Hospital Services Payments and Utilization Dashboard Report: **Definitions**

- **Service Category –** The service categorization in this report is limited to services provided in a hospital setting; using the Type of Bill and Place of Service codes on the medical claim, services are classified as: Inpatient, Outpatient, and Professional, defined as follows:
    - **Inpatient Services –** Facility claims related to hospital stays, whether for the day, overnight, or an extended stay. May include Emergency Room services that resulted in hospital admission and other pre-admission services linked to admissions.
    - **Outpatient Services –** Facility claims related to hospital visits. Includes Emergency Room visits that did not result in hospital admission.
    - **Professional Services –** Non-facility claims related to services provided in the hospital inpatient or outpatient setting, or during Emergency Room visits.
- **Services –** Detailed subcategories within each service category. For example, for inpatient services, the report displays information for diseases and disorders of the respiratory system, circulatory system, and others. For outpatient and professional services, the report displays information on radiology services, Emergency Room services, outpatient surgery, and others.
- **Payor Type –** Payors are grouped into mutually exclusive types that reflect the monthly medical coverage information available in the MHDO APCD eligibility files for distinct individuals: Commercial, MaineCare (Medicaid), Original Medicare, Medicare Advantage, Dual Eligible Medicare-MaineCare, and Commercial and Medicare. The report also displays a Medicare payor type, which aggregates the Original Medicare and Medicare Advantage payor types.
- **Total Payments –** The sum of payor payments and member liability amounts to be paid (see Cost Sharing Payments, below) for medical services and procedures.
- **Cost Sharing Payments –** The out-of-pocket amounts to be paid by the insured member to the hospital (inclusive of copay, coinsurance, and deductible amounts) for medical services and procedures; also referred to as member liability amounts.
- **Payments Per Capita –** The total payments divided by the sum of member months (regardless of whether the member had any claims during the reporting year), then multiplied by 12 – showing the annual per capita values across individuals assigned to the respective payor type.
- **Utilization Count –** The total count of services, calculated by summing the number of days of hospitalization (or inpatient days), the number of outpatient services or the number of professional services, respectively, as follows:

- **Inpatient days** are calculated as the number of days of hospitalization at one of the 36 Maine hospitals, based on the admission and discharge dates that are submitted by the payor for each inpatient stay. Inpatient stays with same day discharges are counted as one inpatient day. Note that transfers from one Maine hospital to another Maine hospital are counted as distinct inpatient stays, therefore the number of days at Hospital A is attributed to Hospital A, and then the number of days of hospitalization post transfer to Hospital B are attributed to Hospital B.
- **Outpatient services** are defined as distinct combinations of HCPCS/CPT codes, date of service and MHDO deidentified Person ID, across multiple claim lines or even multiple claims. Quantity information or number of units of service recorded on the claim are not considered.
- **Professional services** are defined as distinct combinations of HCPCS/CPT codes, date of service and MHDO deidentified Person ID, across multiple claim lines or even multiple claims. Quantity information or number of units of service recorded on the claim are not considered.

- **Utilization Per 1,000 Insureds –** The total utilization counts as described above (Utilization Count), divided by the number of insured years (representing the sum of member months divided by 12, regardless of whether the member had any claims during the reporting year), then the result is multiplied by 1,000.
- **Payments Per Unit –** The average payment for services, calculated as the total payments (combining payor payments and member liability amounts to be paid, as described above) divided by the number of inpatient days or number of services and procedures (i.e. total utilization), respectively, during the specified reporting year.
- **Year-Over-Year (YOY) Percent Change –** The YOY percent change represents the relative difference in values between two consecutive years, for example, 2018 and 2019, calculated as the 2019 value minus the 2018 value, divided by the 2018 value, then multiplying the result by 100. A negative percent change indicates that the 2019 value has decreased compared to 2018. A positive percent change indicates that the 2019 value has increased compared to 2018. If the value was the same in both 2018 and 2019, the YOY percent change is zero. If the value in 2018 is zero, the YOY percent change is not calculated.
- **Cumulative Percent Change –** The cumulative percent change represents the relative difference in values between 2017 and another reporting year, for example, 2020, calculated as the 2020 value minus the 2017 value, divided by the 2017 value, then multiplying the result by 100. A negative percent change indicates that the 2020 value has decreased compared to 2017. A positive percent change indicates that the 2020 value has increased compared to 2017. If the value was the same in both 2017 and 2020, the cumulative percent change is zero. If the value in 2017 is zero, the cumulative percent change is not calculated.

- **Insured Individual –** Individual with health care insurance coverage for medical services, per insurance eligibility information submitted to the MHDO APCD.
- **Average Number of Insureds –** The average number of insured individuals is equivalent to the number of insured years, calculated as the sum of member months divided by 12. The average number of insureds is available in the dashboard's tooltip (hover text) information for selected charts.
- **MHDO Deidentified Person ID –** De-identified identifier is assigned to unique individuals in MHDO datasets, which facilitates the linkage of records for the same individual across submitters and data submissions, and across time. This is a value-add data element developed after data submission to MHDO.