Massachusetts Hospital Case Mix Data: Technical Assistance Group (TAG)

November 14, 2013

Center for Health Information and Analysis

AGENDA

- FY2014 Updates
- Data Review
- Data Usage
- FY2013 Data Release
- Hospitals' Questions/Comments

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FY2014 UPDATES

- ICD-9 to ICD-10
- CURRENCY FIELDS
- OTHER?
- TIMELINE

ICD-9: CURRENT PROCESS

- HOSPITAL INPATIENT DISCHARGE DATA
  - Fixed Length, multi-record set per discharge
  - 15 ICD-9 Diagnosis Codes and POA on one record
  - 15 ICD-9 Procedure Codes and dates on one record*
  - 15 Physician IDs on one record
- HOSPITAL EMERGENCY DEPARTMENT DATA
  - Fixed Length, multi-record set per visit
  - 6 ICD-9 Diagnosis Codes and POA
  - 4 ICD-9 Procedure Codes
  - All submitted on one record

ICD-9: CURRENT PROCESS

- HOSPITAL OBSERVATION STAY DATA
  - Text delimited, one record per visit file
  - 6 ICD-9 Diagnosis Codes and POA
  - 4 ICD-9 Procedure Codes, dates and physician IDs

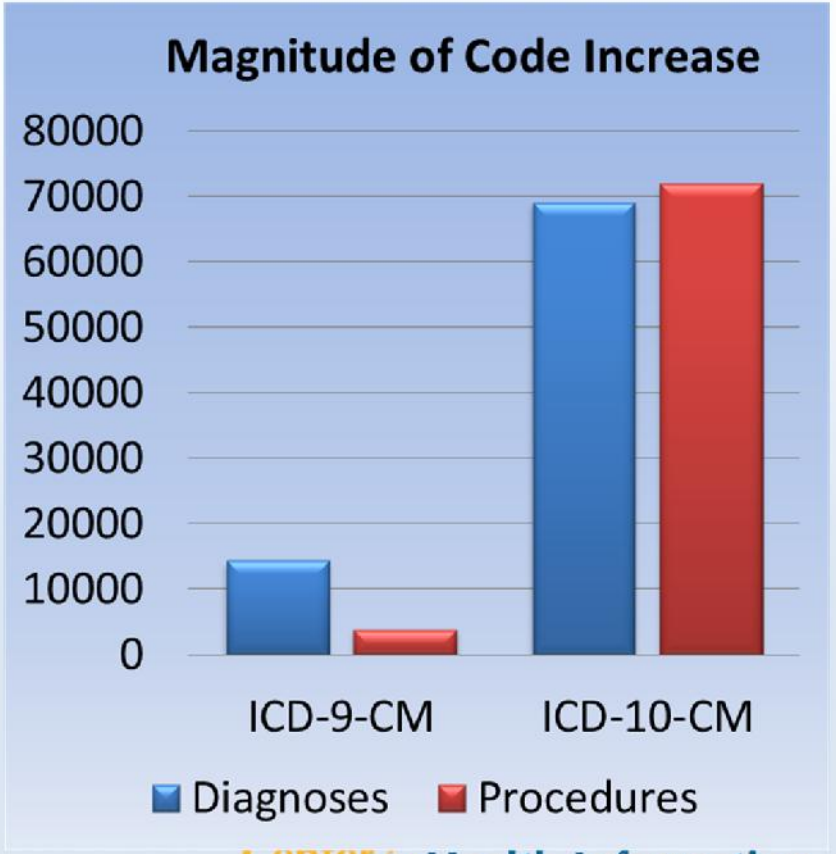
ICD10

- Move to allow variable number of ICD-10 Diagnosis and Procedure Codes
- Variable record sets
- Flag for ICD-9/ICD-10

RATIONALE FOR LIFTING LIMITATION

The transition to the ***International Classification of diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*** will accommodate increases in medical knowledge and diagnostic and interventional technology.

ICD-9-CM	ICD-10-CM
14,315 Diagnoses	69,099 Diagnoses
3,838 Procedures	71,957 Procedures**



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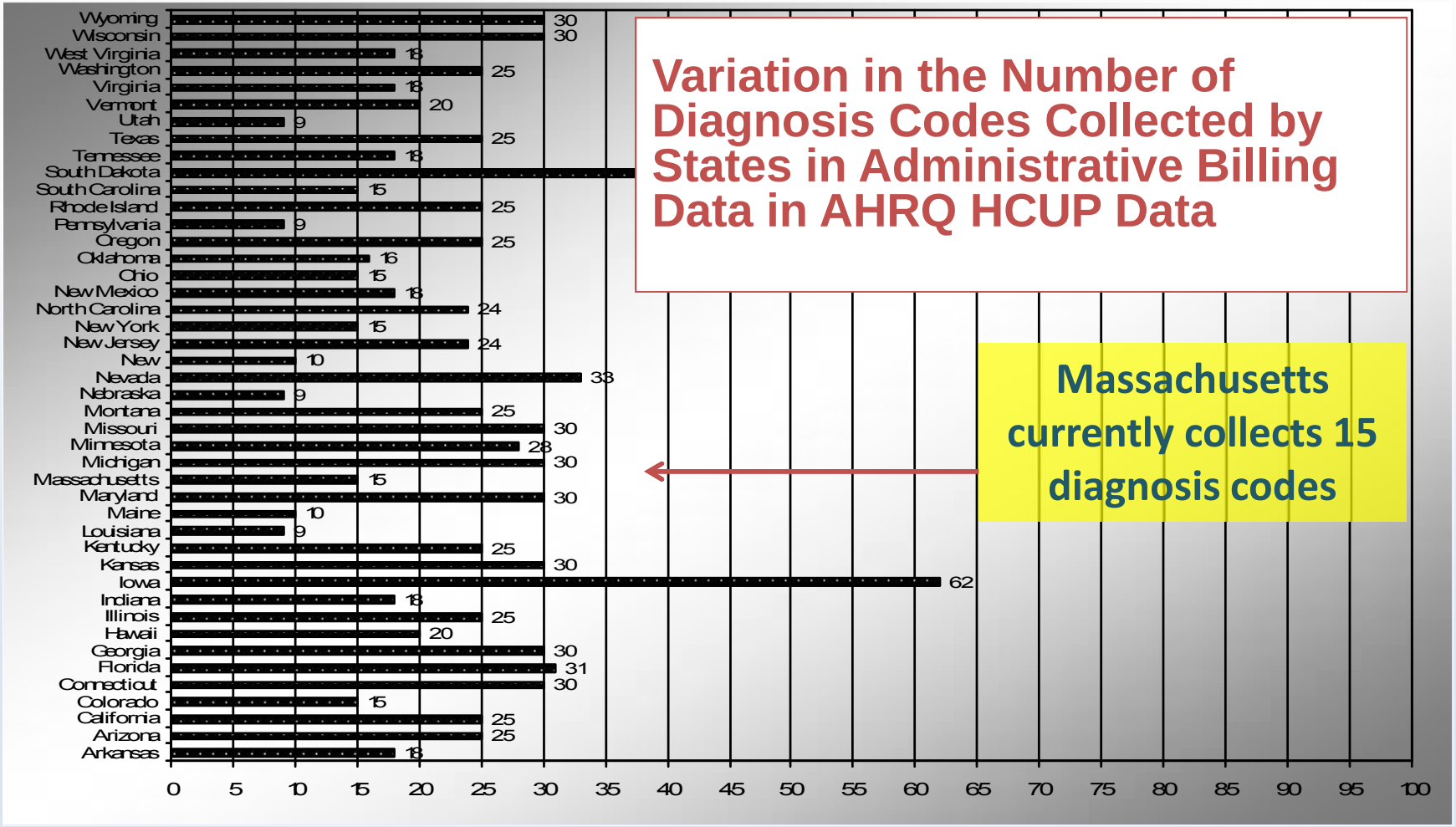
RATIONALE FOR LIFTING LIMITATION

The transition to ICD-10-CM coding enhancements will improve accuracy in medical diagnoses (e.g. describe laterality, the components of GCS, initial or subsequent disease episode) and will provide a much needed update to description of treatment (e.g. updates to surgical technologies, noninvasive procedures). Lifting the limitation to coding fields will ensure that:

- Massachusetts data systems have the capacity to benefit from the ICD-10-CM enhancements
- Diagnostic fields commonly used for severity adjustment and quality of care analysis will not be curtailed by the 15 field limit
- The validity and utility of comparing our state's data with other state's will not be jeopardized by a field limit that might understate the true condition of patients

RATIONALE FOR LIFTING LIMITATION



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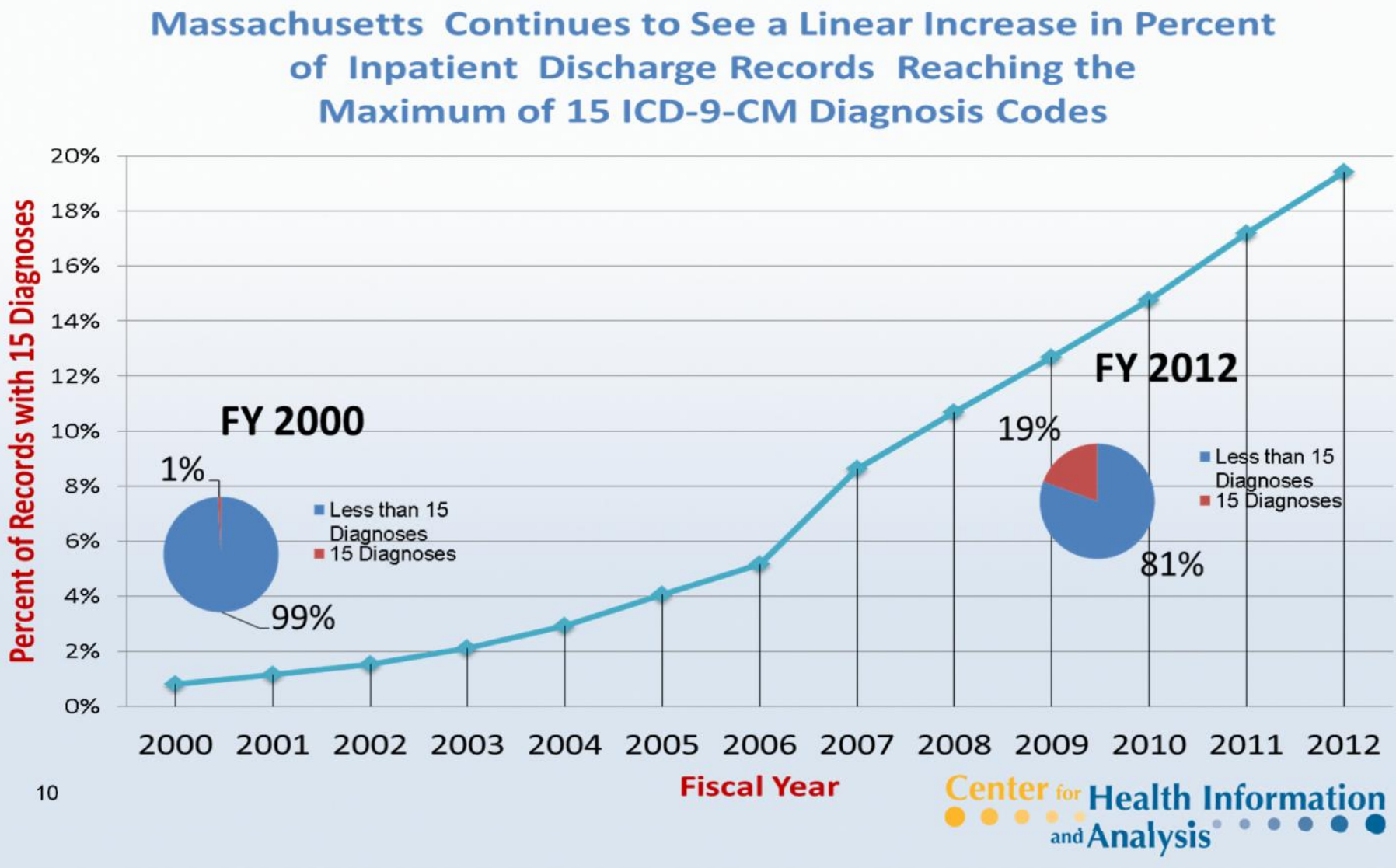
RATIONALE FOR LIFTING LIMITATION



CURRENCY FIELDS

- INPATIENT REVENUE CODE CHARGES
  - LENGTH of 6
- EMERGENCY CHARGES
  - LENGTH of 10
- OUTPATIENT OBSERVATION CHARGES
  - LENGTH of 10

CURRENCY FIELDS

- PATIENT CONTROL TOTAL CHARGES
  - LENGTH OF 8 or 10
- PROVIDER BATCH CONTROL CHARGES
  - LENGTH of 10 or 12

FY2014 UPDATES

OTHER FIELDS YOU WANT TO DISCUSS?

DRAFT TIMELINE

- JAN 2014 – DRAFT SUBMISSION GUIDES
- FEB 2014 – FINAL SUBMISSION GUIDES
- LATE SUMMER/FALL 2014 – PROVIDER TESTING
- JANUARY 2015 – PRODUCTION READY

DATA REVIEW

- VERIFICATION REPORT PROCESS
  - ➢ MID-YEAR
    - LIMITED REPORTS
    - NO RESPONSE REQUIRED
  - ➢ ANNUAL
    - MORE ROBUST
    - RESUBMISSION ALLOWANCE
    - SIGN-OFF REQUIRED

INPATIENT INTERIM

- 001 - Source of Admission
- 002 - Type of Admission
- 003 - Discharges by Month
- 004 - Primary Payer Type
- 005 -Patient Disposition
- 006 - Discharges by Gender
- 007 - Discharges by Race
- 009 - Discharges by Ethnicity
- 011 - Discharges by Age
- 014 - Length of Stay Frequency Report
- 021 - Condition Present on Admission
- 022 – Top 20 Patient Zip Codes

INPATIENT FINAL

- ☐ 001 - Source of Admission
- ☐ 002 - Type of Admission
- ☐ 003 - Discharges by Month
- ☐ 004 - Primary Payer Type
- ☐ 005 -Patient Disposition
- ☐ 006 - Discharges by Gender
- ☐ 007 - Discharges by Race
- ☐ 008 - Discharges by Race/Ethnicity
- ☐ 009 - Discharges by Ethnicity
- ☐ 010 - Discharges by Patient Hispanic Indicator
- ☐ 011 - Discharges by Age
- ☐ 012 - CMS v29 MDCs Listed In Rank Order
- ☐ 013 - Top 20 APR 26.1 DRGs Total Discharges
- ☐ 014 - Length of Stay Frequency Report
- ☐ 015 - Ancillary Services by Discharges
- ☐ 016 - Routine Accommodation Service by Discharges
- ☐ 017 - Special Care Accommodations by Discharges
- ☐ 018 - Ancillary Services by Charges
- ☐ 019 - Routine Accommodation by Charges
- ☐ 020 - Special Care Accommodation Svcs by Charges
- ☐ 021 - Condition Present on Admission
- ☐ 022 - Top 20 Patient Zip Codes

ED REPORT EXAMPLE

Commonwealth of Massachusetts

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Emergency Department Data

Report ED009 – Patient Status Disposition

Departure Status	Q1 Vol	Q2 Vol	Q3 Vol	Q4 Vol
-	0	0	3	3
0 Died during ED Visit	30	25	30	305
1 Routine Discharge	10,000	10,100	9,765	9,800
3 Transferred	400	423	450	400
4 AMA	75	75	75	80
5 Eloped	150	143	175	160

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INPATIENT REPORT EXAMPLE

Commonwealth of Massachusetts

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Hospital Inpatient Discharge Data

Report HDD-04 - Primary Payer Type Frequency Report

PAYER TYPE CODE	PAYER TYPE DEFINITION
1	Self Pay
2	Worker's Compensation
3	Medicare
F	Medicare Managed Care
4	Medicaid
B	Medicaid Managed Care
5	Other Government Payment
6	Blue Cross
C	Blue Cross Managed Care
7	Commercial Insurance
D	Commercial Managed Care
8	HMO
9	Free Care
0	Other Non-Managed Care
E	PPO and Other Managed Care Plans Not Elsewhere
H	Health Safety Net
J	Point-of-Service Plan
K	Exclusive Provider Org
T	Auto Insurance
N	None (Valid only for Secondary Payer)
Q	Commonwealth Care Plans

DATA USAGE: ACUTE HOSPITAL RFA

Hospital discharge filings, as provided and verified by each hospital and submitted to CHIA, are used in the following:

- Acute Hospital casemix data for purposes of SPAD rate development
- Acute Hospital casemix data for 30-Day Potentially Preventable Readmissions
- Acute Hospital casemix data for purposes of Pay-for-Performance Quality Reporting Requirements and Payment Methods

SPAD DEVELOPMENT

Standard Payment Amount Per Discharge – when calculating the SPAD, the base year average operating cost per discharge for each Hospital is adjusted by the Hospital-specific All-Payer Casemix Index.

The capital cost standard is determined by dividing the average capital cost per discharge for each Hospital by the Hospital-specific All-Payer Casemix Index.

P4P PAYMENTS

Pay-for-Performance – P4P incentive payments are based on the eligible Medicaid discharges and per-discharge amount for each measure category using CHIA's Hospital Discharge Data.

PPR IDENTIFICATION

Potentially Preventable Readmissions - PPRs are identified in CHIA's Hospital Discharge Data (HDD) by using the 3M PPR software version 30. Hospitals with a greater number of Actual Potentially Preventable Readmission (PPR) Chains than Expected PPR Chains receive a reduction to their Standard Payment Amount per Discharge (SPAD).

DPH USAGE

- TRAUMA REGISTRY
  - M.G.L. c. 111C, § § 3 and 11(c) require MDPH to develop and maintain a state trauma registry data reporting and analysis system to evaluate and improve the performance of the state trauma system, including patient outcomes and costs.

DPH USAGE

- Pregnancy to Early Life Longitudinal (PELL) Data System
  - innovative population-based data system developed to examine the impact of prenatal and perinatal experiences on subsequent maternal, infant, and child health

DPH USAGE

- Bureau of Substance Abuse Services (BSAS) Studies
  - The Project is intended to optimize outcomes and resources ultimately leading to improved health status of those receiving substance abuse services while enabling greater access to programs and services.

AHRQ: HEALTH CARE COST AND UTILIZATION PROJECT

- A multi-state health care data system for health services research, health policy analysis, and quality measurement and improvement.
- HCUP encompasses a family of administrative, longitudinal databases and related software tools and products that are developed by AHRQ in a Federal-State-Industry partnership.
- Enables research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments.

CHIA DATA APPLICATIONS

Applicant / Application (Status)	Project Title / Study Name	Date of Posting	Level	Comment
April Rowe, Data Analyst, Yale New Haven Hospital (PDF) | Word	Outmigration Discharges	November 12, 2013	Level 1	Comment
Snehal N. Shah, MD, MPH, Director, Research and Evaluation Office, Boston Public Health Commission (PDF) | Word	Continuing Use of Case Mix Data	November 12, 2013	Level 3	Comment
David P. Smith, MHSA, Senior Director, Health Data Analysis Research and Patricia M. Noga, PhD, RN, Vice President, Clinical Affairs, Massachusetts Hospital Association (PDF) | Word	Tracking Aggregate Potentially Preventable Readmission Trends in Massachusetts Acute Care Hospitals	November 12, 2013	Level 5	Comment
Amy Travers, Boston Medical Center Healthnet Plan (PDF) | Word *	Review of Hospital Utilization for BCMHP Casemix versus Other Medicaid	November 12, 2013	Level 1	Comment
Michael Monuteux, Senior Epidemiologist, Boston Children's Hospital (PDF) | Word *	Variation and Trending in Charges for Pediatric Care in Massachusetts	November 12, 2013	Level 1	Comment
MaineHealth (PDF)	Maine Health Planning	October 15, 2013	Level 1	Comment period has ended
Neighborhood Health Plan (PDF)	Hospital Re-Contracting Initiative	October 15, 2013	Level 1	Comment period has ended
Partners HealthCare System (PDF)	Market Data Warehouse - Data Update	Sept. 17, 2013	Level 4	Comment period has ended
Boston University School of Medicine (PDF)	National Estimates for Inpatient Care, Outcomes and Hospital Effect Among	Sept. 17, 2013	Level 5	Comment period

FY2013 DATA RELEASE

Data must be submitted no later than 75 days following the end of the reporting period. Quarterly submissions are due at the Center as follows:

Quarter	Due Date
Quarter 1 (October 1 – December 31)	March 16
Quarter 2 (January 1 – March 31)	June 14
Quarter 3 (April 1 – June 30)	September 13
Quarter 4 (July 1 – September 30)	December 14

Database:	**Process Begins:**
Interim Inpatient Discharge	NOW!
Interim Emergency Department Data	December
Final Inpatient Discharge	January
Final Emergency/Outpatient Data	Quickly Follows!

WRAP-UP

QUESTIONS?

QUESTIONS

Questions emailed to Liaisons:

- Cynthia.Dukes-Reed@state.ma.us
- Betty.Joe@state.ma.us