TIP QIC Targeted Investments Program Quality Improvement Collaborative

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Targeted Investments 2.0 Program

TIP Measure Details Guide:

Follow-Up After Hospitalization/ED Visit for Mental Illness/Substance Use

(FUH, FUM, FUA)

The AHCCCS Targeted Investments Program (TIP) Quality Improvement Collaborative (QIC) evaluates TI-participating Providers' performance on select quality measures and assists providers in performance improvement efforts. This guide is for TI-participating providers to help them understand the Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Follow-Up After Emergency Department Visit for Substance Use (FUA) measures. FUH, FUM, and FUA are Healthcare Effectiveness Data and Information Set (HEDIS®) measures designed and maintained by the National Committee for Quality Assurance (NCQA).

Why It Matters

Approximately one in five Americans will experience a mental illness in a given year[1], and one in five children will have had a seriously debilitating mental illness at some point in their lives.[2] In addition to mental illness, substance use disorders (SUDs) are also a prevalent and serious public health issue. In 2019, 20.4 million individuals aged 12 or older in the U.S., approximately 7.4% of the population, reported having an SUD within the past year.[3] Ensuring coordination of care for individuals leaving inpatient or emergency department (ED) settings is critical. Timely follow-up care after hospitalization or an ED encounter for mental health or substance use concerns is associated with longer community tenure and a reduced risk of subsequent hospitalizations or repeat ED visits.[4] Follow-up visits provide opportunities to coordinate care, identify emerging issues, address treatment barriers, and intervene promptly, supporting better health outcomes and continuity of care.

What We Measure

- *Follow-Up After Hospitalization for Mental Illness (FUH):* 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 7 and 30 days after discharge.

- *Follow-Up After Emergency Department Visit for Mental Illness (FUM):* The percentage of emergency department (ED) visits for persons 18 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within 7 after discharge.
- *Follow-Up After Emergency Department Visit for Substance Use (FUA):* The percentage of ED visits among persons age 18 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 7 after discharge.

Your performance is reported as a percentage calculated as the $\frac{numerator}{denominator}$.

TI Area of Concentration	Measure	Denominator Definition	Numerator Definition
Peds BH	FUH7[1]	Discharges for members 6-17 years of age who were hospitalized for treatment of selected mental illness or intentional self-harm in the report period.	Discharges in the denominator where the member had a qualifying follow-up visit within 7 days after discharge.
	FUH30[1]		Discharges in the denominator where the member had a qualifying follow-up visit within 30 days after discharge.
Adult BH	FUH7	Discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm in the report period.	Discharges in the denominator where the member had a qualifying follow-up visit within 7 days after discharge.
	FUM7	ED visits for members 18 years and older for treatment of	ED visits in the denominator where the member had a qualifying follow-up

		selected mental illness or intentional self-harm in the report period.	visit within 7 days after discharge.
Justice	FUM7	ED visits for Justice members 18 years and older for treatment of selected mental illness or intentional self-harm in the report period.	ED visits in the denominator where the member had a qualifying follow-up visit within 7 days after discharge.
	FUA7	ED visits for Justice members 18 years and older for treatment of substance use disorder in the report period.	ED visits in the denominator where the member had a qualifying follow-up visit within 7 days after discharge.

[1] A qualifying follow-up visit that occurs on days 1-7 post-hospital discharge also puts the member in the numerator for both the FUH 7 and FUH 30 measures.

Note: For the above measures, 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 seven AHCCCS Complete Care (ACC) health plans
- Members with SMI enrolled in an ACC Regional Behavioral Health Agreement (RBHA) health plan are included

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

Member Population and Event Exclusions

- ACC and ACC-RBHA members who utilized hospice services or died at any time during the report period

Note: The following event exclusions apply:

- *FUH*:
  - Hospital discharges followed by a readmission or direct transfer to a non-acute inpatient care setting (except psychiatric residential treatment) within 30 days.
  - Hospital discharges followed by a readmission or direct transfer to an acute inpatient care setting within 30 days when the readmission principal diagnosis is not for a mental illness or intentional self-harm.
  - Hospital discharges occurring within 30 days of the report period end date.
- *FUM*:
  - ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission
  - ED visits occurring within 30 days of the report period end date.
- *FUA*:
  - ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission.
  - ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit.
  - ED visits occurring within 30 days of the report period end date.

Attribution Methods

- In TI 2.0 Year 4 and 5, attribution is done at the billing and servicing provider ID level. For a detailed explanation about the provider IDs used and examples, please see the TI 1.0 Provider Identification Methodology video and slides.
    - If you have any questions about the billing and servicing provider IDs used for your organization, please contact the AHCCCS Targeted Investments team (targetedinvestments@azahcccs.gov).
- Attribution is re-evaluated each month for all report periods displayed on the dashboard. The attribution method used is specific to each AOC. Review the attribution method specific to the TI AOC you are enrolled in:

TI Area of Concentration	Attribution Method
Peds BH	• 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.
Adult BH	• 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.

TI Area of Concentration	Attribution Method
Justice	• Attribution is done using member referral lists (i.e., Justice Referral Lists). Members will be included in a TI provider's denominator if they meet all measure denominator criteria and were referred to a TI-participating organization within the two years prior to the end of the report period. • For more details on this and the other Justice measures, see the TI 1.0 Justice Measure Evaluation & Attribution video (slides).

What Services Qualify for the Numerator?

Billing Codes

- TI 2.0 Years 4 and 5 performance measures use HEDIS® Measurement Year (MY) 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
        - Mercy Care
            - HEDIS® MY 2025 Reference Guide
            - FUH Best Practices (Definitions Only)
            - FUM Best Practices (Definitions Only)
    - 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.

- 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's 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/FUM/FUA 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 measure. This is a CMS and NCQA policy. AHCCCS seeks to align with the national standards to the greatest extent possible.
    - For measures FUM and FUA, follow-up visits that occur on the same day as the ED visit can count toward compliance.
- Any procedure code not listed in the previous section does not qualify.

How Do I Document Services to Get Credit on the Measure?

TI performance measurement relies on claims data. Hybrid chart review does not apply.

What Is My TI Performance Target?

The table below shows the TI target set for the FUH, FUM, and FUA measures. For your organization's specific target, please see your dashboard or the email received from the AHCCCS TI team.

TI Area of Concentration	Measure	Y4 Targets	Y5 Targets
Peds BH	FUH7	75% | 85%	75% | 85%
	FUH30	93%	93%
Adult BH	FUH7	70% | 83%	70% | 83%
	FUM7	58% | 80%	58% | 80%
Justice	FUM7	70%	52% | 70%
	FUA7	55% | 75%	55% | 75%

How Were the Performance Targets Determined?

Please see the TIPQIC website for details on target setting.

Additional TIP Guides

Please see the other TIP measure Details Guides on our website, as well as best Practice Audit Guides. For example, TIP Best Practice Audit: Building Capacity for Performance Excellence provides best practices for an organizational QI system, which is needed to optimize your organization's QI efforts for this measure.

Questions? Contact the ASU TIPQIC Team (TIPQIC@asu.edu) or AHCCCS Targeted Investments Team (targetedinvestments@azahcccs.gov) with questions or to request further assistance.

References

1. Substance Abuse and Mental Health Services Administration (SAMHSA). 2023. Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health. HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

2. Whitney, D.G., M.D. Peterson. 2019. “US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children.” JAMA Pediatr 173(4):389–91. doi:10.1001/jamapediatrics.2018.539
3. Centers for Disease Control and Prevention (CDC). 2019b. “QuickStats: Number of Emergency Department Visits for Substance Abuse or Dependence per 10,000 Persons Aged ≥18 Years, by Age Group — United States, 2008–2009 and 2016–2017.” MMWR Morb Mortal Wkly Rep 2019 68:1171. DOI: http://dx.doi.org/10.15585/mmwr.mm6850a7externalicon
4. McCullumsmith, C., B. Clark, C. Blair, K. Cropsey, & R. Shelton. 2015. “Rapid Follow-Up for Patients After Psychiatric Crisis.” Community Mental Health Journal 51(2), 139–44. https://doi.org/10.1007/s10597-014-9782-z