Peds BH Quality Improvement Collaborative Session #3: 2/5/26

Disclosure: There are no relevant financial relationships, sponsorships, or other disclosures from anyone in control of content associated with this activity. This program is designed to provide educational information and does not involve the promotion of any specific product or service.

Arizona State University

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Targeted Investment Team

ASU TIPQIC

- William Riley, PhD
- George Runger, PhD
- Matthew Martin, PhD
- Kailey Love, MBA, MS
- Taylor Vaughan, MPH
- El-Ham Ismail
- Samantha Basch, MS
- Francisca Dibarrart, PhD
- Min Jang, PhD

AHCCCS Targeted Investment

- Julie Ambur
- Christina Quast
- Jane Otenyo
- Norah Ylang

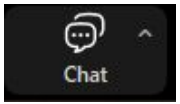
Agenda

Time	Topic	Presenter
12:00 PM to 12:03 PM	Opening & Y4 Performance Measure Updates	William Riley, PhD
12:03 PM to 12:15 PM	Measure Overview & Network Performance	Kailey Love, MBA, MS William Riley, PhD
12:15 PM to 12:35 PM	Measure Details: Definition, Coding, Targets, Attribution	George Runger, PhD Taylor Vaughan, MPH
12:35 PM to 12:45 PM	Common Barriers & Best Practices	Matthew Martin, PhD
12:45 PM to 12:57 PM	Discussion	Matthew Martin, PhD
12:57 PM to 1:00 PM	Closing	Kailey Love, MBA, MS

Learning Objectives

1. Describe strategies to facilitate population health management improvement.
2. Critically analyze the application of improvement methods and techniques to improve HEDIS quality metrics.
3. Evaluate strategies to identify and address upstream drivers of health for high risk populations
4. Explore process improvement strategies for population health management

Guidelines

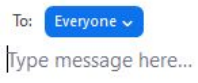


Do not enter your name or organization in the Chat. Zoom will automatically record your attendance. Please only use the chat for questions and comments.

At least one representative from each TI organization must have registered and attend the QIC session using that registration link for the required QIC sessions.

Participants will automatically be muted and videos off as they join.

When interested in participating in the discussion, please raise your hand and unmute yourself.



Please drop your questions into the Chat. If we do not have time to address your question, we will compile all questions into a FAQ document and distribute post-event.

Disclosure

This is a CME activity

Acknowledgment: This CME event is not supported by any commercial entity.

Disclosure: There are no relevant financial relationships, sponsorships, or other disclosures from anyone in control of content associated with this activity. This program is designed to provide educational information and does not involve the promotion of any specific product or service.

Credit Statement: Arizona State University designates this live activity for a maximum of 1-credit from the following:

- ***AMA PRA Category 1 Credit™ – CME – 1 credit hour per session***
- ***Nursing Continuing Professional Development – NCPD – 1 credit hour per session***
- ***Psychology – CEP – 1 credit hour per session***
- ***Social Work – ACE – 1 credit hour per session***
- ***Interprofessional Continuing Education – IPCE – 1 credit hour per session***

**Providers should only claim credit commensurate with the extent of their participation in the activity.*

Y4 Performance Measure Updates

- ASU is upgrading from the MY 2023 HEDIS specifications to the MY 2025 HEDIS specifications for TI 2.0 Year 4 performance measures.
- AHCCCS has approved the following codes for use in the TI 2.0 Peds BH AOC Year 4 performance measure calculations:
  - **T1016** (already part of MY HEDIS 2025 measure specifications) and **H0023** for FUH

ASU TIPQIC will retrospectively calculate performance with the updated measure specifications, using the above codes as numerator-qualifying criteria for the FUH measure. Updated performance will be reflected in the April/May dashboard. Please direct any data-related questions to tipqic@asu.edu.

Measure Overview & Network Performance

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Peds BH QIC Curriculum Overview

Peds BH AOC Measures	TI Year 4: 10/1/2025 - 9/30/2026											
	O	N	D	J	F	M	A	M	J	J	A	S
APM	QIC						QIC					
FUH7			QIC						QIC			
FUH30					QIC						QIC	
Optional Resources	Ongoing Performance Improvement Project (PIP)											
	Ongoing Technical Assistance & Consultation											

- **QIC's** in October, December, and February are **required**
  - Each QIC will focus on the a HEDIS measure as indicated in the above table
- ***QIC's*** in April, June, and August are ***optional***
  - The focus of these sessions may shift based on performance and other priorities

Table 1 Targeted Investments (TI) 2.0 Year 4 Milestones and Incentive Percentages			
MILESTONES	**PEDS BH** **INCENTIVE % OF ANNUAL PAYMENT**		
M1. Performance Measures	**50**		
	FUH7	FUH30	APM
	20	20	10
M2. Screening and Referral Systems for Nonmedical Drivers of Health	**25**		
M3. Closed Loop Referral System (CLRS)	**15**		
M4. Quality Improvement Collaboratives (QICs)	**10**		

Peds BH					
Performance Measure	**Measure Description**	**TI AOC Performance ***	**All AHCCCS Performance ***	**2023 AZ Medicaid Average[1]**	**2023 HEDIS National Average[2]**
✷ = Proposed 2026 ACOM306 Measure; ✲ = MAC 2024 Scorecard Measure; ☣ = 2025 CMS Core Set Measure; ✱ = 2024 UDS Quality of Care Measure; + = 2024 SAMHSA CCBHC Quality Measure; ✪ = NCQA HEDIS Stratified Measure; ❋ = MAC QRS Measure					
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) ☣ +	Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the year	36.6%	33.9%	41.3%	38.4%
Follow-Up After Hospitalization for Mental Illness within 7 Days (FUH7) ✲ ☣ + ✪ ✱	Percentage of child and adolescent beneficiaries with a follow-up visit seven days after hospitalization for mental illness	85.3%	63.6%	68.7%	38.5%
Follow-Up After Hospitalization for Mental Illness within 30 Days (FUH30) ✲ ✱ + ✪ ✱	**Percentage of child and adolescent beneficiaries with a follow-up visit thirty days after hospitalization for mental illness**	**94.8%**	**81.8%**	**84.6%**	**59.1%**

*Report period ending August 31, 2025

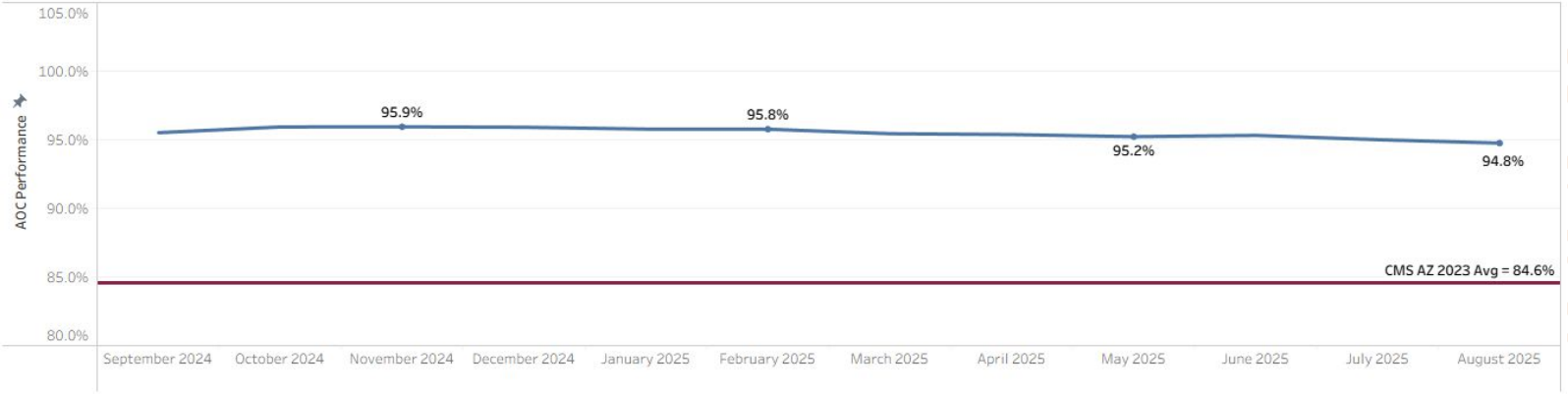
1. https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D
2. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

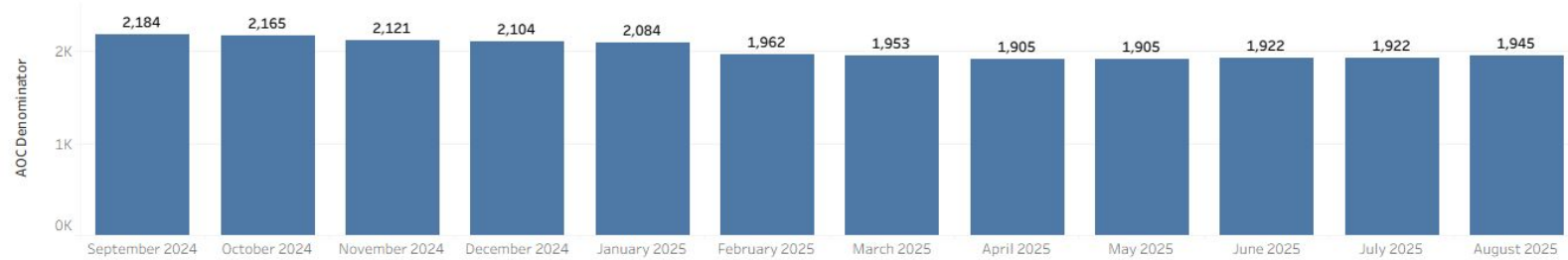
FUH30 Network Performance

Measure Performance (each month is a 12-month report period)

PEDS BH



Measure Denominator



Measure Details

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Follow-up After Hospitalization within 30 Days

FUH30: The percentage of discharges for persons 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within 30 days after discharge.

Quality Alignment

Peds BH									
Performance Measure	Measure Description	TI AOC Performance *	Quality Alignment						
			2026 ACOM 306 Measure	MAC 2024 Scorecard Measure	2025 CMS Core Set Measure	2024 UDS Quality of Care Measure	2024 SAMHSA CCBHC Quality Measure	NCQA HEDIS Stratified Measure	MAC QRS Measure
Follow-Up After Hospitalization for Mental Illness within 30 Days (FUH 30)	Percentage of child and adolescent beneficiaries with a follow-up visit thirty days after hospitalization for mental illness	94.8%		✻	✾		+	✪	❋

*Report period ending August 31, 2025

1. https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D
2. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

FUH30 Importance

Ensures timely outpatient mental health care

Reduces risk of relapse or readmission

Improves continuity of behavioral health services

Supports caregiver engagement and follow-up

Tracks provider and health system performance

Enhances patient safety and recovery

Why the 30-Day Window Matters

Early follow-up prevents gaps in care

Reduces hospital readmissions

Supports stabilization after discharge

Enables timely intervention for emerging symptoms

Reinforces treatment adherence

Improves long-term mental health outcomes

Follow-up After Hospitalization within 30 Days

Your performance is reported as a percentage calculated as the = numerator/denominator

TI Area of Concentration	Measure	Denominator Definition	Numerator Definition
Peds BH	FUH30	Discharges for members 6-17 years of age who were hospitalized for treatment of selected mental illness or intentional self-harm in the reporting period.	Discharges in the denominator where the member had a qualifying follow-up visit within 30 days after discharge.

Note: For the FUH30 measure, the member must be continuously enrolled in medical benefits from the episode end date through 30 days after the episode end date with no breaks in enrollment.

What is the Reporting Period?

- A HEDIS® measure's reporting period is a continuous 12-month window.
- TIP Provider Dashboards show your organization's performance on the selected measure for 12 consecutive, overlapping report periods, where each report period is a 12-month period ending in the month and year shown on the X-axis.
- Your performance levels for 12 report periods are provided so you can track how your performance changes across time. TI incentive payments are based on your performance for the Federal Fiscal Years (October 1st September 30th).

Which Members Are in My Denominator?

To understand the members that you are accountable for and who are attributed to you (i.e., in your denominator) for this measure, you need to know the denominator definition (above), as well as the AHCCCS member population assessed, and the attribution method used.

Member Population Assessed

- Members enrolled in one of the six AHCCCS Complete Care (ACC) health plans
- Members with SMI enrolled in an ACC Regional Behavioral Health Agreement (RBHA) health plan are included

Member Population Exclusions

- ACC and ACC-RBHA members who utilized hospice services or died

Note: These measures are based on the number of hospitalizations, not the number of members. Members with multiple hospitalizations (with sufficient time between them) are counted multiple times in the denominator.

What Services Qualify for the Numerator?

Billing Codes

- TI 2.0 Year 4 will now use HEDIS® Measurement Year 2025 measure definitions.
- Due to licensing agreements, we are not able to publish a list of all qualifying services codes. However, we can direct you to resources containing the billing codes.
  - Please see these Arizona Health Plan Measure Guides. You do not have to be contracted with the plan to access these resources.
    - United Healthcare - HEDIS® MY 2025 Reference Guide
  - For more information on HEDIS measures or to get your own license, see the NCQA HEDIS® site.
  - Value sets and codes used in HEDIS MY 2025 measure calculations are available at no cost. Download the 2025 Quality Rating System (QRS) HEDIS Value Set Directory from the NCQA store.
- Note: While the FUH, FUA, and FUM measures are similar, the numerator-qualifying criteria differ. Carefully review the linked measure guides for differences in qualifying billing codes.

New for MY 2025

- Medical providers (including primary care) as well as mental health providers are allowed to close the FUH gap using qualified billing codes and diagnostic codes
- Diagnosis of a mental health disorder was added to the visit setting scenarios for gap closure criteria
- Peer support and residential treatment services scenarios were added to the gap closure criteria

Measure detail guides will be revised to incorporate all updates.

FUH Accommodations

- In addition to the billing codes listed in the guides linked, the following accommodations have been made for TI performance measurement:
  - The measure's numerator-qualifying telehealth services will get credit if they follow AHCCCS' telehealth billing guidelines allowed on the date of service.
  - Psychiatric Collaborative Care Model (CoCM) services (i.e., codes 99492, 99493, and 99494) will count as a numerator-qualifying visit for all servicing provider types (licensed and non-licensed).
    - CoCM is an approach to behavioral health integration recognized by CMS. Please see TIPQIC.org for billing guidance to maximize CoCM services for FUH compliance and a list of TIP Providers who deliver CoCM services.
  - AHCCCS approved the use of **H0023** and **T1016** (already part of MY 2025 measure specifications) to close HEDIS numerator gaps in care for the FUM, FUA, and FUH measures.

What Services Do Not Qualify for the Numerator?

- Day 0 (Zero) is the day of discharge and is not eligible to be included in the FUH, FUM, and FUA measures. This is a CMS and NCQA policy. AHCCCS seeks to align with the national standards to the greatest extent possible.
- Reach-in (i.e., non-billable) services do not qualify for the numerator. Any procedure code not listed in the previous section does not qualify.

Attribution

- Members are attributed to their prescribing provider. If multiple prescribing providers are identified, attribution considers the strongest relationship based on the frequency and recency of dispensation.
- If there is no prescribing provider, members are attributed to the behavioral health provider with whom they have the strongest relationship with prior to the event or secondarily, the provider with the numerator qualifying services after the event.
- Interested providers can work with the ASU TIPQIC team to examine member events eligible for each measure and attributed to their organization through a member list comparison (Data Harmonization).

Target Setting

- One tier was set for the FUH30 measure
  - AHCCCS emailed each provider organization with individual target setting information
- For your organization's specific target, please see your dashboard or the email received from the AHCCCS TI team.
- TI Peds BH providers need to exceed their target to achieve the incentives associated with this performance measure.

To log in to your dashboards, please visit data.tipqic.org.

If you would like to make any changes to your log-in or password, please email support@tipqic.org

FUH30 Non-Medical Drivers and Closed Loop Referral Systems

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Non-Medical Drivers of Health for FUH30

- Identifies barriers like transportation, housing, or food insecurity
- Detects caregiver stress or mental health challenges
- Allows targeted interventions to remove obstacles to follow-up
- Improves engagement and trust with families
- Supports care coordination and reduces missed visits
- Directly improves FUH 30 compliance by addressing preventable gaps

Non-Medical Drivers of Health (NMDOH) G/Z Codes

- Between May 2024 and August 2025, TI providers screened 35,721 unique patients for non-medical drivers of health, submitting 41,167 G codes via claims.
  - The most commonly identified needs were housing, employment, and larger economic conditions, with over 5,959 NMDOH referrals given to help patients meet these needs.
- NMDOH screening can be associated with higher performance across several HEDIS® quality measures.
- Year 4 Milestone 2B: **ATTEST** to documenting NMDOH screening and referral results via consistent submission of claims using G procedure codes (G9919 and G9920), V4 modifier, and Z diagnosis codes as appropriate.

https://www.azahcccs.gov/PlansProviders/Downloads/TI/Milestone/Year4MilestoneRequirements.pdf

Closed Loop Referral System and FUH30

- Ensures outpatient referrals are received and appointments scheduled
- Confirms that patients complete follow-up visits
- Tracks outcomes in real time for accountability
- Reduces missed care due to unresolved barriers
- Strengthens care coordination across teams
- Improves FUH 30 performance by closing gaps between discharge and follow-up

Case Study: FUH30 & the Post-Discharge Handoff

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

FUH30 & Post-Discharge

- Most FUH30 failures occur after discharge
- Common breakdowns:
  - Follow-ups not scheduled or confirmed before discharge
  - Unclear responsibility between inpatient and outpatient teams
  - Visits completed but not captured for HEDIS
- Result: Care may happen—but follow-up is delayed, missed, or invisible
- FUH30 is a handoff challenge

Case Study

Patient B (Age 14)

- Established patient at outpatient BH clinic; history of depression
- History of depression with prior outpatient visits documented in the EHR
- Patient experiences escalation of suicidal ideation and presents to the emergency department
- Admitted to an inpatient psychiatric unit for stabilization

Case Study

Hospitalization & Discharge

- Inpatient facility does not notify the outpatient BH clinic of the admission
- No automated alert, HIE notification, or direct communication sent to the outpatient team
- Patient is discharged home with family after inpatient stay
- Discharge instructions recommend outpatient follow-up, but responsibility for scheduling is not clearly assigned

Case Study

Post-Discharge Assumptions

- Family assumes the outpatient clinic has been notified of the hospitalization and will proactively schedule follow-up care
- Outpatient clinic remains unaware of both the admission and discharge
- No outreach attempt is made by the outpatient clinic within the 30-day post-discharge window

FUH30 Result

- No outpatient BH visit within 30 days of discharge

FUH30 Common Barriers

- Limited appointment availability post-discharge
- Transportation challenges, despite NEMT availability
- Caregiver work or scheduling conflicts
- Low caregiver awareness of follow-up importance
- Coverage or Medicaid eligibility gaps
- Fragmented care between inpatient and outpatient providers
- Language, cultural, and trust barriers
- Documentation or claims not captured for follow-up visits

FUH30 Best Practices

- Schedule follow-up before discharge
- Use reminder and outreach systems (calls, texts)
- Extend clinic hours and offer same-day appointments
- Assign care coordination or case management staff
- Screen for social and non-medical needs
- Educate caregivers on importance of post-discharge care
- Monitor follow-up completion and address missed visits
- Ensure accurate documentation for HEDIS reporting

Discussion

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Peer Volunteers

- Casa De Los Niños
  - Michelle Quiroz
- New Horizon Youth Homes
  - Joshua Mehdikhan

Discussion Questions

1. **Post-discharge handoffs:** Where do you most often see breakdowns after a patient is discharged from inpatient psychiatric care—notification, scheduling, outreach, or documentation?
2. **Ownership of follow-up:** In your organization, who is responsible for ensuring follow-up occurs within 30 days after discharge, and how clearly is that responsibility defined?
3. **Visibility of hospitalizations:** How do you currently find out that one of your patients has been hospitalized or discharged, and what gaps exist in that process?
4. **Missed FUH30 opportunities:** Can you share an example where follow-up care happened but wasn't captured for FUH30, or where barriers prevented timely follow-up?
5. **What's working:** What strategies, workflows, or tools have helped your organization improve FUH30 performance or reduce post-discharge gaps?

Discussion Questions

Understanding Current Performance

- What are your current FUH 30 rates for pediatric patients?
- Which patient populations are least likely to complete follow-up?
- Where do you see the most frequent gaps post-discharge?

Workflow and Scheduling

- How are follow-up appointments scheduled before discharge?
- What challenges occur in coordinating outpatient follow-up?
- How do you track whether appointments are kept?

Engagement and Communication

- How do you educate caregivers on the importance of timely follow-up?
- Which outreach strategies have been most effective?
- How do you address missed or canceled appointments?

NMDOH Screening

- How do you assess social or non-medical barriers to follow-up?
- Which needs most commonly interfere with completing visits?
- How are NMDOH findings addressed by the care team?

Discussion Questions

Transportation and Access

- How do you identify and support patients needing NEMT?
- What common transportation challenges remain unaddressed?
- How is transportation confirmed before follow-up visits?

Closed-Loop Referrals

- Are closed-loop referral systems used to confirm follow-up completion?
- How do you track and document referral outcomes?
- Where are the gaps between referral, scheduling, and actual follow-up?

Documentation and Reporting

- How do you ensure follow-up visits are accurately documented?
- How do clinical and administrative teams coordinate for HEDIS reporting?
- Where do documentation gaps affect FUH 30 measurement?

Peer Learning

- What strategies have improved FUH 30 performance in your practice?
- Which barriers are hardest to overcome, and where could collaboration help?
- What one change could you implement in the next 30–60 days to increase follow-up rates?

Closing

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Closing & Next Steps

- For those interested in CME, an evaluation survey will be distributed following this event and CME certificates will be distributed to those who complete this survey at the end of the month.
- Register for the Optional QIC session(s)

Questions?

AHCCCS Questions: targetedinvestments@azahcccs.gov
ASU TIPQIC General Inquiries: TIPQIC@asu.edu
Support Tickets: support@TIPQIC.org

Relevant Websites:

- AHCCCS TI: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/
- ASU TIPQIC: tipqic.org
- Dashboards: data.tipqic.org

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM