338.89
							08/23/2022	180	90	$7.69	$1,338.89
							05/25/2022	180	90	$8.28	$1,339.48
		Klepper,Lee	1649268004	MARYLAND CVS PH..	omeprazole	40 mg	12/26/2021	90	90	$3.80	$669.40
		Pinto,Erika	1164977013	MARYLAND CVS PH..	omeprazole	40 mg	02/25/2022	180	90	$8.73	$1,339.93
[redacted]		Kman,Stanley	1851396477	MARYLAND CVS PHARMACY, L.L.C.	omeprazole	40 mg	11/03/2022	180	90	$71.68	$1,402.88
							07/05/2022	180	90	$71.68	$1,402.88
							04/28/2022	180	90	$59.80	$1,391.00
							02/01/2022	180	90	$54.40	$1,385.60
[redacted]		Day,Katherine	1598836801	MARYLAND CVS PHARMACY LLC	omeprazole	40 mg	09/30/2022	180	90	$3.00	$1,334.20
							06/28/2022	180	90	$3.00	$1,334.20

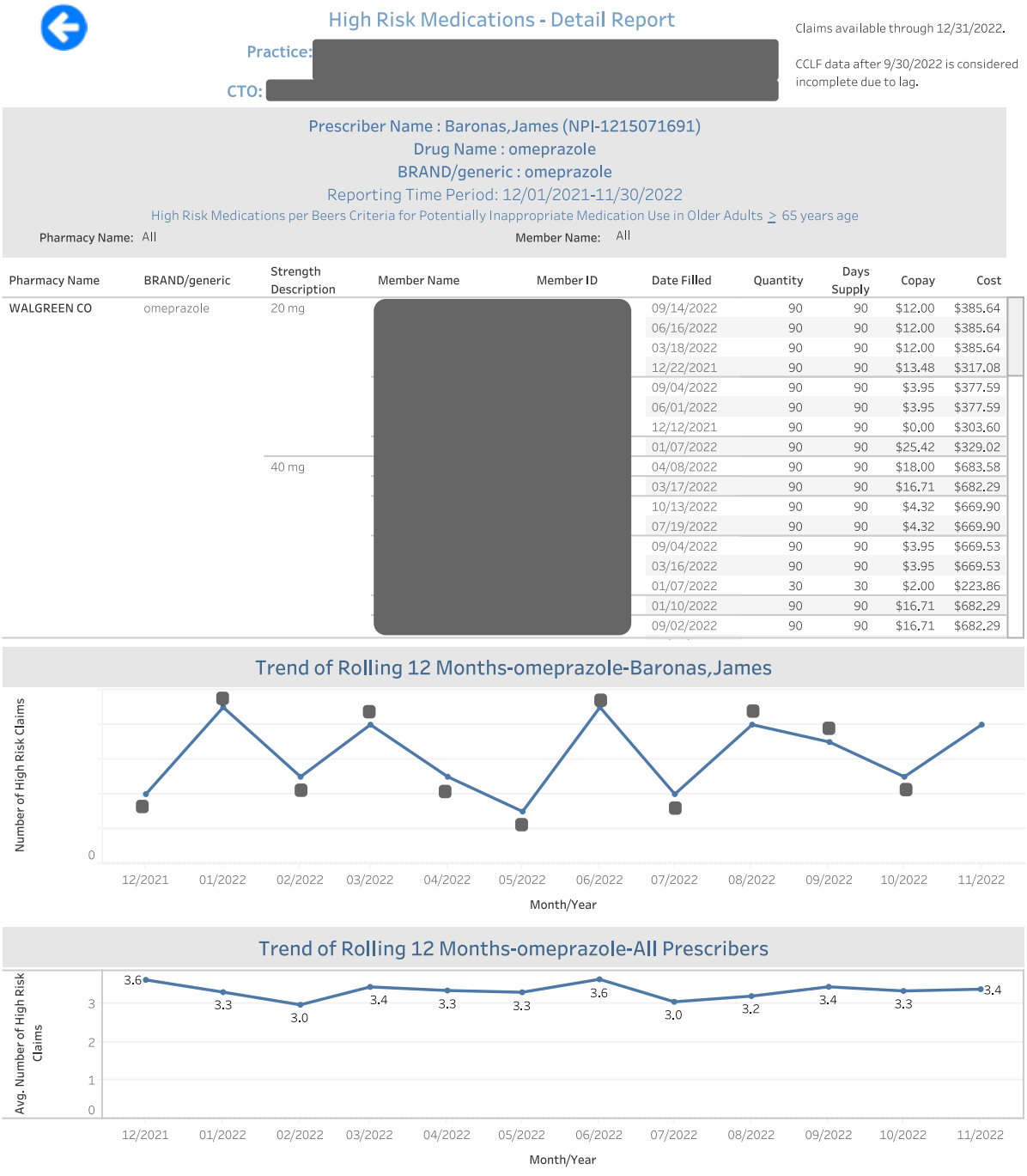
Trend of Rolling 12 Months-All

2.2.4.1.2 HIGH RISK MEDICATION DETAILED CLAIM BY PRESCRIBER

High Risk Medication Detailed Claim by Prescriber report provides detail claims information for a specific high risk medication and prescriber including the Pharmacy name, brand and generic drug name, Member Name, MBI, date filled, quantity, patient copayment, and estimated cost using published average wholesale price. The first trend graph illustrates the number of claims for specified drug prescribed by the selected prescriber for

the last 12 months. The second trend graph illustrates the average number of claims for the same drug across all prescribers by month.

To access this report, select a drug from the High Risk Medications Prescriber Summary report click on the High Risk Medications Detailed Claim by Prescriber report. Click on the back button to return to the previous report.



n.b. Small cell sizes (<11) are masked. No PHI is disclosed.

2.2.5 Payment Band Report

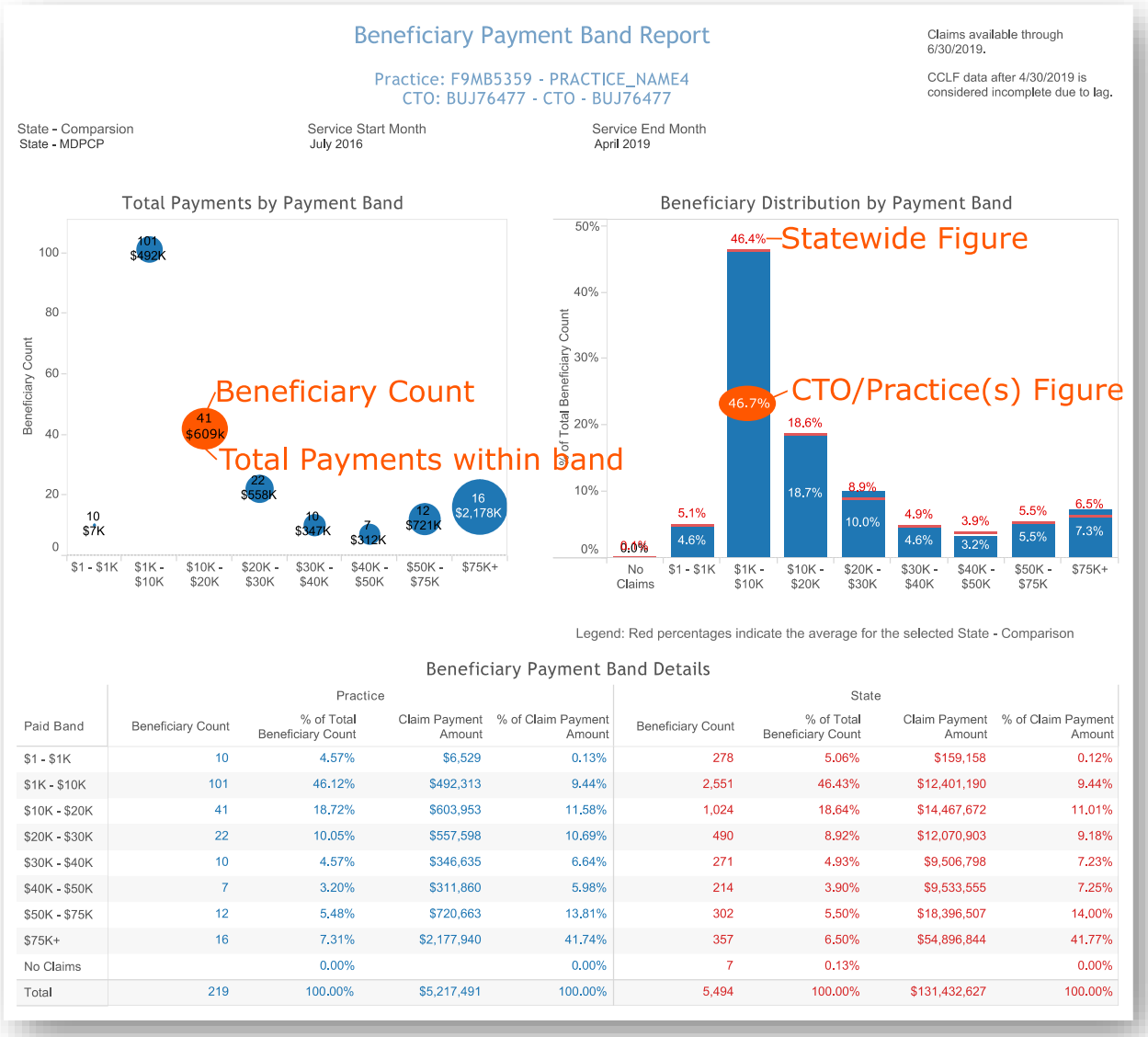
Click here to watch a short MDPCP Basics video explaining how to use this report:

https://www.gotostage.com/channel/6218fe0614ce4de48cb53d75ada41b87/recording/d0ff43b1a930447586cb29fa333c272c/watch

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

The Payment Band report links to drilldowns to Beneficiary Details.

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



Beneficiary Payment Band Details

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

All data are fictitious – for example purposes only.

2.2.6 PQI-Like Utilization Report

Click here to watch a short MDPCP Basics video explaining how to use this report:

https://www.gotostage.com/channel/6218fe0614ce4de48cb53d75ada41b87/recording/aa05dc1d48554c359c40091d85bc9070/watch

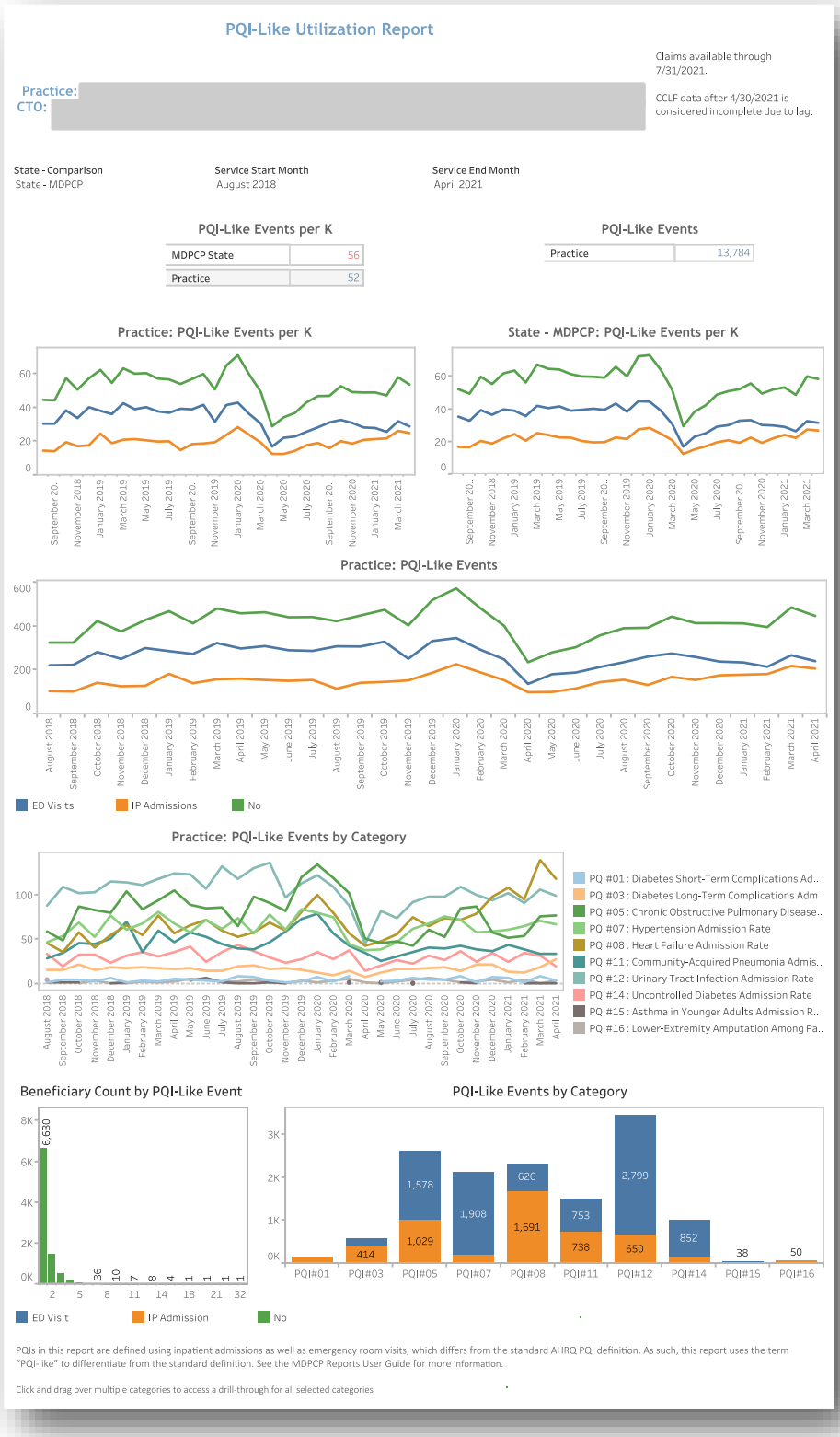
The PQI-Like Utilization Report presents utilization for the selected practice(s) for IP admissions **or ED visits**[1] that fall into one of eleven Prevention Quality Indicator (PQI) categories, using the 2022 AHRQ specifications. Whereas PQIs are described as rates, this report presents IP admissions and ED visits that would be included in the numerator of the rate calculation.

Chart/Table Title	DESCRIPTION
PQI-Like Events per K	The PQI-Like events per thousand beneficiaries for the selected practice(s) and state comparator across the selected time period.
PQI-Like Events	The total number of PQI-Like events for the selected practice(s).
Practice: PQI-Like Events per K	PQI-Like events per thousand beneficiaries by calendar month broken out by IP, ED, and total for the selected practice(s).
State: PQI-Like Events per K	PQI-Like events per thousand beneficiaries by calendar month broken out by IP, ED, and total for the selected state comparator.
Practice: PQI-Like Events	PQI-Like events per month broken out by IP, ED, and total for the selected practice(s).
Practice: PQI-Like Events by Category	PQI-Like events per month by PQI category.
Beneficiary Count by PQI-Like Event	Count and distribution of beneficiaries by count of PQI-Like Events. IP and ED events are grouped together in this chart.
PQI-Like Admissions by Category	Total count of PQI-Like event by PQI category, by IP admission and ED visit.

[1] Standard PQI algorithms do not include ED utilization. However, to be consistent with the definition of avoidable hospitalizations used in the Pre-AH™ model (presented in the Likelihood of Avoidable Hospital Events Report), emergent utilization with diagnosis and procedure codes consistent with the PQI algorithms are used to identify PQI-like events in this report. In practice, this means that the 2020 PQI logic is applied to all Part A claims with claim type of 60 or 61 and/or Part A claim lines with revenue codes corresponding to the ED setting.

Descriptions of the PQI-Like categories are presented below:

Prevention Quality Indicator (PQI) #	DESCRIPTION
PQI #1	Diabetes Short-term Complications Admission Rate
PQI #3	Diabetes Long-term Complications Admissions Rate
PQI #5	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI #7	Hypertension Admission Rate
PQI #8	Heart Failure Admission Rate
PQI #11	Community Acquired Pneumonia Admission Rate
PQI #12	Urinary Tract Infection Admission Rate
PQI #14	Uncontrolled Diabetes Admission Rate
PQI #15	Asthma in Younger Adults Admission Rate
PQI #16	Lower-Extremity Amputation among Patients with Diabetes Rate

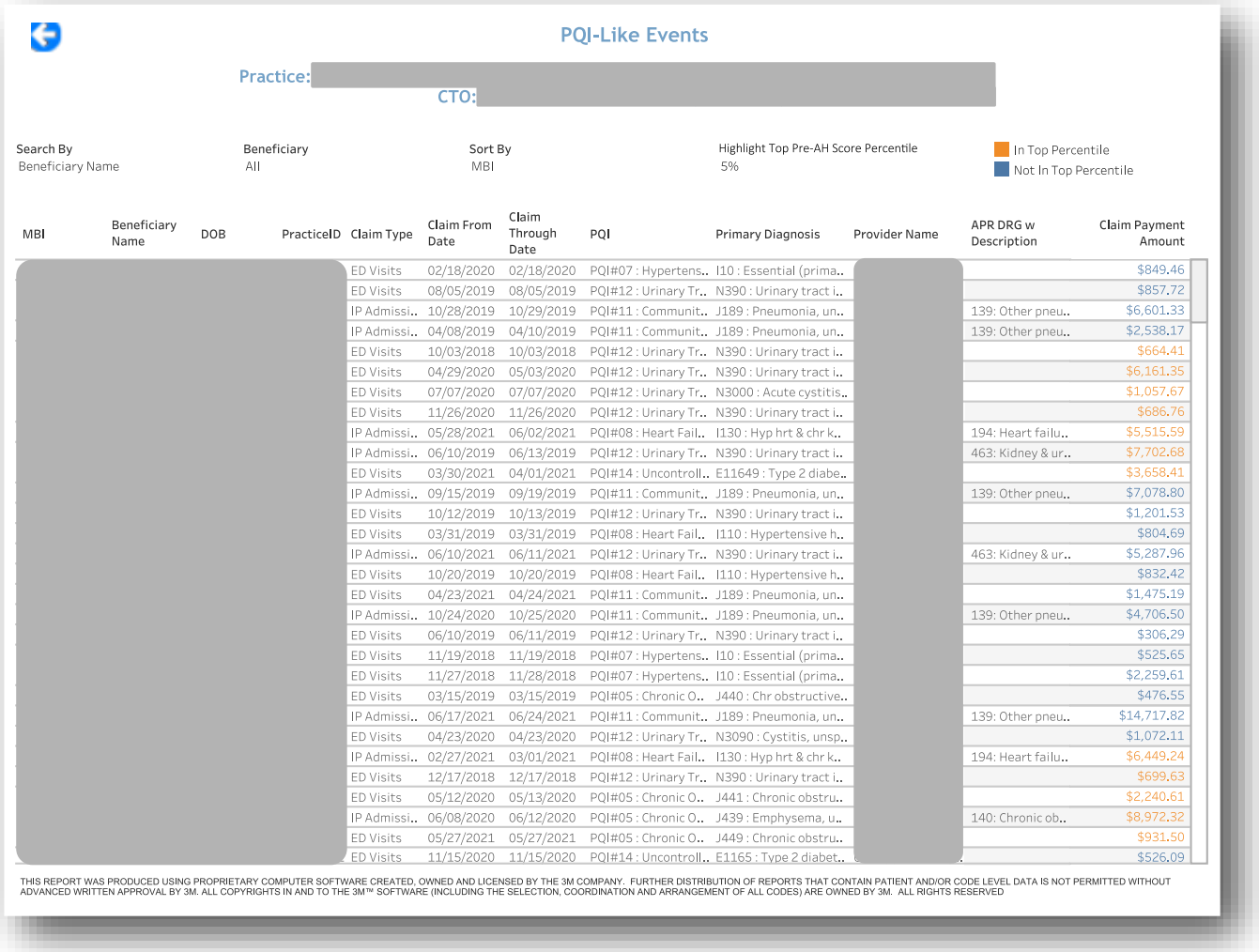

PQI-Like Utilization Report
Claims available through 7/31/2021.
Practice:
CTO:
CCLF data after 4/30/2021 is considered incomplete due to lag.
State - Comparison
State - MDPCP
Service Start Month
August 2018
Service End Month
April 2021
PQI-Like Events per K
MDPCP State 56
Practice 52
PQI-Like Events
Practice 13,784
Practice: PQI-Like Events per K
State - MDPCP: PQI-Like Events per K
Practice: PQI-Like Events
ED Visits
IP Admissions
No
Practice: PQI-Like Events by Category
PQI#01 : Diabetes Short-Term Complications Ad..
PQI#03 : Diabetes Long-Term Complications Adm..
PQI#05 : Chronic Obstructive Pulmonary Disease..
PQI#07 : Hypertension Admission Rate
PQI#08 : Heart Failure Admission Rate
PQI#11 : Community-Acquired Pneumonia Admis..
PQI#12 : Urinary Tract Infection Admission Rate
PQI#14 : Uncontrolled Diabetes Admission Rate
PQI#15 : Asthma in Younger Adults Admission R..
PQI#16 : Lower-Extremity Amputation Among Pa..
Beneficiary Count by PQI-Like Event
6,630
ED Visit
IP Admission
No
PQI-Like Events by Category
PQI#01 414
PQI#03 1,029 1,578
PQI#05 1,908
PQI#07 1,691 626
PQI#08 738 753
PQI#11 650 2,799
PQI#12 852
PQI#14 38
PQI#15 50
PQI#16
PQIs in this report are defined using inpatient admissions as well as emergency room visits, which differs from the standard AHRQ PQI definition. As such, this report uses the term "PQI-like" to differentiate from the standard definition. See the MDPCP Reports User Guide for more information.
Click and drag over multiple categories to access a drill-through for all selected categories

All PHI is redacted – for example purposes only.

2.2.6.1 PQI-Like Utilization Report: PQI-Like Events

This drilldown report is constructed similarly to the Claims Details Report described in section 3.2. However, the claims presented here are those corresponding only to PQI-Like IP admissions or ED visits and are noted in the table. Users can access the drill through from any data point on the PQI Utilization Report.

Please note that the Excel export of this view includes up to 24 secondary diagnosis codes per PQI-Like Event as well as practice name in addition the columns present in the report.



PQI-Like Events

Practice: [redacted]

CTO: [redacted]

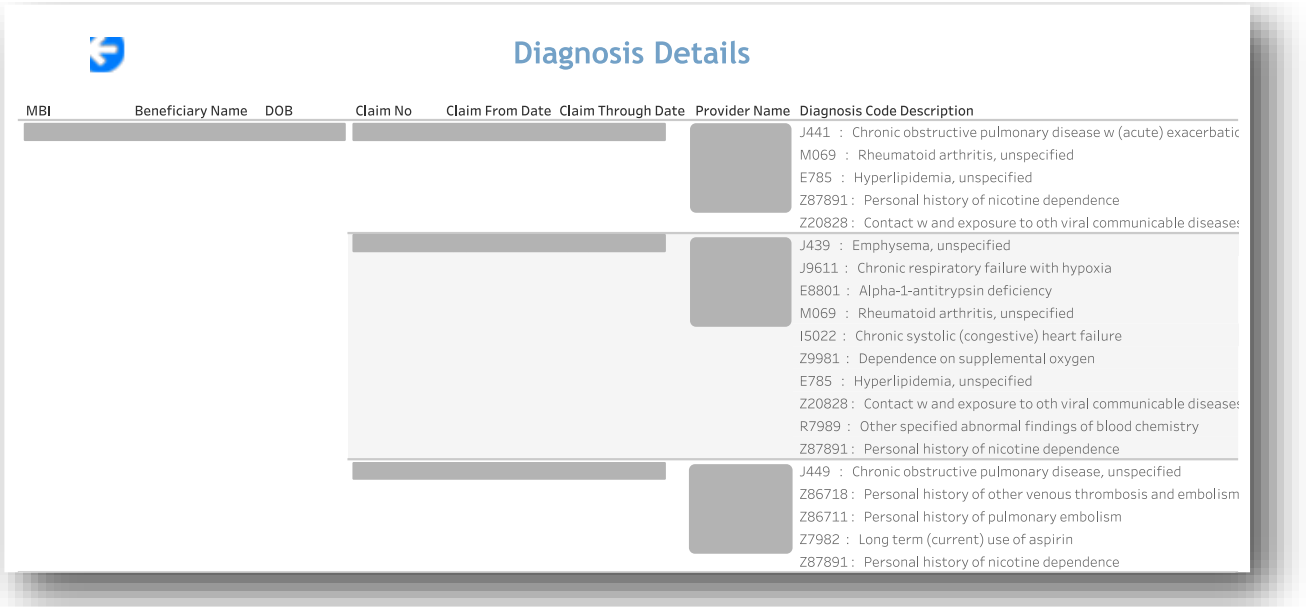
Search By: Beneficiary Name | Beneficiary: All | Sort By: MBI | Highlight Top Pre-AH Score Percentile: 5% | In Top Percentile | Not In Top Percentile

MBI	Beneficiary Name	DOB	PracticeID	Claim Type	Claim From Date	Claim Through Date	PQI	Primary Diagnosis	Provider Name	APR DRG w Description	Claim Payment Amount
[redacted]				ED Visits	02/18/2020	02/18/2020	PQI#07 : Hypertens..	I10 : Essential (prima..	[redacted]		$849.46
				ED Visits	08/05/2019	08/05/2019	PQI#12 : Urinary Tr..	N390 : Urinary tract i..			$857.72
				IP Admissi..	10/28/2019	10/29/2019	PQI#11 : Communit..	J189 : Pneumonia, un..		139: Other pneu..	$6,601.33
				IP Admissi..	04/08/2019	04/10/2019	PQI#11 : Communit..	J189 : Pneumonia, un..		139: Other pneu..	$2,538.17
				ED Visits	10/03/2018	10/03/2018	PQI#12 : Urinary Tr..	N390 : Urinary tract i..			$664.41
				ED Visits	04/29/2020	05/03/2020	PQI#12 : Urinary Tr..	N390 : Urinary tract i..			$6,161.35
				ED Visits	07/07/2020	07/07/2020	PQI#12 : Urinary Tr..	N3000 : Acute cystitis..			$1,057.67
				ED Visits	11/26/2020	11/26/2020	PQI#12 : Urinary Tr..	N390 : Urinary tract i..			$686.76
				IP Admissi..	05/28/2021	06/02/2021	PQI#08 : Heart Fail..	I130 : Hyp hrt & chr k..		194: Heart failu..	$5,515.59
				IP Admissi..	06/10/2019	06/13/2019	PQI#12 : Urinary Tr..	N390 : Urinary tract i..		463: Kidney & ur..	$7,702.68
				ED Visits	03/30/2021	04/01/2021	PQI#14 : Uncontroll..	E11649 : Type 2 diabe..			$3,658.41
				IP Admissi..	09/15/2019	09/19/2019	PQI#11 : Communit..	J189 : Pneumonia, un..		139: Other pneu..	$7,078.80
				ED Visits	10/12/2019	10/13/2019	PQI#12 : Urinary Tr..	N390 : Urinary tract i..			$1,201.53
				ED Visits	03/31/2019	03/31/2019	PQI#08 : Heart Fail..	I110 : Hypertensive h..			$804.69
				IP Admissi..	06/10/2021	06/11/2021	PQI#12 : Urinary Tr..	N390 : Urinary tract i..		463: Kidney & ur..	$5,287.96
				ED Visits	10/20/2019	10/20/2019	PQI#08 : Heart Fail..	I110 : Hypertensive h..			$832.42
				ED Visits	04/23/2021	04/24/2021	PQI#11 : Communit..	J189 : Pneumonia, un..			$1,475.19
				IP Admissi..	10/24/2020	10/25/2020	PQI#11 : Communit..	J189 : Pneumonia, un..		139: Other pneu..	$4,706.50
				ED Visits	06/10/2019	06/11/2019	PQI#12 : Urinary Tr..	N390 : Urinary tract i..			$306.29
				ED Visits	11/19/2018	11/19/2018	PQI#07 : Hypertens..	I10 : Essential (prima..			$525.65
				ED Visits	11/27/2018	11/28/2018	PQI#07 : Hypertens..	I10 : Essential (prima..			$2,259.61
				ED Visits	03/15/2019	03/15/2019	PQI#05 : Chronic O..	J440 : Chr obstructive..			$476.55
				IP Admissi..	06/17/2021	06/24/2021	PQI#11 : Communit..	J189 : Pneumonia, un..		139: Other pneu..	$14,717.82
				ED Visits	04/23/2020	04/23/2020	PQI#12 : Urinary Tr..	N3090 : Cystitis, unsp..			$1,072.11
				IP Admissi..	02/27/2021	03/01/2021	PQI#08 : Heart Fail..	I130 : Hyp hrt & chr k..		194: Heart failu..	$6,449.24
				ED Visits	12/17/2018	12/17/2018	PQI#12 : Urinary Tr..	N390 : Urinary tract i..			$699.63
				ED Visits	05/12/2020	05/13/2020	PQI#05 : Chronic O..	J441 : Chronic obstru..			$2,240.61
				IP Admissi..	06/08/2020	06/12/2020	PQI#05 : Chronic O..	J439 : Emphysema, u..		140: Chronic ob..	$8,972.32
				ED Visits	05/27/2021	05/27/2021	PQI#05 : Chronic O..	J449 : Chronic obstru..			$931.50
				ED Visits	11/15/2020	11/15/2020	PQI#14 : Uncontroll..	E1165 : Type 2 diabet..			$526.09

All PHI is redacted – for example purposes only.

2.2.6.2 Diagnosis Details

For additional detail on a beneficiary or individual PQI-Like Event, select either the beneficiary MBI or name for all PQI-Like Events for that beneficiary, or any field from Claim Type to Claim Payment Amount. After making the selection, click “Diagnosis Details” in the hover over menu to drill through. The below screenshot depicts the view for a beneficiary level drill through who has 3 separate PQI-Like Events.



All PHI is redacted – for example purposes only.

2.2.7 Chronic Condition Report

The Chronic Condition report assigns beneficiaries to Chronic Condition Warehouse (CCW) Chronic Conditions and Other Chronic or Potentially Disabling Conditions according to the presence of diagnosis and procedure codes on beneficiary claims. Unlike the prior CCS Condition Report, the CCW Chronic Condition Report identifies beneficiaries (not claims) based on their chronic condition flags. Since it is a beneficiary-level flag, the payment amounts reflect all Part A and B claims for the beneficiaries with these conditions. Beneficiaries can be included in multiple categories and the payment totals are not exclusive; the total payments for beneficiaries in multiple conditions are included in the totals for each category.

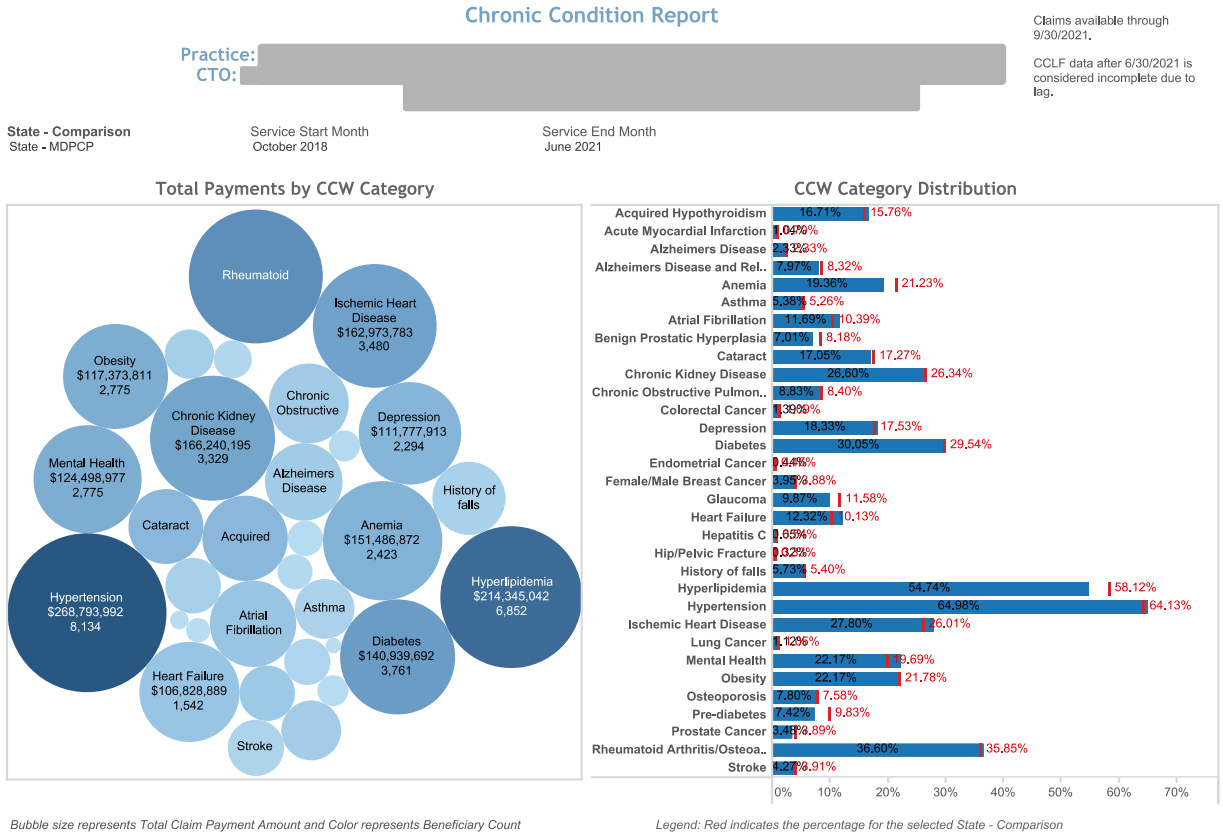
For complete technical definitions, please refer to documentation available at:

https://www2.ccwdata.org/web/guest/condition-categories

CHART NAME	DESCRIPTION
Total Payments by CCW Category	Bubble cluster with the size representing the total claim payment amount for all utilization by beneficiaries in the category and the color representing the beneficiary count (more beneficiaries will have a darker color).
CCW Category Distribution	The percent of beneficiaries attributed to the practice and selected state comparison population with a CCW Chronic Condition or Potential Disabling condition.
CCW Category Summary	Table showing the Beneficiary Count, Claim Count, Claim Payment Amount, Claim Paid Per Beneficiary for beneficiaries for the practice(s) and selected State - Comparison for each CCW Chronic Condition or Other Potential Disabling condition.

In addition to the CCW flags, the report contains additional condition measures:

Measure Details	DESCRIPTION
Mental Health Excluding Depression	The aggregate of the following CCW conditions: Anxiety Disorders Bipolar Disorder Personality Disorders Post-Traumatic Stress Disorder (PTSD) Schizophrenia Schizophrenia and Other Psychotic Disorders
Mental Health Including Depression	The aggregate of the following CCW conditions: Anxiety Disorders Bipolar Disorder Depressive Disorders Personality Disorders Post-Traumatic Stress Disorder (PTSD) Schizophrenia Schizophrenia and Other Psychotic Disorders Depression, Bipolar, or Other Depressive Mood Disorders
Pre-Diabetes	Not a CCW chronic condition. Adapted from the American Diabetes Association. ICD-10 Diagnosis codes to identify Prediabetes: R73.01 R73.02 R73.03 E88.81 R73.09 Source: https://professional.diabetes.org
History of Falls	Not a CCW chronic condition. Adapted from the National Council on Aging (NCOA). Codes used to identify beneficiaries with a history of falls: CPT: 1100F ICD-10: Z91.81 ICD-10: R29.6 Source: https://www.ncoa.org/article/



CCW Category Summary

	Practice				State - MDPCP			
CCW Category	Beneficiary Count	Claim Count	Claim Payment Amount	Claim Paid Per Member	Beneficiary Count	Claim Count	Claim Payment Amount	Claim Paid Per Member
Acquired Hypothyroidism	2,092	227,203	$77,462,424	$37,028	58,902	6,017,368	$1,917,914,801	$32,561
Acute Myocardial Infarction	130	21,795	$13,268,413	$102,065	2,633	388,974	$218,732,257	$83,073
Alzheimers Disease	292	31,524	$13,084,402	$44,810	8,723	934,938	$337,152,699	$38,651
Alzheimers Disease and Rel..	997	133,663	$63,963,208	$64,156	31,091	3,949,793	$1,670,644,498	$53,734
Anemia	2,423	330,296	$151,486,872	$62,520	79,331	9,667,689	$3,794,751,772	$47,834
Asthma	674	94,389	$38,032,561	$56,428	19,641	2,507,276	$849,516,879	$43,252
Atrial Fibrillation	1,463	198,320	$79,462,713	$54,315	38,835	4,968,737	$1,898,188,883	$48,878
Benign Prostatic Hyperplasia	877	93,446	$32,834,845	$37,440	30,556	3,139,878	$1,096,523,571	$35,886
Cataract	2,134	186,761	$59,702,459	$27,977	64,522	5,494,927	$1,534,415,961	$23,781
Chronic Kidney Disease	3,329	409,802	$166,240,195	$49,937	98,419	11,192,295	$4,091,644,155	$41,574
Chronic Obstructive Pulmo..	1,105	154,899	$67,810,678	$61,367	31,382	4,126,319	$1,613,964,552	$51,430

All sensitive data are redacted – for example purposes only.

Note: CCW Category Summary table is cropped – the table includes all CCW Chronic and Potentially Disabling Conditions. The “Grand Total” row in the table deduplicates beneficiaries and claims that are present in multiple condition categories.

2.3 Comprehensiveness and Coordination

2.3.1 Specialist and Ancillary Services Report

The Specialist and Ancillary Services Report (formerly called the Professional Services (BETOS/Place of Service) Report) presents beneficiary counts, claim counts and claim payment amount by type of procedure code. Services are clustered into types of service using the Restructured BETOS Classification System (RBCS) taxonomy, an enhancement from the Berenson Eggers Type of Service (BETOS) taxonomy. Professional services in this report are Part B covered services regardless of site of service that may occur in a physician's office, SNF, hospital, or other settings. RBCS groups Health Care Financing Administration Common Procedure Coding System (HCPCS) codes into 8 procedure types. This report is limited to the key categories of interest. The goal of this report is to help users identify services frequently provided to beneficiaries by provider specialty, place of service, and specific provider.

This report may be filtered by selecting any row(s) (use Ctrl + click to add to current selection) in any table. This report is limited to selected procedure types, including E & M (evaluation and management), Treatment, Procedure, Imaging, and Test. Selecting a procedure type from the top table will filter the Selected Specialties, Selected Places of Service, and Top 20 Providers to represent only claims related to that procedure type. Similarly, a selection in the Selected Specialties table will further filter to show only claims related to that procedure type and specialty, as well as limit the Top 20 Places of Service and Top 20 Providers accordingly.

Once selecting a Provider Name, the bottom table "Provider Services" identifies the specific CPT/Procedure codes provided by that provider. This enables users to better understand the mix of services provided and their associated claim payments.

When applying multiple filters, they are applied sequentially; all affected tables are updated after each selection. The pie chart will similarly update according to selections in the tables.

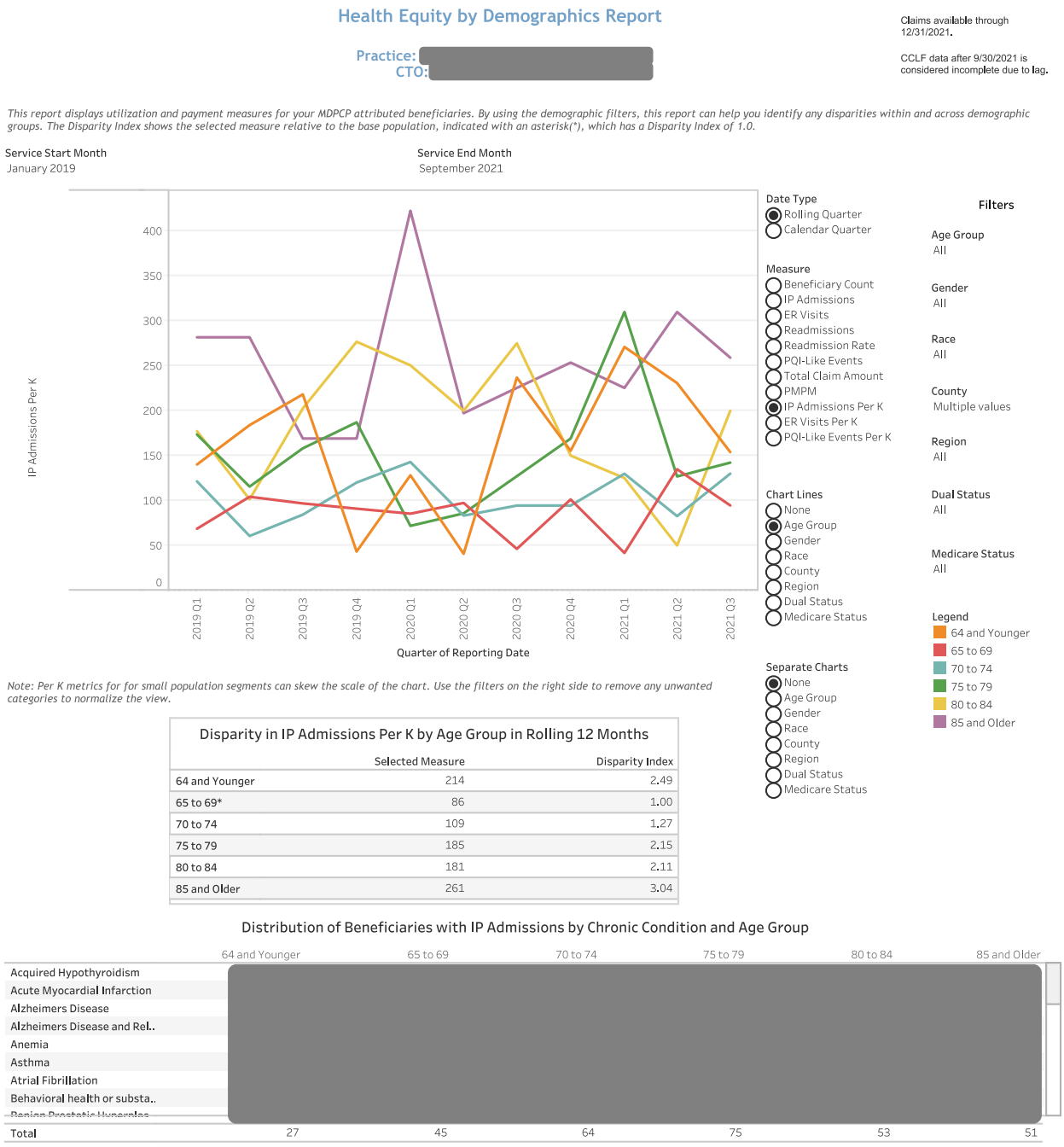
CHART NAME	DESCRIPTION
Procedure Type	The beneficiary, claim count and claim payment amount for each procedure category.
Selected Specialties	By default, shows the specialties by claim payment amount for all claims across all procedure types. After selecting a row from one or more tables, the Selected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

Provider Services	Selecting any provider in the Top 20 Providers list will populate this table with the beneficiary count, claim count, claim payment amount, and average claim payment amount for each procedure code. Please note that changing a selection in any of the above tables will undo the selection in the Top 20 Providers table.
Procedure Type Pie Chart	The distribution by procedure types according to total claim payments.

All sensitive data are redacted – for example purposes only.

2.3.2 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, on Medicare/Medicaid Dual Eligibility status, and Medicare Status (Aged or Disabled).



All sensitive data are redacted – for example purposes only.

Measure	DESCRIPTION
Beneficiary Count	The total number of beneficiaries attributed to the practice(s).
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 4.2.3 for additional detail.
Readmission Rate	The total readmissions divided by the number of admissions eligible for a readmission. See Section 4.2.3 for additional detail.
PQI-Like Events	IP or ED 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 eligible and attributed beneficiaries in a given month multiplied by 1,000.
PQI-Like Events Per K	PQI-Like Events divided by the count eligible and attributed 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	The total number of beneficiaries eligible and attributed to the practice(s)
Age Group	Age bands; 64 and Younger, 5-year age bands from 65 to 84, 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.

2.3.2.1 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	65 to 69
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
Medicare Status	Aged

2.3.2.2 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 2.2.7 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.

2.3.3 PMPM Trend Report

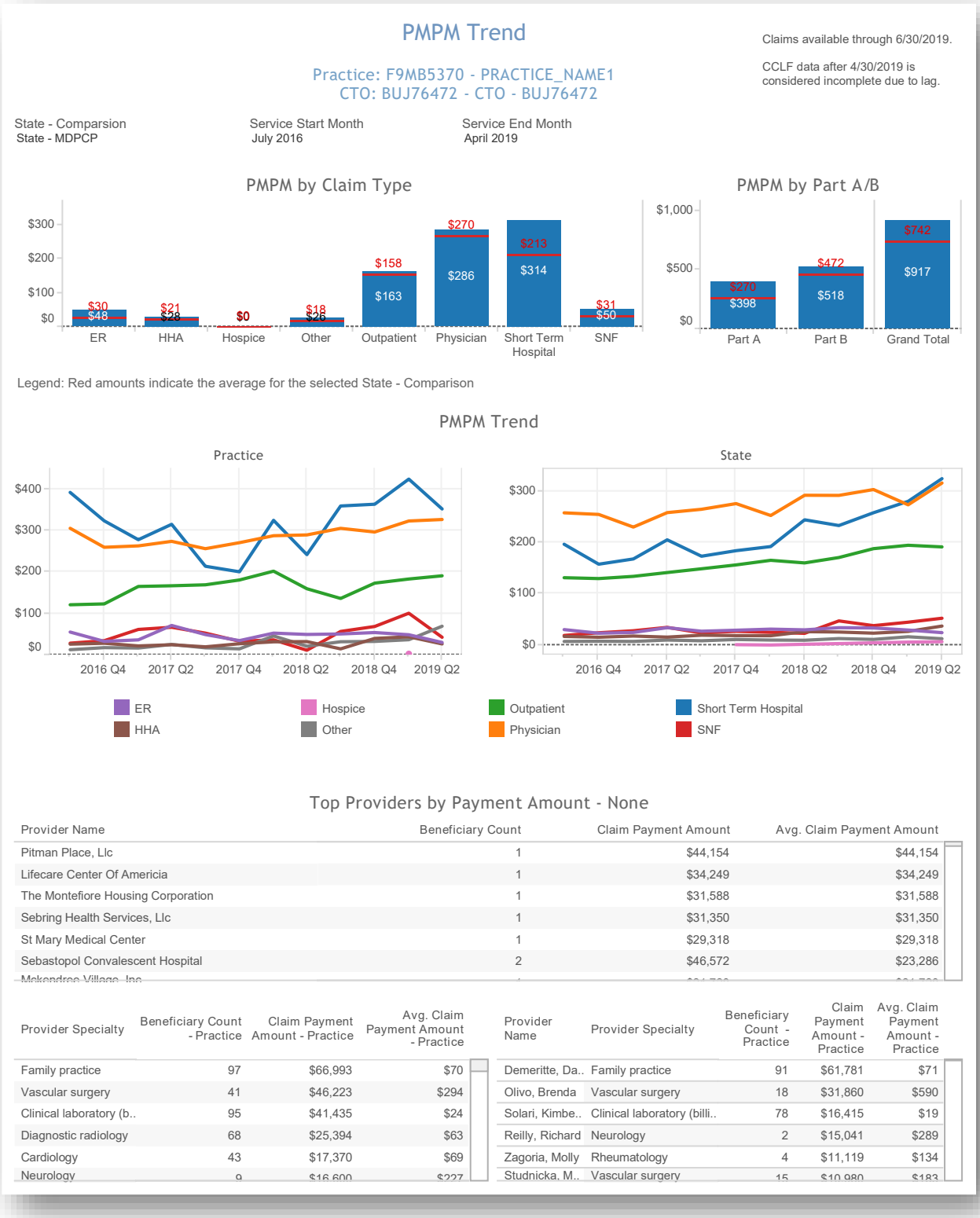
Click here to watch a short MDPCP Basics video explaining how to use this report:

https://www.gotostage.com/channel/6218fe0614ce4de48cb53d75ada41b87/recording/de1af49082954ef7863985a5bf85659a/watch

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

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

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



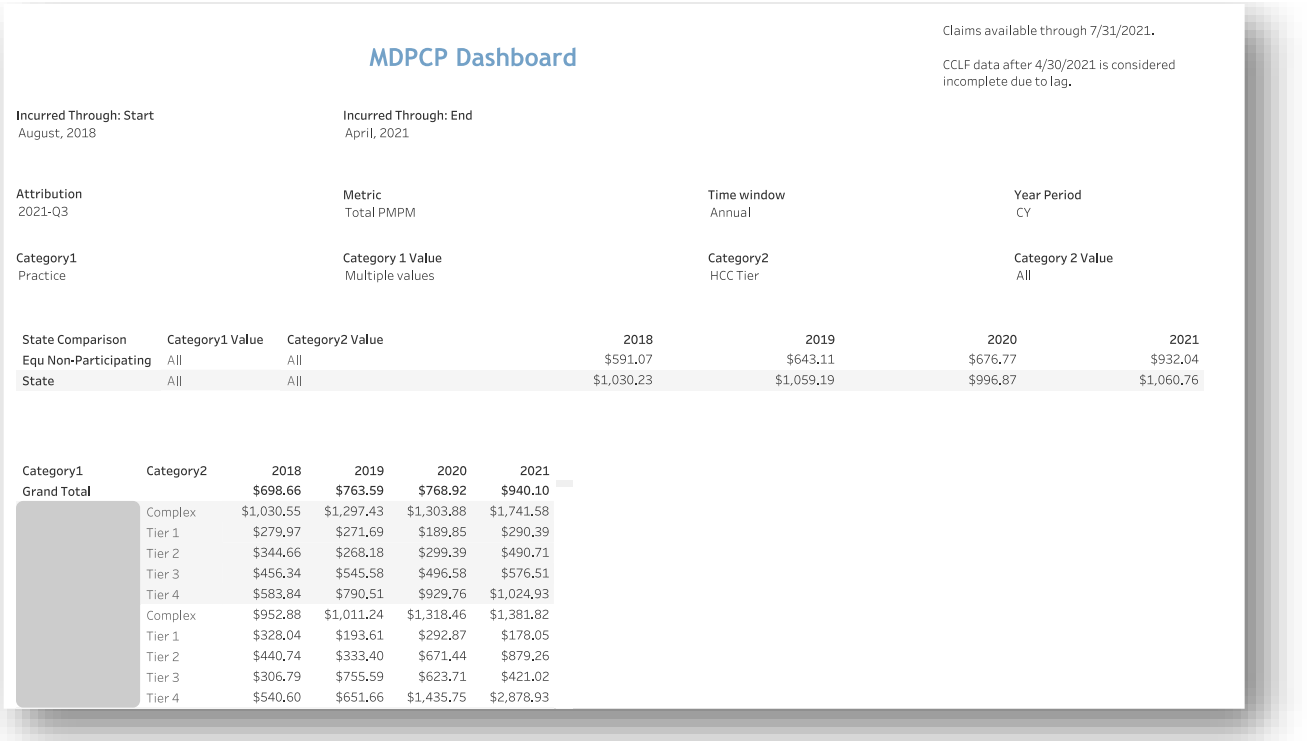
All data are fictitious – for example purposes only.

2.4 Planned Care for Health Outcomes

2.4.1 MDPCP Dashboard

The MDPCP Dashboard allows CTO users to view and compare high level metrics across multiple practices. The filters can be used to specify the metrics, time period, population, and other categories of interest.

Please note that non-CTO users will not see this report in the menu. Please also note that category selections do not apply to the State Comparison populations.



MDPCP Dashboard

Claims available through 7/31/2021.

CCLF data after 4/30/2021 is considered incomplete due to lag.

Incurred Through: Start: August, 2018
Incurred Through: End: April, 2021
Attribution: 2021-Q3
Metric: Total PMPM
Time window: Annual
Year Period: CY
Category1: Practice
Category 1 Value: Multiple values
Category2: HCC Tier
Category 2 Value: All

State Comparison	Category1 Value	Category2 Value	2018	2019	2020	2021
Equ Non-Participating	All	All	$591.07	$643.11	$676.77	$932.04
State	All	All	$1,030.23	$1,059.19	$996.87	$1,060.76

Category1	Category2	2018	2019	2020	2021
Grand Total		$698.66	$763.59	$768.92	$940.10
	Complex	$1,030.55	$1,297.43	$1,303.88	$1,741.58
	Tier 1	$279.97	$271.69	$189.85	$290.39
	Tier 2	$344.66	$268.18	$299.39	$490.71
	Tier 3	$456.34	$545.58	$496.58	$576.51
	Tier 4	$583.84	$790.51	$929.76	$1,024.93
	Complex	$952.88	$1,011.24	$1,318.46	$1,381.82
	Tier 1	$328.04	$193.61	$292.87	$178.05
	Tier 2	$440.74	$333.40	$671.44	$879.26
	Tier 3	$306.79	$755.59	$623.71	$421.02
	Tier 4	$540.60	$651.66	$1,435.75	$2,878.93

Filter Name	Definition
Incurred Through: Start	First month to include in the report
Incurred Through: End	Last month to include in the report
Attribution	Quarterly beneficiary to MDPCP practice attribution.
Metric	Select the metric that will be populated for each cell in the report.
Time Window	Determine the columns in the report; Annual, Quarter, Month
Year Period	CY: Full calendar years where data is available. Rolling: 12-month periods according to the latest non-lagged CCLF data in the report. YTD: January through the latest month of non-lagged CCLF data in the report for each years presented.

2.4.1.1 MDPCP Dashboard Parameters

2.4.1.2 Category Values

Categories selected will present as rows in the report. A second category, when selected, breaks out results within the first category.

Category	Definition
CTO	Care Transformation Organization.
Practice	MDPCP Participating primary care practice
Program Start Year - Practice	The program year that a practice first participated in MDPCP. Ensure this category is used with the Practice category to display a list of Practices grouped by their start year. If used with the CTO category, results may appear inconsistent (i.e., multiple start years for each CTO based on when the Practice joined the program, regardless of past CTO affiliation).
Program Start Year – CTO	The program year that a CTO first participated in MDPCP. Ensure this category is used with the CTO category to display a list of CTOs grouped by their start year. If used with the Practice category, results may appear inconsistent (i.e., a Practice new in Y3 that joined a CTO that participated since Y1 would appear as "Y1" in the report).
Track	MDPCP Practice Participation Track as provided by CMS in the most recent attribution period files.
Race	Race of attributed beneficiaries.
Region	Geographic region in Maryland of beneficiaries.
Age Band	5-year age ranges for beneficiaries. Includes "64 and Younger" and "85 and Older" options.
Dual Eligible	Value 'Yes' for beneficiaries with at least one month of eligibility for Medicaid.
HCC Tier	MDPCP-defined HCC Tiers for beneficiaries.
ACO Beneficiary	Value 'Yes' for beneficiaries with at least one month of ACO enrollment indicated in the CCLF demographics file.
Count of IP Admissions	Assigns beneficiaries to a group based on the number of admissions to short term acute care hospitals during the selected time period.
Count of ER Visits	Assigns beneficiaries to a group based on the number of visits to emergency rooms during the selected time period.
Count of PQI-Like Events	Assigns beneficiaries to a group based on the number of IP admissions and ER visits that are coded as PQI-Like Events. See Section 2.2.6 for more information on PQI-Like Events.
ADI	National Area Deprivation Index Percentile; the 2019 ranking of socioeconomic disadvantage by 9-digit ZIP code. Beneficiaries' ADIs are presented as percentiles, 1 through 100. The most disadvantaged percentile is 100. Those without a percentile ADI are presented as 'N/A' (i.e. the beneficiary ZIP code is present but is not assigned an ADI).
CCW Count	The number of CMS CCW conditions that beneficiaries have.
CCW – [Condition]	Binary (Yes or No) categorization of beneficiaries according to presence of the selected CCW condition.

2.4.1.3 Metrics

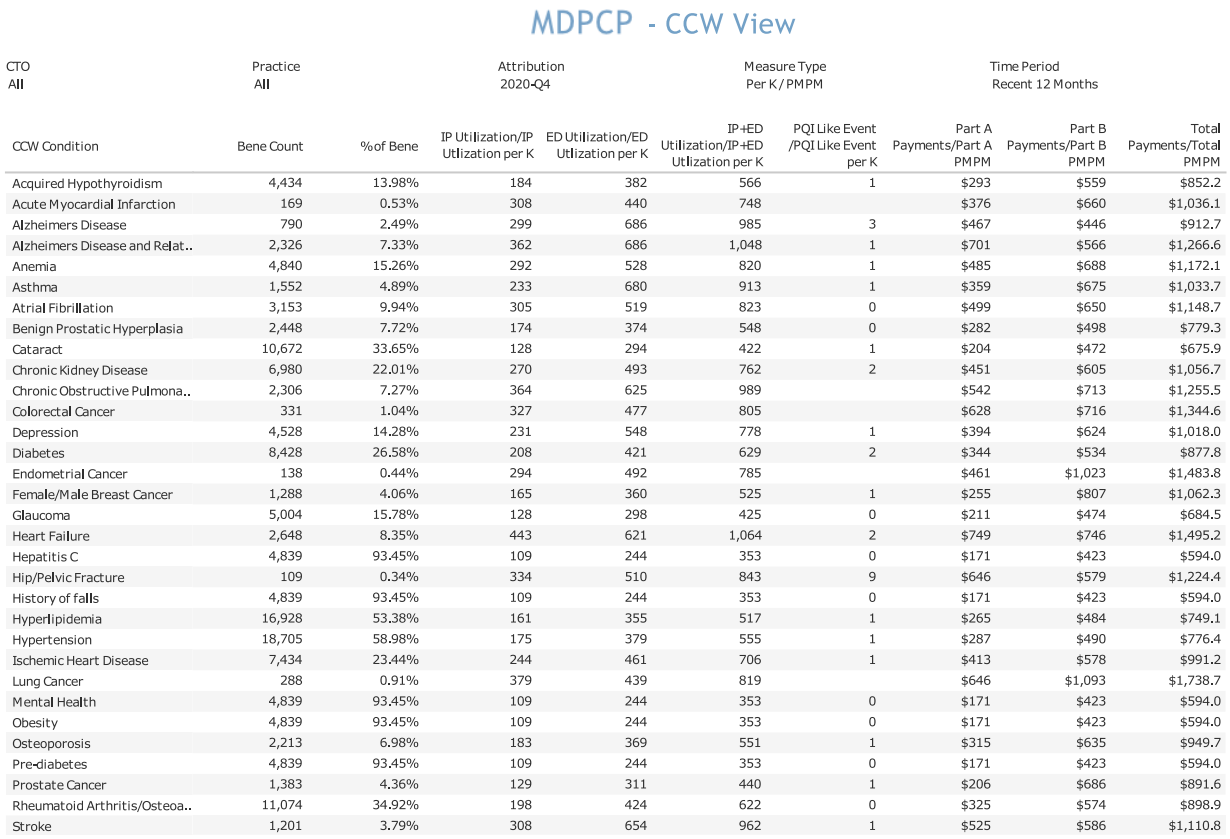
Metric	Definition
Part A PMPM	Part A Per Member Per Month; total Part A payments divided by beneficiary months.
Part B PMPM	Part B Per Member Per Month; total Part B payments divided by beneficiary months.
Total PMPM	Total Per Member Per Month; total Part A and B payments divided by beneficiary months.
Part A Payments	Total Part A payments
Part B Payments	Total Part B payments
Total Payments	Total Part A and Part B payments
Total Payments as a Percent of Maryland Medicare Payments	Total Part A and Part B payments for the selected practice(s) divided by the total Part A and Part B payments for Maryland * 100%
IP Utilization	Count of inpatient admissions in short term acute care hospitals.
ED Utilization	Count of emergency department visits.
IP + ED Utilization	Sum of inpatient admissions and emergency department visits.
PQI-Like Events	IP admissions or ED visits with primary diagnoses that are coded as PQI-Like Events. See section 2.2.6 for more information on PQI-Like Events.
IP Utilization per K	Count of inpatient admissions in short term acute care hospitals divided by the number beneficiary months * 1,000
ED Utilization per K	Count of emergency department visits divided by the number beneficiary months * 1,000
Readmission Rate	Count of admissions to a short term acute care hospital within 30 days of discharge from a short term acute care hospital divided by all admissions eligible for a readmission. See section 4.2.3 for more information on readmissions.
Readmissions	Count of admissions to a short term acute care hospital within 30 days of discharge from a short term acute care hospital. See section 4.2.3 for more information on readmissions.
Average HCC Score	CMS Hierarchical Condition Category; the average risk score for beneficiaries calculated on the base period used to assign participating beneficiaries to HCC Tiers.
Unique Beneficiary Count	The number of unique beneficiaries.
Beneficiary Months	Count of months for which beneficiaries had Part A and Part B Medicare Coverage
Tele-Health	Count of claims for primary care services delivered remotely, defined as a Part B claim with a 95 or CS modifier and the following CPT/HCPCS codes: G2010, G2012, 99441-99443, 99421-99423, G0438-G0439
Primary Care	Count of claims for primary care services rendered. Primary care services are identified using a definition developed by the Robert Graham Center and includes “Office- and outpatient-based services for all primary care physicians.” Primary care physicians are defined as physicians with a specialty of family

Metric	Definition
	medicine, general practice, geriatrics, general internal medicine, or general pediatrics.2
Tele-Health per K	Count of claims for primary care services delivered remotely divided by the count of beneficiary months * 1,000
Primary Care per K	Count of claims for primary care services delivered in office divided by the count of beneficiary months * 1,000
Telehealth Payments	Sum of Medicare payments for primary care services delivered remotely
Primary Care Payments	Sum of Medicare payments for primary care services delivered in office

[2] Source: https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

2.4.1.4 MDPCP Dashboard – CCW View

This report shows metrics grouped by beneficiaries with CMS Chronic Condition Warehouse (CCW) conditions. Beneficiaries may have more than one condition, so the sum of the count of beneficiaries will be greater than the count of attributed beneficiaries for a selected practice(s)/CTO(s) and percentages will sum to greater than 100%.



MDPCP - CCW View

CTO: All | Practice: All | Attribution: 2020-Q4 | Measure Type: Per K / PMPM | Time Period: Recent 12 Months

CCW Condition	Bene Count	%of Bene	IP Utilization/IP Utlization per K	ED Utilization/ED Utlization per K	IP+ED Utilization/IP+ED Utlization per K	PQI Like Event /PQI Like Event per K	Part A Payments/Part A PMPM	Part B Payments/Part B PMPM	Total Payments/Total PMPM
Acquired Hypothyroidism	4,434	13.98%	184	382	566	1	$293	$559	$852.2
Acute Myocardial Infarction	169	0.53%	308	440	748		$376	$660	$1,036.1
Alzheimers Disease	790	2.49%	299	686	985	3	$467	$446	$912.7
Alzheimers Disease and Relat..	2,326	7.33%	362	686	1,048	1	$701	$566	$1,266.6
Anemia	4,840	15.26%	292	528	820	1	$485	$688	$1,172.1
Asthma	1,552	4.89%	233	680	913	1	$359	$675	$1,033.7
Atrial Fibrillation	3,153	9.94%	305	519	823	0	$499	$650	$1,148.7
Benign Prostatic Hyperplasia	2,448	7.72%	174	374	548	0	$282	$498	$779.3
Cataract	10,672	33.65%	128	294	422	1	$204	$472	$675.9
Chronic Kidney Disease	6,980	22.01%	270	493	762	2	$451	$605	$1,056.7
Chronic Obstructive Pulmona..	2,306	7.27%	364	625	989		$542	$713	$1,255.5
Colorectal Cancer	331	1.04%	327	477	805		$628	$716	$1,344.6
Depression	4,528	14.28%	231	548	778	1	$394	$624	$1,018.0
Diabetes	8,428	26.58%	208	421	629	2	$344	$534	$877.8
Endometrial Cancer	138	0.44%	294	492	785		$461	$1,023	$1,483.8
Female/Male Breast Cancer	1,288	4.06%	165	360	525	1	$255	$807	$1,062.3
Glaucoma	5,004	15.78%	128	298	425	0	$211	$474	$684.5
Heart Failure	2,648	8.35%	443	621	1,064	2	$749	$746	$1,495.2
Hepatitis C	4,839	93.45%	109	244	353	0	$171	$423	$594.0
Hip/Pelvic Fracture	109	0.34%	334	510	843	9	$646	$579	$1,224.4
History of falls	4,839	93.45%	109	244	353	0	$171	$423	$594.0
Hyperlipidemia	16,928	53.38%	161	355	517	1	$265	$484	$749.1
Hypertension	18,705	58.98%	175	379	555	1	$287	$490	$776.4
Ischemic Heart Disease	7,434	23.44%	244	461	706	1	$413	$578	$991.2
Lung Cancer	288	0.91%	379	439	819		$646	$1,093	$1,738.7
Mental Health	4,839	93.45%	109	244	353	0	$171	$423	$594.0
Obesity	4,839	93.45%	109	244	353	0	$171	$423	$594.0
Osteoporosis	2,213	6.98%	183	369	551	1	$315	$635	$949.7
Pre-diabetes	4,839	93.45%	109	244	353	0	$171	$423	$594.0
Prostate Cancer	1,383	4.36%	129	311	440	1	$206	$686	$891.6
Rheumatoid Arthritis/Osteoa..	11,074	34.92%	198	424	622	0	$325	$574	$898.9
Stroke	1,201	3.79%	308	654	962	1	$525	$586	$1,110.8

Filter	Definition
CTO	Care Transformation Organization.
Practice	MDPCP Participating primary care practice
Attribution	Quarterly beneficiary to MDPCP practice attribution.
Time Period	'Recent 12 Months' – rolling 12 month period, excludes the latest 3 months of CCLF data. 'YTD' – Year to Date; months from January of 2023, excludes the latest 3 months of CCLF data.

2.4.1.4.1 MEASURE TYPE

Use this to select whether the report shows observed data or rated analysis. Data in columns other than 'Bene Count' and '% of Bene' are affected by this selection.

Measure Type	Definition
Per K / PMPM	Metric per 1,000 beneficiary months **or** Per Member Per Month for each column.
Actual	The count of events **or** total payments.

2.4.1.4.2 COLUMNS

CCW View Column	Definition
Bene Count	Count of beneficiaries that have the respective CCW condition.
% Of Bene	Percentage of beneficiaries with the CCW condition n.b. This will not sum to 100% - beneficiaries may have multiple conditions.
IP Utilization/IP Utilization per K	Actual: Count of IP Admissions at short term acute care hospitals Per k / PMPM: 'Actual' divided by beneficiaries months * 1,000
ED Utilization/ED Utilization per K	Actual: Count of ED Visits Per K / PMPM: 'Actual' divided by beneficiaries months * 1,000
IP+ED Utilization/ IP+ED Utilization per K	Actual: The sum of IP admissions and ED Visits Per K / PMPM: 'Actual' divided by beneficiaries months * 1,000
PQI Like Event/PQI Like Event per K	Actual: Count of PQI Like Events Per K / PMPM: 'Actual' divided by beneficiaries months * 1,000
Part A Payments/Part A PMPM	Actual: Sum of Part A payments Per K / PMPM: 'Actual' divided by beneficiary months
Part B Payments/Part B PMPM	Actual: Sum of Part B payments Per K / PMPM: 'Actual' divided by beneficiary months
Total Payments/Total PMPM	Actual: Sum of Part A and Part B payments Per K / PMPM: 'Actual' divided by beneficiary months

2.4.1.4.3 CCW CONDITIONS

The MDPCP Dashboard and MDPCP Dashboard-CCW View utilize CMS Chronic Condition Warehouse (CCW) defined conditions. Detailed information including the diagnosis and/or procedure codes as well as the lookback period used to assign these conditions to beneficiaries is available on the CCW site indicated below:

https://www2.ccwdata.org/web/guest/condition-categories-chronic

List of CCW Conditions in CTO Dashboard
Acquired Hypothyroidism
Acute Myocardial Infarction
Alzheimer's Disease
Alzheimer's Disease and Related Disorders or Senile Dementia
Anemia
Asthma
Atrial Fibrillation
Benign Prostatic Hyperplasia
Cataract
Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease and Bronchiectasis
Colorectal Cancer
Depression
Diabetes
Endometrial Cancer
Female/Male Breast Cancer
Glaucoma
Heart Failure
Hepatitis C*
Hip/Pelvic Fracture
History of falls*
Hyperlipidemia
Hypertension
Ischemic Heart Disease
Lung Cancer
Mental Health Excluding Depression*
Mental health Including Depression*
Obesity*
Osteoporosis
Parkinson's Disease**

Pneumonia**
Pre-Diabetes*
Prostate Cancer
Rheumatoid Arthritis/Osteoarthritis
Stroke
Urologic Cancer**

* These conditions are defined according to specifications adapted by the MDPCP PMO (see section 2.4.1.4.4 for details).

** These conditions were added to CCW, and implemented in these reports as of July 15th 2022. Please also note that the definitions for the previously available chronic conditions were generally broadened such that counts will generally increase relative to the prior version.

2.4.1.4.4 OTHER CCW CONDITIONS AND CONDITIONS OF INTEREST

Below are conditions included in those among the CCW conditions in the MDPCP Dashboard that are either among the CCW 'Other Chronic or Potentially Disabling Conditions' or use non-CCW definitions.

2.4.1.4.4.1 HEPATITIS C (CCW)

Hepatitis C is presented in the reports for beneficiaries that meet criteria for either the acute or chronic definitions below.

Algorithm	Reference Period (# of Years)	Valid ICD-9/MS DRG/HPCPS Codes	Valid ICD-10 Codes	Number/Type of Claims to Qualify
Hepatitis C (acute)	2 Years	DX 070.41, 070.51 (any DX on the claim)	DX B17.10, B17.11 (any DX on the claim)	At least 1 inpatient **OR** 2 non-inpatient claims with DX codes
Hepatitis C (chronic)	2 Years	DX 070.44, 070.54, V02.62 (any DX on the claim)	DX B18.2, Z22.52 (any DX on the claim)	At least 1 inpatient **OR** 2 non-inpatient claims with DX codes

2.4.1.4.4.2 OBESITY (CCW)

Algorithm	Reference Period (# of Years)	Valid ICD-9/MS DRG/HPCPS Codes	Valid ICD-10 Codes	Number/Type of Claims to Qualify
Obesity	2 Years	DX 278.0, 278.00, 278.01, 278.03, V85.3, V85.30, V85.31, V85.32, V85.33, V85.34, V85.35, V85.36, V85.37, V85.38, V85.39, V85.4, V85.41, V85.42, V85.43, V85.44, V85.45 (any DX on the claim)	DX E66.01, E66.09, E66.1, E66.2, E66.8, E66.9, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45 (any DX on the claim)	At least 1 inpatient OR 2 noninpatient claims with DX codes

2.4.1.4.4.3 PRE-DIABETES (AMERICAN DIABETES ASSOCIATION)

Condition	Valid ICD-10 Codes	Procedure/Documentation
Pre-Diabetes	R73.01	Impaired fasting glucose/ - Has yet to be diagnosed with diabetes
	R73.02	Impaired glucose tolerance test/ - Has not been diagnosed with diabetes
	R73.03	Evidence of other impairment of glucose metabolism/ - Has not been diagnosed with diabetes
	E88.81	3 of the 5 components of cardiometabolic syndrome (e.g., obese, hypertension, elevated triglycerides)/ - Must report which manifestation of the cardiometabolic syndrome the patient has
	R73.09	Other abnormal glucose

Source: https://professional.diabetes.org/sites/professional.diabetes.org/files/media/prediabetes_and_t2d_prevention_haus_0.pdf

2.4.1.4.4.4 MENTAL HEALTH EXCLUDING DEPRESSION (CCW)

This condition as reported is the aggregate of the below CCW conditions.

1. Anxiety Disorder
2. Bipolar Disorder
3. Personality Disorders
4. Post-Traumatic Stress Disorders (PTSD)
5. Schizophrenia
6. Schizophrenia and Other Psychiatric Disorders

Source: https://www2.ccwdata.org/web/guest/condition-categories (see 'Other Chronic Health, Mental Health, and Potentially Disabling Conditions')

2.4.1.4.4.5 MENTAL HEALTH INCLUDING DEPRESSION (CCW)

This condition as reported is the aggregate of the below CCW conditions.

1. Anxiety Disorder
2. Bipolar Disorder
3. Depressive Disorders
4. Personality Disorders
5. Post-Traumatic Stress Disorders (PTSD)
6. Schizophrenia
7. Schizophrenia and Other Psychiatric Disorders
8. Depression, Bipolar, or Other Depressive Mood Disorder

Source: https://www2.ccwdata.org/web/guest/condition-categories (see 'Other Chronic Health, Mental Health, and Potentially Disabling Conditions')

2.4.1.4.4.6 HISTORY OF FALLS (NCOA)

Condition	Code Type	Code – Description
History of Falls	CPT	1100F – fall assessment documented and pat has history of falls
	ICD-10	Z91.81 – history of falls/at risk for falling
	ICD-10	R29.6 – repeated falls

Source: https://www.ncoa.org/wp-content/uploads/2017-CPT-Code-Flyer.pdf

2.4.2 AHU/EDU Report

Click here to watch a short MDPCP Basics video explaining how to use this report:

https://www.gotostage.com/channel/6218fe0614ce4de48cb53d75ada41b87/recording/2c829cf74e764d208252d87171a71a1e/watch

The AHE/EDU report uses data provided directly by CMS. CRISP does not run the algorithms to calculate the observed or expected values, or the benchmark values displayed in this report. Data are provided by CMS on a quarterly basis, including a lag period of one quarter. Due to the alignment with the HEDIS-like AHU/EDU measure, observed counts will **not** align with counts reported elsewhere in the MDPCP Reports.

This report is intended to provide directional results on a practice(s) AHU/EDU utilization relative to their expected utilization, according to CMMI's HEDIS-like measure. Final results calculated by CMMI and used for payment purposes may differ significantly from those presented in this report.

Consistent with the AHU/EDU measure algorithm, a practice is responsible for their population's utilization for the period in which the beneficiaries are attributed to them. Therefore, this report does not reflect a static population like the rest of the MDPCP reports (other than the TPCC Report). Each month's data value reflects the population attributed to that practice/CTO during that specific month, which may differ from neighboring months. Therefore, attribution quarters are not selectable as elsewhere in the MDPCP reports. In order to show directional results for performance year 2023 year-to-date, select "January 2023" with the "Service Start Month" filter and the latest or other month of interest from the "Service End Month" filter.

The HEDIS-like methodology excludes "outlier beneficiaries" who have 4 or more inpatients stays during the year. By presenting these estimates monthly, select beneficiaries may be excluded over time as they exceed this threshold. Expected utilization is calculated annually for the performance period by CMS and converted to monthly estimates without adjusting for seasonality.

An observed-to-expected ratio of greater than 1 represents utilization that is higher than the expected average for a comparable beneficiary population, and a ratio of less than 1 represents utilization that is less than the expected average.

Measure	DESCRIPTION
Observed per 1,000 Beneficiaries	The count of acute (AHU) or emergency (EDU) care utilization per 1,000 beneficiary months during the selected period and presented calendar month(s). "Outlier beneficiaries" with 4 or more inpatient stays are removed entirely – including their observed and expected values.

Observed : Expected Ratio	Observed utilization divided by Expected utilization; Ratios above 1 indicate higher than expected observed utilization and vice versa. Expected utilization AHU and EDU is calculated at the beneficiary level based on 12 months of utilization. The aggregate expected rate will change from month to month within a quarter when beneficiaries leave MDPCP (i.e. become ineligible according to program inclusion criteria).
50th and 80th Percentile	Calculated according to the observed-to-expected ratio for the statewide Maryland FFS population. Performance relative to these percentiles has implications with respect to MDPCP PBIP payments. However, data presented here directional only and are not final or for scorekeeping purposes.

Acute Hospital Utilization / Emergency Department Utilization (AHU/EDU) Tracking Report

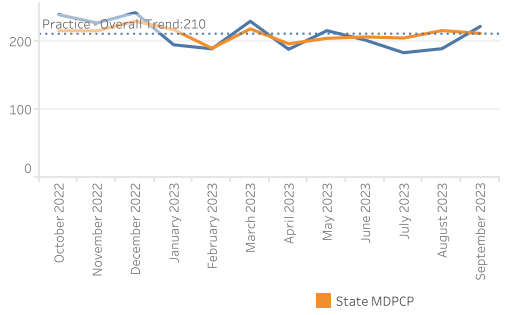
CTO	Practice	Service Start Month	Service End Month
Multiple values	Multiple values	October 2022	September 2023

This report is intended to provide directional results on a practice(s) AHU/EDU utilization relative to their expected utilization, according to CMMI's HEDIS-like measure. These results were calculated by CMMI's contractor and provided to CRISP. Final results calculated by CMMI and used for payment purposes may differ significantly.
The HEDIS-like methodology excludes "outlier beneficiaries" who have 4 or more inpatient stays during the year. By presenting these estimates monthly, select beneficiaries may be excluded over time as they exceed this threshold. Expected utilization is calculated annually for the performance period and converted to monthly estimates without adjusting for seasonality...

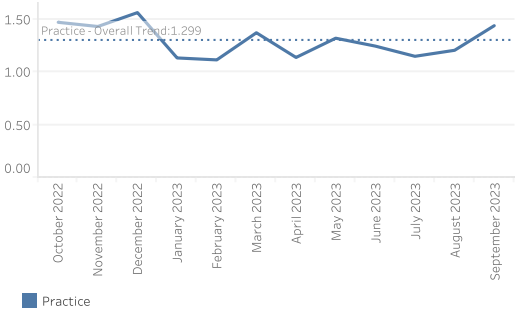
AHU Measure

	AHU Events Observed per 1,000 Beneficiaries	AHU Events Observed : Expected Ratio
Practice	210	1.2991
State MDPCP	210	1.1242
2023 Statewide Benchmark - 50th Percentile	-	1.1204
2023 Statewide Benchmark - 80th Percentile	-	0.9582
2022 Statewide Benchmark - 50th Percentile	-	1.0995
2022 Statewide Benchmark - 80th Percentile	-	0.9383

AHU Events Observed per 1,000 Beneficiaries



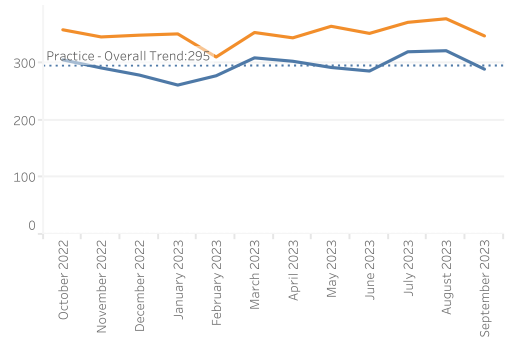
AHU Events Observed : Expected Ratio



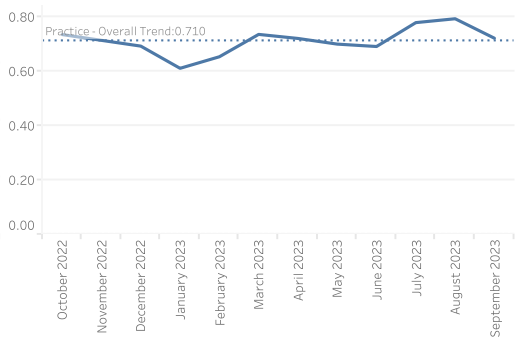
EDU Measure

	EDU Events Observed per 1,000 Beneficiaries	EDU Events Observed:Expected Ratio
Practice	295	0.7103
State MDPCP	352	0.7379
2023 Statewide Benchmark - 50th Percentile	-	0.6774
2023 Statewide Benchmark - 80th Percentile	-	0.5393
2022 Statewide Benchmark - 50th Percentile	-	0.6911
2022 Statewide Benchmark - 80th Percentile	-	0.5579

EDU Events Observed per 1,000 Beneficiaries



EDU Events Observed : Expected Ratio



CY2023 Benchmarking data is sourced from the document, 2023 MDPCP Payment Methodologies, version 3, published December 2023...

Note: Data is only available for practices in periods they participated in MDPCP.

2.4.3 TPCC Report

The TPCC (Total Per Capita Cost) measure will be used to evaluate practice performance for PBIP. Like the AHU/EDU report, the TPCC report uses data provided directly by CMS. CRISP does not run the algorithms to calculate the observed or expected values. Data are provided by CMS on a quarterly basis, including a lag period of one quarter. Due to the risk adjustment component of the TPCC calculation, observed amounts will not align with amounts reported elsewhere in the MDPCP Reports.

This report is intended to provide directional results on a practice(s)'s TPCC relative to their expected utilization, according to the TPCC algorithm. Final results calculated by CMMI and used for payment purposes may differ significantly from those presented in this report.

Consistent with the TPCC algorithm, a practice is responsible for their population's utilization for the period in which the beneficiaries are attributed to them. Therefore, this report does not reflect a static population like the rest of the MDPCP reports (other than the AHU/EDU Reports). Each month's data value reflects the population attributed to that practice/CTO during that specific month, which may differ from neighboring months. Therefore, attribution quarters are not selectable as elsewhere in the MDPCP reports. In order to show directional results for 2023 year-to-date, select "January 2023" with the "Service Start Month" filter and the latest or other month of interest from the "Service End Month" filter.

Note that the benchmarks 2022 and 2023 are only provided for informational purposes. The TPCC benchmark for 2024 will be developed by CMS concurrently with the program year. Therefore, the benchmark thresholds will be calculated and available to practices in 2025.

An observed-to-expected ratio of greater than 1 represents utilization that is higher than the expected average for a comparable beneficiary population, and a ratio of less than 1 represents utilization that is less than the expected average.

The dotted line in each chart indicates the average TPCC or Observed to Expected ratio over the presented time period for the selected practice(s) and corresponds to the Practice values in the table.

Measure	DESCRIPTION
TPCC per Beneficiary Month	The average observed TPCC for all attributed beneficiaries by month.
Observed : Expected Ratio	Observed TPCC divided by Expected TPCC; Ratios above 1 indicate higher than expected observed utilization and vice versa. Expected TPCC is calculated at the NPI level based on attributed beneficiaries' CMS-HCC V22 score. The aggregate expected rate will change from month to month within a quarter when beneficiaries leave MDPCP (i.e. become ineligible according to program inclusion criteria).

Population	DESCRIPTION
Practice	Beneficiaries attributed to the selected practice(s)
State MDPCP	All MDPCP attributed beneficiaries for practices participating in the selected period.
2023 Statewide Benchmark*	CY2023 Benchmarking data is sourced from the document, 2023 MDPCP Payment Methodologies, version 3, published December 2023. ~~All MDPCP attributed beneficiaries for practices that participated in 2023.~~ These~~is~~ ~~is~~ are ~~a~~ static numbers and will not change based on filter selections.

Note: Data is only available for practices in periods they participated in MDPCP. ~~Practices that did not participate in MDPCP in 2019 or 2020 will not have data available for CY2019 or CY2020, respectively, in this report.~~

Total Per Capita Cost (TPCC) Tracking Report

CTO	Practice	Service Start Month	Service End Month
Multiple values	Multiple values	September 2022	August 2023

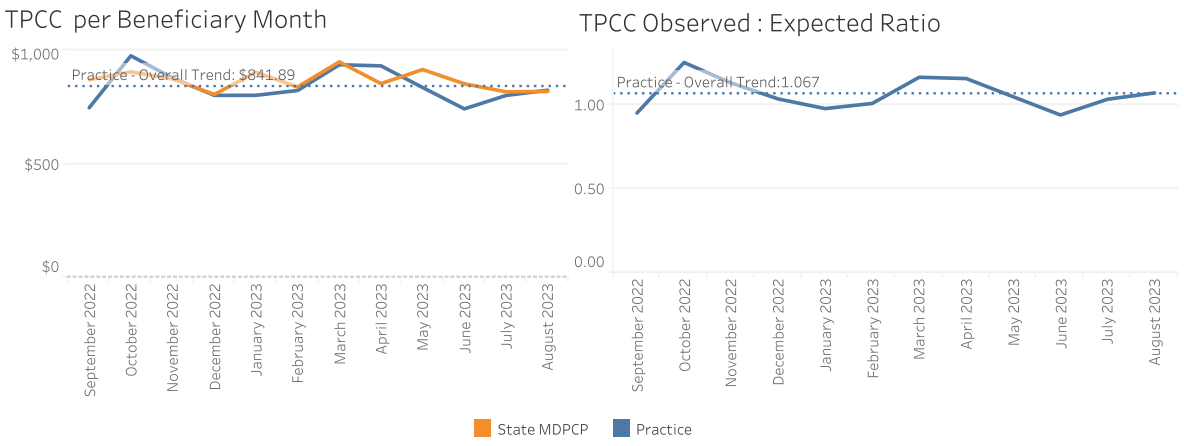
The Q3 2023 September data point for the TPCC per Beneficiary Month and the Observed to Expected ratio have been excluded due to claims runout and data inconsistencies.

This report is intended to provide directional results on a practice(s) Total Per Capita Cost (TPCC) relative to the expected value for this measure, according to CMMI's calculation of these measures. These results were calculated by CMMI's contractor and provided to CRISP. Final results calculated by CMMI and used for payment adjustment purposes may differ significantly.
Expected values are calculated for each month.

An observed-to-expected ratio greater than 1 represents cost that is higher than the expected average for a comparable beneficiary population, and a ratio less than 1 represents cost that is less than the expected average.

TPCC

	TPCC Per Beneficiary Months	TPCC Observed : Expected Ratio
Practice	$841.89	1.0670
State MDPCP	$866.97	1.0611
2023 Statewide Benchmark - 50th Percentile	---	0.9868
2023 Statewide Benchmark - 80th Percentile	---	0.8733
2022 Statewide Benchmark - 50th Percentile	---	0.9868
2022 Statewide Benchmark - 80th Percentile	---	0.8733



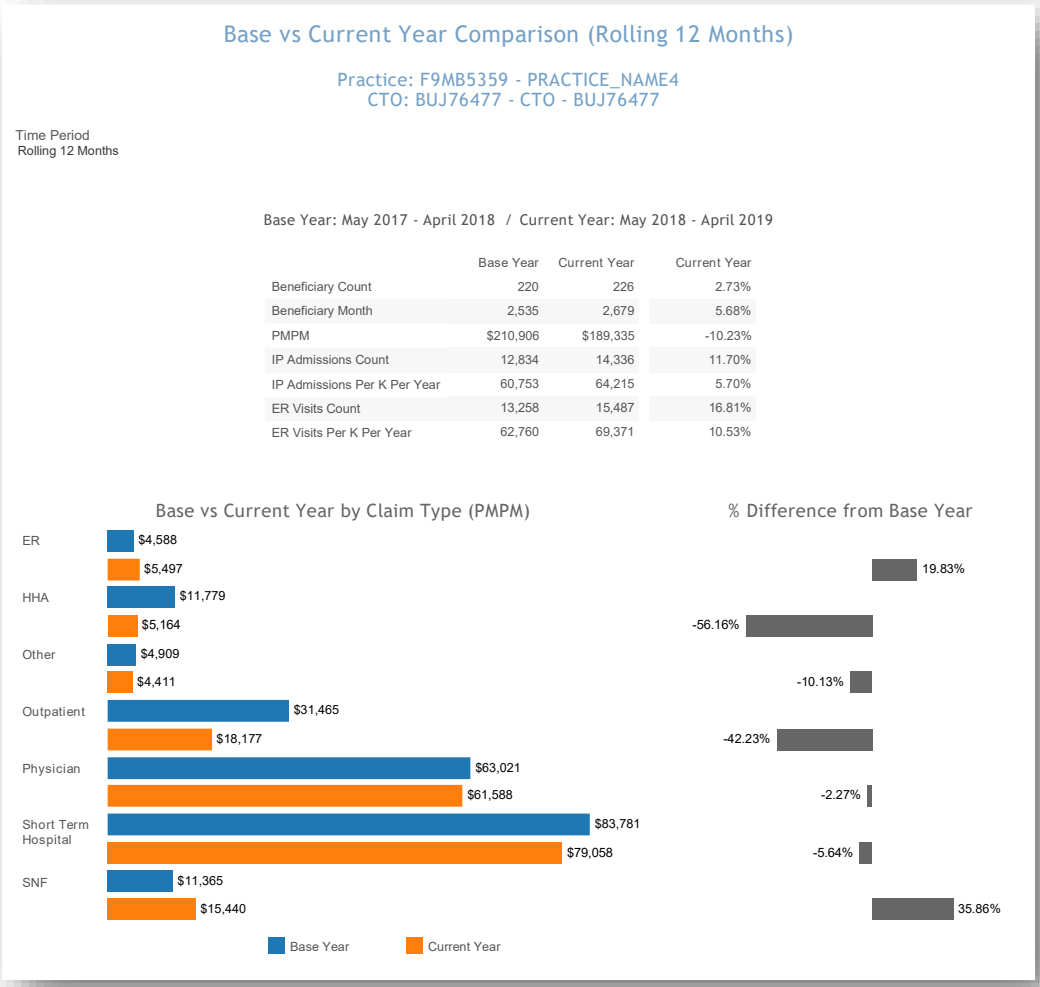
CY2023 Benchmarking data is sourced from the document, 2023 MDPCP Payment Methodologies, version 3, published December 2023.
CY2022 Benchmarking data is sourced from the document, 2022 MDPCP Payment Methodologies, version 7, published September 2023.

2.4.4 Base vs Current Year Comparison Report

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

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

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



All data are fictitious – for example purposes only.

2.4.5 SBIRT Dashboard

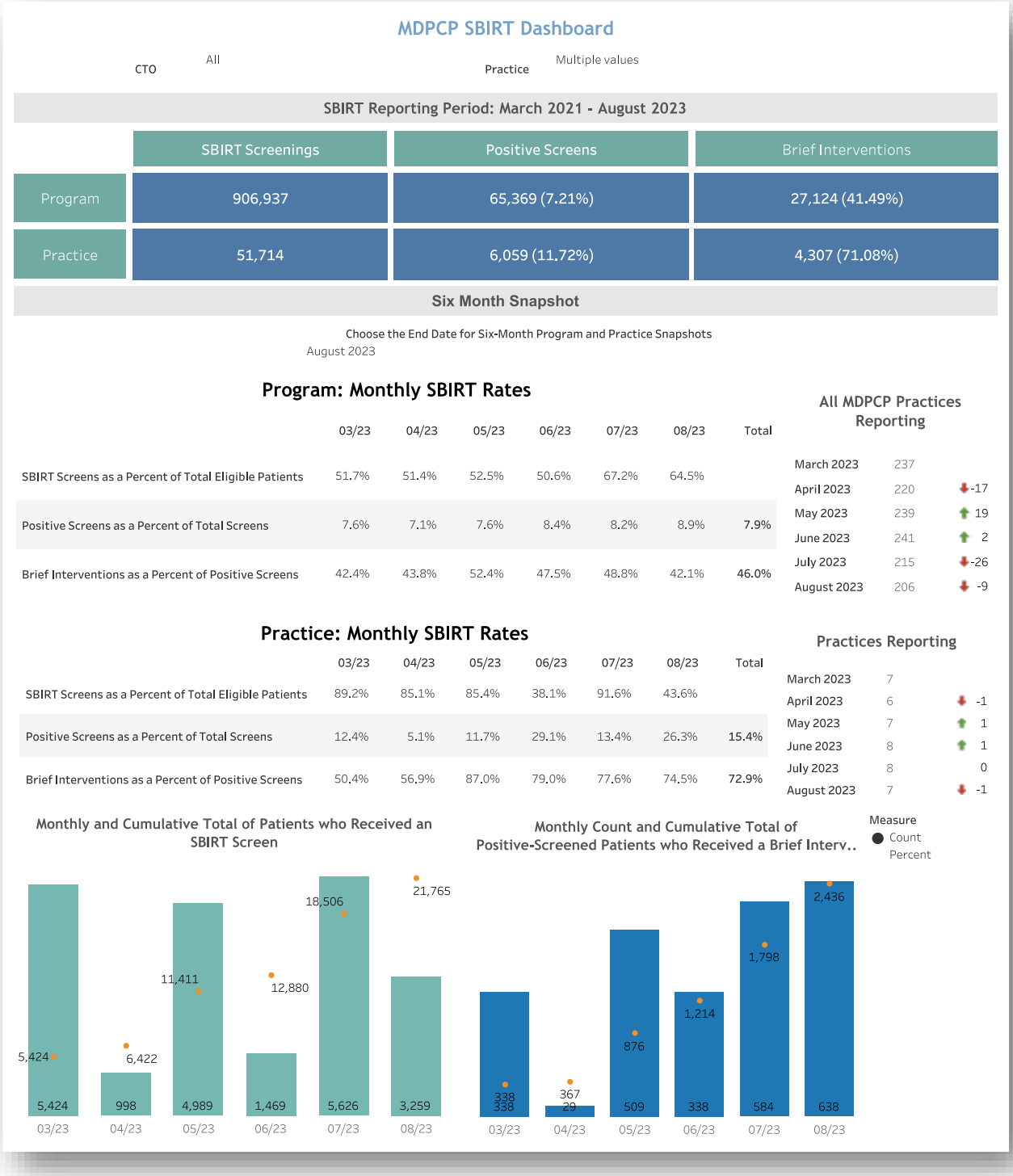
The Screening, Brief Intervention and Referral to Treatment (SBIRT) dashboard uses practices' self-reported data, unlike the other reports in the MDPCP Reporting suite. Each month, practices may submit SBIRT data to CRISP, including the number of patients eligible for an SBIRT screening, the number of SBIRT screens administered, the number of screens with a positive result, and the number of interventions conducted. The figures submitted and used in these reports are aggregate only and cannot be used to access PHI. Due the timing of when practices report SBIRT data, this report is refreshed monthly, two weeks after the primary monthly data refresh.

This dashboard includes the count of SBIRT screenings, the count of positive screens, and the count of positive screens that resulted in a brief intervention for the selected practice(s). In addition to practices to which a user has access, the dashboard includes overall counts and rates for all MDPCP practices that submitted SBIRT data in the selected time period.

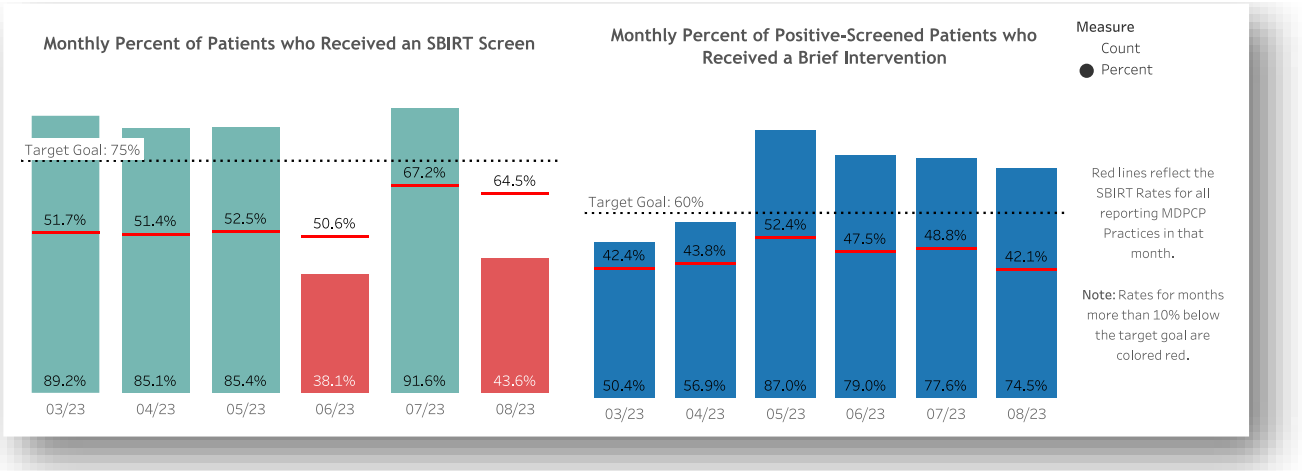
The table at the top of the dashboard includes counts of SBIRT Screenings, and counts and percentages of Positive Screens and Brief Interventions for the program (all reporting practices) and the selected practice(s). Clicking any cell in this table and hovering over that selection yields the option to drill through to Organization Chart.

Use the slider under the header "Six Month Snapshot" to adjust the time period used in the report. Please note this affects everything below the slider, i.e., Program and Practice Monthly SBIRT Rates, and the charts.

METRIC NAME	DESCRIPTION
SBIRT Screens as a Percent of Total Eligible Patients	The reported monthly count of SBIRT screens divided by the reported count of patients eligible in that month.
Positive Screens as a Percent of Total Screens	The reported monthly count of screens with a positive result divided by the reported count of screens reported.
Brief Interventions as a Percent of Positive Screens	The reported monthly count that received a brief intervention divided by the reported monthly count of screens with a positive result.



Use the Measure select to the right of the charts to view either 1) the monthly and cumulative counts of SBIRT screens and brief interventions or 2) the percent of patients who received an SBIRT screen and, of the positive screens, which percent received a brief intervention. The percent view includes Target Goals and the overall rates for all reporting practices. Monthly practice rates below the Target Goal are colored red.

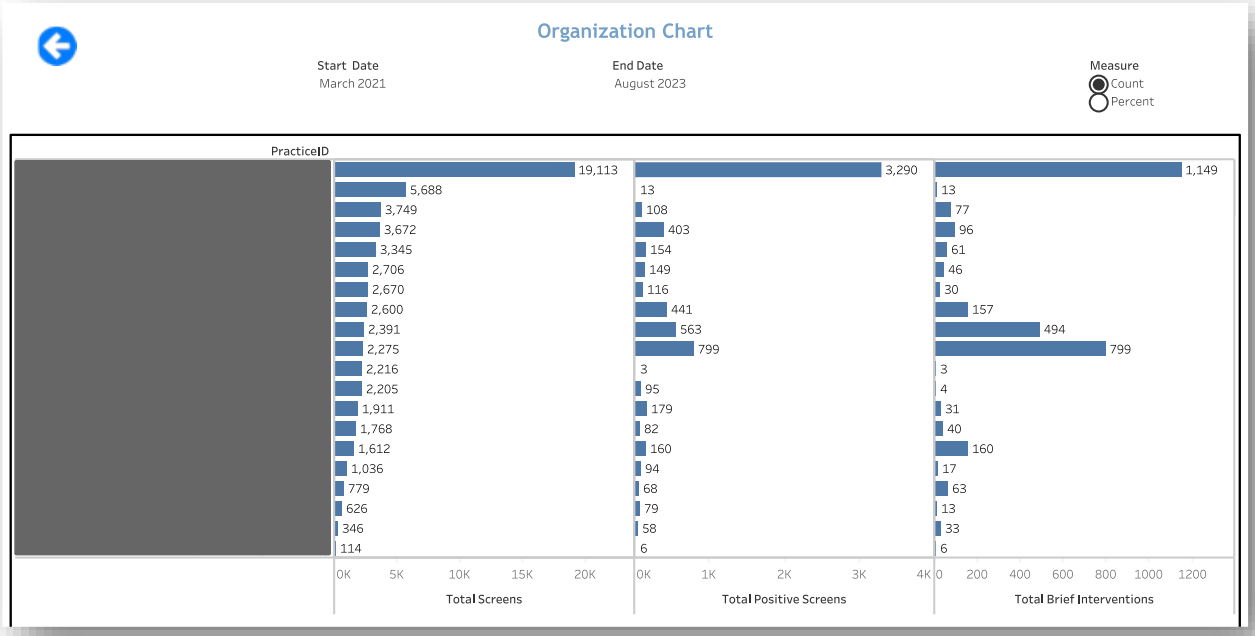


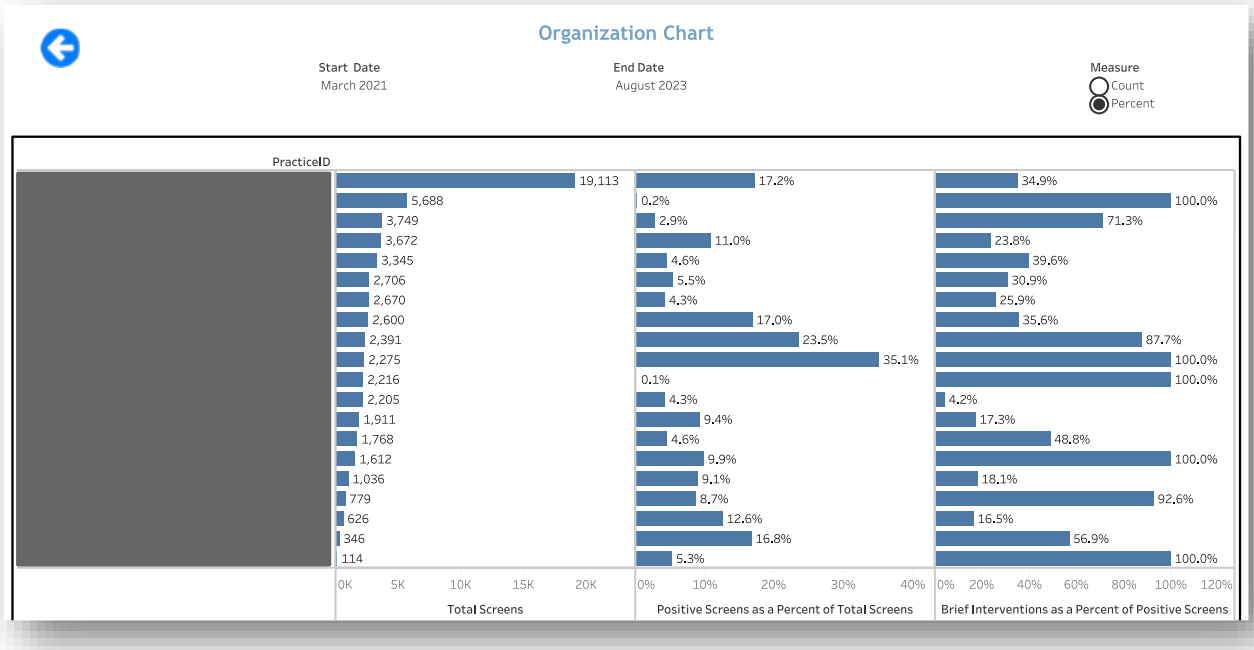
With the Measure set to Percent, months in which the selected practice(s)'s rates for either measure are more than 10% below the Target Goal are colored red.

2.4.5.1 Organization Chart

This view shows the overall count of total SBIRT screens for the selected time period and, depending on the selection, either 1) the overall count of positive screens and brief interventions, or 2) the percentage rates of positive screens and brief interventions. Note that the Measure selection does not change the left most chart, Total Screens.

Use this to view overall counts and rates for periods beyond the 6-month snapshots available in the SBIRT Dashboard and, depending on access, to view multiple individual practices' SBIRT data at once.





2.5 Additional Reports

2.5.1 User Access Report

This report allows users to investigate report accesses by user within their organization, either at the practice or CTO level. The access reports are limited to the specific practice permissions of the user – single practice users can only view report utilization for their practice, while multi-practice or CTO users can see utilization by each practice to which they have access.

2.5.1.1 Filters

Filters	Definition
Report Name	Select one or more reports to view respective usage metrics.
Practice	Select one or more practices to view report utilization for those practice(s)
Time Period	Define the period during which reports were utilized
Program Year	View utilization of reports by MDPCP Program Year.
All/Practice/User ID	The filter determines the aggregation level in the table for selected practice(s): 1. All: All selected practices for which a user has access grouped into a single row/CTO. 2. Practice: Individual practice(s) to which the user has access. Activity Count represents the number of times the practice was loaded in selected report(s). 3. User ID: Counts of reports for selected practices loaded by individual user(s)
User Type	Filter utilization to users with access to a single practice, to multiple or both 1. CTO/Multipractice Users: Users with access at least two Practices in the MDPCP reports. 2. Single Practice User: Users with access to a single Practice in the MDPCP reports.

2.5.1.2 Activity Count

The Activity Count presented in the table is related but distinct from the activity count used to populate the line chart. In the table, Activity Count is the number of times a report was loaded for user according to the "All/Practice/User ID" filter selection. The Activity Count depicted in the chart is the actual number of times a report was loaded by users. The activity counts only differ when a report is loaded for multiple practices by one user. For example, when a multi-practice user loads Population Summary with three practices selected, the activity count in the table is "1" for each practice, but only a total of "1"in the chart below, as the report was only loaded one time. Both Activity Counts will be identical when viewing either utilization by single practice users or when the filter 'All/Practice/User ID' is set to User ID.

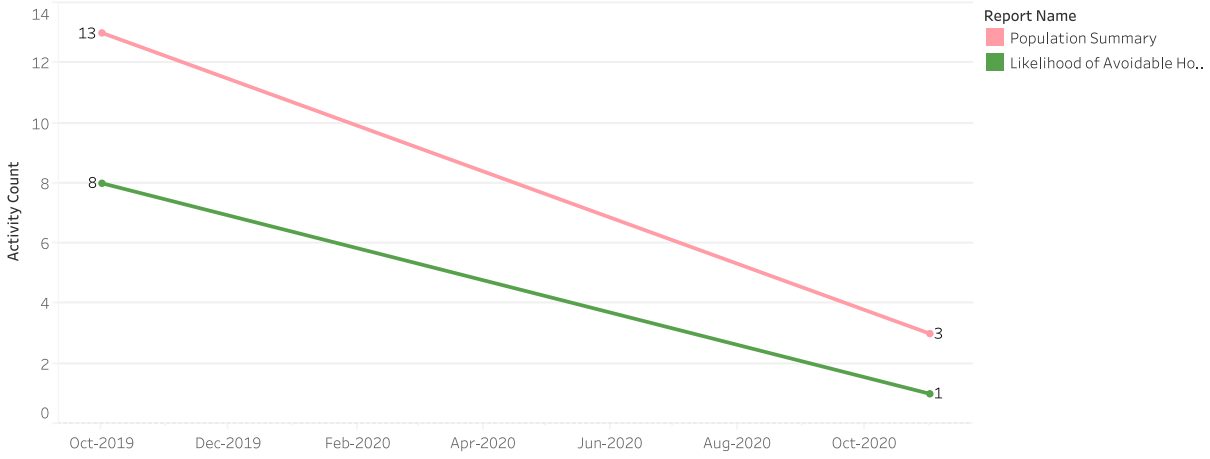
Report-specific Utilization by User and Organization

Report Name	Practice	Time Period
Multiple values	Multiple values	All

Program Year	CTO/Practice/User ID	User Type
All	Practice	All

Regarding the 'CTO/Practice/User ID' filter, please note that the CTO option will include only practice(s) to which a user has access. To confirm which practice(s) are included, select 'Practice.'

Report Name	CTO/Practice/User ID	Activity Count
Population Summary	[redacted]	1
		1
		2
		13
Likelihood of Avoidable Hospital Events	[redacted]	1
		2
		7



2.5.2 MDPCP Historical Practice Dashboard

The MDPCP Historical Practice Dashboard is a static report that provides historical CY2023~~2~~/Program Year 5~~4~~ practice details on MDPCP practices participating in the program in CY2024~~3~~. The goal of the report is to provide key beneficiary and services attributes for a single practice.

Use the global CTO and Practice filters at the top of the page to change selection. See section 1.3 for more information on global filters.

Please note that practices participating in 2023~~4~~ that did not also participate in 2022~~3~~ will not have data with which to populate this report. This report will ~~only be~~ updated ~~once~~ monthly until June 2024, when ~~a year once~~ the full CY data is available.

The Practice Historical HCC table shows the practice's average quarterly HCC score and overall average HCC score for CY2023~~2~~. The Attributed Beneficiaries by Quarter table includes the quarterly and overall breakdown of the practice's population including the total number of beneficiaries, beneficiary months, beneficiaries qualifying for HEART payments, beneficiaries in each HCC tier, and the number of beneficiaries enrolled in a Medicare Shared Savings Program (MSSP).

The Avg 2023~~2~~ HCC Distribution by Practice chart shows where the practice's average 2023~~2~~ HCC is on the distribution of all 2022~~3~~ MDPCP practices' HCC scores as well as the percentile ranges. Hovering the cursor in any of the gray percentile bands will show the respective percentile's value.

The Historical 2023~~2~~ Utilization and Average Payment for SPCS (MDPCP Select Primary Care Services) table shows the practice's distribution of SPCS codes provided by participating physicians within the practice and average CMS payment per service, exclusive of beneficiary cost sharing. Additionally, the table includes the SPCS count per beneficiary, the average practice SPCS Payment weighted according to the distribution of services, and another weighted average that includes any FQHC-specific SPCS codes.

2.5.2.1 Quarterly Table Values

Overall Row	Definition
Avg. HCC	The average HCC score.
Attributed Beneficiaries	Count of quarterly attributed beneficiaries.
Beneficiary Months	Sum of beneficiary months.
Number HEART Benes	Count of beneficiaries that qualified for a HEART payment.
Number HCC Tier 1	Count of attributed beneficiaries in HCC Tier 1.
Number HCC Tier 2	Count of attributed beneficiaries in HCC Tier 2.
Number HCC Tier 3	Count of attributed beneficiaries in HCC Tier 3.
Number HCC Tier 4	Count of attributed beneficiaries in HCC Tier 4.
Number HCC Complex Tier	Count of attributed beneficiaries in HCC Complex Tier.
Number of Beneficiaries in MSSP	Count of attributed beneficiaries in an MSSP.

2.5.2.2 "Overall" Column Quarterly Table Values

Overall Row	Definition
Avg. HCC	The practice average HCC score for CY202332.
Attributed Beneficiaries	Average quarterly attributed beneficiaries.
Beneficiary Months	Sum of all quarterly beneficiary months.
Number HEART Benes	Average quarterly beneficiaries that qualified for a HEART payment.
Number HCC Tier 1	Average quarterly attributed beneficiaries in HCC Tier 1.
Number HCC Tier 2	Average quarterly attributed beneficiaries in HCC Tier 2.
Number HCC Tier 3	Average quarterly attributed beneficiaries in HCC Tier 3.
Number HCC Tier 4	Average quarterly attributed beneficiaries in HCC Tier 4.
Number HCC Complex Tier	Average quarterly attributed beneficiaries in HCC Complex Tier.
Number of Beneficiaries in MSSP	Average quarterly attributed beneficiaries in an MSSP.

MDPCP Historical Practice Report

Please note that practices that did not participate in MDPCP in 2022 will not have data with which to populate this report.

Practice: [redacted]
CTO: [redacted]

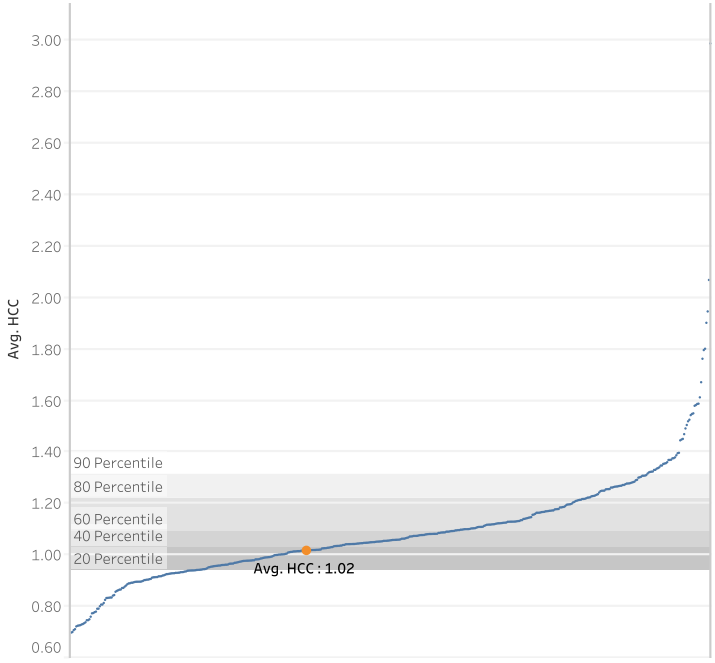
Practice Historical HCC

Measure	2022-Q1	2022-Q2	2022-Q3	2022-Q4	Overall
Avg. HCC	1.00	1.01	1.01	1.05	1.02

Attributed Beneficiaries by Quarter Information

Attributed Beneficiaries	1,807	1,841	1,676	1,681	1,751
Beneficiary Months	5,049	5,180	4,797	4,826	19,852
Number HEART Benes	35	36	23	25	30
Number HCC Tier 1	435	432	433	420	430
Number HCC Tier 2	439	450	397	389	419
Number HCC Tier 3	463	459	411	401	434
Number HCC Tier 4	261	283	245	247	259
Number HCC Complex Tier	209	217	190	224	210
Number of Beneficiaries in MSSP	1,333	1,345	1,397	1,417	1,373

Avg 2022 HCC Distribution by Practice



Historical 2022 Utilization and Average Payment for SPCS

E & M Services	Practice Distribution of Services	Average Medicare Payment*
99202 : Office O/P New Sf 15-29 Min	0.74%	$44.76
99203 : Office O/P New Low 30-44 Min	4.02%	$77.95
99204 : Office O/P New Mod 45-59 Min	4.72%	$120.84
99205 : Office O/P New Hi 60-74 Min	1.37%	$153.43
99211 : Off/Op Est May X Req Phy/Qhp	0.83%	$15.76
99212 : Office O/P Est Sf 10-19 Min	2.62%	$38.53
99213 : Office O/P Est Low 20-29 Min	26.03%	$61.53
99214 : Office O/P Est Mod 30-39 Min	49.92%	$72.64
99215 : Office O/P Est Hi 40-54 Min	5.64%	$116.97
99354 : Prolng Svc O/P 1st Hour	0.03%	$49.63
99355 : Prolng Svc O/P Ea Addl 30	0.01%	$0.00
99422 : Ol Dig E/M Svc 11-20 Min	0.00%	$15.10
99441 : Phone E/M Phys/Qhp 5-10 Min	0.16%	$38.09
99442 : Phone E/M Phys/Qhp 11-20 Min	0.69%	$42.33
99443 : Phone E/M Phys/Qhp 21-30 Min	0.89%	$57.74
99453 : Rem Mntr Physiol Param Setup	0.12%	$10.72
99454 : Rem Mntr Physiol Param Dev	2.02%	$23.53
G2012 : Brief Check In By Md/Qhp	0.03%	$8.80
G2212 : Prolong Outpt/Office Vis	0.15%	$38.08

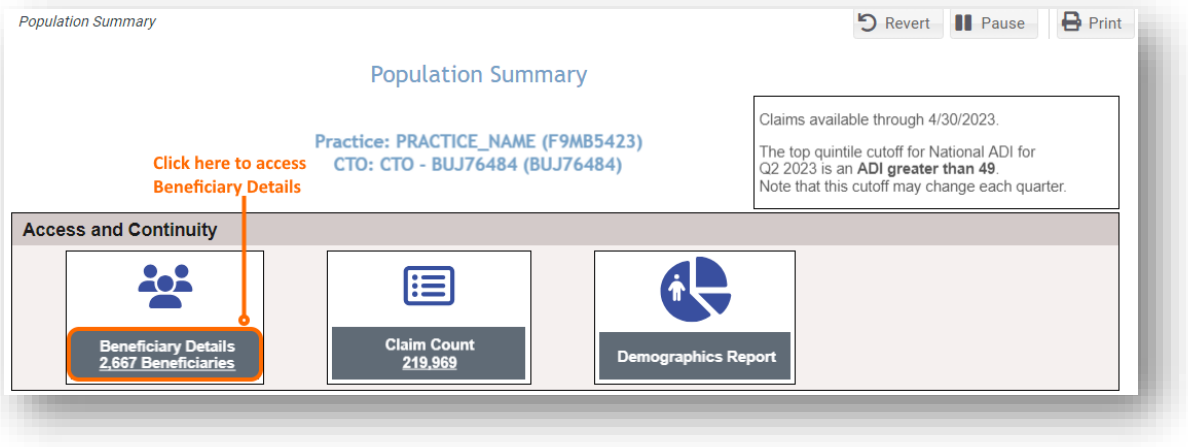
SPCS Count per Beneficiary	1.14
Weighted Avg. Practice SPCS Payment	$72.72
Weighted Average SPCS incl. FQHC SPCS Payment	$72.72

*Average Medicare Payment excludes Beneficiary cost sharing.

3 DRILLDOWN REPORTS

3.1 Beneficiary Details

Beneficiary Details may be accessed directly through the Population Summary, as well as through drill throughs in the Demographics, Payment Band, Chronic Condition Report, Medication Synchronization Opportunity Summary, High-Risk Medications – Top 100 Prescribers, and Inpatient/ER Utilization reports. The report includes several columns including beneficiaries' Medicare Beneficiary Identifier (MBI), Name, Gender, Age, and utilization measures for the time period specified in the report through which was drilled to access Beneficiary Details. See section 3.1.1 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.

3.1.1 Beneficiary Details Columns

Beneficiary Details Column	Definition
MBI	Medicare Beneficiary Identifier (MBI). Unique identifier for the beneficiary assigned by CMS.
Beneficiary Name	Beneficiary's full name.
First Name	Beneficiary's first name.
Middle Name	Beneficiary's middle initial.
Last Name	Beneficiary's last name.
Gender	Gender according to beneficiary demographics file.
DOB	Date of birth according to beneficiary demographics file.
Age	Age calculated using DOB
Medicare Status	Medicare eligibility status. Includes indication that a beneficiary is not enrolled in both Medicare Part A and Part B in the latest month and 'Expired' if beneficiary has a Date of Death included in the CCLF data.

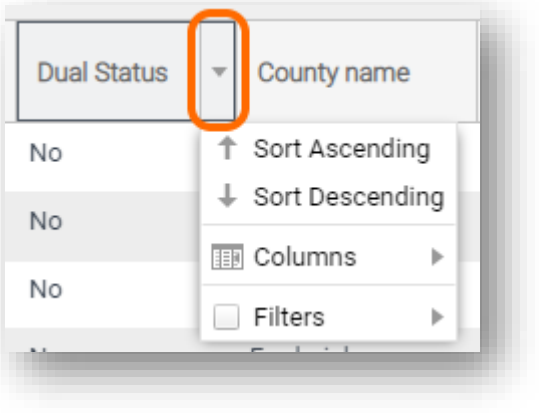
Beneficiary Details Column	Definition
Date of Death	Populated from CCLF data for beneficiaries with 'Expired' Medicare Status.
Dual Status	Whether a beneficiary has had at least one month during which they were also eligible for Medicaid.
County Name	County of beneficiary's residence for beneficiary's address of record with CMS
ZIP+4	ZIP plus 4 digits when available for beneficiary's address of record with CMS.
Practice ID	Code assigned to MDPCP Participating practices. Note that the T1 or T2 component of the code does not necessarily correspond to a practice's current track participation.
HCC Tier	Tier assigned during MDPCP Attribution.
HCC Score	HCC Score at time of attribution. Note that beneficiaries without HCCs are assigned to Tier 2 or Complex if they meet the non-HCC criteria for Complex Tier assignment.
Claim Count	Number of Medicare claims.
IP Claim Count	Number of inpatient admissions.
ER Claim Count	Number of emergency room visits.
Race	Beneficiary race according to CMS beneficiary demographic file.
ADI	Area Deprivation Index; geographic percentile ranking of deprivation within the nation by 9 digit ZIP code.
~~**CVI**~~	~~COVID Vulnerability Index; Model developed by Socially Determined representing an individual's likelihood of exposure to COVID-19, potential severity of complications, and associated socio-clinical needs, based on a multivariate model that includes demographic, social, and environmental factors. 5 indicates severe risk, 4 indicates high risk, 3 indicates moderate risk.~~
Pre-AH™ Score	Hilltop Institute's Prevent-Avoidable Hospital Admissions score. See Section 2.2.1.1 for more information.
Pre-DC™ Score	Hilltop Institute's Prevent-Severe Diabetes Complications score. See Section 2.2.1.1 for more information.
Pre-HE™ Score	Hilltop Institute's Hospice Eligibility and Advanced Care Planning score. See Section 2.2.1.1 for more information.
Receives HEART Payment	Indicator for whether the beneficiary qualifies in the selected attribution quarter for the practice to receive a HEART payment.
PQI-Like Event count	Number of inpatient and ER visits with diagnosis codes included in the AHRQ Prevention Quality Indicator 2020 specifications. See section 2.2.6 for more information.
# of Prescriptions	For beneficiaries with Medicare Part D, this shows the count of prescriptions filled by that individual during the time period selected in the parent report. Click the count of Prescriptions to access Prescription Details.
# of Pharmacies	For beneficiaries with Medicare Part D, this shows the count of pharmacies where the individual filled prescriptions.
# of High Risk Medications	For beneficiaries with Medicare Part D, the count of high risk medications according to Beers criteria for potentially inappropriate medication use in older adults (> 65 years of age or older).
Medications Synchronized	For beneficiaries with Medicare Part D, this indicates whether their prescriptions are filled on a single day per month ("Yes") or on multiple days

Beneficiary Details Column	Definition
	and/or at multiple pharmacies (“No”). This column corresponds to the indicator in Medication Synchronization Opportunity Summary.
Avg Difference Between Fill Dates	The average number of days between scripts filled in the same month.

3.1.2 Beneficiary Details Column Selection, Filter Functionality

Beneficiary Details is a customizable view that shows 20 beneficiaries per page, in which users may select which columns to include as well as filter values within any column(s) to those of interest.

Move the cursor over a column header and click the triangle to access the menu.



Within the menu, select or deselect columns by navigating into that section.

Filter to values of interest by clicking "Filters" and either entering or selecting values. Depending on the column, the filter will allow for entering a range or specific number (e.g., Age), free text (e.g., Name), specific date or date range (e.g., DOB), or multiselect (e.g., Medicare Status).

3.1.3 Prescription Details

For beneficiaries with Part D coverage, clicking the number in the "# of Prescriptions" column will result in a pop-up window containing information on each prescription filled by that beneficiary. The table contains the fill date, drug name, strength description, dosage form, prescriber name, high risk indicator, days supply, and quantity. Use the High Risk Indicator filter to show only prescriptions for medications that fit the Beers criteria for potentially inappropriate medication use in older adults (> 65 years of age or older), only those that do not meet those criteria, or both.

3.1.4 Excel Export and Report Navigation

To export Beneficiary Details to Excel, click the blue "Excel Export" button in the top right corner of the report. Please note that the export will only include columns selected/displayed. Please select all columns of interest before exporting to Excel.

To navigate to the prior view, use the blue “Back To Reports” button in the top left of the report. Using an internet browser’s back button may not work as expected.

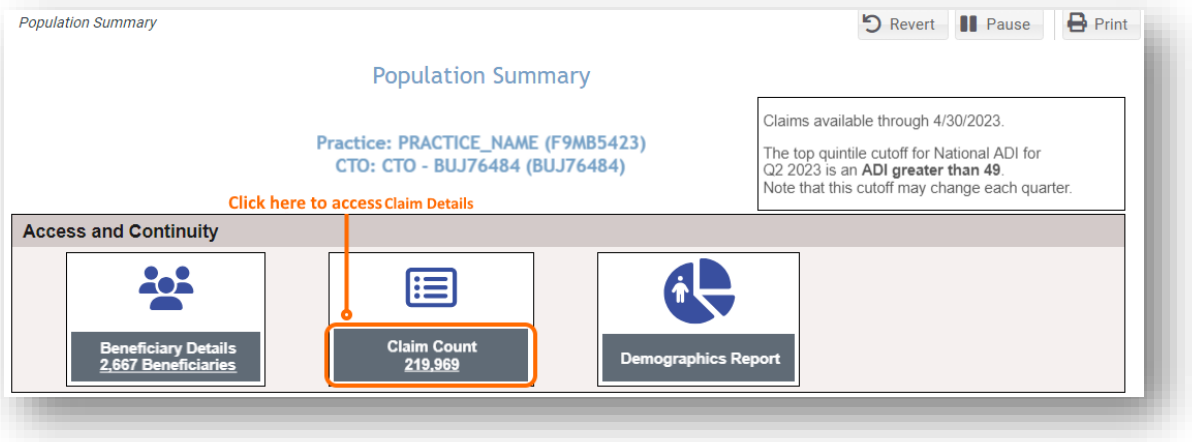
3.2 Claims Details

Claims details may be accessed through Population Summary or through Beneficiary Details. Having drilled through Population Summary, this report includes all claims for each beneficiary attributed to a practice or CTO. Drilling through Beneficiary Details by selecting a beneficiary will show claims for that beneficiary consistent with any filters applied or selections in the parent report (e.g. date ranges).

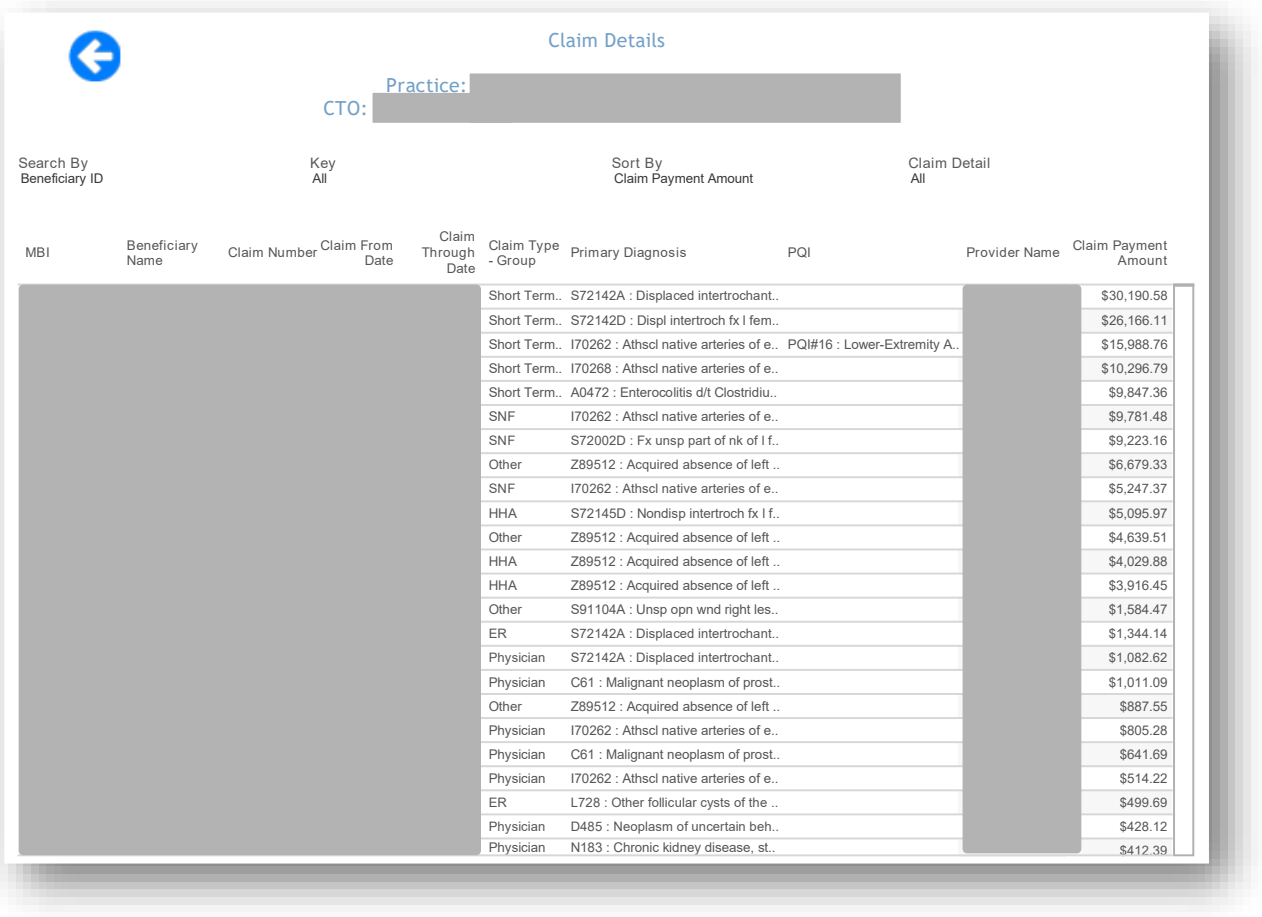
The report includes the Medicare Beneficiary Identifier (MBI), Name, Claim From and Claim Through dates, Claim Type Group, Primary Diagnosis, Provider Name, Claim Count, and Claim Payment Amount.

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

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 reorder the table by any of the columns, make a selection in the “Sort By” filter and/or restrict the types of claims to IP, ED, or PQI-Like events using the “Claim Detail” filter.



To access Claim Details from Beneficiary Details for an individual, click on any beneficiary's blue MBI, 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.



Claim Details

Practice: [redacted]

CTO: [redacted]

Search By	Key	Sort By	Claim Detail
Beneficiary ID	All	Claim Payment Amount	All

MBI	Beneficiary Name	Claim Number	Claim From Date	Claim Through Date	Claim Type - Group	Primary Diagnosis	PQI	Provider Name	Claim Payment Amount
[redacted]					Short Term..	S72142A : Displaced intertrochant..		[redacted]	$30,190.58
					Short Term..	S72142D : Displ intertroch fx l fem..			$26,166.11
					Short Term..	I70262 : Athscl native arteries of e..	PQI#16 : Lower-Extremity A..		$15,988.76
					Short Term..	I70268 : Athscl native arteries of e..			$10,296.79
					Short Term..	A0472 : Enterocolitis d/t Clostridiu..			$9,847.36
					SNF	I70262 : Athscl native arteries of e..			$9,781.48
					SNF	S72002D : Fx unsp part of nk of l f..			$9,223.16
					Other	Z89512 : Acquired absence of left ..			$6,679.33
					SNF	I70262 : Athscl native arteries of e..			$5,247.37
					HHA	S72145D : Nondisp intertroch fx l f..			$5,095.97
					Other	Z89512 : Acquired absence of left ..			$4,639.51
					HHA	Z89512 : Acquired absence of left ..			$4,029.88
					HHA	Z89512 : Acquired absence of left ..			$3,916.45
					Other	S91104A : Unsp opn wnd right les..			$1,584.47
					ER	S72142A : Displaced intertrochant..			$1,344.14
					Physician	S72142A : Displaced intertrochant..			$1,082.62
					Physician	C61 : Malignant neoplasm of prost..			$1,011.09
					Other	Z89512 : Acquired absence of left ..			$887.55
					Physician	I70262 : Athscl native arteries of e..			$805.28
					Physician	C61 : Malignant neoplasm of prost..			$641.69
					Physician	I70262 : Athscl native arteries of e..			$514.22
					ER	L728 : Other follicular cysts of the ..			$499.69
					Physician	D485 : Neoplasm of uncertain beh..			$428.12
					Physician	N183 : Chronic kidney disease, st..			$412.39

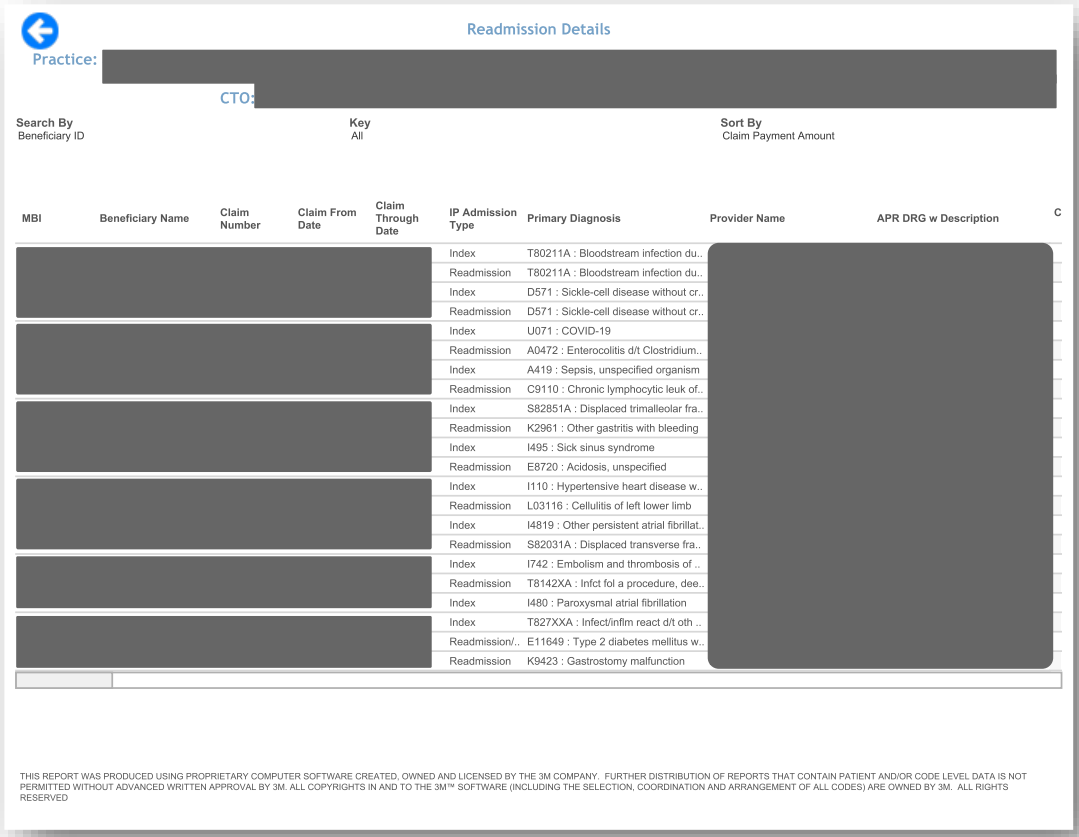
All PHI is redacted – for example purposes only.

3.3 Readmission Details

The Inpatient/ER Utilization report includes a drilldown to Readmission Details.

You 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 your search parameter (i.e. MBI or name), make your selection(s), and click "Apply" when your selections are complete.

Column Name	DESCRIPTION
MBI	Medicare Beneficiary Identifier. A unique code assigned by CMS to beneficiaries that can be used to search within the MDPCP Reports.
Beneficiary Name	The Beneficiary's first name, middle initial, and last name.
Claim Number	The unique number assigned by CMS for the respective admission.
Claim From Date	In this context, this is the admission date.
Claim Through Date	In this context, this is the discharge date.
IP Admission Type	Index: an IP admission that preceded at least one readmission. Readmission: a qualifying IP admission within 30 days of discharge from an Index inpatient admission. Readmission/Index: A readmission that serves as the index stay for a subsequent readmission.
Primary Diagnosis	The primary diagnosis from the claim associated with the admission.
Provider Name	The name of the admitting hospital.
APR DRG w Description	3M™ All Patient Refined Diagnosis Related Group. For the admission, the numeric APR DRG code and its brief description.
Claim Payment Amount	The total claim payments for the respective inpatient admission.



Readmission Details

Practice: [redacted]

CTO: [redacted]

Search By
Beneficiary ID

Key
All

Sort By
Claim Payment Amount

MBI	Beneficiary Name	Claim Number	Claim From Date	Claim Through Date	IP Admission Type	Primary Diagnosis	Provider Name	APR DRG w Description	C
[redacted]					Index	T80211A : Bloodstream infection du..	[redacted]		
					Readmission	T80211A : Bloodstream infection du..			
					Index	D571 : Sickle-cell disease without cr..			
					Readmission	D571 : Sickle-cell disease without cr..			
[redacted]					Index	U071 : COVID-19			
					Readmission	A0472 : Enterocolitis d/t Clostridium..			
					Index	A419 : Sepsis, unspecified organism			
					Readmission	C9110 : Chronic lymphocytic leuk of..			
[redacted]					Index	S82851A : Displaced trimalleolar fra..			
					Readmission	K2961 : Other gastritis with bleeding			
					Index	I495 : Sick sinus syndrome			
					Readmission	E8720 : Acidosis, unspecified			
[redacted]					Index	I110 : Hypertensive heart disease w..			
					Readmission	L03116 : Cellulitis of left lower limb			
					Index	I4819 : Other persistent atrial fibrillat..			
					Readmission	S82031A : Displaced transverse fra..			
[redacted]					Index	I742 : Embolism and thrombosis of ..			
					Readmission	T8142XA : Infct fol a procedure, dee..			
					Index	I480 : Paroxysmal atrial fibrillation			
[redacted]					Index	T827XXA : Infect/inflm react d/t oth ..			
					Readmission/..	E11649 : Type 2 diabetes mellitus w..			
					Readmission	K9423 : Gastrostomy malfunction			

All PHI is redacted – for example purposes only.

4 HELP

4.1 Glossary

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

Term	Definition
ADI	National Area Deprivation Index Percentile; the 2019 ranking of socioeconomic disadvantage by 9-digit ZIP code. Beneficiaries' ADIs are presented as percentiles, 1 through 100. The most disadvantaged percentile is 100. Those without a percentile ADI are presented as 'N/A' (i.e. the beneficiary ZIP code is present but is not assigned an ADI).
Avoidable Hospital Event	According to The Hilltop Institute's Pre-AH Model™, these are inpatient admissions and emergency department visits that can be avoided through proactive management in the primary care practice setting.
Beneficiary Months	For a given month, the number of beneficiaries enrolled in Medicare Part A and Part B. Because enrollment is not necessarily continuous and beneficiaries may enroll in Medicare FFS midway through an attribution quarter, the Beneficiary Months used in calculations may be less than the number of beneficiaries times the number of months shown in a report.
BETOS	Berenson-Eggers Type of Service (BETOS) codes are a classification of CPT and HCPCS codes into broad categories of like services that allow for easy review and analysis of data.
CCS Category	The Clinical Classifications Software (CCS) is a diagnosis and procedure categorization system developed by AHRQ' HCUP project to aggregate diagnosis and procedure codes into a smaller number of clinically meaningful categories.
COVID-19 Vulnerability Index	As shown in the Likelihood of Avoidable Hospital Event Report and Beneficiary Details, an assessment to help care teams identify your most vulnerable patients for proactive outreach and support. This index represents an individual's likelihood of exposure to COVID-19, potential severity of complications, and associated socio-clinical support needs, based on a multivariate model that includes demographic (e.g., advanced age), clinical (e.g., immunocompromised status), social (e.g., at-risk of food insecurity), and environmental (e.g., proximity to congregate sites) factors. **5** indicates **severe risk**, **4** indicates **high risk**, and **3** indicates **moderate risk**.
Dual Eligible	A beneficiary is indicated as Dual Eligible when he/she has at least one month during the available claims window when he/she was eligible for and enrolled in both Medicaid and Medicare benefits.
ER	Emergency Room; type of service.
HCC Tier	CMS-assigned tier for each MDPCP beneficiary based on the distribution of HCC scores across the program. Newly enrolled Medicare beneficiaries without adequate claims data to calculate an HCC tier are defaulted into Tier 2. The Complex tier includes those beneficiaries in the top 10 decile of HCC scores as well as those with "persistent and severe mental illness, substance use disorder or dementia." For a description of the HCC Tier distribution, see Section 2.3.1: Distribution of HCC Tier.

Term	Definition
HCC Score	Hierarchical Condition Categories are a risk score coding system used by Medicare to predict utilization and weight reimbursement.
HHA	Home Health Agency; type of service.
Other (Setting)	Includes care provided in long-term care hospitals, other inpatient facilities such as psychiatric hospitals, DME, inpatient rehabilitation, hospice; type of service.
Outpatient	Type of service; includes all Part B services provided in an outpatient hospital setting, including dialysis center.
Part A + Part B 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.
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.
Pre-AH™ Model	Prevent Avoidable Hospitalizations Model. A risk model developed by the Hilltop Institute to predict likelihood of a hospital admission for a condition that may be avoided through enhanced primary care and care coordination.
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 CCLF 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 MDPCP reports are powered by the latest 36 months of data for 100% of the Maryland Medicare beneficiaries.[3] 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 CCLF Data Lag

Due to the nature of claims processing, not all claims are submitted and/or processed by the time the CCLF data are made available. The default view in the MDPCP reports will exclude the most recent three months of CCLF data because the month prior to the data load is not included in the CCLF data and the preceding 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.

4.2.3 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.

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

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 MDPCP, 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.

4.3 Practice Attribution

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

4.4 IP Admissions and ER Visits Per K Calculations

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

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

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

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

4.5 MDPCP Report Training Webinar

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

Link to MDPCP Webinar Recording