Michigan Value Collaborative

Blue Cross Blue Shield Blue Care Network of Michigan

MVC Report Metrics
Interpretation Guide

This document is intended to provide definitions for common MVC metrics and terminology. For information on how specific claim types are categorized and defined, please refer to the attached appendix. For additional detail related to MVC methodology, please refer to the MVC Data Guide available on the MVC registry.

30 or 90-day Risk-Adjusted Episode Spending

- Definition: Average price-standardized and risk-adjusted total episode spending for a given condition for the index event and 30 or 90 days post-discharge.
- Price Standardization
    - MVC data is price-standardized to Medicare FFS paid amounts. This allows us to remove variation due to contractual agreements, geographical location, wage index, or inflation. It also allows for equitable comparisons of healthcare utilization between all MVC member hospitals.
- Risk Adjustment
    - MVC data is risk-adjusted in order to account for differences in patient characteristics between hospitals.
    - MVC data is risk adjusted for the following patient factors:
        - Patient Age
        - Patient Gender
        - Payer
        - Prior six-month spending
        - 79 HCCs (Hierarchical Condition Categories)
    - HCC Categories
        - A method for assessing the risk of readmission using common comorbidities (as assessed from claims data by Hierarchical Condition Categories (HCCs)).
        - Comorbidities include: chronic kidney disease, cerebrovascular accident, cancer, liver disease, CHF, diabetes, vascular disease, respiratory dysfunction, neurological disorders, and others.

Average Index Length of Stay (LOS)

- Average length of stay in days for a given condition at the index facility.

30 or 90-day Readmission Rate

- Numerator
    - All patients with an acute care hospitalization within 30 or 90-days post-discharge.
- Denominator
    - Total patients that had an index stay for a given condition at a given facility.

30 and 90-day Emergency Department (ED) Rate

- Numerator
  - All patients with an emergency department visit, but not a resulting readmission, within 30 or 90-days post discharge.
- Denominator
  - Total patients that had an index stay for a given condition at a given facility.

Intensive Care Unit/Cardiac Care Unit (ICU/CCU) Utilization Rate

- Numerator
  - Total patients that utilized ICU or CCU during their index stay for a given condition at a given facility.
  - ICU/CCU is defined using the following revenue codes: 200, 201, 202, 203, 204, 206, 207, 208, 209, 210, 212, 213, 214, 219.
- Denominator
  - Total patients that had an index stay for a given condition at a given facility.

Discharge Disposition

Location of Discharge	Medicare Discharge Disposition Code
SNF	3, 61
Home Health	6
Home	1
LTAC	65
IP Rehab	62

- Numerator
  - Percent of patients discharged to a given location after an index stay at a given facility.
- Denominator
  - Total patients with had an index stay at a given facility.

Inpatient Mortality and Hospice

Location of Discharge	Medicare Discharge Disposition Code
Inpatient Mortality	20
Hospice at Home	40
Hospice at Medical Facility	41

- Numerator
  - Percent of patients who died in hospital or were discharged to hospice after an index stay at a given facility.
- Denominator
  - Total patients that had an index stay at a given facility.

Post-Acute Care (PAC) Utilization

- Numerator
  - All patients who utilized each type of post-acute care within 30 or 90-days post discharge.
- Denominator
  - Total patients that had an index stay for a given condition at a given facility.

Outpatient Follow-up

- Numerator
  - Patients that had an outpatient follow-up visit within 30-days or before a readmission, an inpatient procedure, emergency department visit, SNF admission, or a visit for inpatient rehabilitation, depending on which came first.
- Denominator
  - Total patients that had an index stay for a given condition at a given facility.

Appendix A. MVC Claim Categorization Rules

Facility Claim Type	New Definition
Inpatient	(1) Bill Type = 11 (or 12 if DRG present) **and** (2) DRG* is not a rehab code (945, 946, 949, 950) **and** (3) Revenue code is not an IP rehab code (118, 128, 138, 148, 158)
SNF	Bill Type in (18, 21)
Emergency Dept.	(1) Bill Type = 1x **or** Bill Type = 85 **and** (2) Revenue code is an ED code
Home Health	Bill Type in (31, 32, 33, 34)
Inpatient Rehab	(1) Bill Type = 11 **and** (2) DRG* is a rehab DRG **or** revenue code is an IP rehab code.
Outpatient Rehab	(1) Revenue code is an OP rehab code **or** (2) CPT is a rehab CPT **or** (3) Bill Type in (74, 75)
Outpatient / Other	Everything else

**Regrouped DRG*