Proposed Changes to Existing Measures for HEDIS®[1] MY 2025: Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Hospitalization for Mental Illness (FUH)

NCQA seeks comments on proposed modifications to the HEDIS measures *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* and *Follow-Up After Hospitalization for Mental Illness* (FUH).

Measure Descriptions

Measure Title	Measure Descriptions
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: 1. Percentage of ED visits for which the member received follow-up within 30 days after the ED visit. 2. Percentage of ED visits for which the member received follow-up within 7 days after the ED visit.
Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members 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 provider. Two rates are reported: 1. Percentage of discharges for which the member received follow-up within 30 days after discharge. 2. Percentage of discharges for which the member received follow-up within 7 days after discharge.

The intent of these measures is to ensure coordinated care for members discharged from an inpatient or ED setting, who are at an increased risk for disengagement from treatment and repeat visits. To better align the measures with their intent and current evidence, NCQA proposes the following revisions for HEDIS Measurement Year 2025.

Denominator Revisions (apply to both measures)

Diagnosis position criteria: Allow any diagnosis position for intentional self-harm diagnoses, and maintain the principal position requirement for all other mental health diagnoses.

Rationale: This change intends to ensure that all relevant mental health events are captured in the measures' denominator, and ensures inclusion of all self-harm events.

Additional diagnosis codes: Include phobia diagnoses, anxiety diagnoses, intentional self-harm X-chapter codes and the R45.851 suicidal ideation code in the denominator diagnosis code lists. (Refer to the appendix for code lists.)

Rationale: These codes were recommended by expert stakeholders and measure users, who noted the importance of including individuals with these relevant diagnoses for measures of care continuity for the mental health population.

Measure testing results for the Medicare and commercial product lines suggested varied increases in average plan-level denominator size across the measures as a result of these denominator changes. For the FUM measure, average denominator sizes increased by approximately 67% and 94% for the Medicare and commercial product lines, respectively; for the FUH measure, sizes increased by approximately 10% and 7% for the same product lines. Testing results indicated that increases were largely attributed to the addition of the anxiety diagnoses and the R45 suicidal ideation code.

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Numerator Revisions (apply to both measures, unless specified)

Provider Type Requirements (FUH only): Allow addition of follow-up by any care provider, rather than by a mental health provider only, if there is an accompanying mental health diagnosis on the claim.

Rationale: This change was recommended by stakeholders to address the shortage of mental health providers, and acknowledge services by additional providers who may be delivering appropriate care.

Diagnosis Position Criteria at Follow-Up: Allow the mental health diagnosis in any diagnosis position on the follow-up claim for both measures, rather than in the principal position only.

Rationale: This change was recommended by stakeholders, who noted limitations in interpreting diagnosis position on outpatient claims.

Additional Follow-Up Services and Settings: Include psychiatric residential treatment, as well as peer support services and occupational therapy for a mental health diagnosis, as options for follow-up.

Rationale: This change was recommended by stakeholders, who advocated for expansion of the workforce delivering mental health care. Literature indicates that occupational therapy can help support recovery in community integration for individuals with mental illness, and peer services are associated with improved quality of life.[2,3]

Testing results of the revised measure specifications demonstrated performance increases for the Medicare product line in both the FUM and FUH measures: Average performance across the two indicators increased between 17%–19% for the FUM measure and increased 31%–36% for the FUH measure. For the commercial product line, testing results indicated a slight performance decrease for FUM, ranging from about 6%–7%, and a performance increase for FUH, ranging from approximately 18%–28%.

Overall feedback from NCQA's expert panels supported proposed changes.

NCQA seeks general feedback on proposed changes and specific feedback on the following questions:

1. Do you support the proposed revisions for *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness,* as listed above?

2. Inclusion of peer services and occupational therapy is designed to recognize additional options for mental health follow-up, as there is growing evidence for the use of these services in post-discharge interventions. While NCQA received overall support from stakeholder panels for including these services, NCQA seeks additional feedback on whether the services should be considered appropriate follow-up for both measures, or for only the FUM (ED setting) measure.

3. In addition to the changes presented in this memo, stakeholders recommend including school-based services and mobile crisis units to satisfy the follow-up criteria for these measures. NCQA seeks additional feedback on the appropriateness of these services as follow-up, as well as on the service codes to bill for these services.

Supporting documents include the measure specifications, evidence workups and performance data.

NCQA acknowledges the contributions of the Behavioral Health, Geriatric and Technical Measurement Advisory Panels.

[2] Gibson, R.W., M. D'Amico, L. Jaffe, & M. Arbesman. 2011. "Occupational Therapy Interventions for Recovery in the Areas of Community Integration and Normative Life Roles for Adults With Serious Mental Illness: A Systematic Review." *The American Journal of Occupational Therapy* 65(3), 247–56. https://doi.org/10.5014/ajot.2011.001297

[3] Bellamy, C., T. Schmutte, and L. Davidson. 2017. "An Update on the Growing Evidence Base for Peer Support." *Mental Health and Social Inclusion,* Vol. 21 No. 3, pp. 161–7. https://doi.org/10.1108/MHSI-03-2017-0014

Appendix

Table 1. Diagnosis Codes for Anxiety Diagnoses

ICD-10 Code	Definition
F41.0	[F41.0] Panic disorder [episodic paroxysmal anxiety]
F41.1	[F41.1] Generalized anxiety disorder
F41.3	[F41.3] Other mixed anxiety disorders
F41.8	[F41.8] Other specified anxiety disorders
F41.9	[F41.9] Anxiety disorder, unspecified

Table 2. Diagnosis Codes for Phobia Diagnoses

ICD-10 Code	Definition
F40.00	[F40.00] Agoraphobia, unspecified
F40.01	[F40.01] Agoraphobia with panic disorder
F40.02	[F40.02] Agoraphobia without panic disorder
F40.10	[F40.10] Social phobia, unspecified
F40.11	[F40.11] Social phobia, generalized
F40.210	[F40.210] Arachnophobia
F40.218	[F40.218] Other animal type phobia
F40.220	[F40.220] Fear of thunderstorms
F40.228	[F40.228] Other natural environment type phobia
F40.230	[F40.230] Fear of blood
F40.231	[F40.231] Fear of injections and transfusions
F40.232	[F40.232] Fear of other medical care
F40.233	[F40.233] Fear of injury
F40.240	[F40.240] Claustrophobia
F40.241	[F40.241] Acrophobia
F40.242	[F40.242] Fear of bridges
F40.243	[F40.243] Fear of flying
F40.248	[F40.248] Other situational type phobia
F40.290	[F40.290] Androphobia
F40.291	[F40.291] Gynephobia
F40.298	[F40.298] Other specified phobia
F40.8	[F40.8] Other phobic anxiety disorders
F40.9	[F40.9] Phobic anxiety disorder, unspecified

Table 3. Summary of X-Chapter of ICD-10 Diagnosis Codes for Intentional Self-Harm

ICD-10 Code Range	Descriptions
X71-X83: Intentional Self-Harm ***Note:*** *These codes may take only a secondary position on the billing claim*	Intentional self-harm by: • X71: Drowning & submersion • X72: Handgun discharge • X73: Rifle, shotgun, & larger firearm discharge • X74: Other and unspecified firearm & gun discharge • X75: Explosive material • X76: Smoke, fire, & flames • X77: Steam, hot vapors, & hot objects • X78: Sharp object • X79: Blunt object • X80: Jumping from a high place • X81: Jumping / lying in front of moving object • X82: Crashing of motor vehicle • X83: Other specified means

Table 4. Draft Occupational Therapy Value Set

CPT Code	Definition
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument (For an emotional/behavioral assessment, use (96127)
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments when performed) by physician or other qualified health care professional, with interpretation and report, first hour
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96156	Health behavior assessment, or reassessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face to-face; initial 30 minutes
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97150	Therapeutic procedure(s), group (2 or more) (Report for each member of the group) (Group therapy procedures involve constant attendance by the physician or other qualified health care professional [i.e., therapist], but by definition do not require one-on-one patient contact by the same physician or other health care professional.)
97165	Occupational therapy evaluation, low complexity

CPT Code	Definition
97166	Occupational therapy evaluation, moderate complexity
97167	Occupational therapy evaluation, high complexity
97168	Occupational therapy re-evaluation
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living [ADLs] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)

Table 5. Peer Services Codes

HCPCS Code	Definition
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) (G0177)
H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude) (H0024)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior) (H0025)
H0038	Self-help/peer services, per 15 minutes (H0038)
H0039	Assertive community treatment, face-to-face, per 15 minutes (H0039)
H0040	Assertive community treatment program, per diem (H0040)
H0046	Mental health services, not otherwise specified (H0046)
H2014	Skills training and development, per 15 minutes (H2014)
H2023	Supported employment, per 15 minutes (H2023)
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session (S9445)
T1012	Alcohol and/or substance abuse services, skills development (T1012)
T1016	Case management, each 15 minutes (T1016)

Note: *For MY 2025, NCQA is reviewing inclusion of new HCPCS codes G0140 and G0146, because they are related to peer services, as well as additional Principal Illness Navigation codes.*

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2025

- Modified the denominator criteria to allow intentional self-harm diagnoses to take any position on the acute inpatient discharge claim.
- Added codes to the denominator criteria to include phobia diagnoses, anxiety diagnoses, intentional self-harm ICD-10 X-chapter codes and suicidal ideation ICD-10 R code.
- Added the option to satisfy the measure's follow-up criteria in the numerator with any practitioner, rather than only with mental health provider, if the service was coded for any diagnosis of a mental health disorder.
- Added residential treatment services to the numerator (and removed from denominator removal criteria).
- Added peer support services and occupational therapy services for diagnosis of a mental health disorder to the numerator.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for a principal diagnosis of mental illness or any diagnosis of intentional self-harm, and who had a follow-up visit for mental illness. Two rates are reported:

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

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Stratifications For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic or Latino.

- Not Hispanic or Latino.
- Asked But No Answer.
- Unknown.
- Total.

Note: *Stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.*

Ages

6 years and older as of the date of discharge. Report three age stratifications and a total rate:

- 6–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

Date of discharge through 30 days after discharge.

Allowable gap

None.

Anchor date

None.

Benefits

Medical and mental health (inpatient and outpatient).

Event/diagnosis

An acute inpatient discharge with a principal diagnosis of mental illness or any diagnosis of intentional self-harm (Mental Illness and 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:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis ~~(use only the principal diagnosis on the discharge claim)~~ of mental health disorder or any diagnosis of intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

Commented [LN1]: Note for HEDIS MY 2025 Public Comment: This value set would be split into individual Mental Illness and Intentional Self-Harm value sets. The Mental Illness value set would be updated to include phobia diagnoses and anxiety diagnoses. The Intentional Self-Harm value set would be updated to include the X-chapter of the ICD-10 codes for self-harm, and the R45.851 suicidal ideation code.

Commented [LN2]: Note for HEDIS MY 2025 Public Comment: The Intentional Self-Harm value set would be updated to include the X-chapter of the ICD-10 codes for self-harm, and the R45.851 suicidal ideation code.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis, and intentional self-harm was not on the claim in any diagnosis position ~~(use only the principal diagnosis on the discharge claim)~~, exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the ~~principal~~ diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

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

Commented [LN3]: **Note for HEDIS MY 2025 Public Comment:** This value set would be updated to remove the UBREV 1001 code to account for the addition of residential treatment services in the numerator.

Required exclusions

Exclude members who meet either of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.
  - Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit with a mental health provider, or with any practitioner for ~~any diagnosis of~~ a mental health disorder ~~with a mental health provider~~ within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up

A follow-up visit with a mental health provider, or with any practitioner for ~~any diagnosis of~~ a mental health disorder ~~with a mental health provider~~ within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.

- An outpatient visit (BH Outpatient Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** POS code 52).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Transitional Care Management Services Value Set) ***with*** POS code 53.
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set).
- Transitional care management services (Transitional Care Management Services Value Set) ***with*** a mental health provider.

Transitional care management services (Transitional Care Management Services Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set).

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- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.

A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set).

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- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).
- Peer support services (Peer Support Services Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set).
- Occupational Therapy (Occupational Therapy Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set).
- Psychiatric residential treatment (UBREV code 1001; Residential Behavioral Health Treatment Value Set; POS code 56).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*

Commented [LN4]: **Note for HEDIS MY 2025 Public Comment:** This is a new draft value set for MY 2025. Code list included in the appendix of the memo.

Commented [LN5]: **Note for HEDIS MY 2025 Public Comment:** This is an existing HEDIS value set that would be added to the FUH measure for HEDIS MY 2025.

- *Refer to Appendix 3 for the definition of* mental health provider. *Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-A-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Table FUH-B-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions
FollowUp30Day	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	Asian	Indirect	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

Table FUH-C-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	NotHispanicOrLatino	Indirect	Numerator	For each Metric and Stratification
	AskedButNoAnswer*	Unknown**	Rate	(Percent)
	Unknown**	Total		

*AskedButNoAnswer is only reported for Source= "Direct."

**Race/Ethnicity= "Unknown" is only reported for Source= "Unknown"; ~~and~~ Source= "Unknown" is only reported for Race/Ethnicity= "Unknown."

Follow-Up After Hospitalization for Mental Illness
Measure Workup

Topic Overview

Measure Intent

Follow-Up After Hospitalization for Mental Illness (FUH) focuses on post-hospitalization care coordination for individuals with a principal diagnosis of a mental illness or intentional self-harm during an acute inpatient visit. The measure promotes successful recovery and preventing relapse. Follow-up services are a crucial link between the inpatient setting and the transition back into the community, ensuring continuity of care and ongoing support. During follow-up care, professionals evaluate progress, address emerging symptoms and concerns and make necessary adjustments to the treatment plan. Timely follow-up enables early interventions and proactive management of potential health challenges, reducing the risk of readmission and promoting sustained well-being. Health plans are well positioned to facilitate care coordination, as they have access to information across care settings and the ability to implement care management processes to ensure follow-up (Benjenk & Chen 2019).

Importance and Prevalence

Mental disorders are common in the U.S; an estimated 1 in 5 adults live with a mental illness, which translates to about 57.8 million people (SAMHSA, 2022). Recent research estimates that 1 in 6 children experience a mental health disorder (Whitney & Peterson, 2019; NAMI, 2023). Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion—about 5.5%, 14.1 million people—who suffer from a serious mental illness (SMI) (SAMHSA, 2022).

Over the last decades, deinstitutionalization shifted mental health services from psychiatric hospitals to community services and supports, increasing the need to ensure that individuals leaving the acute care setting are connected to community-based services (Lutterman, 2022; Shah et al., 2020). Recent data indicate that readmission among the psychiatric population is common. In 2018, schizophrenia spectrum and other psychotic disorders was the 7th most common principal diagnosis for 30-day readmission rates (Weiss & Jiang, 2021).

Financial importance and cost-effectiveness

The cost of hospitalization for mental illness is expensive and burdensome for individuals, families and the healthcare system. In 2019, total expenditures on treatment for mental disorders for adults exceeded $106B, of which $15.6B (14.7%) was paid out of pocket by individuals and families (AHRQ, 2022). Substantial costs can be due to various factors. First, the length of hospital stays for mental health conditions can often require weeks, or even months, of care. This prolonged duration can result in high medical expenses, including room charges, medication costs and specialized treatments. Additionally, mental health hospitalizations may involve intensive interventions such as psychiatric evaluations, therapy sessions and 24-hour nursing care—which all contribute to overall cost. Furthermore, indirect costs of hospitalization, such as lost productivity and potential job loss, can have long-lasting financial implications for individuals and their families.

There are no clear estimates of individual hospital stay costs. One study conducted at a community hospital deduced that, on average, Medicare patients experience the highest costs, while uninsured individuals face the lowest expenses (Stensland et al., 2012). Although these cost findings are not

representative of other hospital settings, they underscore the significant financial implications associated with mental illness hospitalizations, and highlight varying costs depending on insurance coverage.

Overall, the associated economic costs of mental illness include health care expenses, loss of productivity and strain on social support systems. The Social Security Administration has estimated that 1 in 5 recipients of Social Security Disability Insurance have a behavioral health condition (SSA, 2020).

Supporting Evidence for Follow-Up

Continuity of care is an important aspect of care for individuals with mental illness. Existing clinical practice guidelines recommend ongoing monitoring and management using a variety of interventions, including post-hospitalization follow-up (Gelenberg et al., 2010; Hirschfeld et al., 2010). Studies have shown that timely follow-up after psychiatric hospitalization can increase the likelihood of medication adherence and reduce suicidal ideation (Fontanella et al., 2020; Chung et al., 2017; Fontanella et al., 2011).

Recent literature indicates that individuals who receive prompt follow-up after hospitalization are equally (if not more) likely to be readmitted or have an ED visit as those who did not receive care (Bardach et al., 2020; Beadles et al., 2015; Hermer et al., 2022).This seemingly paradoxical finding can be explained by several factors. First, individuals who receive follow-up care may have more severe or complex mental health conditions that require ongoing monitoring and treatment. These individuals may have a higher risk of relapse or recurrent episodes, leading to a greater likelihood of readmission. Second, increased access to care through follow-up visits may result in more accurate identification and reporting of symptoms. Patients who receive regular follow-up care are more likely to have their symptoms recognized and documented, which can contribute to a higher likelihood of readmission. In contrast, individuals who do not receive follow-up care may not have their symptoms adequately assessed or reported, potentially leading to an underestimation of their need for readmission.

Last, it is important to consider that readmission rates can also be influenced by systemic factors, such as limited community-based mental health resources or insufficient support networks. In some cases, patients may not have access to appropriate outpatient care, or may face challenges in accessing necessary medications or therapies. These barriers can contribute to a higher readmission rate among individuals receiving follow-up care as they continue to navigate complex mental health systems with limited resources (Owusu et al., 2022).

While the finding that patients who receive follow-up care are more likely to be readmitted may seem counterintuitive, it underscores the complex nature of mental illness and the multifaceted factors influencing readmission rates. Findings highlight the need for comprehensive and individualized care that goes beyond follow-up visits, addressing underlying systemic issues and providing ongoing support to promote successful community reintegration and reduce the risk of readmission.

Health importance

Individuals discharged from the hospital face many health risks, including potential medication noncompliance, social isolation, substance abuse, suicidal ideation or self-harm, as well as financial or practical challenges like stable housing. Individuals with mental illness who lose contact with outpatient care providers may begin a cycle of symptom deterioration that necessitates further crisis intervention in emergency and acute care settings (Fischer et al., 2008; Jencks et al., 2009; Killaspy, 2007). Research further indicates that individuals engaged in outpatient mental health services prior to an ED visit are least likely to relapse and be admitted to a hospital (Geissler et al., 2021; Schmutte et al., 2022). Preserving individuals' engagement with care requires high-quality handoffs from discharge to appropriate follow-up settings.

Simultaneously, the behavioral health workforce shortage has exacerbated the lack of access to mental health care. According to SAMHSA, only 40.6% of adolescents and 47.2% of adults with a mental illness received mental health treatment in the year, including any inpatient, outpatient, prescription for mental health issue or virtual service (SAMHSA, 2022). Individuals affected by a serious mental illness are at even greater risk of negative outcomes—including impaired functioning, reduced quality of life, increased risk of disability and premature mortality (i.e., reduced life expectancy of 10–25 years, compared to their healthy counterparts)—and only 65.4% of these individuals received care during the year (SAMHSA, 2022; Sippel et al., 2022). These findings indicate significant health care needs within the population with mental health disorders, and reinforce the importance of accessing outpatient care.

Gaps in care and opportunities for improvement

Recent performance trends for the FUH measure indicate continued room for improvement. Between 2014 and 2021, average performance for the Medicare, commercial and Medicaid enrollee populations indicate that, on average, follow-up within 7 days after hospital discharge occurred for approximately 30%–50% of inpatient discharges for a mental health condition, with Medicare plans performing the worst, with averages around 30%. Across all 3 product lines, performance on the FUH measure has not exhibited overall improvement over the last 7 years.

Research on pediatric and geriatric populations indicates that higher follow-up rates among patients are linked to previously established relationships with mental health or primary care providers (Hugunin et al., 2023; Schmutte et al., 2022). One study examining psychiatric discharge planning practices found that individuals with Medicaid who received more discharge activities were more likely to keep a follow-up appointment within 30 days of discharge, and experienced shorter time to follow-up after discharge (Smith et al., 2017). These findings demonstrate the need for continued quality improvement for different populations that typically interact with multiple systems and agencies to promote successful transitions throughout follow-up care.

Provider types

Research indicates that including different care providers in follow-up settings may be beneficial for patients experiencing acute mental illness. Evidence suggests that implementing a recovery peer-mentor program has the potential to be an important component of treatment for patients with a serious mental illness (Sledge, et al., 2011), and that occupational therapy as a component of follow-up care can have an important role in community integration and normative life roles for individuals with mental illness (Gibson et al., 2011). Integration of peers and occupational therapists in behavioral health networks may address gaps in follow-up care for patients, as well as workforce shortages in the behavioral health care system.

Health care disparities

Overall mental illness

According to SAMHSA, in 2021, multiracial adults were 11% more likely than Whites to experience mental illness. Additionally, multiracial, Hispanic, Black and Asian adults were more likely to have a diagnosed SMI than their White counterparts (SAMHSA, 2022). Over 50% of individuals who identified as White or multiracial received treatment for any mental illness, while under 40% of Black individuals received care for the same diagnoses. Individuals who identified as Hispanic received care only 36% of the time, and those who identified as Asian received care only about 25% of the time (SAMHSA, 2022).

Disparities in follow-up

Disparities in follow-up care after hospital visits for mental illness also persist across different demographic groups. Among geriatric populations, evidence indicates that White patients and females are most likely to receive follow-up care (Schmutte et al. 2022). Additionally, Black individuals are not only less likely to receive timely follow-up care, but when they do receive it, the care is often deemed inadequate (Carson et al., 2014). These findings highlight significant racial disparities in accessing high-quality follow-up care, potentially contributing to poorer health outcomes and increased risks of relapse among Black individuals with mental illness.

In April 2021, the CMS Office of Minority Health published its sixth annual report highlighting racial, ethnic and gender disparities among Medicare beneficiaries enrolled in Medicare Advantage (MA) plans. Among MA members hospitalized for a mental health disorder, Black individuals were least likely to receive appropriate follow-up care after discharge. Across all racial and ethnic groups, women were more likely to receive appropriate follow-up care than men (Centers for Medicare & Medicaid Services, 2021).

Disparities in treatment and outcomes

Researchers have identified various factors associated with adverse outcomes after discharge, including racial and ethnic background, insurance coverage, comorbidities, age, gender, and level of social functioning. One study found that patients who identified as Hispanic or Black with fee-for-service insurance, comorbidities, history of suicide attempts or history of discharge from a medical-surgical unit have an increased likelihood of ED visits or hospital readmissions (Bardach et al., 2020).

For individuals with schizophrenia, literature indicates that various factors, such as younger age, male gender, ethnic minority background and low social functioning are associated with disengagement from mental health treatment. Additionally, individuals with co-occurring psychiatric and substance use disorders, and those with early onset psychosis, are at particularly high risk of treatment dropout. These findings suggest that engagement strategies specifically targeting individuals with these risk factors during high-risk periods, such as after a hospital admission and during the initial period of treatment, are needed (Kreyenbuhl et al., 2009).

Overall, the existing literature collectively emphasizes the persistence of health care disparities in follow-up care for numerous subpopulations in the mental health population. Addressing these disparities is critical for ensuring equitable access to post-hospitalization care, and ultimately improving patient outcomes.

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HEDIS Health Plan Performance Rates: Follow-Up After Hospitalization for Mental Illness (FUH)

Commercial Results: Tables 1–8

Table 1. HEDIS FUH Measure Performance—Commercial Plans (30 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	353 (84.9)	69.6	9.4	58.5	64.8	70.6	76.3	80.2
2021	419	363 (86.6)	70.4	9.1	60.0	65.6	71.0	76.3	81.1
2022	417	342 (82.0)	69.5	9.7	56.9	63.5	70.5	76.3	80.5

Table 2. HEDIS FUH Measure Performance—Commercial Plans (30 Day Rate—6-17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	250 (60.1)	76.6	9.2	66.7	71.4	77.4	82.9	87.9
2021	419	262 (62.5)	77.1	9.4	65.7	72.1	77.8	83.7	87.3
2022	417	252 (60.4)	75.7	10.5	63.5	70.0	77.0	83.0	87.2

Table 3. HEDIS FUH Measure Performance—Commercial Plans (30 Day Rate—18–64 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	332 (79.8)	67.4	9.9	55.7	62.0	68.1	73.5	79.2
2021	419	333 (79.5)	68.0	9.8	56.6	63.1	68.2	74.5	79.9
2022	417	322 (77.2)	67.0	10.4	53.8	60.9	67.3	74.0	79.9

Table 4. HEDIS FUH Measure Performance—Commercial Plans (30 Day Rate—65+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	12 (2.9)	58.5	10.3	47.1	52.9	59.0	63.5	67.4
2021	419	12 (2.9)	61.5	14.4	41.0	49.7	63.5	69.8	81.4
2022	417	11 (2.6)	58.9	14.7	40.0	44.0	61.4	73.5	74.6

Table 5. HEDIS FUH Measure Performance—Commercial Plans (7 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	353 (84.9)	49.7	10.4	36.9	42.9	49.4	56.4	63.9
2021	419	363 (86.6)	47.9	10.6	33.8	41.5	48.1	54.2	61.4
2022	417	342 (82.0)	47.5	10.7	34.8	40.2	47.0	54.5	61.5

Table 6. HEDIS FUH Measure Performance—Commercial Plans (7 Day Rate—6–17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	250 (60.1)	55.9	11.1	42.2	49.0	55.5	64.0	70.1
2021	419	262 (62.5)	54.6	11.4	40.7	46.5	54.5	61.9	68.3
2022	417	252 (60.4)	53.3	12.6	37.4	45.6	53.5	61.4	69.2

Table 7. HEDIS FUH Measure Performance—Commercial Plans (7 Day Rate—18–64 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	332 (79.8)	47.6	11.1	34.8	40.0	47.6	54.8	62.3
2021	419	333 (79.5)	46.0	10.9	32.3	38.7	45.6	52.8	61.0
2022	417	322 (77.2)	45.4	11.2	31.4	37.8	44.8	52.2	61.1

Table 8. HEDIS FUH Measure Performance—Commercial Plans (7 Day Rate—65+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	416	12 (2.9)	37.2	13.5	25.8	27.8	34.3	44.7	54.5
2021	419	12 (2.9)	36.8	17.5	16.2	23.8	35.6	48.7	58.1
2022	417	11 (2.6)	40.3	16.1	21.8	22.2	40.5	55.3	55.9

Medicaid Results: Tables 9–16

Table 9. HEDIS FUH Measure Performance—Medicaid Plans (30 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	193 (71.0)	59.2	13.2	42.6	51.9	60.4	67.7	73.8
2021	270	193 (71.5)	58.9	13.3	40.8	51.2	59.6	67.1	74.1
2022	272	205 (75.4)	57.1	13.0	39.7	50.6	57.7	65.4	72.8

Table 10. HEDIS FUH Measure Performance—Medicaid Plans (30 Day Rate—6-17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	155 (57.0)	70.5	13.1	58.8	63.8	72.1	79.5	83.7
2021	270	164 (60.7)	70.1	12.5	54.4	62.6	71.5	79.2	83.0
2022	272	177 (65.1)	69.4	12.0	54.6	64.0	71.9	77.5	83.3

Table 11. HEDIS FUH Measure Performance—Medicaid Plans (30 Day Rate—18–64 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	179 (65.8)	53.8	13.5	36.5	45.1	54.3	63.4	70.4
2021	270	181 (67.0)	53.1	13.8	34.8	45.0	53.3	62.1	70.8
2022	272	196 (72.1)	51.3	13.3	34.3	43.6	50.9	61.3	68.0

Table 12. HEDIS FUH Measure Performance—Medicaid Plans (30 Day Rate—65+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	31 (11.4)	48.9	14.4	30.6	39.3	48.4	57.9	67.4
2021	270	34 (12.6)	45.7	13.7	25.5	39.1	45.0	55.1	61.2
2022	272	37 (13.6)	47.1	15.4	28.9	39.4	45.2	57.7	66.7

Table 13. HEDIS FUH Measure Performance—Medicaid Plans (7 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	194 (71.3)	39.6	12.8	23.7	30.9	39.0	47.7	57.8
2021	270	194 (71.9)	38.5	12.4	22.9	30.0	38.0	46.1	55.0
2022	272	206 (75.7)	36.6	12.4	21.8	28.9	35.2	44.3	52.9

Table 14. HEDIS FUH Measure Performance—Medicaid Plans (7 Day Rate—6-17 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	156 (57.4)	49.8	13.6	35.6	41.7	50.1	58.3	68.0
2021	270	165 (61.1)	47.6	13.7	29.7	38.6	48.0	56.1	66.7
2022	272	177 (65.1)	46.3	13.7	30.0	37.7	46.3	54.0	64.5

Table 15. HEDIS FUH Measure Performance—Medicaid Plans (7 Day Rate—18–64 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	180 (66.2)	35.1	12.8	19.7	26.2	33.7	43.8	53.7
2021	270	182 (67.4)	34.0	12.8	18.5	25.8	32.0	41.7	54.1
2022	272	197 (72.4)	32.2	12.3	17.5	24.0	29.5	39.5	51.1

Table 16. HEDIS FUH Measure Performance—Medicaid Plans (7 Day Rate—65+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	272	31 (11.4)	29.1	10.8	16.7	18.2	26.4	36.6	45.6
2021	270	34 (12.6)	25.4	11.6	10.6	15.4	24.0	32.5	41.8
2022	272	37 (13.6)	27.2	12.3	17.4	19.6	23.9	31.7	47.6

Medicare Results Tables 17–22

Table 17. HEDIS FUH Measure Performance—Medicare Plans (30 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	649	342 (52.7)	50.6	14.5	33.1	40.5	50.3	59.3	71.7
2021	714	374 (52.4)	49.2	14.9	32.0	39.5	48.0	58.9	68.4
2022	750	394 (52.5)	48.6	14.9	30.3	38.3	47.4	59.0	69.7

Table 18. HEDIS FUH Measure Performance—Medicare Plans (30 Day Rate—18–64 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	649	279 (43.0)	52.3	14.3	34.8	42.4	51.4	62.5	72.9
2021	714	313 (43.8)	51.1	14.5	33.3	41.7	50.0	59.3	71.2
2022	750	325 (43.2)	50.1	15.1	32.3	40.5	49.1	61.1	70.6

Table 19. HEDIS FUH Measure Performance—Medicare Plans (30 Day Rate—65+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	649	204 (31.4)	48.6	15.1	30.4	38.0	46.2	58.6	69.7
2021	714	226 (31.7)	48.0	16.3	28.8	35.1	46.3	59.6	70.0
2022	750	238 (31.7)	45.4	16.1	25.9	32.8	43.8	56.6	67.6

Table 20. HEDIS FUH Measure Performance—Medicare Plans (7 Day Rate—Total, All Ages)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	649	342 (52.7)	30.6	13.0	16.1	21.5	27.7	37.9	50.2
2021	714	374 (52.4)	29.2	12.9	15.0	20.7	26.9	36.5	45.4
2022	750	394 (52.5)	28.6	12.9	14.5	20.0	26.1	35.7	46.2

Table 21. HEDIS FUH Measure Performance—Medicare Plans (7 Day Rate—18–64 Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	649	279 (43.0)	32.2	13.3	17.5	22.7	29.4	39.9	52.0
2021	714	313 (43.8)	31.0	12.9	17.1	21.7	28.4	38.5	47.8
2022	750	325 (43.3)	29.6	13.0	15.4	21.1	26.9	37.3	48.1

Table 22. HEDIS FUH Measure Performance—Medicare Plans (7 Day Rate—65+ Years)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Std Dev	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2020	649	204 (31.4)	29.5	13.8	14.8	19.7	26.2	36.3	50.0
2021	714	226 (31.7)	27.9	14.4	13.1	17.4	24.6	35.6	46.0
2022	750	238 (31.7)	26.5	13.8	12.3	17.3	23.5	32.8	45.9