Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

Behavioral Health & Developmental Disabilities Administration
Bureau of Community Based Services

SPECIFICATIONS FOR:

- ***Follow-Up After Hospitalization for Mental Illness***
- ***Plan All-Cause Acute 30-Day Readmission***
- ***Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Dependence***

MEDICAID MANAGED CARE / PIHPs

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

FY 2019

Follow-Up after Hospitalization for Mental Illness (30 days)

MEASURE	
The percentage of discharges for individuals age six (6) and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	
MINIMUM STANDARD	
The minimum standard for ages six (6) to 20 is at least 70%. The minimum standard for ages 21 and older is at least 58%.	
ELIGIBLE POPULATION	
Age	Age six (6) and older as of date of discharge.
Continuous Enrollment	Date of discharge through 30 days after discharge.
Allowable Gap	None.
Anchor Date	None.
Event/Diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) during the 12-month measurement period. To identify acute inpatient discharges: • Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). • Exclude non-acute inpatient stays (Non-acute Inpatient Stay Value Set). • Identify the discharge date for the stay to determine whether it falls during the 12-month measurement period.
Exclusions	Exclude discharges followed by readmission or direct transfer to a **non-acute** inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an **acute** inpatient care setting within 30-day follow-up period if the principal diagnosis was for non-mental health.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population. **Note:** The denominator for this measure is based on discharges, not individuals.
Numerator	A follow-up visit with a mental health practitioner within 30 days after discharge. Does not include visits that occur on the date of discharge.
DATA ELEMENTS	
Data is extracted from the Medicaid Data Warehouse.	

Please refer to the *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting* for the current list of the specific codes and exclusions for this measure*:*

https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

Please refer to the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting* for the current list of the specific codes and exclusions for this measure*:*

https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

Month of Performance Report	Month of Extract	Measurement Period
October 2019	September 2019	07/01/18 – 06/30/19

PROCESS

The plan-specific percentages will be electronically transmitted to each MHP and PIHP. Quarterly results will also be available via CC360.

MEASUREMENT FREQUENCY

Annually

Plan All-Cause Acute 30-Day Readmissions

MEASURE	
The percentage of acute inpatient stays during the measurement period that were followed by an unplanned acute readmission for any diagnosis within 30 days.	
MINIMUM STANDARD	
N/A – This measure is Informational Only	
ELIGIBLE POPULATION	
Age	18 to 64 years old as of the Index Discharge Date.
Continuous Enrollment	Continuously enrolled in the same Health Plan 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable Gap	No more than a one-month gap in enrollment during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor Date	Index Discharge Date.
Event/Diagnosis	An acute inpatient stay with a discharge date on or between day 1 and before month 11 of the 12-month measurement period.
Exclusions	Acute inpatient stays where the cause for discharge was death; inpatient stays where the principal diagnosis indicates pregnancy or a condition originating in the perinatal period (perinatal conditions); and inpatient stays where the admission and discharge dates are on the same date. Acute inpatient stays with a discharge date within 30 days of a previous Index Discharge Date are excluded if it is a Planned Hospital Stay. See the **CMS Value Set Directory** for criteria for a Planned Hospital Stay.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population. **Note:** This is the number of Index Discharge Dates during the measurement period, not individuals.
Numerator	Number of acute readmissions for any diagnosis within 30 days of an Index Discharge Date.

DATA ELEMENTS

Index Hospital Stay: An acute inpatient stay with a discharge on or between day 1 and before month 11of the 12-month measurement period that does not meet any of the exclusion criteria.

Index Admission Date: The Index Hospital Stay admission date.

Index Discharge Date: Index Hospital Stay discharge date. This must occur on or between day 1 and before month 11 of the 12-month measurement period.

Index Readmission Stay: An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.

Planned Hospital Stay: A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the eligible population in the CMS 2017 measure specification.

***Please refer to the CMS Value Set Directory for the current list of the specific codes for this measure.**

CMS Value Set Directory AND Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting:

https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

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MEASUREMENT FREQUENCY

Annually

Follow-Up after Emergency Department (ED) Visit for Alcohol and Other Drug Dependence

MEASURE	
The percentage of emergency department (ED) visits for individuals age 13 and older with a principle diagnosis of alcohol or other drug (AOD) abuse or dependence, who also had a follow up visit for AOD within 30 days of the ED visit.	
MINIMUM STANDARD	
N/A – This measure is Informational Only	
ELIGIBLE POPULATION	
Age	Age 13 and older as of date of the ED visit.
Continuous Enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable Gap	None.
Anchor Date	None.
Event/Diagnosis	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) during the 12-month measurement period.
Exclusions	Exclude ED visits followed by an admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population. **Note:** The denominator for this measure is based on ED visits, not individuals. If the member had more than one ED visit during the measurement period, only one visit per 31-day period will be included.
Numerator	A follow-up visit with any practitioner with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. These additional CPT codes were added by MDHHS to the list of qualified follow-up services for FUA:

Code Set	MI Specific SUD Service Codes:
All H0006s	Substance Use Disorder Case Management.
All H0010s	Substance Use Disorder: Sub-Acute Withdrawal Management (Sub-Acute Detoxification); medically monitored residential detox.
All H0012s	Substance Use Disorder: Sub-Acute Withdrawal Management (Sub-Acute Detoxification); residential addiction program outpatient.
H00118 – Except H0018 PO	Substance Use Disorder: Residential Services.
All H0019s	Substance Use Disorder: Residential Services.
All H0038s – Except when reported with NO modifier	Substance Use Disorder: Recover Coach (Peer Services).
All H0049s	Alcohol and/or drug screening.
All H0050s	Substance Use Disorder: Outpatient Care.

DATA ELEMENTS

Data is extracted from the Medicaid Data Warehouse.

Please refer to the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting* for the current list of the specific codes and exclusions for this measure*:*

https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

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