Michigan Value Collaborative

Blue Cross Blue Shield Blue Care Network of Michigan
Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

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 website.

30 or 90-day Average Risk-Adjusted Price-Standardized Total Episode Payments

- Definition: Average price-standardized and risk-adjusted total episode payments – including services indicated on facility and professional medical claims – for a given condition, encompassing claims for the index event and 30 or 90-days post-index discharge.
- Price Standardization
    - MVC payment data are price-standardized to Medicare FFS paid amounts. This removes 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 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 CMS-based method for risk-adjusting using patient comorbidities as assessed by diagnosis codes on claims data which are then organized into Hierarchical Condition Categories (HCCs).
        - MVC assesses HCCs for a given patient/episode using diagnosis codes on claims for the 6 months prior to each corresponding index event.
        - Examples of HCC Categories include chronic kidney disease, cerebrovascular accident, cancer, liver disease, CHF, diabetes, vascular disease, respiratory dysfunction, neurological disorders, among others.

Average Index Length of Stay (LOS)

- Average length of stay in days for a given condition at the index facility, with each length of stay calculated with a minimum length of stay of 1 day.
- Length of stay = Discharge date – Admission date + 1

30 or 90-day Readmission Rate

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

30 or 90-day Emergency Department (ED) Rate

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

30 or 90-day Post-Acute Care (PAC) Utilization Rate

- Numerator
  - Number of patients who utilized each type of post-acute care within 30 or 90-days post discharge. Utilization of categories of post-acute care is assessed according to presence of facility claims categorized by type of claim according to bill type, DRG, revenue codes, and CPT codes. Categories of post-acute care commonly assessed include ED, skilled nursing facility (SNF), home health, inpatient rehabilitation, outpatient rehabilitation, and outpatient services
- Denominator
  - Total number of 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
  - Number of patients that utilized ICU or CCU care during their index stay for a given condition at a given facility. MVC typically does not include step down/intermediate ICU/CCU utilization in its reporting and analyses.
  - ICU/CCU is defined using the following revenue codes: 200, 201, 202, 203, 204, 207, 208, 209, 210, 211, 212, 213, 219.
  - Step down/intermediate ICU/CCU is defined using revenue codes 206 and 214.
- Denominator
  - Total number of patients that had an index stay for a given condition at a given facility.

Discharge Disposition Rate

Location of Discharge	Medicare Discharge Disposition Code
SNF	3
Home Health	6
Home	1

- Numerator
  - Number of patients discharged to a given location after an index stay at a given facility, as assessed per discharge disposition on the index claim.
- Denominator
  - Total number of patients that had an index stay for a given condition at a given facility.

30-day Post-Discharge Mortality Rate (Medicare FFS Only)

- Numerator
  - Number of patients that died within 30 days post-discharge, indicated by patient's death date in the Medicare Master Beneficiary Summary Files (MBSF).
- Denominator
  - Total number of patients that had an index stay for a given condition at a given facility.

3, 7, 14, or 30-Day Outpatient Follow-up Rate

- Numerator
  - Patients that had an outpatient follow-up visit within 3, 7, 14, or 30 days following an index event, not including the date of index discharge. Follow-up is assessed by the presence of a professional claim containing CPT codes indicating receipt of Evaluation and Management services. Telehealth and remote follow-up are included in this definition.
  - A patient is considered to have received outpatient follow-up if this care was received following the index event but prior to a readmission, an inpatient procedure, or an emergency department visit.
- Denominator
  - Total number of patients that had an index stay for a given condition at a given facility who were discharged to home or home health per index discharge disposition and who did not receive SNF or inpatient rehabilitation services within the 30 days post-index discharge.

Trends in Rates or Payments Over Time

- When assessing trends over time, note that episodes are attributed to a year, six-month interval, or quarter according to the date of the index admission/event. Therefore, each data point on a trend graph will reflect data for episodes with index admissions during that time window.

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*