Follow-up after hospitalization for mental illness is associated with lower rates of re-hospitalization, and with greater likelihood that gains made during hospitalization are retained. This measure supports coordination between hospitals and Oregon’s Coordinated Care Organizations (CCOs) to facilitate appropriate follow-up care for those hospitalized with mental illness.

This measure tracks the percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment (had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner) within seven days of discharge. **This measure is limited to Medicaid members enrolled in a CCO.**

**Name and date of specifications used:**
OHA modification of HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

**URL of Specifications:** N/A

**Measure Type:**
HEDIS ☐  Joint Commission ☐  Survey ☐  Other ☐  Specify: HEDIS-like

**Data Source:** MMIS/DSSURS. OHA will calculate rates for this measure through encounters/claims.

**Measurement Period:**
Year One: October 1, 2013 – September 30, 2014 (baseline)
Year Two: October 1, 2014 – September 30, 2015 (performance year)

**Benchmark:** Alignment with CCO benchmark (will change with any amendments to CCO benchmark). 2015 CCO benchmark is 70.0% (2014 National Medicaid 90th percentile).

The equation used is patients receiving follow-up within seven days of discharge for a mental illness / number of patients discharged after hospitalization for mental illness * 100, and is reported as a percentage.

**Improvement Target:** Alignment with CCO improvement target - MN method with 3 percentage point floor¹

¹ Information on improvement target calculations can be found in the ‘Hospital Improvement Target Brief’, here: [http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx)
Overview: For this measure, OHA will match individual CCO members with the hospitals from which they are discharged, as below:

- OHA will identify all CCO members with a hospital discharge.
- Members from each individual CCO will then be matched back to the hospital from which they are discharged and a follow-up rate will be calculated. For example, CCO 1 members discharged from Hospital A are assigned to Hospital A’s rate. CCO 2 members discharged from Hospital A are also assigned to Hospital A’s rate. Members of the other CCOs who are also discharged from Hospital A will also be assigned to Hospital A’s rate.
- Follow-up provided by any CCO will count in the hospital’s rate (e.g., if member of CCO 1 is discharged from Hospital A but receives follow-up at CCO 2, Hospital A will receive credit).
- This measure is tracked for CCO-A and CCO-B enrollees only. Mental Health only CCO enrollees are not included in this measure.
- As below, these specifications align with that for the CCOs, and will be updated per changes to the CCO measure specifications.

Data elements required denominator: Discharges from acute inpatient settings (including acute care psychiatric facilities) for members age 6 years of age and above at hospital of interest who were hospitalized for treatment of selected mental health disorders.

Mental Health Diagnosis is identified by the following codes: ICD-9-CM Diagnosis (principal): 295-299, 300.3, 300.4, 301, 308, 309, 311-314.

See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.
**Required exclusions for denominator:**

| Mental health readmission or direct transfer | Exclude discharges followed by readmission or direct transfer to an **acute** facility for any mental health principal diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow up period; count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalizations might not be for a selected mental health disorder, it is probably for a related condition. Exclude discharges followed by readmission or direct transfer to a **non-acute** facility (HEDIS 2014 Nonacute Value Set) for any mental health principal diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1020</td>
<td>HK</td>
<td>Residential Tx Home</td>
</tr>
<tr>
<td>T1020</td>
<td>HK &amp; HE</td>
<td>Residential Tx Facility</td>
</tr>
<tr>
<td>T1020</td>
<td>HK &amp; TG</td>
<td>Secure Residential Tx Facility</td>
</tr>
<tr>
<td>Non-mental health readmission or direct transfer</td>
<td>Exclude discharges in which the patient was transferred directly or readmitted within 30-days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis (any principal diagnosis other than those included in the Mental Health Diagnosis Value Set). These discharges are excluded from the measure because rehospitalizations or transfer may prevent an outpatient follow-up visit from taking place. See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.</td>
<td></td>
</tr>
</tbody>
</table>

Use only facility claims to identify discharges with a principal mental health diagnosis. Do not use diagnoses from professional claims to identify discharges.

**Note transfers to the Oregon State Hospital will be excluded only if hospitals alert OHA that a patient was transferred to the Oregon State Hospital. Hospitals can alert OHA that a patient**
was transferred as part of the data verification process (see instructions here http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx). If OHA is able to verify that the patient was transferred to the Oregon State Hospital, that discharge will be excluded from the measure.

**Deviations from cited specifications for denominator:** None. HEDIS 2015® specifications leave it up to the organization to identify exclusions.

**Data elements required numerator:** Discharges for members age 6 years of age and above who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, reflected by following codes, within 7 days of discharges, and on the date of discharge.

See Deviations section below for the detailed data layout for the numerator.

**Required exclusions for numerator:** None.

**Deviations from cited specifications for numerator:**
HEDIS® specifications cite follow-up with a “mental health practitioner.” Follow-up visits do not have to be limited to mental health care practitioners.

For 2015, the CCO Metrics & Scoring Committee and CCO Metrics Technical Advisory Group agreed that follow-up visits occurring on the day of discharge needed to be incorporated into the measure. To do this, OHA has reinstated the use of place of service (POS) codes, as per the original HEDIS® specifications. Place of service codes must be on the same claim as the qualifying procedure codes. However, the additional codes to identify community-based follow-up services are still counted as qualifying numerator events. This reinstatement of the POS codes allows OHA to capture qualifying follow-up services provided on the date of discharge.

OHA has added several codes to the HEDIS® 2015 specifications to identify follow up care. These codes are listed in the table below and include: 90846, H0006, H2021, T1016.

While the place of service requirements for FUH Visits Group 1 Value Set and FUH Visits Group 2 Value Set have been reinstated for the 2015 measurement, OHA has also moved several CPT codes from the FUH Visits Group 1 Value Set to be standalone compliant.
## Based on HEDIS® 2015 FUH Stand Alone Visits Value Set with OHA deviation

<table>
<thead>
<tr>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
</table>

OR

## Based on HEDIS® 2015 FUH Visits Group 1 Value Set with OHA deviation

<table>
<thead>
<tr>
<th>CPT</th>
<th>FUH POS Group 1 Value Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>90839, 90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876</td>
<td>WITH 03,05,07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72</td>
</tr>
</tbody>
</table>

OR

## FUH Visits Group 1 Value Set

<table>
<thead>
<tr>
<th>CPT</th>
<th>FUH POS Group 2 Value Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221-99223, 99231-99233, 99238, 99239, 99251-99255</td>
<td>WITH 52,53</td>
</tr>
</tbody>
</table>

OR

## FUH RevCodes Group 1 Value Set

**UB Revenue**

There is no need to determine the practitioner type for follow-up visits identified by the following UB revenue codes.

0513, 0900-0905, 0907, 0911-0917, 0919

OR

## FUH RevCodes Group 2 Value Set

**UB Revenue**

A visit to a non-behavioral health facility in conjunction with a principal diagnosis code from an ICD-9 code in the [Mental Illness Value Set].

0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

OR

## TCM 7 Day Value Set

**CPT**

Transitional care management services where the date of service on the claim is 29 days after the mental illness discharge date.

99496
**What are the continuous enrollment criteria:** Date of discharge through 30 days regardless of CCO in which enrolled or from which follow-up is received. Considered continuously enrolled if enrolled in any CCO (not necessarily the same CCO).

**What are allowable gaps in enrollment:** None.

**Notes:**

- Only facility claims should be used, not professional claims, to identify discharges with a principal mental health diagnosis.
- Additional codes and modifiers for exclusions of adult mental health residential services have been added to the specifications. See table on page 2 above.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. OHA is not using all codes listed in the HEDIS specifications. Codes OHA is not using include, but are not limited to: LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure. This is the case with follow-up after hospitalizations for mental illness.

Follow-up may be provided through any CCO (it is not tied to the specific CCO in which the member was enrolled at the time of discharge).

**Explanation of Exclusions and Deviations**

**List other required exclusions and or deviations from cited specifications not already indicated:** None.

**Additional Notes**

**Member Allocation:** An allocation methodology will be used in instances in which hospitals that are part of a hospital system do not submit separate claims to OHA, but claims are instead submitted for the aggregated hospital system (e.g., claims from PeaceHealth Sacred Heart at Riverbend and PeaceHealth Sacred Heart University District submitted only as ‘PeaceHealth’). The allocation methodology will also be used in instances when there are fewer than 10 discharges for a hospital in the measurement period. This process is as follows:

1. OHA will pull the discharges for an 11 month period for all DRG hospitals in the state (discharges occurring in the final month of the full 12 month program year are not included to allow time for follow-up to occur)
2. The discharge data will be sent to each hospital/hospital system for validation. In the case of hospital systems, this will include breaking apart system rates and attributing to individual hospitals where possible. Hospitals/hospital systems will provide validated discharge information back to OHA. **In the baseline year (year one), hospitals must respond with any requested changes by February 28, 2015, and in the performance year (year two), hospitals must respond with any requested changes by March 31, 2016.**

3. OHA will then calculate the rates and identify the numerator. If a hospital or hospital system does not provide OHA with any requested changes to the discharge file by the dates above, OHA will calculate the rate based upon the initial pull.

**Performance Attribution:**

1. OHA is taking a tiered approach to attribution: (1) Use individual hospital rate; (2) Use system rate if individual hospital rate is unavailable and hospital is part of a system; and (3) Use statewide CCO rate if neither individual nor system rates are available.

2. In any instance in which a hospital is a part of a system and a hospital-level denominator is unavailable (because the hospital system chose not to, or was unable to attribute system-wide data to individual hospitals; a hospital did not have any discharges; or a hospital does not have a psychiatric ward), the hospital-system rate will be attributed to the individual hospital.

3. If a hospital is not a part of a hospital system and it does not have a psychiatric ward, the statewide CCO rate will be applied.

4. If a hospital is not a part of a hospital system and has a psychiatric ward but zero discharges, the statewide CCO rate will be applied.

5. If the validated denominator is <10 but >0 for any hospital:
   a. If the hospital is part of a hospital system, the system rate will be used.
   b. If the hospital is not part of a hospital system, the statewide CCO rate will be used.

**Version Control**

- **10 February 2015.** This measure specification sheet was updated on 10 February 2015 to note that transfers to the Oregon State Hospital will be excluded from the measure if hospitals alert OHA that a patient was transferred to the Oregon State Hospital and OHA is able to verify the transfer.

- **6 January 2015.** This measure specification sheet was updated on 6 January 2015 to align with the revised specifications for the CCO follow-up after hospitalization for mental illness incentive measure. In addition, the benchmark was updated to align with a change to the CCO benchmark.