MOLINA HEALTHCARE QUALITY BULLETIN

Behavioral Health

Follow-up Care and Readmission Reductions

Individuals with substance use disorder (SUD) are at high risk of hospital readmissions. Readmission rates for individuals with SUD are reported to be between 18%–26%[1]. SUD is linked to greater complexity of care and hospital-related complications, longer stays and greater likelihood of readmission, even when addiction treatment is not the reason for hospitalization.

Among Medicaid enrollees, alcohol and drug use disorders have been shown to be among the top ten conditions with the greatest number of all-cause 30-day readmissions. For Medicaid enrollees with a mental health disorder, a comorbid SUD diagnosis is known to be a major predictor of readmission. Medicaid patients and providers have identified inadequate planning and unsuccessful follow-up care as root causes of high readmission rates.[1]

Addressing both SUD and timely follow-up care is important to reducing readmissions. The Healthcare Effectiveness Data and Information Set (HEDIS®)* measure, Follow-Up After Emergency Department (ED) Visit for Substance Use (FUA), is described as: The percentage of ED visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

Here are ways providers can increase timely follow-up care and reduce readmissions:

1. Schedule follow-up visits for members with a primary diagnosis of SUD, or any diagnosis of drug overdose, within seven days of being seen in the ED. Telephone and/or telehealth appointments within the required timeframe meets compliance.
2. Refer the member to a Molina Healthcare of Ohio, Inc. Care Manager or work collaboratively with the Molina Care Manager if one is already assigned to help increase member's access and motivation for treatment.
3. Follow-up visits must be supported by a claim, encounter or note from the mental health practitioner's medical chart to count toward the measure.

4. Document identified substance use in the member chart and submit a claim with the correct billing codes.
5. Review situations where there are comorbid medical conditions. Be sure to include all diagnoses and use substance use related codes (ex. Cellulitis - L03.90 related to Intravenous Drug use F11.20), as these also qualify members for the measures.
6. Provide member educational materials and resources that include information on the treatment processes and options, including mutual support groups and other community-based programs.

[1]Reif, S., Acevedo, A., Garnick, D. W., & Fullerton, C. A. (2017). *Reducing behavioral health inpatient readmissions for people with substance use disorders: do follow-up services matter?* Psychiatric services, 68(8), 810-818. pubmed.ncbi.nlm.nih.gov/28412900/

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Chronic Conditions

Glycemic Status Assessment for Patients with Diabetes (GSD)

Effective 2024, the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure has been revised to Glycemic Status Assessment for Patients with Diabetes (GSD).

The GSD HEDIS® measure assesses the percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%
- Glycemic Status >9.0%

Codes included in the Current HEDIS® Measure:

Description	Code
HbA1c Lab Test	**CPT:** 83036, 83037 **LOINC:** 97506-0
HbA1c Test Results or Findings	**CPT II:** 3044F – Results HbA1c < 7.0 **CPT II:** 3046F – Results HbA1c > 9% **CPT II:** 3051F – Results HbA1c ≥ 7.0% to < 8.0% **CPT II:** 3052F – Results HbA1c > 8.0% to ≤ 9.0% Do *not* include codes with CPT CAT II Modifier: 1P, 2P, 3P, 8P

Best Practices for Quality of Care:

- Review diabetes services needed at each office visit. Order labs prior to member appointments.
- Schedule telehealth appointments to diagnose members with diabetes.
- Bill for point-of-care testing if completed in office and ensure HbA1c result and date are documented in the chart.
- Adjust therapy to improve HbA1c and BP levels. Follow up with members to monitor changes.
- Prescribe statin therapy to all patients with diabetes aged 40 to 75 years.
- Refer members for Health Management interventions and coaching by contacting Member Services at Molina Healthcare at 800-642-4168.

The Centers for Disease Control and Prevention (CDC) recommends individuals diagnosed with diabetes get an HbA1c test at least twice a year and more often if their medication changes or if they have other health conditions.[2]

[2]Centers for Disease Control and Prevention. (2024, May 15). *Testing for Diabetes and Prediabetes: A1C*. Retrieved from cdc.gov/diabetes/diabetes-testing/prediabetes-a1c-test.html?CDC_AAref_Val=https://www.cdc.gov/diabetes/managing/managing-blood-sugar/a1c.html

Healthy Children and Adults

Did you know that patients 20-21 years of age might be included in both the Adults' Access to Preventative/Ambulatory Health Services (AAP) and Child and Adolescent Well-Care Visits (WCV) HEDIS® measures?

- Adults' Access to Preventative/Ambulatory Health Services (AAP): The percentage of members, 20 years of age and older, who had an ambulatory or preventive care visit during the measurement year.
- Child and Adolescent Well-Care Visits (WCV): The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.

If a patient is included in both measures, and the billing code used is included in both measures, a single visit will count if all other clinical documentation is satisfied. (A well-care visit must occur with a PCP or OB/GYN practitioner).

Molina is finding that some Medicaid members are compliant for the AAP measure, but still have a gap in care for the WCV measure (see example below). Remember, take advantage of every office visit, including sick visits when possible, to complete well-care visits.

Example: The AAP care gap is closed, but the WCV care gap remains opened possibly due to visit type, measure criteria, coding, or lack of awareness that the patient is included in both measures.

Last Service Date	Measure	Care Gap Status
3/25/24	AAP	Closed
3/25/24	WCV	Open

If you have any questions about these measures, email Jamie.Keener@MolinaHealthcare.com.

Molina Incentivizes Healthy Behaviors

Molina supports provider practice efforts to help members get needed services. Molina offers a robust assortment of member incentives to assist and encourage our members to get needed visits and screenings.

Molina Medicaid members with a gap in care for a corresponding incentive have received postcards in the mail. When they complete their service, the Molina member can fill out the postage-paid postcard and mail it back to Molina. They may also attest online at MyMolina.com instead of mailing the postcard. Members will then receive a reloadable gift card with incentive dollars pre-loaded once Molina has validated the completion of their visit through claims.

Through our combined efforts, we hope your patients and our members will be healthier. Below is a list of some of the member incentives:

Members earn rewards for making healthy choices and completing needed screenings:

- $50 for a breast cancer screening.
- $50 for a cervical cancer screening.
- $20 for at least one well-care visit, for ages 18 to 21.
- $10 for at least one well-care visit, for ages 3 to 17.
- $20 for taking an antidepressant medicine for at least six months, for ages 18 to 64.
- $20 for completing a follow-up appointment within seven calendar days of discharge after a mental health hospitalization, for ages 18 to 64.

Parents earn rewards for completing prenatal, postpartum and well-baby visits:

- $50 for a prenatal visit within the first trimester or within 42 days of enrollment.
- $100 for a postpartum visit 7 to 84 days after your baby is born.
- $100 for six well-baby visits from newborn to age 15 months.

If your practice would like to collaborate with Molina's Quality department to improve any of these measures, please reach out to Gretchen Conturo at Gretchen.Conturo@MolinaHealthcare.com. We welcome the opportunity to partner with your team!

Questions?

Provider Relations – OHProviderRelations@MolinaHealthcare.com

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