

Follow-up After Hospitalization for Mental Illness

Metric Information

Metric description: The percentage of discharges for eligible Medicaid beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two submetrics are reported:

1. The percentage of discharges for which the Medicaid beneficiary received follow-up within 7 days after discharge.
2. The percentage of discharges for which the Medicaid beneficiary received follow-up within 30 days after discharge.

Metric specification version: HEDIS® 2020 Technical Specifications for Health Plans, NCQA.

Data collection method: Administrative only.

Data source: ProviderOne Medicaid claims/encounter and enrollment data.

Claim status: Include only final paid claims or accepted encounters in metric calculation.

Identification window: Measurement year.

Direction of quality improvement: Higher is better.

URL of specifications: www.ncqa.org/hedis/measures

DSRIP Program Summary

Metric utility: ACH Project P4P ACH High Performance DSRIP statewide accountability

ACH Project P4P – Metric results used for achievement value: Submetric results reported for: follow-up within 7 days of the ED visit and follow-up within 30 days of the ED visit. Each submetric contributes equal weight in the final AV calculation for the overall metric.

ACH Project P4P – improvement target methodology: improvement over self (1.9% improvement over reference baseline performance).

ACH regional attribution: Residence in the ACH region for 11 out of 12 months in the measurement year.

DSRIP Metric Details

Eligible Population	
Age	6 years and older at the time of the discharge.
Gender	N/A

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Minimum Medicaid enrollment	Date of the discharge through 30 days after the discharge (31 total days). Enrollment must be continuous.
Allowable gap in Medicaid enrollment	No gaps in enrollment allowed.
Medicaid enrollment anchor date	Date of discharge.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator (for both submetrics):

The denominator for this metric is based on discharges, not on Medicaid beneficiaries. If an eligible Medicaid beneficiary has more than one discharge, all discharges between January 1 and December 1 of the measurement year are identified.

Data elements required for denominator: An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) or intentional self-harm (Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. 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.

See HEDIS® for additional specifications and appropriate exclusions.

Value sets required for denominator.

Name	Value Set
Mental Illness Value Set	See HEDIS®
Intentional Self-Harm Value Set	See HEDIS®
Inpatient Stay Value Set	See HEDIS®
Nonacute Inpatient Stay Value Set	See HEDIS®
Mental Health Diagnosis Value Set	See HEDIS®

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
 - Beneficiaries in hospice care.
 - 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. See HEDIS® for specific instructions.

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- Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period. See HEDIS® for specific instructions.

These discharges are excluded from the metric because re-hospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Deviations from cited specifications for denominator.

- None.

Numerator (different for the two submetrics reported):

Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator.

Data elements required for 7-day follow-up numerator: A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge. See HEDIS® for specific instructions on identifying follow-up visits and mental illness diagnosis.

Data elements required for 30-day follow-up numerator: A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge. See HEDIS® for specific instructions on identifying follow-up visits and mental illness diagnosis.

Value sets required for numerator.

Name	Value Set
Visit Setting Unspecified Value Set	See HEDIS®
Outpatient POS Value Set	See HEDIS®
Mental Health Practitioner	See HEDIS®
BH Outpatient Value Set	See HEDIS®
Partial Hospitalization POS Value Set	See HEDIS®
Partial Hospitalization or Intensive Outpatient Value Set	See HEDIS®
Community Mental Health Center POS Value Set	See HEDIS®
Electroconvulsive Therapy Value Set	See HEDIS®
Ambulatory Surgical Center POS Value Set	See HEDIS®
Outpatient POS Value Set	See HEDIS®
Telehealth POS Value Set	See HEDIS®
Observation Value Set	See HEDIS®
Transitional Care Management Services Value Set	See HEDIS®

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Required exclusions for numerator.

- None

Deviations from cited specifications for numerator.

- None

Version Control

July 2018 release: The specification was updated to HEDIS® 2018 specifications.

January 2019 update: Minor formatting updates were made to the metric specification sheet. This includes updating the URL of the source specification and changing HEDIS™ to HEDIS®. No substantive changes were made to the specification.

August 2019 update: The specification sheet has been updated to reflect the current version of the HEDIS® technical specification (from HEDIS® 2018 to HEDIS® 2019). Substantial changes have been made to this metric including expansion of the eligible population to include intentional self-harm, the inclusion of telehealth, and clarification of instructions for readmissions and direct transfers. See HEDIS® for specific instructions.

August 2020 update: The specification sheet has been updated to reflect the current version of the HEDIS® technical specification (from HEDIS® 2019 to HEDIS® 2020). No substantive changes were made to the DSRIP Metric Details. Per HEDIS® General Guideline 43, unless specifically excluded, HEDIS® metrics include telehealth by default and do not require the use of a specific value set to identify relevant CPT and HCPCS place of service modifiers. Note that while the names of the value sets included in the specifications have not changed, the underlying values may have been updated. See HEDIS® for specific instructions.