

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)	<p>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:</p> <ol style="list-style-type: none"> 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)	<p>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:</p> <ol style="list-style-type: none"> 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 <i>Note: These codes may take only a secondary position on the billing claim</i>	Intentional self-harm by: <ul style="list-style-type: none"> • 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 Emergency Department Visit for Mental Illness (FUM)*

*Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

SUMMARY OF CHANGES TO HEDIS MY 2025

- Modified the denominator criteria to allow intentional self-harm diagnoses to take any position on the ED visit 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.
- Allowed any diagnosis position for the mental health diagnosis on the follow-up claim in the numerator.
 - This revision rendered the numerator options requiring both an intentional self-harm diagnosis and mental health diagnosis redundant with the existing follow-up options, and thus were removed from the specification.
- Added residential treatment services to the numerator (and removed from the denominator removal criteria).
- Added peer support services and occupational therapy services for a diagnosis of a mental health disorder to the numerator.
- Added additional care settings in the numerator to improve alignment with the Follow-Up After Hospitalization for Mental Illness (FUH) measure:
 - Behavioral healthcare setting.
 - Transitional care management services with a mental health diagnosis.
 - Psychiatric collaborative care management.
- Removed the mental health diagnosis requirement on follow-up claims for partial hospitalization/intensive outpatient visits, community mental health center visits and electroconvulsive therapy to improve alignment with the FUH measure.

Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or any diagnosis of intentional self-harm, who had a follow-up visit for mental illness. 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 7 days of the ED visit (8 total days).

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Stratifications	<p>For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:</p> <ul style="list-style-type: none"> • Race: <ul style="list-style-type: none"> – 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: <ul style="list-style-type: none"> – Hispanic or Latino. – Not Hispanic or Latino. – Asked But No Answer. – Unknown. – Total. <p>Note: Stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.</p>
Ages	<p>6 years and older as of the date of the ED visit. Report three age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 6–17 years. • 18–64 years. • 65 years and older. • Total. <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	<p>An ED visit (<u>ED Value Set</u>) with a principal diagnosis of mental illness or <u>any diagnosis of intentional self-harm (Mental Illness and Intentional Self-Harm Value Set)</u> on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.</p> <p>The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between</p>

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.

January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

Multiple visits in a 31-day period If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: Removal of multiple visits in a 31-day period is based on **eligible** visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

ED visits followed by inpatient admission Exclude ED visits that result in an inpatient stay. Exclude 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. To identify admissions to an acute or nonacute inpatient care setting:

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

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

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.

Commented [LN2]: 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.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up ~~A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. A follow-up visit for any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.~~

7-Day Follow-Up ~~A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Follow-up visit for any~~

diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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 any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) **with any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** POS code 52 **with any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53 **with any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53) **with a principal diagnosis of a mental health disorder** (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) **with any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) **with any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) **with any principal**-diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Intensive outpatient or partial hospitalization visit (Visit Setting Unspecified Value Set) with POS 52 or (Partial Hospitalization or Intensive Outpatient Value Set).
- Community mental health center visit (Visit Setting Unspecified Value Set) with POS 53.
- 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).
- Visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set) or psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).

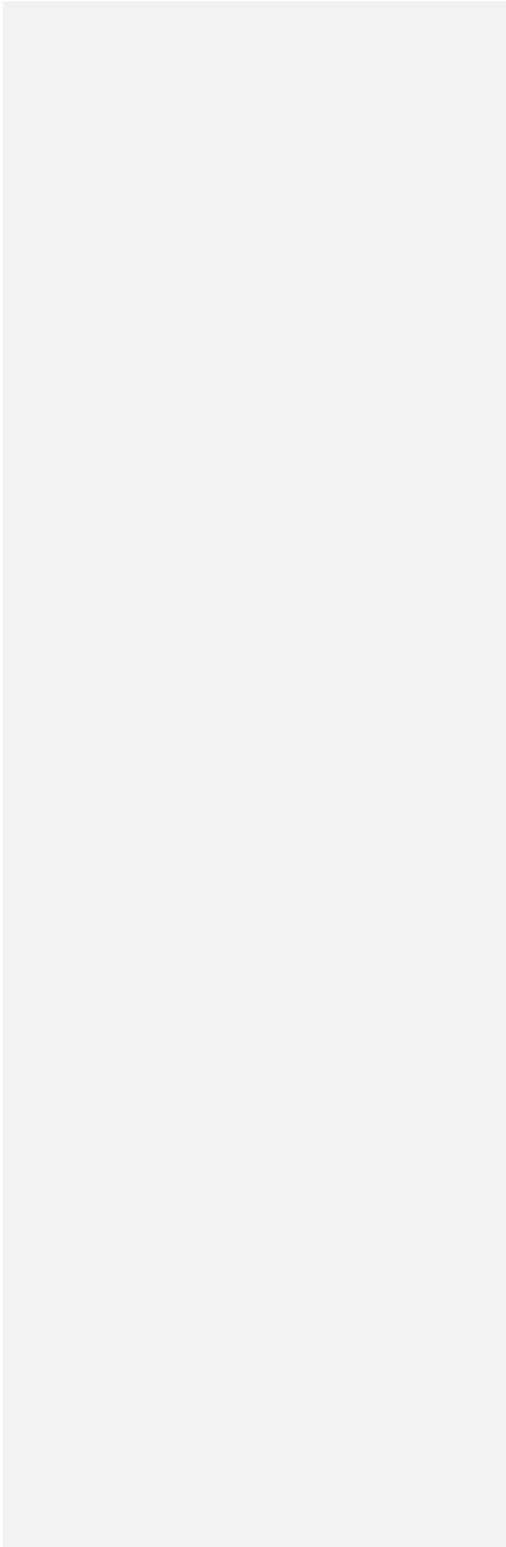
Commented [LN3]: Note for HEDIS MY 2025 Public Comment: This is a new draft value set for MY 2025. Code list included in the appendix of the memo.

Commented [LN4]: Note for HEDIS MY 2025 Public Comment: These are existing HEDIS value sets that would be added to the FUM measure for HEDIS MY 2025.

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 (within 30 days after the ED visit or within 7 days after the ED visit).*

DRAFT



Data Elements for Reporting

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

Table FUM-A-1/2/3: Data Elements for Follow-Up After Emergency Department Visit 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 FUM-B-1/2/3: Data Elements for Follow-Up After Emergency Department Visit 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 FUM-C-1/2/3: Data Elements for Follow-Up After Emergency Department Visit 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 Emergency Department Visit for Mental Illness

Measure Workup

Topic Overview

Measure Intent

Follow-Up After Emergency Department Visit for Mental Illness (FUM) focuses on post emergency department (ED) care coordination for individuals with a principal diagnosis of a mental illness or intentional self-harm during an ED visit. These individuals return to the community and may be vulnerable to losing contact with the health care system. The FUM measure plays a vital role in ensuring comprehensive and effective treatment for individuals in crisis. Providing care after discharge from the ED is a critical bridge between acute care and ongoing management of the mental health condition. Follow-up visits not only provide the opportunity for continuity of care, but also allow providers to identify changing or emerging issues, address treatment barriers and intervene promptly. Health plans are well positioned to facilitate care coordination because they have access to information across care settings and the ability to implement care management processes that ensure follow-up (Benjenk & Chen 2019).

Importance and Prevalence

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). While mental health disorders are widespread in the population, about 5.5% of the population, or 14.1 million people, suffer from a serious mental illness (SMI) (SAMHSA, 2022).

Research indicates that a substantial number of ED visits are related to mental health crises, including psychiatric emergencies, suicidal ideation, self-harm and acute exacerbations of mental health disorders. Between 2017 and 2019, 52.9 of every 1,000 ED visits were due to mental illness (Santo et al., 2021). The ED is an initial point of contact for individuals experiencing a mental health crisis, especially when other resources, such as outpatient mental health services, may not be readily accessible or available outside regular office hours.

Financial importance and cost-effectiveness

In 2017, it was estimated that the total cost of ED visits due to mental illness was more than \$5.5 million (Karaca & Moore, 2020). ED visits related to mental illness are estimated to be about one fifth of all ED costs. Medicaid accounted for the majority of ED expenses related to alcohol, suicidal behaviors and schizophrenia disorders; private insurance had the largest cost share for anxiety disorders (Karaca & Moore, 2020). The high financial burden associated with ED visits, coupled with the potential long-term costs of untreated mental illness, underscore the cost-effectiveness of investing in timely follow-up care. By allocating resources to facilitate seamless transitions to outpatient care, health care providers can mitigate the financial strain on systems and individuals, reduce the burden on EDs and ultimately achieve better mental health outcomes.

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-ED follow-up (Beauchemin et al., 2019; Hirschfeld et al., 2010). While there is established evidence on timely follow-up resulting in improved patient outcomes, there are limited studies describing

a direct link between follow-up after an ED visit for mental illness and improved patient outcomes (Geissler et al., 2021)

Timely follow-up care is associated with remaining in the community for a longer period of time and avoidance of future emergency visits (McCullumsmith et al., 2015). Evidence suggests that patients who fail to receive aftercare following an emergency psychiatric visit have 6 times higher odds of returning to the ED within 2 months, compared with patients who received aftercare (Bruffaerts et al., 2005). Additionally, patients' physical and mental functioning improve significantly by having a case manager assist in accessing primary care for their mental and physical health after discharge from an ED for a psychiatric crisis (Griswold et al., 2008).

Health importance

Individuals with mental illness who are discharged from the ED face two main risks: disengaging from treatment and return to the ED. The risk of treatment disengagement is problematic because individuals with the most serious mental health issues may require ongoing support and counseling to independently live in the community. 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 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 have the lowest likelihood of relapse and admission to a hospital (Geissler et al., 2021; Schmutte et al., 2022).

Simultaneously, the behavioral health workforce shortage has exacerbated the lack of access to mental health care. According to SAMHSA, over half of adults with any mental illness did not receive treatment in 2021 (SAMHSA, 2022). Only 47.2% of adults with any mental illness received mental health treatment, including any inpatient, outpatient, prescription for mental health condition or virtual service (SAMHSA, 2022). 65.4% of individuals with SMI received care during the year, while only 40.6% of adolescents with any mental illness received care (SAMHSA, 2022).

Gaps in care and opportunities for improvement

Many patients do not receive timely follow-up care after a mental illness ED visit. Prior to the measure's development, studies suggested that only about half of patients with ED visits for mental illness had timely follow-up care. Analysis of national 2006 Medicaid claims data found that only 52% of adult patients who left the ED for self-harm had a follow-up outpatient mental health visit within 30 days (Olfson, 2012). Evidence indicates that scheduling a follow-up visit for a patient at the time of discharge, appointment reminders and assertive community treatment programs can all increase the likelihood of patient follow-up after an ED visit for mental illness (Kyriacou et al., 2005; Kreyenbuhl et al., 2009). Similarly, post discharge compliance increases significantly for individuals with a primary care provider (Kyriacou et al., 2005). Overall, preserving an individual's engagement in treatment post-ED setting requires attention and high-quality handoffs between ED staff and ambulatory care providers.

Between 2016 and 2021, average performance for both the 7- and 30-day indicators remained relatively flat, and ranged between 30% and 63% across the Medicare, commercial and Medicaid enrollee populations. Results indicate that across all product lines, between 30% and 50% of individuals received follow-up within 7 days, and between 45% and 63% of individuals received follow-up within 30 days following an ED visit for a mental health condition. These performance trends illustrate areas of improvement for the FUM measure.

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 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). These findings suggest that the 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

The prevalence of mental illness is not equally distributed across different populations; disparities persist among various demographic groups, particularly related to race and ethnicity. Among adults, multiracial individuals are 11% more likely than Whites to experience mental illness. Multiracial, Hispanic, Black and Asian adults are also more likely to have a diagnosed SMI than their White counterparts (SAMHSA, 2022).

Over 50% of individuals who identified as White or multiracial receive treatment for any mental illness, while under 40% of Black individuals receive care for the same diagnoses. Individuals who identify as Hispanic receive care only 36% of the time, and those who identify as Asian receive care about 25% of the time (SAMHSA, 2022).

Research indicates that Black individuals exhibit an ED utilization rate for mental health conditions that is twice as high as the national average (Peters J. et al., 2023). They are more likely to wait an hour or longer to be seen, compared to their White and Hispanic counterparts (Peters J. et al., 2023). Research also demonstrates that Black individuals are less likely to receive follow-up care than their White counterparts (Croake et al., 2017). These statistics are underscored by the fact that Black individuals and other underserved populations face significant barriers to accessing appropriate and timely care, including financial constraints and a shortage of mental health providers.

According to the April 2021 CMS Office of Minority Health annual report, among Medicare Advantage members who had an ED visit for mental illness, Black and Hispanic individuals were less likely than White individuals to have had a follow-up visit with a mental health provider within 30 days of discharge. Across all racial and ethnic groups, women were more likely to have had a follow-up visit with a mental health provider within 30 days of discharge than men (Centers for Medicare & Medicaid Services, 2021).

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HEDIS Health Plan Performance Rates: Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Commercial Results: Tables 1–8

Table 1. HEDIS FUM 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	295 (70.9)	60.9	11.2	45.5	54.2	61.5	68.5	76.0
2021	419	299 (71.4)	63.6	11.1	48.6	56.5	63.8	71.2	77.2
2022	417	303 (72.7)	63.0	11.4	47.7	54.8	63.3	70.6	77.9

Table 2. HEDIS FUM 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	195 (46.9)	72.1	9.9	58.5	66.0	72.9	79.0	85.0
2021	419	208 (49.6)	74.5	9.6	62.5	67.7	73.5	81.9	87.9
2022	417	209 (50.1)	73.3	9.6	60.2	66.2	73.6	79.7	86.7

Table 3. HEDIS FUM 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	269 (64.7)	57.0	11.1	42.8	49.7	57.1	64.3	72.3
2021	419	271 (64.7)	58.7	11.0	43.0	51.8	58.9	66.4	72.9
2022	417	274 (65.7)	58.8	11.1	44.2	51.0	58.3	66.3	74.1

Table 4. HEDIS FUM 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	5 (1.2)	54.5	12.0	39.2	46.8	57.1	58.5	70.6
2021	419	6 (1.4)	54.5	19.5	28.9	41.9	52.0	67.7	84.4
2022	417	4 (1.0)	52.6	19.8	34.3	36.5	49.6	68.6	76.7

Table 5. HEDIS FUM 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	295 (70.9)	46.3	12.0	31.6	37.5	45.9	53.5	62.9
2021	419	299 (71.4)	48.3	12.3	32.6	39.9	46.9	55.5	65.0
2022	417	303 (72.7)	46.9	12.5	31.8	38.7	46.5	54.6	62.7

Table 6. HEDIS FUM 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	195 (46.9)	56.2	12.1	40.1	48.2	56.5	63.4	72.6
2021	419	208 (49.6)	57.7	12.7	43.2	49.2	56.1	64.7	77.6
2022	417	209 (50.1)	55.8	12.0	41.7	48.0	54.1	62.4	74.2

Table 7. HEDIS FUM 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	269 (64.7)	42.8	12.0	28.0	34.6	42.5	50.7	58.2
2021	419	271 (64.7)	43.8	11.6	28.6	36.5	43.6	50.9	60.0
2022	417	274 (65.7)	43.7	12.0	28.8	36.2	43.0	50.0	59.5

Table 8. HEDIS FUM 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	5 (1.2)	35.5	16.0	15.7	25.5	34.3	46.3	55.9
2021	419	6 (1.4)	41.9	20.7	8.9	35.5	42.2	51.4	71.1
2022	417	4 (1.0)	42.3	22.0	19.4	24.2	41.3	60.5	67.4

Medicaid Results: Tables 9–16**Table 9. HEDIS FUM 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	200 (73.5)	54.5	13.8	38.1	45.5	53.5	64.6	73.6
2021	270	216 (80.0)	53.4	15.1	30.5	44.8	54.5	63.4	72.0
2022	272	226 (83.1)	55.2	13.7	38.2	47.0	54.9	64.3	73.3

Table 10. HEDIS FUM 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	165 (60.7)	66.7	15.3	47.5	56.8	69.4	78.5	84.4
2021	270	187 (69.3)	64.6	16.8	44.6	54.9	67.8	76.9	83.8
2022	272	201 (73.9)	67.3	14.2	49.6	57.4	69.6	77.4	84.5

Table 11. HEDIS FUM 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	191 (70.2)	49.7	14.4	31.7	40.0	48.5	59.3	71.3
2021	270	206 (76.3)	48.6	15.5	28.6	38.6	48.7	58.2	70.8
2022	272	213 (78.3)	49.6	13.8	33.1	40.9	48.3	56.9	68.1

Table 12. HEDIS FUM 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	14 (5.1)	46.3	10.2	32.6	36.4	48.6	54.3	56.5
2021	270	20 (7.4)	46.9	15.0	25.6	32.5	47.6	59.0	66.6
2022	272	26 (9.6)	49.8	15.7	34.1	38.6	45.9	59.4	68.0

Table 13. HEDIS FUM 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	202 (74.3)	40.4	14.9	23.1	30.2	38.6	49.5	61.4
2021	270	220 (81.5)	40.1	15.7	20.5	29.6	40.4	50.4	60.6
2022	272	228 (83.8)	41.5	14.4	23.7	30.8	40.6	51.3	61.7

Table 14. HEDIS FUM 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	166 (61.0)	51.4	17.9	29.9	37.3	50.0	65.8	75.4
2021	270	191 (70.7)	49.9	18.5	25.2	37.6	50.0	64.4	74.3
2022	272	203 (74.6)	52.0	16.3	31.8	40.0	51.4	63.0	74.3

Table 15. HEDIS FUM 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	193 (71.0)	36.4	15.1	19.2	25.1	33.6	45.6	61.4
2021	270	210 (77.8)	36.1	15.9	17.3	25.3	34.7	46.1	60.5
2022	272	215 (79.0)	36.9	14.4	20.5	26.9	34.4	45.1	58.9

Table 16. HEDIS FUM Measure Performance—Medicaid Plans (7 Day Rate—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	14 (5.1)	34.5	8.8	23.9	29.4	34.9	43.1	43.9
2021	270	21 (7.8)	35.3	13.2	19.2	25.7	35.0	41.5	58.1
2022	272	26 (9.6)	36.8	15.8	22.0	26.4	34.9	43.8	57.6

Medicare Results Tables 17–22**Table 17. HEDIS FUM 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	264 (40.7)	50.5	14.1	34.1	40.9	48.5	58.6	70.1
2021	714	289 (40.5)	50.0	13.6	33.1	40.1	48.0	58.7	70.0
2022	750	301 (40.1)	50.6	13.5	33.8	41.5	49.2	60.0	68.7

Table 18. HEDIS FUM 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	195 (30.0)	53.2	14.1	36.3	43.3	51.6	61.0	74.3
2021	714	213 (29.8)	52.0	14.1	35.0	41.3	50.3	59.4	70.8
2022	750	228 (30.4)	52.6	13.9	35.3	43.4	51.4	61.9	72.2

Table 19. HEDIS FUM 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	135 (20.8)	44.0	13.0	29.8	34.8	42.7	50.8	62.3
2021	714	148 (20.7)	44.5	12.7	27.6	35.8	43.9	52.0	61.4
2022	750	164 (21.9)	44.3	12.4	29.5	34.9	44.5	51.6	61.1

Table 20. HEDIS FUM 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	264 (40.7)	35.0	14.6	20.0	24.7	31.7	43.0	56.5
2021	714	289 (40.5)	34.2	14.0	18.2	24.1	32.4	42.1	53.9
2022	750	301 (40.1)	34.8	13.5	20.3	25.1	32.6	42.0	53.6

Table 21. HEDIS FUM 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	195 (30.0)	36.5	15.5	19.6	24.5	33.3	44.2	59.9
2021	714	213 (29.8)	35.4	14.5	19.1	24.3	33.1	44.0	55.7
2022	750	228 (30.4)	35.9	13.8	20.0	26.5	34.2	44.0	54.7

Table 22. HEDIS FUM 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	135 (20.8)	31.2	12.5	17.6	22.0	28.9	36.8	51.4
2021	714	148 (20.7)	30.8	12.4	16.2	20.6	29.4	38.5	48.0
2022	750	164 (21.9)	30.8	12.9	15.7	22.6	29.8	37.0	47.6