Detailed Business Requirements

Version1.00

Tennessee Health Link

Table of Contents

1 Introduction

1.1 VERSIONS AND REVISIONS

Program design for Tennessee Health Link (Health Link), serving members with high behavioral health (BH) needs, is an iterative process that involves multiple stakeholders. Once the initial program design is finalized and implemented, experience with the new care delivery and payment model will generate new insights. These insights will be used to modify and improve the initial program design. To keep track of the version of the program model used at any given time, a versioning system is employed:

Version	Date	Changes
0.1	07-01-2016	First internal version. Formerly named a1.1 c01 d01
0.2	09-30-2016	Second internal version. Rearranged and removed some quality measures; removed the concept of auto passing; set quality gates; updated provider reporting section; set efficiency improvement cap at 20%; data in reports should now include the most up to date quality/efficiency metrics data available
0.3	10-31-2017	Third internal version. Updated efficiency metrics; changed outcome payment formula; incorporated several status changes; removed counseling for nutrition sub-metric; added reweighting logic; updated report section
0.4	12-07-18	Fourth internal version. Updated logo; Updated quality and efficiency metrics; changed outcome payment formula; added additional language around efficiency improvement percentage; replaced the work “benchmark” with “threshold”; updated reporting period member table; updated reporting period Health Link table; updated reporting only metrics to include new metrics; updated information around stabilization rate; change new TCOC value; updated reporting timeframe charts
0.5	09-26-19	Fifth internal version. Updated quality and efficiency metrics; updated dates to reflect upcoming year;

Version	Date	Changes
		corrected grammatical errors, updated reporting timeframe schedules; added guidance related to calculating member months, updated the Engagement Evaluation section, update language around the efficiency baseline performance
0.6	07-30-2021	Sixth version. Updated 10% cap logic; quality metrics; star weights; exclusion logic; corrected grammatical errors.
0.7	07-30-2021	Seventh version. Updated exclusion logic to include Katie Beckett.
0.8	10-28-2021	Eighth version. Added exclusion language for Intensive Community-Based Treatment. Updated dates to reflect upcoming year. Updated core metrics, reporting only metrics, and thresholds. Updated reporting timeframe schedule. Updated star value % for re-weighting.
0.9	02-23-2022	Ninth version. Updated Section 3.8.2 to note that the efficiency metric values used in the efficiency improvement percentage calculation should be rounded to the nearest hundredth decimal place. Updated file attribution language.
1.0	09-19-2022	Tenth version. Updated years where appropriate throughout document. Updated language and tables to reflect not rounding redistributed star values. Added examples for composite measures and star redistribution diagram. Added new Reporting-Only Metrics where appropriate throughout document. Revised language to clarify member month calculation. Removed historical language where appropriate and throughout document. Fixed formatting issues 84throughout document.

1.2 SCOPE OF THIS DOCUMENT

The DBR document serves as a guide to understand the design of the Health Link program. The DBR addresses three audiences:

- The Health Link program owner who is accountable for the Health Link program design and implementation
- The analytics team tasked with testing the design of the program and quality controlling the outputs from the algorithm
- The Information Technology (IT) team tasked with implementing the algorithm to produce outputs

Section 2 of the DBR contains a description of the program design and is written for the Health Link program owner and the analytics team. It addresses the following questions:

- **Member status**: How does a member enter the Health Link program and how does his or her status change over time?
- **Sources of value**: How does the program aim to improve the quality of behavioral health care services for Medicaid members, the capabilities and practice standards of behavioral health care providers, and the overall value of health care delivered to the members?

Section 3 of the DBR contains a description of the decisions that underlie the design of the program. It is written for the Health Link program owner and the analytics team, and addresses the following questions:

- **Identify the eligible members**: What criteria are used to identify members eligible for the program?
- **Attribute members to Health Link organizations**: What criteria are used to identify Health Link organizations eligible for attribution? How are Health Link members attributed to Health Link organizations?
- **Identify enrolled members**: How are members actively participating in the Health Link program identified?
- **Define outcome panels**: How is the member panel for performance reporting of each Health Link organization defined?
- **Calculate performance metrics**: How are quality and efficiency performance metrics calculated?
- **Calculate activity payments**: How is each Health Link organization activity payment amount determined?
- **Calculate total cost of care**: How is each Health Link organization's total cost of care and BH total cost of care determined?
- **Calculate outcome payments**: How is each Health Link organization's outcome payment amount determined?
- **Generate data for the Care Coordination Tool and provider reports**: What are the inputs needed for the Care Coordination Tool and the Health Link provider reports?

Section 4 of the DBR explains the data flow for the Health Link program. It is written for the analytics team and the IT team and addresses the following questions:

- **Input data**: What input files are required to build the Health Link algorithm?
- **Configuration file**: Where can parameters (e.g., number of days) and medical codes (e.g., diagnosis codes) referenced in the DBR be found?
- **Output tables**: What are the recommended outputs of the Health Link algorithm, which inform the provider reports?
- **Acceptance criteria**: Do the output data reflect the intent of the Health Link algorithm?

Section 5 of the DBR is written for the IT team. Section 5 contains the specific elements of the Health Link algorithm described in the earlier sections of the DBR. Section 5 defines the program at a level of granularity that will allow an IT implementation team to create an algorithm that matches the design intent. This section may also be helpful to the analytics team in communications with the IT team during quality control checks. This section addresses the following questions:

- **Overall process**: What are the logical tasks the algorithm needs to complete in order to produce the required outputs?
- **Detailed logic**: What cases does the algorithm need to address?
- **Exceptions**: Are there exceptions to the overall logic?

The DBR document does not cover the following topics:

- Background on how the Health Link program compares to any current program
- Clinical rationale for program design
- Analyses used during the Health Link program design
- Meeting materials used during the Health Link program design
- Guidance on data collection/transformation/storage
- Guidance on Health Link algorithm coding approach

2 Tennessee Health Link Program Overview

2.1 HEALTH LINK PROGRAM DESCRIPTION

The primary objective of Health Link program is to coordinate behavioral and primary health services for patients with the highest behavioral health needs in the State.

There are two payment streams that support and incentivize the transformational goals of the Health Link program:

1. **Activity payments**: these are claim-based payments made to Health Links to support care delivery under the Health Link model, paid at most once per month per member.
2. **Outcome payments**: another important aspect of the Health Link program is the focus on provider accountability for the outcomes of their patient panels. Health Links will be eligible for payments based on improvement in quality and efficiency.

Finally, a number of performance metrics are generated as part of the Health Link program. These are collected and reported on a quarterly basis in order to:

- Provide Health Link organizations with information on the composition of their attributed members in order for them to better manage their practices.
- Equip Health Link organizations with quality and efficiency information needed to improve and coordinate care delivery.

2.2 MEMBER STATUS ACROSS HEALTH LINK PROGRAM

The Health Link program described in this document applies to members with the highest BH needs. The member's interaction with the Health Link program begins when a member has clinical indications that meet the eligibility requirements for Health Link support.

Once a member is eligible for the Health Link program, he/she is categorized into one of the following six different statuses:

- **Active** (this status is referred to as "*Enrolled*" in the remainder of the DBR)
  - A member who is enrolled in the program
  - Once a member is "Active", he/she is deemed active in the next months, unless Inactive criteria are met or the member loses eligibility
- **Inactive No BH Treatment**
  - A member who did not receive any BH treatment in the past 180 days (with full run-out of 4 months)
  - Whether the member had a BH treatment is checked every month beginning October 1, 207, but only for members who are in "Active" status; if the member

has a BH treatment again, then his/her active status becomes “Attributed Not Enrolled”
    - Exclude all dual members who are not aligned D-SNP duals from consideration for this status
- **Inactive No Contact**
    - A member who could not be contacted for 6 months or more and the MCO has made the explicit decision to put into “Inactive No Contact” status
- **Inactive Opt Out**
    - A member who explicitly expressed the desire to opt out of the Health Link program
    - Members remain in “Inactive Opt Out” status in the next months, unless they have specifically expressed the desire to opt in. Please populate Termination date when member has opted out.
    - Members in the “Inactive Opt Out” status should be removed as soon as possible from the attribution file
- **Attributed Not Enrolled**
    - A member who is attributed to a Health Link but have not yet been enrolled into the program.
- **Discharged**
    - Member who has been identified as discharged from the Health Link program for either meeting program goals or having made no progress. Please populate termination date in the file.
    - The date of discharge should be the “Date of Switch, Opt-in/out or Discharged” from the **Input Data Field for Non-Claims data** table
    - Retroactive dates are not acceptable dates of discharge
    - Discharged members should be removed from visibility in the CCT after 6 months
    - Members who have been discharged, may become eligible for Health Link following a “requalifying event”
    - A “requalifying event” is defined as an event involving a Category 3 provider attestation of the member having functional need based on the medical necessity criteria

Note: There is an intermediary step referred to as “*Not Attributed*” but this is not a status field for the purposes of the Health Link attribution file.

While eligible members are attributed to a Health Link organization based on their clinical history, each member also has the option to receive Health Link services from a different eligible provider, by requesting a switch.

If a member meets criteria for more than one of the following Health Link statuses, the following hierarchy should be applied:

1. Inactive Opt Out
2. Discharged
3. Inactive No BH Treatment

4. Inactive No Contact

2.3 SOURCES OF VALUE

As a comprehensive care delivery model, the Health Link program has been designed to improve:

1) The quality of behavioral health care services for members
2) The capabilities and practice standards of behavioral health care providers
3) The overall value of health care delivered to members

Successfully executed, the Health Link program will deliver a number of benefits to members, providers, and the system as a whole. A few of the more substantial benefits are outlined in the table below.

TABLE 1: Sources of Value

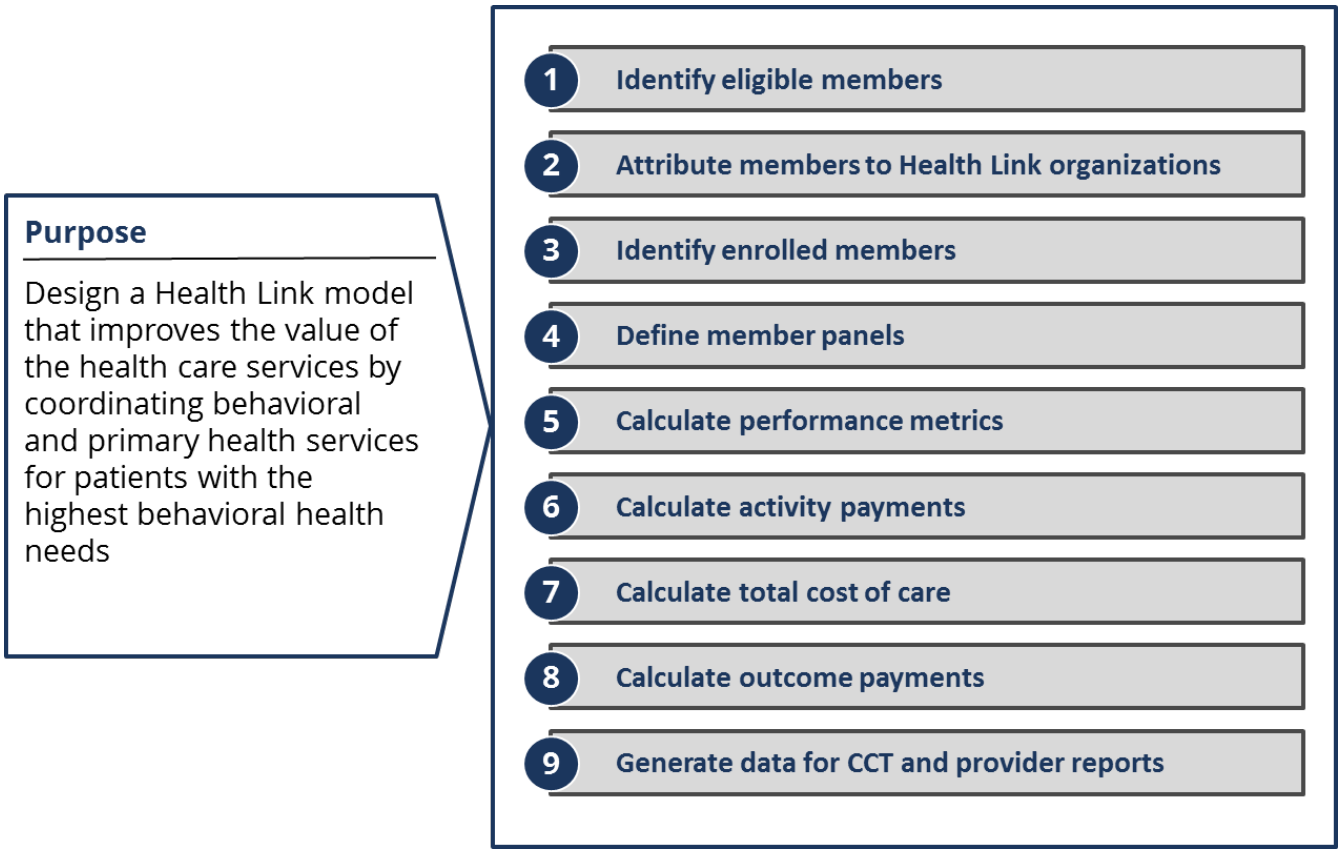
Members	Providers	System
▪ Better access to behavioral health care providers ▪ Specialized care for those most in need ▪ Care coordination services leading to improved quality and outcomes ▪ Greater emphasis on preventive care	▪ Support for performance improvement ▪ Specialized training for practice transformation ▪ Access to outcome payments ▪ Input from other members of the care delivery team ▪ Access to more accurate and timely	▪ Better outcomes – Higher quality care – Greater emphasis on preventive care ▪ Reduced total cost of care – Reduced utilization of secondary care through better management of chronic conditions

Members	Providers	System
▪ Less unnecessary or duplicative treatment due to increased coordination across providers ▪ Greater understanding of the care they receive and how to better navigate the healthcare system	member information with which to make decisions ▪ Improved work flows and processes that positively impact productivity and efficiency	– Reduced utilization of unnecessary procedures and visits (e.g., unnecessary emergency room visits) – More cost conscious referrals ▪ System shift toward greater coordination and information sharing

3 Tennessee Health Link Program Design

The Health Link program comprises nine dimensions. Each dimension is associated with a set of data manipulations that convert the data inputs to the desired data outputs.

EXHIBIT 1: Health Link Program Design Dimensions



3.1 IDENTIFY ELIGIBLE MEMBERS

Members are eligible for the Health Link program if they meet one or more of the eligibility inclusion criteria and none of the eligibility exclusion criteria.

3.1.1 Identification of members meeting the eligibility inclusion criteria

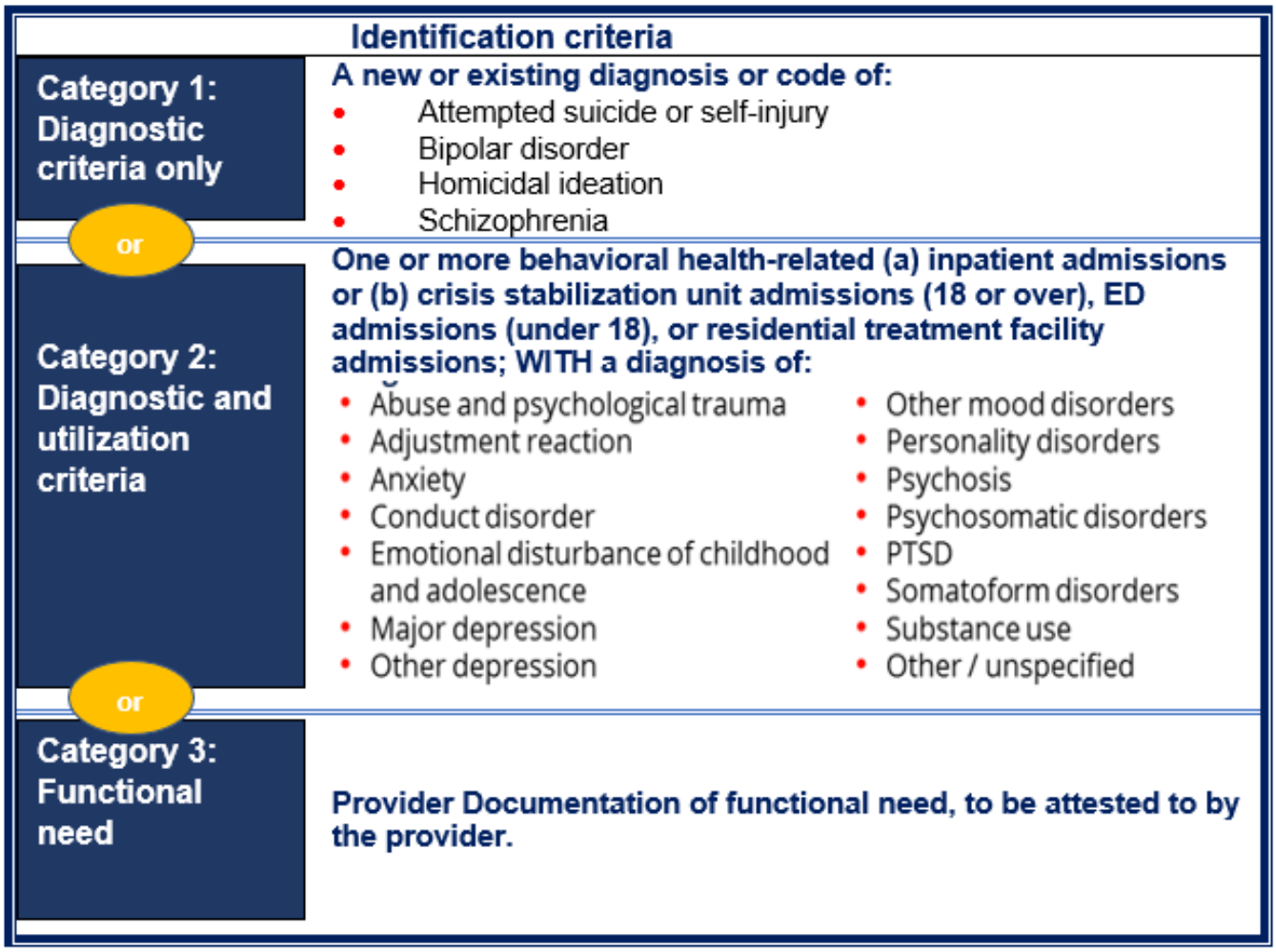
The eligibility inclusion criteria is based on the clinical history of the member, as demonstrated using a claims-based approach (e.g., medical claims) and non-claims-based approach (e.g., hospital and provider data feeds). Non-claims-based eligibility is in place to ensure prompt availability of Health Link services for members in need, due to the potentially significant time delays in claim filing and processing.

The frequency at which the member eligibility identification is conducted is:

- Monthly for claim-based eligibility update
- At least monthly for non-claim-based eligibility update

Once a member is identified as meeting the eligibility inclusion criteria, he or she remains eligible, regardless of whether he or she meets the eligibility criteria in the most recent update. Members lose eligibility to the Health Link program only if they meet the eligibility exclusion criteria described in Section 3.1.2.

EXHIBIT 2: Health Link Eligibility Inclusion Criteria



For all eligiblity inclusion criteria defined in Exhibit 2, diagnosis codes may only be in the 1st, 2nd or 3rd code positions to be applicable.

There are three categories of eligibility inclusion criteria: Category 1 – Diagnostic criteria only, Category 2 – Diagnostic and utilization criteria, and Category 3 – Functional need. If a

member meets the criteria for multiple categories, he/she is classified into the lowest numeric category for which the criteria were met.

- Claims-based eligibility inclusion criteria

Members meet the claims-based eligibility inclusion criteria if they meet one or more of the following requirements:

  - **Category 1 – Diagnostic criteria only**: The member has a one or more claims with a category 1-specific diagnosis within the specified time period.
  - **Category 2 – Diagnostic and utilization criteria**: The member has one or more claims with a Category 2-specific diagnosis for an inpatient, crisis stabilization unit, residential treatment facilities, or ED (for age less than 18) admission with a BH cause within the specified time period.
  - **Category 3 – Functional need**: The member has two or more Level 2 Case Management visits within the specified time period.

As Level 2 Case Management is incorporated into the Health Link program, the claim-based member eligibility update for Level 2 Case Management will include fewer and fewer claims. Eventually, the Category 3 eligibility will be based on attestation of functional need only, described in the next section.

The claim look-back period used for claims-based member eligibility updates differs depending on the eligibility category and whether the member eligibility update is conducted before or after the program launch. Only claims for services provided during the following timeframe should be used:

TABLE 2: Claims-Based Member Eligibility Update Claim Look-back Windows

	Category 1	Category 2	Category 3
Before program launch on December 1, 2016	180 days before the member eligibility update start date or from April 1, 2016 to	150 days before the member eligibility update start date or from July 1, 2016 to	180 days before the member eligibility update start date or from April 1, 2016 to

	Category 1	Category 2	Category 3
	member eligibility update start date, whichever is shorter	member eligibility update start date, whichever is shorter	member eligibility update start date, whichever is shorter
On or after program launch on December 1, 2016	180 days before the member eligibility update start date or from April 1, 2016 to member eligibility update start date, whichever is shorter	150 days before the member eligibility update start date or from July 1, 2016 to member eligibility update start date, whichever is shorter	180 days before the member eligibility update start date or from December 1, 2016 to member eligibility update start date, whichever is shorter

Note: These are the look-back periods for each algorithm run. Aggregate eligibility extends back to either April 1, 2016 or December 1, 2016 for Category 1 and Category 3 and to July 1, 2016 for Category 2.

- Non-claims-based eligibility

There are certain cases where a member's eligibility is determined based on sources other than claims. These cases are outlined in the table below.

TABLE 3: Sources of Information for Non-Claims-Based Eligibility

3.1.2 Eligibility exclusions of members from the Health Link program

Source	Description
Hospital triggered eligibility	Member is eligible if the hospital triggered eligibility demonstrates: • Category 1: Hospital admission or visit with one of the diagnoses specified for claims-based eligibility for Category 1 • Category 2: Hospital inpatient, crisis stabilization unit, residential treatment facility or ED (for age less than 18) admission with one of the diagnoses specified for claims-based eligibility for Category 2
Provider triggered eligibility	Member is eligible if the provider triggered eligibility demonstrates: • Category 1: Visit with one of the diagnoses specified for claims-based eligibility for Category 1 • Category 2: Crisis stabilization unit or residential treatment facility admission with one of the diagnoses specified for claims-based eligibility for Category 2 • Category 3: Attestation of member having functional need, based on the medical necessity criteria
MCO transition	If a member with Health Link eligibility makes a new MCO selection, his/her Health Link eligibility is transferred to the new MCO

Similar to the inclusion criteria, the eligibility exclusion criteria is based on both claims-based and non-claims-based criteria.

- **Member loses eligibility for TennCare**: The member lost eligibility for TennCare since the last member eligibility update start date.
- **Member is a current resident of a nursing home for longer than the minimum specified days**: The member has one or more nursing home facility claims that cover more than 90 consecutive days that are ongoing as of the eligibility update start date. The member must be discharged to home from a previous nursing home stay to be eligible for the Health Link program.
- **Member is a current resident of a residential treatment facility (RTF) for longer than the minimum specified days**: The member has one or more residential treatment facility (RTF) claims that cover more than 90 consecutive days that are ongoing as of the eligibility update start date. The member must be discharged to home from a previous RTF stay to be eligible for the Health Link program.
- **Member has eligibility under certain programs by the Department of Children Services (DCS) for longer than the minimum specified days**: The member was enrolled in Level 3 and above programs by the DCS for more than 30 consecutive days, including the date of the member eligibility data extract. The MCO may choose to specifically include certain members who meet this criteria.

- **Member is receiving Systems of Support (SOS) Level 1 or Level 2 services**: The member was enrolled in SOS Level 1 or Level 2 for more than 30 consecutive days, including the date of the member eligibility data extract. The comprehensive care coordination at the core of SOS Level 1 and Level 2 services is duplicative with the activities of the Health Link.
- **Member is receiving Intensive Community-Based Treatment (Continuous Treatment Team or Comprehensive Child and Family Treatment (CTT/CCFT)) services**: The member is receiving CTT or CCFT services determined by service authorization. The comprehensive care coordination at the core of CTT or CCFT services is duplicative with the activities of the Health Link program. The member must be discharged from CTT or CCFT to become eligible for the Health Link program again.
- **Member has eligibility under the TennCare for Prisoners Program:** The member was enrolled in the TennCare for Prisoners Program as determined by a Q code in the Member ID. This program only covers acute inpatient hospital services so any THL claim for members would not be eligible for payment.
- **Member has eligibility under Katie Beckett Part B:** The member was enrolled in Katie Beckett Part B and therefore has no TennCare Eligibility.
- **MCO or provider assessment indicates that the member no longer needs Health Link membership or member is making little to no progress in meeting targeted goals:** A MCO or provider decision is made between the last member eligibility update start date and the date of the current member eligibility data extract (see Glossary for discharge criteria), that the member is no longer benefitting from the Health Link program.

Once excluded, a member may become eligible for the Health Link program again, if his/her exclusion status changes.

Note: Select Community and Choices members, Lifecares FITT members, members with DCS services other than the programs specifically excluded, and ECF Choices members are included in the program if they meet the eligibility criteria, unless they meet one of the exclusion criteria listed above. D-SNP dual members are included if they are enrolled in an aligned D-SNP health plan. Being “aligned” means that the member is enrolled in a Medicare Advantage D-SNP plan with the same MCO as his/her MCO for the TennCare Medicaid program. Examples of not being enrolled in an aligned D-SNP health plan include cases where the member is dual-eligible but enrolled in a Medicare Advantage health plan that is not a D-SNP, a D-SNP health plan with another insurer, or Medicare fee-for-service. Members in CoverKids program are not included.

A mechanism for MCOs to flag for the State any additional programs that provide duplicative services for potential exclusion will be added.

3.2 ATTRIBUTE MEMBERS TO HEALTH LINK ORGANIZATIONS

Only members eligible for the Health Link program are included in attribution. All Health Link eligible members must be attributed to a Health Link. Attribution of members to Health Link organizations requires three steps: the identification of Health Link organizations eligible for new member attribution, claims-based attribution, and non-claims-based attribution.

3.2.1 Identification of eligible Health Link organizations

All Health Link organizations selected through the application process are eligible for member attribution. Going beyond the initial attribution, member attribution needs to take into account the following changes in eligible Health Link organizations who qualify for member attribution:

- Addition of new Health Link organizations participating in the program;
- Organizations that stop participating in the Health Link program;
- Health Link organizations removed from the model by the State;
- Health Link organizations in remediation, in which case no new members can be attributed. Remediation occurs when a Health Link organization fails to meet model requirements for one performance period (i.e., calendar year).

A list of Health Link organizations qualifying for attribution, is provided as an input file for member attribution. Each update of attribution should use an up-to-date list of eligible Health Link organizations.

3.2.2 Attribution of members to eligible providers based on claims

Claims-based attribution is conducted every month and becomes effective as of the day when the attribution update is finalized.

- Initial attribution

In the initial attribution, members are attributed to Health Link organizations based on the following criteria, in hierarchical order:

1) If the member has two or more behavioral health outpatient visits with any Health Link organizations during the 180 days before the attribution update is conducted, the member is attributed to the Health Link organization with the most visits. If there is a tie, the member is attributed to the Health Link organization with the most recent behavioral health outpatient visit.
2) For members not attributed based on the first criterion, if the member receives two Level 2 Case Management visits, the member is assigned to the Health Link organization with the most recent Level 2 Case Management visit during the 365 days before the attribution update is conducted.
3) For members not attributed based on the first and second criteria, if the member is attributed to a primary care practice that is a Health Link organization, then the member is assigned to that primary care practice.

In conducting attribution based on criteria 1 and 2, only claims for services provided on or after April 1, 2016, should be included. If the claims within the specified look-back period defined above include claims for services rendered before April 1, 2016, then those claims should not be included in the attribution decision.

Behavioral health outpatient visits used for the first criteria must be of a clinical nature. Visits for services that fall in the Tennessee BH service categories of “Supportive services”, “Ancillary services”, “Case management, Level 2”, “Health Link activities” and “Other types of care”, as defined in the Glossary, are not included. Visit types are defined in the Glossary.

- Subsequent claim-based attribution

After the initial attribution, subsequent updates of the claims-based attribution are conducted only for the subset of members who do not have an attributed Health Link organization. Subsequent attributions are conducted based on a methodology identical to the initial attribution.

There are four scenarios where members may require a new attribution:

- Members who become newly eligible and have no attribution recorded
- Eligible members who become active after an inactive period due to opt-out, as defined in Section 3.3.3.
- Of the eligible members who could not be contacted by the attributed Health Link organization during a certain time period, the members that the MCO has identified for reattribution, as described in Section 3.3.2.
- Members who were previously excluded from the Health Link program due to exclusion criteria but have since regained eligibility (Exclusion: Members who lost TennCare eligibility and then regained their eligibility may be attributed to their previously attributed provider.)

Consistent with the initial attribution, the claims-based attribution, i.e., criteria 1 and 2, should use only claims for services provided on or after April 1, 2016. As Level 2 Case Management services are incorporated into Health Link activities, fewer members will be attributed by the second attribution criteria based on claims.

Members with an attributed Health Link organization from a previous month who are not subject to a subsequent claims-based attribution, remain attributed to the same Health Link organization.

3.2.3 Non-claims-based attribution

There are certain cases where a member’s attribution is modified outside of the claims-based attribution update. These cases are outlined in the table below. For these cases, the attribution data is updated as of the date when the attribution modification requests, or feeds are received. If the member has an existing attribution in place, non-claims-based attribution data is considered invalid except for cases where the member is requesting a switch of Health Link organization.

TABLE 4: Non-Claims-Based Attribution Cases

Member characteristic	Attribution methodology
Newly eligible members identified through hospital triggered eligibility	Member is attributed to the Health Link organization to which the hospital referred the member at discharge. This does not apply to members with an existing attribution.
Newly eligible members identified through provider triggered eligibility	Member is attributed to the Health Link organization which attested the eligibility and enrollment of the given member, or the Health Link organization to which the provider referred the member at encounter. This does not apply to members with an existing attribution.
Members requesting switch of Health Link organization	If a member with Health Link eligibility requests a switch of Health Link organization, then the Health Link organization to which the member has requested the switch becomes the attributed provider. The member requesting a switch may or may not have a previous attribution on file.
Members switching MCOs	If a member with Health Link eligibility switches MCOs and if the member's previous Health Link organization is also a Health Link organization with the new MCO, then the member remains attributed to the same Health Link organization. If the member's previous Health Link organization is not a Health Link organization with the new MCO, then the member requires a new attribution (e.g., based on member switch, attestation, or claims)
All other members without attribution	If an eligible member does not have an attribution on file after the claims-based attribution update, then the MCO manually attributes the member to an appropriate Health Link organization, incorporating factors such as provider performance, geographic proximity, or member characteristics.

3.3 IDENTIFY ENROLLED MEMBERS

Enrolled members are members who are active participants of the Health Link program, with ongoing BH needs and interaction with their Health Link organization. Identifying enrolled members includes identifying members who newly enroll, members who become inactive, and members who resume activity after an inactive period.

3.3.1 New enrollment of attributed members

Enrollment refers to the activity that marks the day when the member begins to receive Health Link services. Additionally, on this day, the Health Link organization becomes eligible for activity payments. A member can enroll only with the Health Link organization to which he/she is attributed. If a member wishes to enroll with a Health Link organization to which he/she is not attributed to, then he/she needs to request a switch of the attribution, as described in Section 3.2.3, to change the Health Link attribution before enrolling with the Health Link organization of choice.

A member is considered enrolled with his/her Health Link organization when one of the following criteria is met:

- **Health Link reporting of enrollment:** The Health Link organization to which the member is attributed attests to the MCO that the member is enrolled. The member is considered enrolled as of the date of notification.
- **Initiation of the first Health Link activity:** The Health Link organization to which the member is attributed files a billing code and activity claim for the member, which includes a face-to-face interaction with the member and initiation of a comprehensive care plan. The member is considered enrolled as of the service date of the claim that identified the initial Health Link activity. (See Glossary) Member enrollment status is based on Health Link claims submitted by the attributed Health Link organization only.
- **Auto-enrollment for Level 2 Case Management recipients:** Members who are eligible for Health Link as defined in Section 3.1 and who also receive Level 2 Case Management, are considered as auto-enrolled in the Health Link program. The member is considered as enrolled with the Health Link organization he/she is attributed to on the date his/her Health Link attribution is finalized. (See Glossary)

Enrollment applies to members who are attributed but yet to be enrolled as well as members who opted in after a period of opt-out. Enrollment data needs to be collected once the Health Link program is launched on December 1, 2016. For auto-enrollment, i.e., the third criteria for enrollment, claims data are screened at the same frequency as the eligibility and attribution update to identify any new members requiring auto-enrollment, i.e., having two or more Level 2 Case Management visits in the previous 180 days.

3.3.2 Inactive member identification

Identifying the correct set of enrolled members also requires identifying inactive members, as these members should not be in an active/enrolled status. There are three criteria that identify members as inactive:

- **Member opt-out from Health Link program**: If the member indicates a desire to opt out of the program to the MCO or attributed Health Link organization, then the member is recorded as inactive effective the date of the opt-out indication.
- **Member without BH-related treatments**: If the member does not receive any BH-related treatments within a set time threshold, as evidenced in the claims data, then the member is considered inactive, effective the date when the claims-based enrollment

update was finalized. The time threshold is set to 300 days, and this criteria is applied to aligned D-SNP duals and non-dual members only.

- **Member unable to be contacted following attribution**: If the member could not be contacted by the Health Link organization for 180 days since the attribution date, then the member is flagged for further review, effective the 180th day following the date of attribution. The MCO reviews the member file and can choose to switch the member to an inactive status, effective the date of the decision, or reattribute, as described in Section 3.2.2. Should the MCO choose to reattribute an already enrolled member to another Health Link, the MCO will need to obtain State approval of the process.

Presence of BH-related treatments are defined as either of the following:

- **BH treatment OP visits**: Identified by the presence of an outpatient professional or outpatient facility claim with a BH-related primary diagnosis or with a BH-specific treatment as defined in the Glossary on BH Service Categories. In addition, the claim should have services outside of "Ancillary services", "Supportive services", "Case management, Level 2", "Health Link activities", "Medication / Pharmacy", and "Other types of care" as defined in the BH Service Category section of the Glossary.
- **BH inpatient, residential treatment facilities, ED, or crisis unit admissions**: Identified by the presence of a claim with a BH-related primary diagnosis or with a BH-specific treatment, which also fall in BH Service Categories of "Hospital inpatient care", "Mental health residential", "ED care", or "Crisis services" as defined in the Glossary. In addition, the claims or claims detail lines for "Hospital inpatient care", "Mental health residential", and "ED care" should be part of facility claims.

Members remain in inactive status, unless they resume activities as described in Section 3.3.3.

3.3.3 Activity resumption of previously inactive members

Members who became inactive through the opt-out process or because of lack of qualifying BH treatment may resume their status under certain conditions:

- **For members who had previously opted out**: Members can opt back in to the program by contacting the MCO or any Health Link organization. Members identified as opting back in to Health Link may be attributed a new provider. If a provider is specified on the "Opt in" record or provider triggered eligibility record, that provider will be the member's attributed provider. Otherwise, the member will go through the standard attribution process to determine their Health Link. Members will become enrolled once the face-to-face interaction occurs and the comprehensive care plan is developed.
- **For members who resume BH treatment after an inactive period due to lack of BH-related treatments for an extended period of time:** Members can resume a status of "Attributed Not Enrolled" if they have incurred a qualifying BH treatment encounter while they are still eligible for the Health Link program. The member is considered as resuming his/her status of "Attributed Not Enrolled" with the attributed Health Link organization effective the date of the BH treatment service. The presence of BH treatment is identified by a screening of claims at a monthly interval.

3.4 DEFINE MEMBER PANELS

Each member must have one attributed Health Link organization for each month, based on the attribution and enrollment record. While the member may switch Health Link organizations, only one Health Link organization is designated as the attributed Health Link organization for the month based on the Health Link the member was attributed to on the assignment update date.

There are two different panels. One is used to generate monthly activity payments. The other panel is used to measure performance and generate the outcome payment.

3.4.1 Activity payment panels

The activity payment panels contain the set of members for whom each Health Link organization provided Health Link services during the month. These member panels include members who meet the following requirements:

- Member is active in the Health Link program for the month, as evidenced in the claims (e.g. one of the six Health Link activities is completed by the provider); and
- The given Health Link organization is the member's enrolled Health Link organization for the month or
- The given Health Link organization is not the member's enrolled Health Link organization for the month but a valid payment within the look back period is present.

Each month, Health Link organizations receive activity payments only for the members who meet the above listed requirements.

3.4.2 Outcome panels

Quarterly reports aim to provide Health Link organizations with an interim view of the member panels that they are held accountable for during the performance period. Each quarterly report provides a summary of the Health Link organization's total cost of care performance from the beginning of the performance period to the end of each quarter, and incorporates 90 days of claims run-out after the end of the quarter. The final report of the performance period incorporates 180 days of claims run-out after the end of the reporting period. Metric performance will include the most recent data available.

Members that meet the following criteria are considered to be part of the outcome panel of a Health Link organization:

- The member is part of the Health Link organization's panel for which he/she is attributed to for the most number of months during the months covered by the quarterly report. Months during which the member opted out of the Health Link program are not taken into account in identifying the member panel for quarterly reporting.

- If there is a tie, the member is attributed to the Health Link organization to which he/she was attributed to in the most recent month.

In addition, members that meet at least one of the following criteria are excluded from the Health Link organization's outcome panel:

- The member is a dual member other than an aligned D-SNP dual at any time during the months covered by the quarterly report
- The member has a third-party liability at any time during the months covered by the quarterly report
- The member has an extended nursing home stay of over 90 days during the months covered by the quarterly report
- The member has an extended residential treatment facility stay of over 90 days during the months covered by the quarterly report.
- The member received Intensive Community-Based Treatment for more than 90 days during the months covered by the quarterly report.

Note that the treatment of dual eligible members, including aligned D-SNP duals and other duals, and members with third party liability is different for Health Link service provision and the panel for metrics calculation. Additionally, the PCMH program and the Health Link program treat these members differently (see Glossary).

Lastly, members must have been attributed to the Health Link organization for a minimum of nine months in order to be part of the Health Link organization's outcome panel for the last report of the performance period. Please note final calculation of members months should be rounded to a whole number.

The final quarterly report of the performance period contains the performance results for which each Health Link organization is evaluated. For outcome payments, members are considered to be part of the panel for a given Health Link organization if they are part of the Health Link organization's panel used for the last performance report of the performance period.

3.5 CALCULATE PERFORMANCE METRICS

The Health Link program has eleven core metrics and eleven reporting-only metrics. Metrics are further categorized into quality metrics and efficiency metrics.

For the quarterly reports, performance metrics are calculated based on claims and non-claims supplemental data for services provided from the beginning of the calendar year to the last day of the reporting period, unless specified differently in the metric definition. Each metric for a Health Link organization is calculated based on the members in the member panels for quarterly reporting for the given Health Link organization for the quarter as defined in Section 3.4.

3.5.1 Core metrics

NOTE: The National Committee of Quality Assurance (NCQA) released specification changes for several measures for Measurement Year 2020 and Measurement Year 2021, including core measures related to child and adolescent well-care visits. As a result of this change, THL's core metrics were reduced from 10 core metrics to 9 core metrics on July 1, 2020, for MY2020.

The eleven core metrics for the Health Link program are outlined in Table 5. Certain metrics are calculated as composites of multiple sub-metrics. In addition, certain metrics are calculated for a specific age group only, e.g., adults only or children only. All core metrics use the definition, including continuous enrollment requirements, provided by the source organization.

TABLE 5: Core Metrics for Health Link Program

Category	Core metric	Source
Quality metrics	**Core Quality Metric 1**: 7- and 30-day psychiatric hospital / RTF readmission rate – Core Quality Metric 1a: 7- and 30-day psychiatric hospital / RTF readmission rate – 7 days – Core Quality Metric 1b: 7- and 30-day psychiatric hospital / RTF readmission rate – 30 days	TennCare
	Core Quality Metric 2: Adherence to Antipsychotic medications for individuals with Schizophrenia	HEDIS® (SAA)
	Core Quality Metric (3): Antidepressant Medication Management: Antidepressant Medication Management (adults only)-Effective Continuation Phase Treatment	HEDIS (AMM)
	Core Quality Metric (4): - **Core Quality Metric 7a:** Child & Adolescent Well-Care Visits - 7-11 years - **Core Quality Metric 7b:** Child & Adolescent Well-Care Visits - 12-17 years	HEDIS (WCV)

Category	Core metric	Source
	- **Core Quality Metric 7c:** Child & Adolescent Well-Care Visits – 18-21 years	
	Core Quality Metric (5) Controlling High Blood Pressure	HEDIS (CBP)
	Core Quality Metric (6) Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using antipsychotic medications	HEDIS (SSD)
	Core Quality Metric (7) **Eye Exam for Patients With Diabetes**	HEDIS (EED)
	Core Quality Metric (8) Follow-up after hospitalization for mental illness within 7 days	HEDIS (FUH)
	Core Quality Metric (9) Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS (APM)
Efficiency metrics	**Core Efficiency Metric 1:** Ambulatory care -– ED visits per 1,000 member months	HEDIS (AMB)
	Core Efficiency Metric 2: Inpatient discharges per 1,000 member months – Total inpatient	HEDIS (IPU)

3.5.2 Stars earned based on core metric performance

In each quarterly report, Health Link organizations may earn stars based on their performance across the core quality and efficiency metrics.

- Each quality metric that meets or outperforms the State threshold translates into one quality star.

- Each efficiency metric that meets or outperforms the MCO threshold translates into one efficiency star.

Quality metrics and efficiency metrics are defined in Section 3.5.1. State thresholds for each quality metric and the methodology to be used to set thresholds for efficiency metrics are provided in a separate document.

While quality and efficiency metrics are calculated for all Health Link organizations regardless of the number of observations in the denominator of a given metric, Health Link organizations can only earn a star for quality metrics with 30 or more observations in the metric's denominator. If a Health Link organization does not have at least 30 observations in the denominator of a given quality metric, it does not earn a star for the metric.

3.5.3 Value of stars earned

Performance must meet or exceed the threshold in order to earn a quality star. Each quality star earned by the Health Link organization contributes to the quality performance. The maximum total quality performance percentage is 50.00%. Beginning with the 2018 performance year, the redistribution of quality values may be applied under certain circumstances.

Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least 30 observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least 30 observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed.

The guidelines for this quality value redistribution are as follows:

- The fully calculated (not rounded) value (using the formula below) of each star will be used. Organizations must still meet or exceed the quality gate to qualify for an outcome payment. For Health Link the quality gate is 4 stars.
- If a provider is panel eligible for less than the minimum required number of stars, then their quality percentage toward their outcome payment will be 0.00%.
- The value of up to 4 stars may be redistributed.
- The value of the ineligible stars (maximum 4) is redistributed evenly among the remaining measures regardless of the denominator of those remaining measures.
- Composite measures are defined as quality measures which consist of 2 or more sub-metrics. For example, child and adolescent well-care visits is a composite measure with three sub-metrics, broken down by age (ages 7-11, 12-17, and 18-21).
- The value of composite measures will be re-distributed when the minimum denominator is not met for all of its sub-metrics. In other words, the only way a composite measure's star value is redistributed is if the organization does not meet all of the sub-metric denominators. E.g., A practice has less than 30 observations for child and adolescent well-care visits across **all** age groups (7-11 years, 12-17 years, and 18-21 years). If this

practice meets the denominator requirement for one age group, i.e., ages 12-17 years, the star value will not be redistributed. See Composite Measure Scenarios 1 and 2.

- If an organization has an eligible denominator for at least one of the composite's sub-metrics, that organization will be measured against the threshold(s) and may be eligible to earn a star. In other words, organizations will be measured on their performance, and therefore eligible for a star, for any metric for which they have a sufficient denominator in at least one sub-metric. See Composite Measure Scenario 2.
    - Organizations must meet or exceed the threshold for every eligible sub-metric in order to earn a star. See Composite Measure Scenario 3.

Composite Measure Scenarios

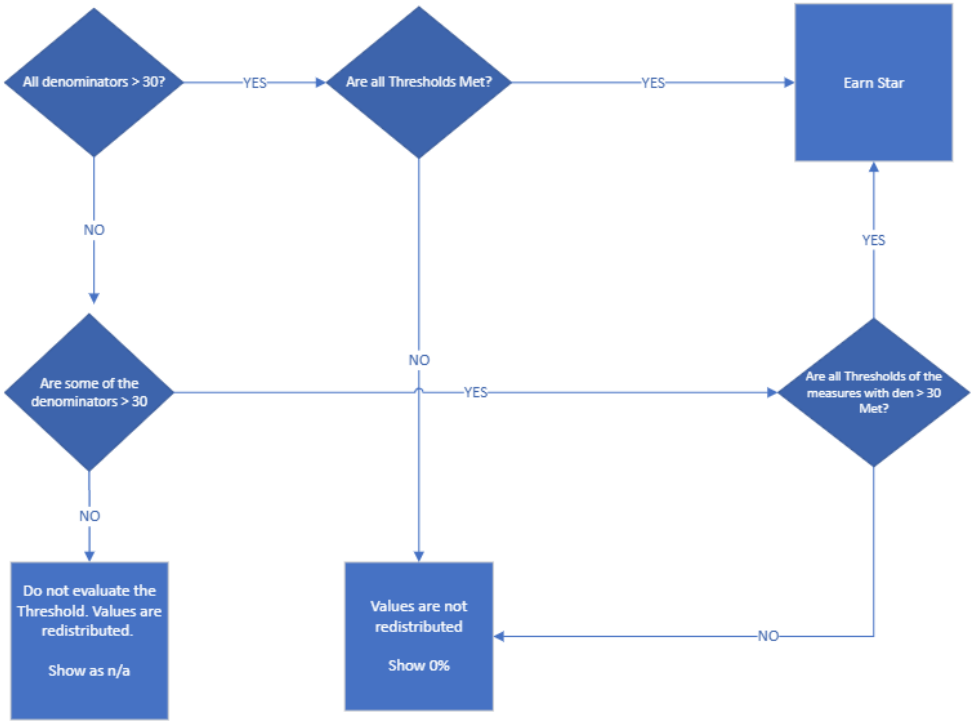
Using the Child and Adolescent Well-Care Visit composite measure as an example.

Scenario 1			
	Denominator Met (Y/N)	**Threshold Met (Y/N)**	**Star Earned/Not Earned/ Redistributed**
7-11	N	Due to denominators not being met, thresholds are not relevant and star will be redistributed.	
12-17	N		
18-21	N		

Scenario 2			
	Denominator Met (Y/N)	**Threshold Met (Y/N)**	**Star Earned/Not Earned/ Redistributed**
7-11	Y	Y	Star is NOT redistributed due to meeting the denominator for one of the sub-metrics. The organization would NOT earn a star due not meeting the threshold for the sub-metrics where the denominator is met.
12-17	Y	N	
18-21	N	N	

Scenario 3			
	Denominator Met (Y/N)	**Threshold Met (Y/N)**	**Star Earned/Not Earned/ Redistributed**
7-11	Y	Y	Star is NOT redistributed due to meeting the denominator for one of the sub-metrics. The organization would earn a star due to meeting the threshold for the sub-metric where the denominator is met.
12-17	Y	Y	
18-21	N	N	

Star Redistribution Diagram.



Due to the change from 10 metrics to 9, reweighting will be impacted. The value of each star will be 5.555555555555556% instead of 5%. Star values may be calculated using this formula:

$$\boldsymbol{Value\ of\ Each\ Star} = \frac{(Maximum\ Total\ Star\ Value\ (50\%))}{(Max\left(Eligible\ Stars, \begin{pmatrix} Total\ Stars - Stars\ that\ may \\ be\ redistributed(4) \end{pmatrix}\right))}$$

Example #1:10 possible stars and the provider has sufficient denominator value for 5:

$$\boldsymbol{Value\ of\ Each\ Star} = \frac{50\%}{(Max(5, (10-4)))}$$

$$\boldsymbol{Value\ of\ Each\ Star} = \frac{50\%}{6}$$

$\boldsymbol{Value\ of\ Each\ Star} = 8.333333333333333\%$ (use non rounded value)

Example #2: 9 possible stars and the provider has sufficient denominator value for 5:

$$\boldsymbol{Value\ of\ Each\ Star} = \frac{50\%}{(Max(5, (9-4)))}$$

$$\boldsymbol{Value\ of\ Each\ Star} = \frac{50\%}{5}$$

$$\boldsymbol{Value\ of\ Each\ Star} = 10\%$$

The following tables display the value of each quality star under different circumstances:

10 Possible Stars

		Number of Panel Eligible Stars									
Number of Stars Earned		1	2	3	4	5	6	7	8	9	10
		*8.3333%	*8.3333%	*8.3333%	*8.3333%	*8.3333%	*8.3333%	*7.1429%	*6.25%	*5.5556%	*5.00%
	1	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	2		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	3			0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	4				33.33%	33.33%	33.33%	28.57%	25.00%	22.22%	20.00%
	5					41.67%	41.67%	35.71%	31.25%	27.78%	25.00%
	6						50.00%	42.86%	37.50%	33.33%	30.00%
	7							50.00%	43.75%	38.89%	35.00%
	8								50.00%	44.44%	40.00%
	9									50.00%	45.00%
	10										50.00%

*Redistributed star values are not rounded.

9 Possible Stars

Number of Panel Eligible Stars										
Number of Stars Earned		1	2	3	4	5	6	7	8	9
		*8.3333%	*8.3333%	*8.3333%	*8.3333%	*8.3333%	*8.3333%	*7.1429%	*6.25%	*5.5556%
	1	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	2		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	3			0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	4				33.33%	33.33%	33.33%	28.57%	25.00%	22.22%
	5					41.67%	41.67%	35.71%	31.25%	27.78%
	6						50.00%	42.86%	37.50%	33.33%
	7							50.00%	43.75%	38.89%
	8								50.00%	44.44%
	9									50.00%
	10									

*Redistributed star values are not rounded.

3.5.4 Reporting-only metrics

The quality and efficiency metrics defined in Table 6 are metrics that are not core to the Health Link program but are required to be reported. These metrics are not used in determining star performance for outcome payments but will appear on Health Link provider reports for informational purposes. Certain metrics are calculated for a specific age group only, e.g., adults only or children only.

TABLE 6: Reporting-Only Metrics for Health Link Program

Category	Reporting- only metric	Source
Quality metrics	**Reporting-Only Quality Metric 1:** Statin Therapy for Patience with Cardiovascular Disease	
	– **Reporting-Only Quality Metric 1a:** Statin Therapy for Patience with Cardiovascular Disease – Received Statin Therapy	HEDIS (SPC)
	– **Reporting-Only Quality Metric 1b:** Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%	HEDIS (SPC)
	Reporting-Only Quality Metric 2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDS (APP)

Category	Reporting- only metric	Source
	Reporting-Only Quality Metric 3: Depression Screening and Follow-up for Adolescents and Adults	HEDIS (DSF-E)
	Reporting-Only Quality Metric 4: Social Need Screening and Intervention	HEDIS (SNS-E)
Efficiency metrics	**Reporting-Only Efficiency Metric 1:** Panel opt-out rate	TennCare
	Reporting-Only Efficiency Metric 2: Panel enrollment rate	TennCare
	Reporting-Only Efficiency Metric 3: Psychiatric inpatient days	TennCare
	Reporting-Only Efficiency Metric 4: Rate of residential treatment facility admissions	TennCare
	Reporting-Only Efficiency Metric 5: All-cause hospital readmissions rate	HEDIS (PCR)
	Reporting-Only Efficiency Metric 6: Diagnosed Mental Health Disorders	HEDIS (DMH)
	Reporting-Only Efficiency Metric 7: Rate of inpatient psychiatric admissions per 1,000 member months	TennCare

All reporting-only metrics use the same definition as the existing definition provided by the source organization (see Appendix).

3.5.5 Reporting-only metrics for phase-in

In addition to the reporting-only metrics for the Health Link program described in Section 3.5.3, there are additional reporting-only metrics that will be phased in over time, which are outlined in Table 7. There is currently no specific timeframe for the phase-in of any of these metrics, but at least a year of advance notice will be provided before implementation. Certain metrics are calculated for a specific age group only, e.g., adults only or children only.

TABLE 7: Reporting-Only Metrics for Phasing In for the Health Link Program

Category	Reporting-only metric for phasing in	Source
Quality metrics	Appraisal for alcohol or chemical substance use (children and adolescents only)	NQF (#0110)
	Screening for clinical depression and follow-up plan	NQF (#0418)
	Care transitions: timely transmission of record	NQF (#0648)
	Suicide risk assessment	NQF (#0104)
	Care transitions: timely assessment and initiation of treatment by a mental health professional following discharge/referral (w/in 7 days)	TBD
	Prescription fill rate for BH related medications	TBD
	Follow-up after emergency department visit for mental illness (ages 6 and older)	HEDIS (FUM)
	Follow-up after emergency department visit for alcohol and other drug dependence (ages 13 and older)	HEDIS (FUA)
	Depression remission or response for adolescents and adults	HEDIS (DRR)
	Cardiovascular screening for individuals prescribed antipsychotic medications (adults only)	NQF (#1927)
	Infectious disease screenings (e.g., Hep C, HIV, TB)	NQF (#0395, #0396, #0398, #0408, #0409)
	Chronic condition composite (adults only)	AHRQ (PQI 92)

Category	Reporting-only metric for phasing in	Source
Efficiency metrics	Nursing facility utilization	CMS (NFU-HH)
	Rate of residential substance abuse admissions	TBD
	Rate of crisis stabilization service admissions	TBD
	BH episodes of care through high performing or low performing PAPs	TBD
	Episodes of care through high performing or low performing PAPs	TBD
	Efficiency metrics for populations with previous admission history	TBD
	Use of after-hours care	TBD
	Use of home- and community-based services	TBD

3.6 CALCULATE ACTIVITY PAYMENTS

Monthly activity payments are made to the Health Link organization only for the members who are in the Health Link organization's panel for activity payment for the given month.

3.6.1 Variation based on each member's Health Link activities and program maturity

There are different activity payment base rates, which are paid based on the member's enrollment period with the Health Link program and the maturity of the Health Link program:

Health Link joining prior to January 1, 2018:

- Transition rate: Monthly activity payment amount is set to $200 for all members, for Health Link services rendered until November 30, 2017.
- Stabilization rate: Monthly activity payment amount is set to $175 for all members for Health Link services rendered until December 31, 2018.

Health Link joining on or after January 1, 2018:

- Monthly activity payment amount is set to $139 for all members, for Health Link services rendered until December 31, 2018.

A member must continue to meet the Health Link eligibility inclusion criteria outlined in Exhibit 3 for the Health Link to be able to receive any of the activity payments described in Section 3.6.1.

After December 31, 2018, each MCO will be responsible for determining the reimbursement rate for Health Link services.

3.6.2 Calculation of adjusted activity payments

The Health Link activity payment is disbursed each month, based on the members identified in the activity payment panel described in Section 3.4.1. The month when the Health Link activity claim is received may not be the same as the month when the actual service occurred; in which case the activity payment is disbursed after the activity claim is received. Qualifying Health Link activity claims include:

- Comprehensive care management
- Care coordination
- Health promotion
- Transitional care
- Patient and family support
- Referral to social supports

Activity payment amounts for Health Link activities for each member should be set to reflect the rate variations described in Sections 3.6.1. Further details regarding qualifying Health Link activity claims for specific members can be found in the Glossary.

3.7 CALCULATE TOTAL COST OF CARE

“Total cost of care” (TCOC) refers to the total monthly spend of the average member of a given Health Link organization’s panel. At a high level, the TCOC includes all of the relevant costs incurred by the members of the Health Link organization, adjusted for the number of months those members were enrolled in TennCare. At the end of each quarter, two different TCOC metrics are generated, based on each Health Link organizations’ member panels for performance reporting as defined in Section 3.4.2:

- Total cost of care
- Behavioral health total cost of care

For purposes of the Health Link program, certain spend is excluded from the TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life
- PCMH practice new clinical activity payments
- Gain-sharing payments made to the Health Link as a Principle Accountable Provider (i.e. Quarterback) of episode-based payment models
- Medication therapy Management (MTM) payments for CY2023

Mobile Crisis Capitation payments are also not included in TCOC. These payments do not appear on the claims extract so exclusion should not require an extra step.

Health Link activity payments are considered a cost associated with delivering care. Health Link payments during the reporting period are included in the TCOC calculation.

Total cost of care for a Health Link organization is calculated as a per member per month metric, on a separate basis for each MCO with which the Health Link organization contracts. Non-risk-adjusted TCOC, referred as **TCOC**, is defined as the sum of spend included in TCOC calculation, as defined above, divided by the sum of the number of enrollment months with the MCO, for all the members in the Health Link organization's panel.

BH total cost of care is defined analogously with the TCOC above but taking into account only the BH spend. BH spend is defined in the Glossary.

3.8 CALCULATE OUTCOME PAYMENTS

Outcome payments are designed to reward Health Link organizations for providing high-quality care in an efficient manner. Outcome payments for each Health Link organization are based on its performance on the core metrics described in Section 3.5.1. Core metric performance is used as a prerequisite to identify Health Link organizations that can be considered for outcome payments as well as a measure to define the amount of outcome payments at the end of the performance period.

Health Link organizations are eligible for outcome payments only if the Health Link organization earned at least four quality stars. In an effort to ensure the sustainability of the program moving forward and to better plan for yearly expenditures, TennCare directed the MCOs to cap the outcome payments for Tennessee Health Link starting in performance year 2020.

The maximum outcome payment will not exceed 10% of the total activity payments within a performance year. This capitation was effective January 1, 2020, and shall extend into future performance years at the discretion of TennCare.

For Health Link organizations who qualify for an outcome payment by meeting the minimum requirements outlined in previous sections, the outcome payment amount is calculated as follows:

Average Cost of Care (PMPM)		Efficiency Improvement Percentage + Efficiency Stars		Maximum Share of Savings		Quality Stars		Member Months	=	Outcome Payment
Average		%		25%		%		# Attributed		Calculated

		OR		
Activity Payment	X	10%	=	Max Outcome Payment (with 10% Cap)
N/A	X	10%	=	N/A

Max Outcome Payment (with 10% Cap): The total outcome payment may be capped at 10% of total activity claims paid during the measurement year. Either the calculated earned outcome payment, or 10% of total activity claims payment will be paid, whichever is less. The maximum outcome payment will not exceed 10% of the total activity payments within a performance year.

The following subsections detail each component of this formula.

3.8.1 Average total cost of care (TCOC) per member per month (PMPM)

This is the average total cost of care per member per month for members in Health Links across all of TennCare. The statewide average TCOC amount to be used is $801.

3.8.2 Efficiency performance

Efficiency performance is calculated by adding the percentages earned from both efficiency improvement and efficiency stars. The maximum total efficiency performance percentage is 50.00%.

a. Efficiency Improvement Percentage

The efficiency improvement percentage will have an effect on the efficiency performance, to reward higher levels of improvement in efficiency metrics over the prior year. Note that the

prior year values for each efficiency metric are set on calendar year basis, i.e., for performance period CY2023, values based on the full calendar year CY2022 are used. Calculate the organization's efficiency baseline performance on each metric using performance data from August of the prior calendar year. For example, calculate the organization's CY2023 efficiency performance at baseline using the organization's performance on each metric in August 2022. The efficiency improvement percentage is the average of improvement in each efficiency metric compared to the previous year's performance for the Health Link. The values for the efficiency metrics used in the calculation should be rounded to the nearest hundredth decimal place. Efficiency improvement for a given metric is calculated as the following:

$$\begin{pmatrix} Efficiency \\ Improvement \\ Percentage \end{pmatrix} = \frac{\begin{pmatrix} Efficiency\ metric\ 1 \\ Prior\ year\ value \end{pmatrix} - \begin{pmatrix} Efficiency\ Metric\ 1 \\ Current\ value \end{pmatrix}}{\begin{pmatrix} Efficiency\ metric\ 1 \\ Prior\ year\ value \end{pmatrix}}$$

If the efficiency metric value for the previous year could not be calculated, then the efficiency improvement for that given metric is considered to be zero. Both efficiency metrics are averaged together. The resulting average of the two metrics should be rounded to the nearest hundredth decimal place.

TABLE 8: Illustrative Example of Efficiency Improvement Percentage
Note: Values rounded to nearest hundredth decimal place. Note: The individual efficiency improvement values should be displayed using the hundredth decimal place. When calculating the final efficiency improvement percentage (average) round to the nearest hundredth decimal place.

Efficiency Measure per 1,000 Member Months	Performance at Baseline (CY2022)	Performance Since 1/1/2023	Efficiency Improvement
ED Visits	78.10	76.00	2.69%
Inpatient Discharges	3.00	2.80	6.67%
EFFICIENCY IMPROVEMENT PERCENTAGE (AVERAGE)			**4.68%**

If the value of the efficiency improvement percentage exceeds 20.00%, then the value is capped at 20.00%. If the value of the efficiency improvement percentage is less than 0.00%, then the value is capped at 0.00%. Each individual measure's efficiency improvement is capped at both positive and negative 20.00%.

b. Efficiency Stars

Performance must meet or exceed the threshold in order to earn an efficiency star. Each efficiency star earned contributes 15.00% to the efficiency performance. The value of each star should be rounded to the nearest hundredth decimal place.

3.8.3 Maximum share of savings

Health Link organizations may earn up to 25% of the total savings achieved during a year.

3.8.4 Quality performance

Performance must meet or exceed the threshold in order to earn a quality star. Each quality star earned by the Health Link organization contributes to the quality performance. The maximum total quality performance percentage is 50.00%. Beginning with the 2018 performance year, the redistribution of quality values may be applied under certain circumstances. Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least 30 observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least 30 observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed. See Section 3.5.3 for details.

3.8.5 Member months

Number of member months enrolled with the MCO for all members in the Health Link's panel, as defined in Section 3.4.2. As a reminder, the Health Link must be a member's attributed Health Link for nine or more months during the performance period for the member to be included in the Health Link's panel for outcome payment calculation. Please note final calculation of member months should be rounded to a whole number.

3.9 GENERATE DATA FOR CARE COORDINATION TOOL AND PROVIDER REPORTS

Using the output tables defined in the following sections, additional tables required for provider communication and provider reports are defined. These include:

- Attribution table for care coordination tool
- Attribution counts and lists
- Preview reports
- Performance reports

4 Health Link Algorithm Data Flow

The analytics underlying the Health Link model are performed by a payment model algorithm. The algorithm takes an input dataset, transforms the data in accordance with the intent of the program design, and produces a set of output tables. The output tables are used to determine payment amounts and create provider reports.

Several of the payment model design dimensions require input parameters such as age ranges, and medical codes such as diagnosis, procedure, and revenue codes to specify the intent of the episode. All parameters and medical codes are provided in the configuration file.

It is recommended that the Health Link algorithm data flow includes two elements for quality assurance: (1) an input summary table to assess the content and quality of the input dataset; and (2) an output summary table to assess the content and quality of the output tables.

4.1 INPUT DATA

To build the Health Link payment model, the following input data are needed:

Claims data

- **Member Extract**: List of members and their health insurance enrollment information.
- **Provider Extract**: List of participating providers and their addresses.
- **Claims Extract**: Facility claims (UB-04 claim form), professional claims (CMS1500 claim form), and pharmacy claims (NCPDP claim form) at the member level. For the remainder of the DBR, "facility claim form" is defined as a UB-04 and a "professional claim form" is defined as a CMS-1500.

The table below provides a description of the required input fields. In the algorithm section, input fields are referred to by the "Source field name in DBR" and are written in italics, e.g., *Member ID*.

TABLE 9: Input Data Fields for Claims Data

Source field name in DBR	Description
Member Extract	
Member ID	Unique member identifier
Member Name (Last, middle, first)	Member name (Last, middle, first as separate fields)
Eligibility Start Date	First date member is eligible for coverage by payer
Eligibility End Date	Last date member is eligible for coverage by payer
Date Of Birth	Member date of birth
Dual Status	Whether the member is a dual eligible member. Options are "Aligned D-SNP dual", "Other dual" and "Non-dual"
Member Zip Code	Zip code of the member's address

Source field name in DBR	Description
TPL Status	Whether the member has TPL liability based on the plan. Options are “TPL” and “Not TPL”
Provider Extract	
Contracting Entity Name	Contracting entity name
Contracting Entity	Unique identifier of provider by contracting entity
Tax ID	Provider’s tax ID
Provider Name	Provider name
Provider ID	Unique identifier of provider
Provider Type	Provider type associated with the Provider ID
Primary Taxonomy	Primary taxonomy associated with the Provider ID or the NPI associated with the Provider ID
Claims Extract	
Internal Control Number	Unique claim identifier
Type Of Bill	Type of bill
Member ID	Unique member identifier
Billing Provider ID	Unique billing provider identifier
Header From Date Of Service	Date on which service begins on claim header
Header To Date Of Service	Date on which service ends on claim header
Detail From Date Of Service	Date on which service begins on claim detail line
Detail To Date Of Service	Date on which service ends on claim detail line
Admission Date	Admission date
Patient Discharge Status	Patient discharge status
Header Diagnosis Code	All diagnosis codes on claim header
Header Surgical Procedure Code	All surgical procedure codes on claim header
Detail Procedure Code	Procedure code on claim detail line
All Modifiers	All procedure code modifiers on claim detail line
Place Of Service	Place of service
National Drug Code	National drug code
Header Paid Amount	Header paid amount
Detail Paid Amount	Detail paid amount
Header TPL Amount	Header third party liability amount
Detail TPL Amount	Detail third party liability amount
Revenue Code	Revenue code

Health Link algorithm claim input data extract for member eligibility, attribution, and enrollment identification and update, conducted every month, includes claims or claim detail lines with *Header To Date Of Service* or *Detail To Date Of Service* during the 365 days preceding the day when the member eligibility, attribution, and enrollment identification or update is started (exclusive). The date range for the Health Link claim input data extract for the quarterly outputs includes claims or claim detail lines with *Header To Date Of Service* or *Detail To Date Of*

Service during the defined performance period as well as **at least** during the time period 730 days before the beginning of the performance period. Please note that for certain HEDIS measures that require a longer date range for the claim input data extract, the time period should be adjusted as needed. Facility claim forms with claim type inpatient and pharmacy claims are included based on *Header To Date Of Service*, and claim detail lines for other claim types based on *Detail To Date Of Service*.

The input data must contain only unique and paid claims. It is the responsibility of each payer to apply appropriate methods to ensure that all claims in the input data are valid, de-duplicated, and paid. Payers should use denied claims for the purpose of determining quality metrics performance.

If the value of an input field from the Claims Extract that is required for the Health Link algorithm is missing or invalid, then the corresponding claim is ignored when running the algorithm. For example, a claim detail line that identifies a Level 2 Case Management visit, but is missing the *Detail To Date Of Service*, cannot be counted as a Level 2 Case Management visit.

Non-claims data

- **Primary Care Practice Attribution File:** List of members, with their assigned PCPs and attributed primary care practices
- **Hospital Triggered Eligibility**: List of members with clinical interactions that can qualify them to participate in the Health Link program, along with information on diagnoses, type of interaction, and Health Link organization referral at discharge from the hospital.
- **Provider Triggered Eligibility:** List of members with clinical visits that can qualify them to participate in the Health Link program, along with information on diagnoses, type of interaction, and Health Link organization attesting the eligibility and enrollment of the member.
- **MCO Transition Feed**: List of members eligible for Health Link who switch MCOs. The original MCO must provide information on the member's Health Link eligibility, attribution, and enrollment status.
- **Member Switch and Opt-out Request**: List of eligible members who requested a switch in attributed Health Link organization or opt-out from the Health Link program, maintained by the MCO.
- **MCO Removal Feed:** List of members for whom the MCO or provider deemed that Health Link services are not necessary or effective, maintained by the MCO. This list also includes the list of members who were excluded from Level 2 case management services with the introduction of medical necessity criteria.
- **DCS Enrollment Feed**: List of members who are enrolled in certain DCS programs, along with enrollment dates.
- **Intensive Community-Based Treatment Authorization Feed**: List of members who are enrolled in certain CTT/CCFT programs, along with enrollment dates.

- **Eligible Health Link Organization List**: List of Health Link organizations participating in the Health Link program, along with their remediation status.
- **Manual attribution by MCO**: List of members and their attributed Health Link organization, in cases where the MCO had to conduct manual attribution. An illustrative approach for manual attribution is described in the Glossary.
- **Inactivity and Reattribution Decision**: List of members that could not be contacted by the attributed Health Link organization, with MCO decision on whether to set the status as inactive or to reattribute.
- **Other**: Non-claims data (e.g., medical or lab records) used to calculate performance metrics based on hybrid methods for HEDIS.

The table below provides a description of the required input fields. In Section 5, input fields are referred to by the "Source field name in DBR" and are written in italics.

TABLE 10: Input Data Fields for Non-Claims Data

Source field name in DBR	Description
Primary Care Practice Attribution File	
Member ID	Unique member identifier
Member Name	Member name
Primary Care Practice Tax ID	Unique identifier (tax ID) of the primary care practice that the member is attributed to
Primary Care Practice Name	Name of the primary care practice that the member is attributed to
Practice Attribution Start Date	First date when the member was attributed to the primary care practice
Practice Attribution End Date	Last date when the member was attributed to the primary care practice
Attributed PCP NPI	National Provider Identifier of the PCP the member is attributed to
Attributed PCP	Name of the PCP the member is attributed to
PCP Attribution Start Date	First date when the member was attributed to the PCP
PCP Attribution End Date	Last date when the member was attributed to the PCP
Hospital Triggered Eligibility	
Member ID	Unique member identifier
Member Name	Member name
Discharge Date	Date the member was discharged from the hospital
Main BH Diagnosis for Admission	BH diagnosis most relevant to the admission (select one from a set list)
Type of Admission	Type of admission, with options being: Inpatient, Emergency Department, Crisis Stabilization Unit, Residential Treatment Facility

Source field name in DBR	Description
Tax ID of the Health Link Organization Referred By Hospital	Unique identifier (tax ID) of Health Link organization to which a referral was made to the member at discharge
Name of Health Link Organization Referred By Hospital	Name of Health Link organization to which a referral was made to the member at discharge
Referring Hospital Provider ID	Provider ID of the hospital recommending the members to be eligible for Health Link program
Referring Hospital Name	Name of the hospital recommending the members to be eligible for Health Link program
Provider Triggered Eligibility	
Member ID	Unique member identifier
Member Name	Member name
Service Date	Date of service when the provider had the encounter with the member
Main BH Diagnosis for Encounter	BH diagnosis most relevant to the encounter (select one from a set list)
Type of Encounter	Type of encounter, with options being: Emergency Department, Crisis Stabilization Unit, Residential Treatment Facility, Level 2 Case Management, Medical Necessity Approval Received
Tax ID of the Health Link Organization Referred By Provider	Unique identifier (tax ID) of Health Link organization to which a referral was made by the attesting provider
Name of Health Link Organization Referred By Provider	Name of Health Link organization to which a referral was made to the member by the attesting provider
Referring Provider ID	Provider ID of the provider recommending the members to be eligible for Health Link program
Referring Provider Name	Name of the provider recommending the members to be eligible for Health Link program
Eligibility Attestation	Indicator on whether the provider triggered eligibility also attests the enrollment of the given member. Options are “Enrollment” or “Not enrollment”
MCO Transition Feed	
Member ID	Unique member identifier
Member Name	Member name
MCO Transition Date	Date on which the change in MCO for the member is effective

Source field name in DBR	Description
Original MCO	Name of the MCO that was acting as the payer for the member originally
Receiving MCO	Name of the MCO that is newly becoming the payer for the member
Original Eligibility Category	Health Link *Eligibility Category* listed in the latest Monthly member assignment table of the original MCO
Original L2CM Status	*L2CM Status* listed in the latest Monthly member assignment table of the original MCO
Original Health Link Organization Tax ID	Identifier (tax ID) of the Health Link organization the member was attributed to during tenure with the original MCO
Original Health Link Organization Name	Name of the Health Link organization the member was attributed to during tenure with the original MCO
Member Status	Status of member listed in the latest CCT attribution file of the original MCO
Member Switch, Opt-in/out Requests or Discharge	
Member ID	Unique member identifier
Member Name	Member name
Type of Request	Type of transaction requested by the member/provider; options are Switch, Opt-in, Opt-out, Discharge
Date of Switch, Opt-in/out or Discharge	Date the MCO recorded the switch, opt-in/out request or discharge from the member/provider.
Tax ID of the Original Health Link Provider	Unique identifier (tax ID) of Health Link organization to whom the member was originally attributed
Name of the Original Health Link Provider	Name of Health Link organization to whom the member was originally attributed
Tax ID of the Health Link Provider After Switch/Opt-In	Unique identifier (tax ID) of Health Link organization to whom the member requested to switch or opt-in
Name of the Health Link Provider After Switch/Opt-In	Name of Health Link organization to whom the member requested to switch or opt-in
MCO	Name of MCO providing information
MCO Removal Feed	
Member ID	Unique member identifier
Member Name	Member name
Date of Eligibility Revocation	Date the MCO recorded the decision that Health Link program is unnecessary for the member
MCO	Name of MCO providing information
DCS Enrollment Feed	

Source field name in DBR	Description
Member ID	Unique member identifier
Member Name	Member name
DCS Program	DCS program to which the member enrolled
DCS Program Enrollment Start Date	First date member is eligible for the DCS program
DCS Program Enrollment End Date	Last date member is eligible for the DCS program (can be open-ended)
MCO Manual Inclusion	MCO manual decision to include members who would otherwise have been excluded. Options are “No inclusion” or “Manual inclusion”
Eligible Health Link Organization List	
Health Link Organization Tax ID	Unique Health Link organization identifier (tax ID)
Health Link Organization Name	Name of the Health Link organization
Remediation Status	Whether the Health Link organization is under remediation and not eligible for new attribution; options are “Yes” and “No”
Health Link Eligibility Start Date	First date the provider qualified to be a Health Link organization
Health Link Eligibility End Date	Last date the provider qualified to be a Health Link organization (can be open ended)
Remediation Start Date	First date the Health Link organization is under remediation
Remediation End Date	Last date the Health Link organization is under remediation
Manual Attribution by MCO	
Member ID	Unique member identifier
Member Name	Member name
Date of Manual Attribution	Date the MCO recorded the manual attribution decision
Tax ID of Health Link Provider Manually Attributed	Unique Health Link organization identifier (tax ID) to whom the member is manually attributed
Name of Health Link Provider Manually Attributed	Name of the Health Link organization to whom the member is manually attributed
MCO	Name of MCO conducting the attribution
Inactivity and Reattribution Decision	
Member ID	Unique member identifier
Member Name	Member name
Inactivity Status Start Date	Date when MCO switched the member’s status into inactive

Source field name in DBR	Description
Date of Reattribution Decision	Date when MCO decided to reattribute the member
MCO	Name of MCO that set the inactive status for the member or made the decision for reattribution
CTT/CCFT Enrollment Feed	
Member ID	Unique member identifier
Member Name	Member name
CTT/CCFT Program Start Date	First date member is enrolled in CTT/CCFT Program
CTT/CCFT Program Enrollment End Date	Last date member is enrolled in CTT/CCFT Program
Prisoner Enrollment Feed	
Member ID	Unique member identifier
Member Name	Member name
Prisoner Program Start Date	First date member is eligible for the Prisoner Program
Prisoner Program Enrollment End Date	Last date member is eligible for the Prisoner Program (can be open ended)

Non-claims based input data must be provided for each update on eligibility, attribution, and enrollment. Each extract should include records for which the key date associated with the record is between the last eligibility, attribution, or enrollment update start date and the day before the current update is started (inclusive). The key date for each extract is defined as the following:

TABLE 11: Non-Claim Input Data Key Date

Non-claim input data	Key date
Hospital triggered eligibility	*Discharge Date*
Provider triggered eligibility	*Service Date*
MCO transition feed	*MCO Transition Date*
Member switch and opt-in/out request	*Date of Switch or Opt-in/out*
MCO removal feed	*Date of Eligibility Revocation*
Manual attribution by MCO	*Date of Manual Attribution*
Inactivity and reattribution decision	*Date of Inactivity Status Start or Reattribution Decision*
DCS enrollment feed	*DCS Program Enrollment Start Date*

Non-claim input data	Key date
Eligible Health Link organization list	*Health Link Eligibility Start Date*

In addition to the date requirement above, the records included for the DCS enrollment feed and the Eligible Health Link Organization list must be valid as of the day before the current update is conducted (i.e., the input fields *DCS Program Enrollment End Date* or *Health Link Eligibility End Date* must be on or later than the day the current update is started).

Monthly member assignment tables

Monthly member assignment tables: The subsequent update of eligibility, attribution, and enrollment requires the output of the previous update, called "Monthly member assignment tables", as input. Fields for the Monthly member assignment table are defined in Section 4.3.

The following exhibit lays out the frequency of refresh for each Health Link algorithm input.

EXHIBIT 3: Health Link Input Data Timing

Input Data	Frequency for refresh	First reporting used for	First date to be produced
Member Extract	Monthly	Initial counts/lists	July 2016
Provider Extract	Monthly		
Claims Extract	Monthly		
Primary Care Practice Attribution File	Monthly		
DCS Enrollment Feed	Monthly		
Eligible Health Link Organization List	As necessary[2]		
Manual Attribution by MCO	Monthly		
Hospital Feed[1]	Weekly	Second preview reports	February 2017
Provider Feed[1]	Weekly		
MCO Transition Feed[1]	Weekly		
Member Switch & Opt-Out Request[1]	Weekly		
MCO Removal Feed[1]	Weekly		
Inactivity and Reattribution Decision	Monthly		

1 These data elements are incorporated into the monthly member assignment table
2 Table provided by the State

4.2 HEALTH LINK CONFIGURATION FILE

The parameters and medical codes needed to define the Health Link algorithm are listed in the configuration file, which is provided as an attachment to the DBR. The file includes:

- **Parameters sheet:** Values for parameters used in the algorithm, for example the time period used for specific eligibility requirements.
  - Design Dimension: Health Link design dimension, e.g., Identify eligible members
  - Parameter Description: Description of the parameter, e.g., Duration of SNF stay for member eligibility exclusion
  - Parameter Value: Value of the parameter, e.g., 89
  - Parameter Unit of Measure: Unit of measure of the parameter, e.g., Days
- **Code sheet:** Medical codes used in the algorithm, such as diagnosis codes for identifying the eligible members. The columns contained in the code sheet are:
  - Design Dimension: Health Link design dimension, e.g., Identify eligible members
  - Subdimension: Grouping of codes used for a specific purpose within the design dimension, e.g., Schizophrenia diagnosis
  - Time Period: Time for which the code is relevant, e.g., Claim look back period
  - Code Type: Code system to which the code belongs, e.g., ICD-9 Dx
  - Code Group: Code group level classification, e.g., Schizophrenia and other psychotic disorders
  - Code Description: Code detailed description, e.g., Simple Type Schizophrenia Chronic State
  - Code: Code number, e.g., 29502

Section 5 of the DBR explains the intended use of the parameters and medical codes in the Health Link algorithm. References to medical codes in the configuration file are made using the name for the relevant sub-dimension in the code sheet of the configuration file. References to parameters in the configuration file are made using the name for the relevant design dimension in the parameters sheet of the configuration file.

The code sheet may contain CPT codes. CPT is a registered trademark of the American Medical Association (AMA). Vendor purchases one single CPT distribution license for the configuration file of Health Link algorithm that is delivered to a recipient. If its recipient wishes to further distribute a configuration file, it is the recipient's responsibility to comply with AMA CPT license requirements.

4.3 OUTPUT TABLES

Using the input data tables and the configuration file, the Health Link algorithm creates five output tables:

- **Monthly member assignment table**: This table provides a monthly retrospective view of each member that was potentially eligible for the Health Link program, including whether the member was eligible for the Health Link program, whether the member was excluded from services, which Health Link organization he/she was attributed to or enrolled with, and whether the member was an enrolled member or opted out from the program. This table is generated weekly for the Care Coordination Tool.
- **Reporting period member table**: This table provides a quarterly view of each member, from the beginning of the performance period to the end of the quarter, i.e., the reporting period. Member level information on this table includes which Health Link organization the member was attributed to or enrolled with for the majority of the reporting period, whether there were any months during which the member was a dual or TPL member, whether there were any months for which the member was excluded from Health Link services due to extended nursing facility stay, what was the total number of months the member was attributed, enrolled, or opted out with the program, to which Health Link organization the member is assigned for quarterly reporting, and what are the performance metric outcomes for the member.
- **Monthly Health Link table**: This table provides a monthly view of each Health Link organization, including how many members were attributed or enrolled with the organization and, the activity payments due to the Health Link organization for the current month.
- **Reporting period Health Link table:** This table provides a view of the Health Link organization for the reporting period, including how many members were attributed to or enrolled with the organization and their member months, the member months that were active or opted out, the Health Link's performance metric outcomes, including the quality and efficiency star counts, the size of the panel for the outcome payment (outcome payment report only), and the amount of outcome payment for the Health Link organization. (Please reference section 3.4.2 or 3.8.5 for guidance on calculating final member months.)
- **Activity payment table**: This table provides a view of each member and his/her monthly activities with the Health Link organization, to facilitate the calculation of the monthly activity payments. The fields in this table include, for each month of service; whether the member was active in the Health Link program, the Health Link organization the member was enrolled with, and the Health Link organization that received the look back claim payment, if applicable. The date when the Health Link service was provided, the month the Health Link activity claim for the given month of service was received by the payer, and the activity payment rate applicable to the member for the given month of service.

The following exhibit lays out the reporting frequency of each output table and provider reports.

EXHIBIT 4: Output Table Reporting Frequency

Output Tables	Frequency for reporting	Frequency for CCT	First reporting used for	First date to be produced
Monthly Member Assignment Table	Monthly	Weekly	Initial counts/lists	July 2016
Monthly Health Link Table	Monthly	N/A	Initial counts/lists	July 2016
Reporting Period Member Table	Quarterly	N/A	Initial preview reports	November 2016
Report Period Health Link Table	Quarterly	N/A	Initial preview reports	November 2016
Activity Payment Table	Monthly	N/A	Second preview reports	February 2017

Section 5 of this DBR describes the definition of each output field. In these sections output fields are referred to by the output field names provided in the tables below and are written in italics. Efficiency measure outputs are rounded to the hundredth place and quality measure outputs are rounded to the tenth decimal place.

4.3.1 Monthly member assignment table

The monthly member assignment table contains the full list of members that meet the eligibility requirement for the Health Link program and their characteristics, including eligibility, attribution, and enrollment status. The output is updated at least every month, with a weekly update for the Care Coordination Tool. The table “Monthly member assignment table” below lists the required output fields.

TABLE 12: Monthly Member Assignment Table

Design dimension	Output field name
	Identify eligible members
1 – Identify eligible members	Assignment Table Update Date
1 – Identify eligible members	Member ID
1 – Identify eligible members	Member Name (Last, middle, first as separate fields)
1 – Identify eligible members	Eligibility Category
1 – Identify eligible members	L2CM Status
1 – Identify eligible members	Exclusion
1 – Identify eligible members	DCS Exclusion

Design dimension	Output field name
1 – Identify eligible members	Prisoners Program Exclusion
1 – Identify eligible members	Intensive Community-Based Services
1 – Identify eligible members	TennCare Eligibility
1 – Identify eligible members	RTF Stay Status
1 – Identify eligible members	NF Stay Status
1 – Identify eligible members	MCO Removal Status
1 – Identify eligible members	Dual Status
1 – Identify eligible members	Initial Eligibility Date
1 – Identify eligible members	Latest Date of Claim-Based Eligibility
1 – Identify eligible members	Eligibility Via Claims
1 – Identify eligible members	Non-Claim Eligibility
	Attribute members to providers
2 – Attribute members to providers	Attributed Health Link ID
2 – Attribute members to providers	Attributed Health Link Name
2 – Attribute members to providers	Attribution Method
2 – Attribute members to providers	Attribution Effective Date
	Identify enrolled member
3 – Identify enrolled members	Enrolled Health Link ID
3 – Identify enrolled members	Enrolled Health Link Name
3 – Identify enrolled members	Enrollment Effective Date
3 – Identify enrolled members	Enrollment End Date

Design dimension	Output field name
3 – Identify enrolled members	Last BH Treatment Date
3 – Identify enrolled members	Status

4.3.2 Reporting period member table

The member table for each quarterly reporting period aggregates the full list of members eligible for Health Link services during the reporting period and their characteristics, and is updated every quarter, to include data from the beginning of the performance period to the end of reporting period. The table “Reporting period member table” below lists the required output fields.

TABLE 13: Reporting Period Member Table

Design dimension	Output field name
	Define member panels
4 – Define member panels	Reporting Period Start Date
4 – Define member panels	Reporting Period End Date
4 – Define member panels	Member ID
4 – Define member panels	Member Name (Last, middle, first as separate fields)
4 – Define member panels	Reporting Period Eligible Months
4 – Define member panels	Reporting Period Attributed Health Link ID
4 – Define member panels	Reporting Period Attributed Health Link Name
4 – Define member panels	Reporting Period Attribution Months
4 – Define member panels	Reporting Period Enrolled Health Link ID
4 – Define member panels	Reporting Period Enrolled Health Link Name

Design dimension	Output field name
4 – Define member panels	Reporting Period Health Link Active Months
4 – Define member panels	Reporting Period Health Link Opt-Out Months
4 – Define member panels	Reporting Period Health Link Discharged Months
4 – Define member panels	Reporting Period Total Attributed Months
4 – Define member panels	Reporting Period Total Active Months
4 – Define member panels	Reporting Period Total Opt-Out Months
4 – Define member panels	Reporting Period TPL Status
4 – Define member panels	Reporting Period Intensive Community-Based Treatment Status
4 – Define member panels	Reporting Period RTF Status
4 – Define member panels	Reporting Period NF Status
4 – Define member panels	Reporting Period Dual Status
4 – Define member panels	Reporting Period Health Link For Performance
	Calculate performance metrics
5 – Calculate performance metrics	Member MCO Months
5 – Calculate performance metrics	Member Core Quality Metric 1a
5 – Calculate performance metrics	Member Core Quality Metric 1b
5 – Calculate performance metrics	Member Core Quality Metric 2
5 – Calculate performance metrics	Member Core Quality Metric 3
5 – Calculate performance metrics	Member Core Quality Metric 4
5 – Calculate performance metrics	Member Core Quality Metric 5

Design dimension	Output field name
5 – Calculate performance metrics	Member Core Quality Metric 6
5 – Calculate performance metrics	Member Core Quality Metric 7
5 – Calculate performance metrics	Member Core Quality Metric 8
5 – Calculate performance metrics	Member Core Quality Metric 9
5 – Calculate performance metrics	Member Core Efficiency Metric 1
5 – Calculate performance metrics	Member Core Efficiency Metric 2
5 – Calculate performance metrics	Member Reporting-Only Quality Metric 1a
5 – Calculate performance metrics	Member Reporting-Only Quality Metric 1b
5 - Calculate performance metrics	Member Reporting-Only Quality Metric 2
5 - Calculate performance metrics	Member Reporting-Only Quality Metric 3
5 – Calculate performance metrics	Member Reporting-Only Quality Metric 4
5 – Calculate performance metrics	Member Reporting-Only Efficiency Metric 1
5 – Calculate performance metrics	Member Reporting-Only Efficiency Metric 2
5 – Calculate performance metrics	Member Reporting-Only Efficiency Metric 3
5 – Calculate performance metrics	Member Reporting-Only Efficiency Metric 4
5 – Calculate performance metrics	Member Reporting-Only Efficiency Metric 5
5 – Calculate performance metrics	Member Reporting-Only Efficiency Metric 6
5 – Calculate performance metrics	Member Reporting-Only Efficiency Metric 7
	Calculate total cost of care
7 – Calculate total cost of care	Member Total Spend
7 – Calculate total cost of care	Member Dental Spend
7 – Calculate total cost of care	Member Transportation Spend

Design dimension	Output field name
7 – Calculate total cost of care	Member NICU Nursery Spend
7 – Calculate total cost of care	Member Age 1 Month Spend
7 – Calculate total cost of care	Member Included Spend
7 – Calculate total cost of care	Member Total Cost Of Care
7 – Calculate total cost of care	Member Total Cost Of Care By Reporting Care Category
7 – Calculate total cost of care	Member BH Total Cost Of Care
7 – Calculate total cost of care	Member BH Total Cost Of Care By BH Reporting Care Category

4.3.3 Monthly Health Link table

The monthly Health Link table contains the full list of Health Link organizations and their member characteristics, including number of attributed members, number of enrolled members, number of opt-out members, number of members eligible for activity payments, and the activity payment amount. The output is updated every month. The table “Monthly Health Link table” below lists the required output fields.

TABLE 14: Monthly Health Link Table

Design dimension	Output field name
	Define member panels
4 – Define member panels	Monthly Health Link Table Update Date
4 – Define member panels	Health Link ID
4 – Define member panels	Health Link Name
4 – Define member panels	Monthly Number of Attributed Members
4 – Define member panels	Monthly Number of Enrolled Members
4 – Define member panels	Monthly Number of Active Members

Design dimension	Output field name
4 – Define member panels	Monthly Number of Opt-Out Members
	Calculate activity payments
6 – Calculate activity payments	Count of Activity Payments Due
6 – Calculate activity payments	Total Activity Payment Due
6 – Calculate activity payments	Total Annual Activity Payment Due

4.3.4 Reporting period Health Link table

The Health Link table for each quarterly reporting period aggregates the full list of Health Link organizations during the reporting period and the performance period. It is produced every quarter, and includes data from the beginning of the performance period to the end of each reporting period. The table “Reporting period Health Link table” below lists the required output fields. The last quarterly report of a performance period is based on data for the entire performance period, and contains additional output fields.

TABLE 15: Reporting Period Health Link Table

Design dimension	Output field name
	Define member panels
4 – Define member panels	Reporting Period Start Date
4 – Define member panels	Reporting Period End Date
4 – Define member panels	Health Link ID
4 – Define member panels	Health Link Name
4 – Define member panels	Reporting Period Number of Attributed Members
4 – Define member panels	Reporting Period Number of Enrolled Members
4 – Define member panels	Reporting Period Attributed Member Months
4 – Define member panels	Reporting Period Active Member Months
4 – Define member panels	Reporting Period Opt-Out Member Months

Design dimension	Output field name
4 – Define member panels	Reporting Period Number of Attributed Members Valid
4 – Define member panels	Reporting Period Number of Enrolled Members Valid
4 – Define member panels	Reporting Period Attributed Member Months Valid
4 – Define member panels	Reporting Period Active Member Months Valid
4 – Define member panels	Reporting Period Opt-Out Member Months Valid
	Calculate performance metrics
5 – Calculate performance metrics	Health Link Attributed Member MCO Months
5 – Calculate performance metrics	Health Link Core Quality Metric 1a
5 – Calculate performance metrics	Health Link Core Quality Metric 1b
5 – Calculate performance metrics	Health Link Core Quality Metric 2
5 – Calculate performance metrics	Health Link Core Quality Metric 3
5 – Calculate performance metrics	Health Link Core Quality Metric 4
5 – Calculate performance metrics	Health Link Core Quality Metric 5
5 – Calculate performance metrics	Health Link Core Quality Metric 6
5 – Calculate performance metrics	Health Link Core Quality Metric 7
5 – Calculate performance metrics	Health Link Core Quality Metric 8
5 – Calculate performance metrics	Health Link Core Quality Metric 9
5 – Calculate performance metrics	Health Link Core Efficiency Metric 1
5 – Calculate performance metrics	Health Link Core Efficiency Metric 2
5 – Calculate performance metrics	Health Link Core Quality Metric 1 Minimum
5 – Calculate performance metrics	Health Link Core Quality Metric 2 Minimum
5 – Calculate performance metrics	Health Link Core Quality Metric 3 Minimum
5 – Calculate performance metrics	Health Link Core Quality Metric 4 Minimum

Design dimension	Output field name
5 – Calculate performance metrics	Health Link Core Quality Metric 5 Minimum
5 – Calculate performance metrics	Health Link Core Quality Metric 6 Minimum
5 – Calculate performance metrics	Health Link Core Quality Metric 7 Minimum
5 – Calculate performance metrics	Health Link Core Quality Metric 8 Minimum
5 – Calculate performance metrics	Health Link Core Quality Metric 9 Minimum
5 – Calculate performance metrics	Health Link Core Efficiency Metric 1 Minimum
5 – Calculate performance metrics	Health Link Core Efficiency Metric 2 Minimum
5 – Calculate performance metrics	Health Link Quality Star Count
5 – Calculate performance metrics	Health Link Efficiency Star Count
5 – Calculate performance metrics	Health Link Reporting-Only Quality Metric 1a
5 – Calculate performance metrics	Health Link Reporting-Only Quality Metric 1b
5 - Calculate performance metrics	Health Link Reporting-Only Quality Metric 2
5 - Calculate performance metrics	Health Link Reporting-Only Quality Metric 3
5 – Calculate performance metrics	Health Link Reporting-Only Quality Metric 4
5 – Calculate performance metrics	Health Link Reporting-Only Efficiency Metric 1
5 – Calculate performance metrics	Health Link Reporting-Only Efficiency Metric 2
5 – Calculate performance metrics	Health Link Reporting-Only Efficiency Metric 3
5 – Calculate performance metrics	Health Link Reporting-Only Efficiency Metric 4
5 – Calculate performance metrics	Health Link Reporting-Only Efficiency Metric 5
5 – Calculate performance metrics	Health Link Reporting-Only Efficiency Metric 6
5 – Calculate performance metrics	Health Link Reporting-Only Efficiency Metric 7
	Calculate total cost of care
7 – Calculate total cost of care	Health Link Total Cost Of Care

Design dimension	Output field name
7 – Calculate total cost of care	Health Link Total Cost Of Care By Reporting Care Category
7 – Calculate total cost of care	Health Link BH Total Cost Of Care
7 – Calculate total cost of care	Health Link BH Total Cost Of Care By BH Reporting Care Category
	Calculate outcome payments
8 – Calculate outcome payments	Improvement in Health Link Efficiency Metric 1
8 – Calculate outcome payments	Improvement in Health Link Efficiency Metric 2
8 – Calculate outcome payments	Health Link Quality Performance
8- Calculate outcome payments	Health Link Efficiency Performance
8 – Calculate outcome payments	Health Link Efficiency Improvement Percentage
8 – Calculate outcome payments	Health Link Outcome Payment

4.3.5 Activity payment table

The activity payment table is a table to help facilitate MCO's activity payments to Health Link organizations. The table "Activity payment table" below lists the required output fields.

TABLE 16: Activity Payment Table

Design dimension	Output field name
	Define member panels
4 – Define member panels	Member ID
4 – Define member panels	(for each service month) Enrollment Effective Date
4 – Define member panels	(for each service month) Status
4 – Define member panels	(for each service month) Enrolled Health Link ID

Design dimension	Output field name
4 – Define member panels	(for each service month if applicable) Health Link ID for Look Back Payment
	Calculate activity payment
6 – Calculate activity payment	(for each service month) Health Link Claim Date
6 – Calculate activity payment	(for each service month) Activity Claim Receipt Month
6 – Calculate activity payment	(for each service month) Activity Payment Level

4.4 OUTPUT GENERATION TIMELINE

Output tables are generated at pre-determined frequencies, which are defined taking into account the claim run-out period needed.

TABLE 17: Output Table Generation Timeline

Output tables	Claims run-out	Generation timing	Estimated completion timing
• Monthly member assignment table	None	At the beginning of each month, for the month that just ended; for the input file for the care coordination tool, at the beginning of each week	Within a week from the end of the month; within a week from the end of the week for the input file for the care coordination tool
• Monthly Health Link table • Activity payment table	None	At the beginning of each month, for the month that just ended	Within a week from the end of the month
• Reporting period member table, for end of Q1-4 • Reporting period Health Link table, for end of Q1-4	90 days	Three months after the end of the quarter	4-5 months after the end of each quarter
• Reporting period member table, for outcome payment	180 days	Six months after the end of the quarter	7-8 months after the end of each quarter

Output tables	Claims run-out	Generation timing	Estimated completion timing
• Reporting period Health Link table, for outcome payment			

4.5 CARE COORDINATION TOOL AND PROVIDER REPORTS

The following exhibit lays out the reporting frequency of the attribution table for the care coordination tool and the provider reports.

EXHIBIT 5: Output Table Reporting Frequency

Attribution/Provider Reports	Frequency for reporting	Frequency for CCT	First reporting used for	First date to be produced
Attribution Table for CCT	N/A	Weekly	Provider reports	October 2016
Preview Reports	Quarterly (for 3 quarters)	N/A	Provider reports	November 2016
Performance Reports	Quarterly	N/A	Provider reports	August 2017

4.5.1 Attribution table for care coordination tool

Health Link attribution file instructions and file format are provided in the Appendix. For formatting and sending the attribution files, follow the specifications as laid out in the Appendix. The attribution file should be uploaded into the SFTP server by noon each Friday.

4.5.2 Provider reports

Layout for the provider reports is provided as a separate document.

5 Health Link Algorithm

The algorithm may use illustrative values to specify the output fields (e.g., “Not applicable”). These are sample values to communicate the intent of the algorithm; however, each MCO is free to use a different set of output field values, as long as the distinction can be made (e.g., use flag of 0/1 instead of “Excluded”/ “Included”).

When specifying a date range, the algorithm sometimes uses the notation of “inclusive”. This should be interpreted as the start and end dates of the date range should be treated as being part of the date range.

5.1 IDENTIFY ELIGIBLE MEMBERS

As described in Section 3.1, the first design dimension of building a Health Link payment model is to identify eligible members. This includes identifying members who meet the eligibility requirement, excluding the members who meet the exclusion criteria, and setting the output fields.

5.1.1 Initial claim-based eligibility identification

Monthly member assignment table output fields created: *Assignment Table Update Date, Member ID, Member Name (Last, middle, first as separate fields), Eligibility Category, L2CM Status, Dual Status, Initial Eligibility Date, Latest Date of Claim-Based Eligibility, Eligibility Via Claims*

To be eligible for Health Link services through **Category 1**, a member needs to have at least 1) one facility claim form of claim type inpatient as defined in the Glossary, or 2) one facility claim form detail line of claim type other than inpatient as defined in the Glossary, or 3) one CMS-1500 claim form detail line as defined in the Glossary (i.e., claim type: transportation, DME, or professional) that meet all of three following criteria:

1. Input field *Member ID* is the same as the member’s *Member ID*
2. Input field *Header To Date Of Service* (for claims) or *Detail To Date Of Service* (for claim detail lines) falls within the specified look-back window, but is not before the pre-launch claim-based eligibility look-back date limit. The duration of the look-back window for the Category 1 claim-based eligibility prior to program launch, the program launch date, and the pre-launch claim-based eligibility look-back date limit are listed as parameters in the Configuration file under “01 – Identify eligible members”. The look-back window is set to last for the specified duration and end on the date of the claim-based eligibility data extract used (inclusive).
3. At least one input field *Header Diagnosis Code* (any diagnosis position) matches one of the diagnosis codes listed under “Category 1 diagnoses – ICD” of the Configuration file.

To be eligible for Health Link services through **Category 2**, a member needs to have at least 1) one facility claim form with claim type inpatient as defined in the Glossary, or 2) one facility claim form detail line of claim type other than inpatient as defined in the Glossary, or 3) one CMS-1500 claim form detail line as defined in the Glossary (i.e., claim type: transportation, DME, or professional) that meets the following criteria:

- All three of the criteria below:
  - Input field *Member ID* is the same as the member's *Member ID*
  - Input field *Header To Date Of Service* (for claims) or *Detail To Date Of Service* (for claim detail lines) falls within or after the specified look-back window, but is not before the pre-launch claim-based eligibility look-back date limit. The duration of the look-back window for the Category 2 claim-based eligibility prior to program launch, the program launch date, and the pre-launch claim-based eligibility look-back date limit are listed as parameters in the Configuration file under "01 – Identify eligible members". The look-back window is set to last for the specified duration and end on the date of the claim-based eligibility data extract used was finalized (inclusive).
  - At least one input field *Header Diagnosis Code* (any diagnosis position) matches one of the diagnosis codes listed under "Category 2 diagnoses – ICD" of the Configuration file.
- And also at least one of the three criteria below:
  - Claim or claim detail line is part of a facility claim form that is categorized as BH Service category "Hospital inpatient care" as defined in the Glossary.
  - Claim or claim detail line is part of a facility claim form that is categorized as BH Service category "ED care" as defined in the Glossary. In addition, the member must be less than 18 years of age at the date specified in the same claim's input field *Header From Date Of Service*.
  - Claim or claim detail line is categorized as BH Service category "Mental health residential" or "Crisis services" as defined in the Glossary.

To be eligible for Health Link services through **Category 3**, a member needs to have at least two qualifying Level 2 Case Management visits. Visits are defined in the Glossary. In order to be a qualifying Level 2 Case Management visit, the claim detail line(s) that compose the visit must meet all of the following criteria:

1. Claim detail line has the input field *Member ID* that is the same as the member's *Member ID*

2. Claim detail line has the input field *Detail To Date Of Service* that falls within or after the specified look-back window, but is not before the pre-launch claim-based eligibility look-back date limit. The duration of the look-back window for the Category 3 claim-based eligibility prior to program launch, the program launch date, and the pre-launch claim-based eligibility look-back date limit are listed as parameters in the Configuration file under "01 – Identify eligible members". The look-back window is set to last for the

specified duration and end on the date of the claim-based eligibility data extract used (inclusive).

3. Claim detail line is a detail line that is categorized as BH Service category “Case management, Level 2” as defined in the Glossary.

Monthly member assignment table output field *Assignment Table Update Date* is set to the date when the claim-based eligibility identification was finalized. Each member meeting the eligibility criteria for the Health Link program is a record on the ***Monthly member assignment table***, with the output field *Member ID* being the input field *Member ID* in the claims extract and the output field *Member Name (Last, middle, first as separate fields)* being the input field *Member Name (Last, middle, first as separate fields)* from the eligibility extract associated with *the Member ID*.

Output field *Eligibility Category* can be set to “Category 1”, “Category 2”, or “Category 3”, based on the category through which the member met the Health Link eligibility requirement. If the member qualifies under multiple eligibility categories, then Category 1 through 3 are applied in a hierarchical manner, with Category 1 being the first priority. Output field *L2CM Status* is set to value “Receiving” if the member meets the Category 3 criteria, regardless of the value in output field *Eligibility Category*. If the member does not meet the Category 3 criteria, then output field *L2CM Status* is set to value “Not receiving”.

Output field *Initial Eligibility Date* is set to the *Header To Date Of Service* or the *Detail To Date Of Service* of the claim or claim detail line that confirmed the member’s eligibility. *Header To Date Of Service* is used if a claim confirmed the eligibility, and *Detail To Date Of Service* is used if a claim detail line confirmed the eligibility. When there are multiple possible dates, the earliest date is used.

Output field *Latest Date of Claim-Based* Eligibility is set to be the latest of the claim extract input field *Header To Service Date* or *Detail To Service Date* of the claims or claim detail lines that met the Category 1 through 3 criteria above for the given member. Output field *Eligibility Via Claims* is set to value “Claim confirmed” for all members who met the Health Link eligibility requirement based on claims data.

Output field *Dual Status* is set to be the same as the input field *Dual Status* on the member eligibility extract used for the eligibility identification, as of the day before the *Assignment Table Update Date.* Output field *Non-Claim Eligibility* is set to “Not applicable”.

5.1.2 Subsequent updates in claim-based eligibility, prior to program launch

Monthly member assignment table output fields created: *Assignment Table Update Date, Member ID, Member Name (Last, middle, first as separate fields), Eligibility Category, L2CM Status, Dual Status, Initial Eligibility Date, Latest Date of Claim-Based Eligibility, Eligibility Via Claims*

For the subsequent updates in the claim-based identification of eligible members, the ***Monthly member assignment table*** output field *Assignment Table Update Date* is set to the date when the current claim-based eligibility update is finalized. Other output fields for the subsequent eligibility updates are defined differently for *Member IDs* already listed on the ***Monthly member assignment table*** and the newly identified *Member IDs*:

- Members whose *Member IDs* were listed in the previous ***Monthly member assignment table***:
  - Output field *Member ID* is the same as the output field *Member ID* from the previous ***Monthly member assignment table***. All *Member IDs* in the previous ***Monthly member assignment tables*** are included.
  - Output fields *Member Name (Last, middle, first as separate fields)*, *Initial Eligibility Date, Eligibility Via Claims* are set to be identical to the values in the previous ***Monthly member assignment table***.
  - Output field *L2CM Status* is set in an identical manner as the initial claim-based identification of members meeting the eligibility requirement.
  - Output fields *Eligibility Category* and *Latest Date of Claim-Based Eligibility* are set in an identical manner as the initial claim-based identification of members meeting the eligibility requirement. If the current eligibility update did not contain any new data for these output fields, then the values for these two output fields are set to be identical to the respective output fields from previous ***Monthly member assignment table***.
  - Output field *Dual Status* is set in an identical manner as the initial claim-based identification of members meeting the eligibility requirement.
- Members whose Member IDs were not listed in the previous **Monthly member assignment table**: Output fields Member ID, Member Name (Last, middle, first as separate fields), Eligibility Category, L2CM Status, Dual Status, Initial Eligibility Date, Latest Date of Claim-Based Eligibility, and Eligibility Via Claims are set in an identical manner as the initial claim-based identification of members meeting the eligibility requirement.

For the subsequent updates in claim-based identification of eligible members prior to program launch, the claim look-back windows are set using the same look-back window and date limit as the initial claim-based identification of eligible members, listed as parameters under “01 – Identify eligible members” of the Configuration file.

5.1.3 Subsequent updates in claim-based eligibility, after program launch

Monthly member assignment table output fields created: *Assignment Table Update Date, Member ID, Member Name (Last, middle, first as separate fields), Eligibility Category, L2CM Status, Dual Status, Initial Eligibility Date, Latest Date of Claim-Based Eligibility, Eligibility Via Claims*

Monthly member assignment table output fields for subsequent updates in claim-based identification of eligible members at or after program launch are defined in an identical manner as the "Subsequent updates in claim-based identification of eligible members, prior to program launch" described above, except for two differences:

- Claim-based eligibility look-back window: The look-back windows are specified for Categories 1, 2, and 3 for post-launch claim-based eligibility. The values are listed as parameters in the Configuration file under "01 – Identify eligible members".
- Claim-based eligibility look-back limit: The look-back limits are specified for Categories 1, 2, and 3 for post-launch claim-based eligibility. The values are listed as parameters in the Configuration file under "01 – Identify eligible members".

5.1.4 Non-claim-based eligibility

Monthly member assignment table output fields created: *Member ID, Member Name (Last, middle, first as separate fields), Eligibility Category, L2CM Status, Initial Eligibility Date, Latest Date of Claim-Based Eligibility, Eligibility Via Claims, Non-Claim Eligibility*

Non-claim-based identification of eligible members is applicable only to members who are not listed in the previous ***Monthly member assignment table***. Output fields associated with *Member IDs* already listed in the previous ***Monthly member assignment table*** are not affected. Non-claim-based identification of eligible members is conducted using the Hospital triggered eligibility, Provider triggered eligibility, and MCO transition feed.

For the **Hospital triggered eligibility**, members with at least one Hospital triggered eligibility record row that meets at least one of the following criteria are added to the ***Monthly member assignment table***:

- Category 1: Input field *Main BH Diagnosis for Admission* is one of the Category 1 diagnoses as defined in Section 3.1.
- Category 2: Input field *Main BH Diagnosis for Admission* is one of the Category 2 diagnoses as defined in Section 3.1 and the input field *Type of Admission* is "Inpatient", "Crisis Stabilization Unit", or "Residential Treatment Facility".
- Category 2: Input field *Main BH Diagnosis for Admission* is one of the Category 2 diagnoses as defined in Section 3.1, the input field *Type of Admission* is "Emergency Department", and member's age as of the date listed in input field *Discharge Date* is less than 18 years.

For newly eligible members identified by the Hospital triggered eligibility, ***Monthly member assignment table*** output field *Assignment Table Update Date* is set to the date of the eligibility update. For each member to be added to the ***Monthly member assignment table*** based on the Hospital triggered eligibility, the output fields *Member ID* and *Member Name (Last, middle, first as separate fields)* are the input field *Member ID* in the Hospital triggered eligibility and the

output fields *Member Name (Last, middle, first as separate fields)* from the eligibility extract associated with the *Member ID*.

Output field *Initial Eligibility Date* is the same as the Hospital triggered eligibility input field *Discharge Date* of the Hospital triggered eligibility record row that met the eligibility criteria. If there are multiple rows that meet the eligibility criteria, then the earliest input field *Discharge Date* is chosen. Output field *Eligibility Category* is set to "Category 1" or "Category 2", based on categories set forth in the Hospital triggered eligibility qualification criteria. If the member qualifies under multiple eligibility categories, then the *Eligibility Category* associated with the *Discharge Date* selected as output field *Initial Eligibility Date* is chosen.

Output field *Non-Claim Eligibility* is set to "Hospital triggered eligibility"; output fields *Latest Date of Claim-Based, Eligibility Via Claims,* and *L2CM Status* are set to values "Not applicable" , "Not claim confirmed", and "Not receiving" respectively. Output field *Dual Status* is set to be the same as the input field *Dual Status* on the member eligibility extract used for the eligibility identification, as of the day before the *Assignment Table Update Date*.

For the **Provider triggered eligibility**, members with at least one Provider triggered eligibility record row that meets at least one of the following criteria are added to the ***Monthly member assignment table***:

- Category 1: Input field *Main BH Diagnosis for Encounter* is one of the Category 1 diagnoses as defined in Section 3.1.
- Category 2: Input field *Main BH Diagnosis for Encounter* is one of the Category 2 diagnoses as defined in Section 3.1 and the input field *Type of Encounter* is "Crisis Stabilization Unit" or "Residential Treatment Facility".
- Category 2: Input field *Main BH Diagnosis for Encounter* is one of the Category 2 diagnoses as defined in Section 3.1, the input field *Type of Encounter* is "Emergency Department", and member's age as of the date listed in input field *Service Date* is less than 18 years.
- Category 3: Input field *Type of Encounter* is "Level 2 Case Management" or "Medical Necessity Approval Received".

For newly eligible members identified by the Provider triggered eligibility, the output field *Assignment Table Update Date* is set to the date when the non-claim-based eligibility identification was incorporated. For each member to be added to the ***Monthly member assignment table*** based on Provider triggered eligibility, the output field *Member ID* is the input field *Member ID* in the Provider triggered eligibility and the output field *Member Name (Last, middle, first as separate fields)* is the input fields *Member Name (Last, middle, first as separate fields)* from the eligibility extract associated with the *Member ID*.

Output field *Initial Eligibility Date* is the same as the Provider triggered eligibility input field *Service Date* of the Provider triggered eligibility record that met the eligibility criteria. If there are multiple Provider triggered eligibility record for the same *Member ID* that meet the eligibility

criteria, then the earliest input field *Service Date* is chosen. Output field *Eligibility Category* is set to “Category 1”, “Category 2”, or “Category 3”, based on categories set forth in the Provider triggered eligibility qualification criteria. If the member qualifies under multiple eligibility categories, then the *Eligibility Category* associated with the *Service Date* selected as output field *Initial Eligibility Date* is chosen.

Output field *Non-Claim Eligibility* is set to “Provider triggered eligibility”; output fields *Latest Date of Claim-Based, Eligibility Via Claims,* and *L2CM Status* are set to values “Not applicable”, “Not claim confirmed”, and “Not Receiving”, respectively. Output field *Dual Status* is set to be the same as the input field *Dual Status* on the member eligibility extract used for the eligibility identification, as of the day before the *Assignment Table Update Date*.

If the member meets the requirement for non-claim-based eligibility for both Hospital triggered eligibility and Provider triggered eligibility, then the record that would lead to the earliest *Initial Eligibility Date* in the output field for the ***Monthly member assignment table*** is chosen.

For **MCO transition**, members with *Member IDs* listed in the MCO transition input table for the given monthly eligibility update are considered to meet the eligibility requirement for the Health Link program.

Output field *Assignment Table Update Date* is set to the date when the MCO transition information was incorporated. For each member to be added to the ***Monthly member assignment table***, the output field *Member ID* is the input field *Member ID* in the MCO transition feed and the output fields *Member Name (Last, middle, first as separate fields)* and *Dual Status*, respectively, are the input field *Member Name (Last, middle, first as separate fields)* and *Dual Status* from the eligibility extract associated with the *Member ID*. Output fields *Eligibility Category, L2CM Status* and *Initial Eligibility Date* are set to be the same as the input fields *Original Eligibility Category, Original L2CM Status*, and *MCO Transition Date* in the MCO transition input file. The output field *Non-Claim Eligibility* is set to “MCO transition”; output fields *Latest Date of Claim-Based* and *Eligibility Via Claims,* are set to values “Not applicable” and “Not claim confirmed”, respectively.

5.1.5 Exclusion of members from the Health Link program

Monthly member assignment table output fields created: *Exclusion, DCS Exclusion, Prisoners Program Exclusion, Intensive Community-Based Treatment Exclusion, TennCare Eligibility, RTF Stay Status, NF Stay Status, MCO Removal Status*

During each eligibility update, the full list of potentially eligible members is checked against the list of members who were excluded from the Health Link program during the time period between the previous round of eligibility data update of eligibility and the current one. A member loses eligibility to the Health Link program if one of the situations described in Section 3.1.2 occurs. *Member IDs* associated with excluded members are identified based on the following criteria:

- **Member loses eligibility for TennCare**: If output field *Member ID* in the current ***Monthly member assignment table*** is not found in the input field *Member ID* of the Member extract used or the input field *Eligibility End Date* of the Member extract associated with the *Member ID* is prior to or identical to the output field *Assignment Table Update Date*, then output field *TennCare Eligibility* is set to "Medicaid Ineligible"; if not, output field *TennCare Eligibility* is set to "Medicaid Eligible".
- **Member is a current resident of a nursing home for longer than the minimum specified days**: Member has an ongoing nursing home facility stay of more than 90 days, composed of one or more facility claims, without being discharged to home or community, which requires all four of the following conditions. If all four conditions are met, output field *NF Stay Status* is set to "Extended NF Stay"; for all others, the output field is set to "No Extended NF Stay":
  - *Member ID* in the current claims extract has one or more facility claims with input field *Type Of Bill* that start with the values listed under "Nursing facility - Type of bill" of the Configuration file during the specified look-back window listed as a parameter under "01 – Identify eligible members" of the Configuration file.
  - The consecutive time period covered by these claims when the input field *Header From Date Of Service* and *Header To Date Of Service* are combined is greater than the Minimum nursing home stay duration for exclusion listed as a parameter under "01 – Identify eligible members" of the Configuration file.
  - Input field *Patient Discharge Status* of the last facility claim form identified must not be one of the values listed under "Discharge to home or community – Discharge Status" of the Configuration file. If there are overlapping days between multiple qualifying claims, then those days are counted only once.
  - Input field *Header To Date Of Service* of the last facility claim form must be within 150 days of the output field *Assignment Table Update Date* of the current ***Monthly member assignment table*** (exclusive). The 150 days date requirement for last nursing facility claim form is set as a parameter under "01 – Identify eligible members" of the Configuration file.
- **Member is a current resident of a residential treatment facility (RTF) for longer than the minimum specified days**: Member has an ongoing RTF stay of more than 90 days, composed of one or more facility claim forms, without being discharged to home or community, which requires all four following conditions. If all four conditions are met, output field *RTF Stay Status* is set to "Extended RTF Stay" for all others, the output field is set to "No Extended RTF Stay":
  - *Member ID* in the current claims extract has one or more facility claim forms with at least one claim detail line with: 1) input field *Detail Procedure Code* with the values listed under "RTF stay – CPT or HCPCS" of the Configuration file during the specified look-back window listed as a parameter under "01 – Identify eligible members" of the Configuration file, or 2) input field *Revenue Code* with the values listed under "RTF stay – Revenue code" of the Configuration file during the specified look-back window listed as a parameter under "01 – Identify eligible members" of the Configuration file.

- The consecutive time period covered by these claims when the input field *Header From Date Of Service* and *Header To Date Of Service* are combined is greater than the Minimum RTF stay duration for exclusion listed as a parameter under “01 – Identify eligible members” of the Configuration file. If there are overlapping days between multiple qualifying claims, then those days are counted only once.
- Input field *Patient Discharge Status* of the last facility claim form identified must not be one of the values listed under “Discharge to home or community – Discharge Status” of the Configuration file.
- Input field *Header To Date Of Service* of the last facility claim form must be within 150 days of the output field *Assignment Table Update Date* of the current ***Monthly member assignment table*** (exclusive). The 150 days date requirement for last residential treatment facility claim form is set as a parameter under “01 – Identify eligible members” of the Configuration file.

– **Member has eligibility under certain programs by DCS for longer than minimum specified days**: Members meeting the following four requirements are excluded from the Health Link program. If all four conditions are met, output field *DCS Exclusion* is set to “Excluded DCS Program”; if not, the output field is set to “Not Excluded DCS Program”:

- Member assignment field *Member ID* is listed in the input field *Member ID* of the DCS Enrollment Feed, with the input field DCS Program being one of the values listed under “Excluded DCS programs” of the Configuration file.
- Input field *MCO Manual Inclusion* of the DCS Enrollment Feed for the given *Member ID* is “No inclusion”.
- Input field *DCS Program Enrollment End Date* of the DCS Enrollment Feed associated with the excluded program must be after the output field *Assignment Table Update Date.*
- Input field *DCS Program Enrollment Start Date* of the DCS Enrollment Feed associated with the excluded program must be before the minimum specified days prior to the output field *Assignment Table Update Date.* The minimum date requirement for the *DCS Program Enrollment Start Date* is listed as a parameter under “01 – Identify eligible members” of the Configuration file.

– MCO or provider assessed the member to no longer need Health Link membership or to be making little to no progress in meeting targeted goals: Output field *Member ID* in the current *Monthly member assignment table* is the input field *Member ID* of the MCO Removal Feed and the input field *Date of Eligibility Revocation* is on or after the latter of *Latest Date of Claim-Based Eligibility* or *Initial Eligibility Date* of the current *Monthly member assignment table*. Output field *MCO Removal Status* is set to “MCO Removal” if this criterion is met; if not, the output field is set to “Not MCO Removal”.

– **Member is enrolled in an Intensive Community-Based Services Treatment (CTT/CCFT):** Members enrolled in CTT or CCFT programs are excluded from the Health Link program and the output field *CTT/CCFT Program Exclusion* is set to “Excluded CTT/CCFT Program”

- Input field CTT/CCFT Authorization End Date associated with the excluded program must be after the output field Assignment Table Update Date.
- Input field CTT/CCFT Authorization Start Date of the CTT/CCFT authorization associated with the excluded program must be before the output field Assignment Table Update Date.

– **Member has eligibility under the Prisoners Program:** Members with Prisoners Programs are excluded from the Health Link program and the output field Prisoners Program Exclusion is set to "Excluded Prisoners Program"

- Input field Prisoners Program Enrollment End Date associated with the excluded program must be after the output field Assignment Table Update Date.
- Input field Prisoners Program Enrollment Start Date of the Prisoners Enrollment Feed associated with the excluded program must be before the minimum specified days prior to the output field Assignment Table Update Date. The minimum date requirement for the Prisoners Program Enrollment Start Date is listed as a parameter under "01 – Identify eligible members" of the Configuration file.

Monthly member assignment table output field *Exclusion* is set to "Excluded" for the *Member IDs* associated with members excluded as identified above and to "Included" for all other *Member IDs*. Output field *Exclusion* is updated with each eligibility update.

5.2 ATTRIBUTE MEMBERS TO HEALTH LINK ORGANIZATIONS

As described in Section 3.2, the second design dimension of building a Health Link payment model is to attribute eligible members to eligible Health Link organizations. This includes identifying eligible Health Link organizations and members for attribution, attributing members based on claims data, and attributing members based on non-claims data.

5.2.1 Identification of eligible Health Link Organizations and members for attribution

Monthly member assignment table output fields created: None

Health Link Organization Tax IDs eligible for attribution for the current update are identified from the Eligible Health Link Organization List. *Health Link Organization Tax ID* must meet both of the following criteria to be eligible for new member attribution:

– Input field *Remediation Status* is "No".

– Input field Health Link Eligibility End Date is after the output field Assignment Table Update Date of the **Monthly member assignment table** (including open-ended dates).

Member IDs eligible for attribution are defined differently depending on whether the attribution is the initial attribution or subsequent attributions:

– For the initial attribution, all eligible *Member IDs* are subject to the attribution. Eligible *Member IDs* are defined as the *Member IDs* listed in the current ***Monthly member assignment table*** and the value in output field *Exclusion* is "Included".

– For subsequent attributions, only a subset of eligible *Member IDs* are attributed. This includes members who meet at least one of the criteria below:
  - **Newly eligible members**: *Member ID* is listed on the current ***Monthly member assignment table*** and the value in output field *Exclusion* is “Included”. However, the *Initial Eligibility Date* is not earlier than the day when the data was extracted for the previous ***Monthly member assignment table***.
  - **Members attributed to invalid Health Links organizations**: *Member IDs* whose *Attributed Health Link ID* in the previous Monthly member assignment file have the following characteristics need a new attribution:
    - *Attributed Health Link ID* in the previous ***Monthly member assignment table*** is not part of the Eligible Health Link Organization List
    - Attributed Health Link ID in the previous **Monthly member assignment table** has an input field Health Link Eligibility End Date before the output field Assignment Table Update Date of the current **Monthly member assignment table**
  - **Eligible members who were previously inactive due to opt-out but opted back in**: Members who previously opted out but opted back into the Health Link program need a new attribution before being able to participate in the program. In order to be considered for new attribution, the *Member ID* needs to meet the following requirements:
    - In the previous ***Monthly member assignment table*** output, *Member ID* was associated with output field *Status* with value of “Inactive Opt out”.
    - A record exists to opt a member back in to Health Link. A record may meet one of the following criteria:

    a) *Member ID* is part of the input field *Member ID* of the input file Member Switch and Opt-out Request and the input field *Type of Request* is “Opt in”. If the input file Member Switch and Opt-out Request has multiple rows for the same *Member ID*, opt-in is considered valid only if the row with the latest *Date of Switch or Opt-in/out* is the row indicating the opt-in.

    b) *Member ID* is found on a provider triggered eligibility record following an “Opt out.” The most recent provider triggered eligibility record following the “Opt out” will be used for attribution.
  - **Eligible members who were previously inactive due to no BH treatment**: Members who were previously inactive due to no BH treatment but are found to have received BH treatment need a new attribution before being able to participate in the program.
  - **Eligible members who were previously inactive due to no contact**: Members who were previously inactive due to no contact need a new attribution before being able to participate in the program.
  - **Members identified as requiring reattribution by the MCO**: *Member ID* is part of the input field *Member ID* of the Inactivity and Reattribution Decision input table and

the input field *Date of Reattribution Decision* is on or after the *Assignment Table Update Date* of the previous ***Monthly member assignment table****.*

- **Members who were previously excluded but regained eligibility**: *Member ID* is listed on the current ***Monthly member assignment table*** and the value in output field Exclusion is "Included". Also, the *Member ID* was part of the output field *Member ID* of the previous ***Monthly member assignment table*** but the output field *Exclusion* was "Excluded".

All members who require a new attribution or reattribution should be assigned the status of "Attributed Not Enrolled".

5.2.2 Initial claim-based attribution

Monthly member assignment table output fields created: *Attributed Health Link ID, Attributed Health Link Name, Attribution Method, Attribution Effective Date*

In the initial attribution, *Member IDs* eligible for attribution are attributed to eligible Health Link organizations based on the following criteria, by order of hierarchy:

1) *Health Link Organization Tax IDs* with which the *Member ID* had the most behavioral health (BH) outpatient visits
2) For *Member IDs* not assigned based on the first criterion, *Health Link Organization Tax IDs* with which the *Member ID* had the most recent Level 2 Case Management visit
3) For *Member IDs* not assigned based on the first and second criteria, *Health Link Organization Tax ID* that is the *Member ID's* PCP practice

Health Link Organization Tax IDs with which the *Member ID* had the most behavioral health outpatient visits is defined as the following:

- Of the *Health Link Tax IDs* eligible for attribution, the *Tax ID* associated with the *Provider ID* that is the *Billing Provider ID* with the most BH outpatient visits in the claims extract during the specified look-back window, but not earlier than the specified look-back limit. In addition, the identified *Tax ID* must be associated with at least two BH outpatient visits. The look-back window, the look-back limit, and the minimum visit are listed as parameters under "02 – Attribute members to Health Link organizations" in the Configuration file.
- If a *Tax ID* is associated with multiple *Billing Provider IDs*, all qualifying visits to the associated *Provider IDs* should be considered in identifying the *Tax ID* with the most BH outpatient visits.
- Visits are defined in the Glossary. Visits are considered to be occurring on the *Detail From Date Of Service* of the visit.
- BH outpatient claims or claim detail lines included in identifying the visits are the claim or claim detail lines categorized as being part of the BH spend but not assigned to BH service categories "Hospital inpatient care"; "Mental health residential"; "ED care"; "Case management, Level 2"; "Ancillary services"; "Supportive services"; "Medication / Pharmacy"; and "Other types of care", as defined in the Glossary.

– *Tax ID* association to *Provider ID* is based on the respective input fields in the Provider extract used.

– If there is a tie, the *Tax ID* with the most recent visit is selected. In case further tie-break is needed, the *Tax ID* associated with the most recent visit with the greater spend is selected. Spend for the visit is calculated by adding the *Detail Paid Amount* of the claim detail lines that constitute the visit.

Health Link Organization Tax IDs with which the *Member ID* had the most recent Level 2 Case Management visits is defined as the following:

– Of the *Health Link Tax IDs* eligible for attribution, the *Tax ID* associated with the *Provider ID* that is the *Billing Provider ID* with the most recent Level 2 Case Management visit in the claims extract during the specified look-back window, but not earlier than the specified look-back limit. In addition, the *Member ID* must have at least two Level 2 Case Management visits during the look-back window, but not applying the look-back limit, for this criterion to be used. The look-back window, the look-back limit, and the minimum visit are listed as parameters under “02 – Attribute members to Health Link organizations” in the Configuration file.

– Visits are defined in the Glossary. Visits are considered to be occurring on the *Detail From Date Of Service* of the visit.

– Only claims or claim detail lines categorized as BH service category “Case management, Level 2” are included in identifying the visits. Service categories are defined in the Glossary.

– *Tax ID* association to *Provider ID* is based on the respective input fields in the Provider extract used.

– If there is a tie, the *Tax ID* with the most number of visits during the look-back period is selected.

Health Link Organization Tax ID that is the *Member ID’s* PCP practice is defined as the tax ID that meets the following requirements:

– ***Primary Care Practice attribution file*** input field *Primary Care Practice Tax ID* associated with the *Member ID* is part of the *Health Link Organization Tax ID* eligible for attribution.

– The day before the current update is conducted must fall between the ***Primary Care Practice attribution file*** input field *Practice Attribution Start Date* and *Practice Attribution End Date* (inclusive) associated with the *Primary Care Practice Tax ID* for the *Member ID*

The *Member ID* is attributed to the *Health Link Organization Tax ID* that met the criteria defined above. ***Monthly member assignment table*** output field *Attributed Health Link ID* is the *Health Link Organization Tax ID* identified. Output field *Attributed Health Link Name* is the input field *Health Link Organization Name* associated with the *Health Link Organization Tax ID* identified.

Output field *Attribution Method* is set to the following values, based on how the *Attributed Health Link ID* was identified:

- *Health Link Organization Tax IDs* with which the *Member ID* had the most behavioral health outpatient visits: “BH OP”
- *Health Link Organization Tax IDs* with which the *Member ID* had the most recent Level 2 Case Management visit: “L2CM”
- Health Link Organization Tax ID that is the Member ID’s PCP practice: “PCP”

Output field *Attribution Effective Date* is set to be *Assignment Table Update Date* of the attribution update when the *Health Link Organization Tax ID* was identified. Output field *Status* is set to “Attributed Not Enrolled”.

5.2.3 Attribution of members based on non-claims data

Monthly member assignment table output fields created: *Attributed Health Link ID, Attributed Health Link Name, Attribution Method, Attribution Effective Date*

There are certain cases in which a member’s attribution is modified outside of the claim-based attribution update. These cases are outlined in the table below. In addition to the criteria listed, the *Member IDs* must be listed on the current ***Monthly member assignment table*** and the value in output field *Exclusion* could be “Included” for the data to be incorporated into non-claim-based attribution.

TABLE 18: Criteria for Non-Claim-Based Attribution

Member characteristic	Member ID identification
Member IDs identified through Hospital triggered eligibility	• *Member ID* was not on the ***Monthly member assignment table*** for the previous month. • Output field *Non-Claim Eligibility* of the current ***Monthly member assignment table*** is “Hospital triggered eligibility”
Member IDs identified through Provider triggered eligibility	• *Member ID* was not on the ***Monthly member assignment table*** for the previous month. • Output field *Non-Claim Eligibility* of the current ***Monthly member assignment table*** is “Provider triggered eligibility”
Member IDs identified through Member switch and opt-out request	• *Member ID* is on input field *Member ID* of the input table Member switch and opt-out request • Input field *Type of Request* of the input table Member switch and opt-out request is “Switch” • Input field *Date of Switch or Opt-in/out* of the input table Member switch and opt-out request is between the *Assignment Table Update Date* of the ***Monthly member assignment table*** for the previous month (inclusive) and

Member characteristic	Member ID identification
	the *Assignment Table Update Date* of the ***Monthly member assignment table*** for the current month (exclusive) • If there are multiple qualifying input data rows, then the information with the latest *Date of Switch or Opt-in/out* on the input table Member switch and opt-out request is used
Member IDs identified through MCO transition feed	• *Member ID* was not on the ***Monthly member assignment table*** for the previous month. • Output field *Non-Claim Eligibility* of the current ***Monthly member assignment table*** is "MCO Transition"
All other *Member IDs* without attribution	• Any *Member ID* without output field *Attributed Health Link ID* as populated after claim-based attribution update and other non-claim-based attribution. MCOs create an attribution for these members incorporating factors such as geographic proximity, provider performance, and member characteristics. A potential approach for logic based on geographic proximity is described in the Glossary.

Monthly member assignment table output field *Attributed Health Link ID*, *Attribution Method,* and *Attribution Effective Date* are defined as the following, based on the five types of non-claim-based attribution above:

TABLE 19: Select Output Field Definition for Non-Claim-Based Attribution

	Output field ***Attributed Health Link ID***	Output field ***Attribution Method***	Output field ***Attribution Effective Date***
Member IDs identified through Hospital triggered eligibility	Input field *Tax ID of the Health Link Organization Referred By Hospital* of the Hospital triggered eligibility	"Hospital triggered eligibility"	Input field *Discharge Date* of the Hospital triggered eligibility
Member IDs identified through Provider triggered eligibility	Input field *Tax ID of the Health Link Organization Referred By Provider* of the Provider triggered eligibility	"Provider triggered eligibility"	Input field *Service Date* of the Provider triggered eligibility

	Output field *Attributed Health Link ID*	Output field *Attribution Method*	Output field *Attribution Effective Date*
Member IDs identified through Member switch and opt-in/out request	Input field *Tax ID of the Health Link Provider After Switch or Opt-In* of the input table Member switch and opt-in/out request	"Switch" or "Opt-In"	Input field *Date of Switch or Opt-in/out* of the Member switch and opt-in/out request
Member IDs identified through MCO transition feed	Input field *Original Health Link Organization Tax ID* of the MCO Transition Feed, if the field *Original Health Link Organization Tax ID*	"MCO Transition"	Input field *MCO Transition Date* of the MCO transition feed
All other *Member IDs* without attribution	Input field *Tax ID of Health Link Provider Manually Attributed* in input file Manual attribution by MCO	"Manual Attribution"	Output field *Assignment Table Update Date* of the current Monthly member assignment table

Output field *Attributed Health Link Name* is the input field *Health Link Organization Name* associated with the *Health Link Organization Tax ID* on the input file Eligible Health Link Organization List.

For the non-claim-based attribution to be valid, there are several conditions that need to be met. If these conditions are not met, the output fields are populated in an identical manner as the members without any attribution data:

- Input fields Tax ID of the Health Link Organization Referred By Hospital, Original Health Link Organization Tax ID must meet the requirement for a Health Link Organization Tax ID to be eligible for new member attribution, as defined in Section 3.2.2.
- Input field *Tax ID of the Health Link Provider After Switch* must be a valid Health Link organization. The given tax ID must listed as a *Health Link Organization Tax ID* on the Health Link Organization List and also be associated with *Health Link Eligibility End*

Date that is after the output field *Assignment Table Update Date* of the ***Monthly member assignment table*** (including open-ended dates).

– Non-claim-based attribution using input file Hospital triggered eligibility, Provider triggered eligibility, and Manual attribution by MCO are valid only if the output field *Attributed Health Link ID* was not populated for the given *Member ID* on the current ***Monthly member assignment table***. After program launch, non-claim-based attribution are valid only if the output filed *Attributed Health Link ID* was not populated for the given *Member ID* on the previous ***Monthly member assignment table.***

For all remaining *Member IDs* with no Health Link attribution, output fields *Attributed Health Link ID, Attributed Health Link Name, Attribution Method,* and *Attribution Effective Date* are set to "Not applicable".

For the initial attribution, non-claim-based attribution is conducted after the claim-based attribution. For subsequent attribution, claim-based attribution is conducted followed by attribution based on input file Manual attribution by MCO after other non-claim-based attribution is conducted.

The hierarchy for subsequent attribution is as follows:

1) Attribution from the Member Switch and Opt-in/out Request Feed
2) Attribution from Hospital Triggered Eligibility/Provider Triggered Eligibility (Most recent record has priority)
3) Attribution from the MCO Transition
4) Claim-based attribution (BHOP, L2CM, Assigned PCP)
5) Attribution from the Manual Attribution by MCO Feed

For either initial or subsequent attribution, output field *Status* is set to "Attributed Not Enrolled" for members with the output field *Attributed Health Link ID* that is not "Not applicable"; for *Member IDs* with *Attributed Health Link ID* of "Not applicable", *Status* is set to "Not Attributed".

5.2.4 Subsequent updates in claim-based attribution

Monthly member assignment table output fields created: *Attributed Health Link ID, Attributed Health Link Name, Attribution Method, Attribution Effective Date*

After the initial attribution, subsequent updates of the claim-based attribution are conducted only for a subset of members as defined in Section 5.2.1. Subsequent claim-based attributions are conducted in a methodology identical to the initial claim-based attribution. For *Member IDs* that are not subject to subsequent attribution, ***Monthly member assignment table*** output fields *Attributed Health Link ID, Attributed Health Link Name, Attribution Method,* and *Attribution Effective Date* are set to values identical to the respective output fields from the previous month's ***Monthly member assignment table.***

5.3 IDENTIFY ENROLLED MEMBERS

Identifying enrolled *Member IDs* includes identification of *Member IDs* that are becoming newly enrolled and *Member IDs* who were previously inactive but becoming enrolled again. Enrollment data are collected only after program launch on December 1, 2016. For all ***Monthly member assignment tables*** created before program launch, these output fields are set to "Not applicable".

5.3.1 New enrollment of attributed members

Monthly member assignment table output fields created: *Status*, *Enrolled Health Link ID, Enrolled Health Link Name, Enrollment Effective Date*

- Initial identification of new enrollment

In the initial identification of new enrollment, *Member IDs* that meet one of the following two criteria are searched for new enrollment:

- *Status* for the current ***Monthly member assignment table*** is yet to be populated
- *Status* for the current ***Monthly member assignment table*** is "Attributed Not Enrolled"

Member IDs that are becoming enrolled in the Health Link program are identified in three ways:

- **Health Link reporting of enrollment:** *Member ID* appearing on Provider triggered eligibility with the input field *Eligibility Attestation* with value of "Enrollment".
- **Presence of the initial Health Link activity claim**: *Member ID* with a claim detail line in the claim extract with input field Detail Procedure Code that is a value listed under "Health Link enrollment – CPT Or HCPCS" of the Configuration file. The *Detail To Date Of Service* of the claim detail line must fall within the claim look-back window for activity initiation listed as a parameter in "03 – Identify enrolled members" of the Configuration file. Member enrollment status is based on Health Link claims submitted by the attributed Health Link organization only.
- **Presence of Level 2 Case Management activities**: *Member ID* with current ***Monthly member assignment table*** output field *L2CM Status* with value of "Receiving".

Member IDs meeting at least one of the criteria above is considered enrolled. For these *Member IDs*, ***Monthly member assignment table*** output field *Enrolled Health Link ID* is set to be the same as the output field *Attributed Health Link ID* of the current ***Monthly member assignment table***. Output field *Enrolled Health Link Name* is the input field *Health Link Organization Name* associated with the *Enrolled Health Link ID* on the input table Eligible Health Link Organization List.

Output fields *Enrollment End Date* and *Status* are set to “Not applicable” and “Enrolled”, respectively. Output field *Enrollment Effective Date* is set differently based on how the enrollment was identified:

- ***Member IDs* enrolled through Provider triggered eligibility:** Output field *Enrollment Effective Date* is set to be the same as the input field *Service Date* of the Provider triggered eligibility row that identified the enrollment.
- ***Member IDs* enrolled through initial Health Link activity claim:** Output field *Enrollment Effective Date* is set to be the same as the input field *Detail To Date Of Service* of the claim detail line that identified the initial Health Link activity.
- ***Member IDs* auto-enrolled through Level 2 Case Management:** Output field *Enrollment Effective Date* is set to be the same as the output field *Attribution Effective Date*.

For all other *Member IDs*, output fields *Enrolled Health Link ID*, *Enrolled Health Link Name, Enrollment Effective Date,* and *Enrollment End Date* are set to “Not applicable”.

- Subsequent identification of enrolled members

In subsequent updates, output fields related to enrollment are filled differently depending on the *Status* for the *Member IDs* in the current and previous ***Monthly member assignment tables***:

- Output field *Status* of the current ***Monthly member table*** is “Inactive No BH treatment,” “Inactive No contact”, “Discharged”, or “Inactive Opt out”: Output fields *Enrolled Health Link ID*, *Enrolled Health Link Name,* and *Enrollment Effective Date* are set to “Not applicable”.
- Output field *Status* of the current ***Monthly member table*** is “Attributed Not Enrolled”: Output fields *Enrolled Health Link ID*, *Enrolled Health Link Name, Enrollment Effective Date, Enrollment End, Status* are set using the identical methodology to the initial identification of enrolled members.
- Output field *Status* of the current ***Monthly member table*** is yet to be populated and output field *Status* of the previous ***Monthly member table*** was not “Enrolled”: Output fields *Enrolled Health Link ID*, *Enrolled Health Link Name, Enrollment Effective Date, Enrollment End,* and *Status* are set using the identical methodology to the initial identification of enrolled members.
- Output field *Status* of the current ***Monthly member table*** is yet to be populated and output field *Status* of the previous ***Monthly member table*** was “Enrolled”: Output fields *Enrolled Health Link ID*, *Enrolled Health Link Name, Enrollment Effective Date, Enrollment End,* and *Status* are set to identical values as the previous ***Monthly member table***.

5.3.2 Inactive member identification

Monthly member assignment table output fields created: *Status, Last BH Treatment Date*

In the initial update, *Member IDs* can be deemed inactive if they meet one of the three criteria below:

- ***Member ID* with opt-out from Health Link program**: *Member ID* is part of the input field *Member ID* of the input file Member Switch and Opt-out Request and the input field *Type of Request* is "Opt out". If the input file Member Switch and Opt-out Request has multiple rows for the same *Member ID*, opt-out is considered valid only if the row with the latest *Date of Switch or Opt-in/out* is the row indicating the opt-out.
- ***Member ID* without BH-related treatments**: *Member ID* does not have any claims or claim detail lines that represent BH-related treatment during the specified look-back window. This applies only to members who are aligned D-SNP duals or non-duals. Members also should not have TPL coverage:
  - Claims or claim detail lines for BH-related treatment are defined as claims or claim detail lines in any BH service categories except for "Ancillary services", "Supportive services", "Case management, Level 2", "Health Link activities", "Medication / Pharmacy" and "Other types of care" as defined in the BH Service Category section of the Glossary,
  - Claims or claim detail lines that occurred during the specified look-back window are defined as claims with *Header To Date Of Service* or claim detail lines with *Detail To Date of Service* falling in the claim look-back window for BH treatment, specified as parameter under "03 – Identify enrolled members" of the Configuration file.
  - Members who are aligned D-SNP duals or non-duals are defined as *Member IDs* with: 1) ***Monthly member assignment table*** output field *Dual Status* with values of "Non-Dual" or "Aligned D-SNP dual" and also 2) input field *Dual Status* of the current eligibility extract without value of "Other Dual" during the claim look-back window for BH treatment specified as parameter under "03 – Identify enrolled members" of the Configuration file.
  - Members who do not have TPL coverage are defined as *Member IDs* that do not meet any of the following criteria:
    - *Member ID* has at least one claim with *Header TPL Amount* greater than zero and also with *Header To Date Of Service* that falls within in the claim look-back window for BH treatment, specified as parameter under "03 – Identify enrolled members" of the Configuration file.
    - *Member ID* has at least one claim detail line with *Detail TPL Amount* greater than zero and also with *Detail To Date Of Service* that falls within in the claim look-back window for BH treatment, specified as parameter under "03 – Identify enrolled members" of the Configuration file.
- ***Member ID* unable to be contacted following attribution**: *Member ID* is part of the input field *Member ID* of the Inactivity and Reattribution Decision input table and the

input field *Inactivity Status Start Date* is between output field *Assignment Table Update Date* of the previous ***Monthly member assignment table*** (inclusive) and the output field *Assignment Table Update Date* of the current ***Monthly member assignment table*** (exclusive).

For *Member IDs* that meet one of the three requirements above, ***Monthly member assignment table*** output field *Status* is set to "Inactive Opt out", "Inactive No BH treatment", and "Inactive No contact", respectively. If a *Member ID* meets multiple requirements above, value for output field *Status* is chosen in the order listed, starting with "Inactive Opt out". For members with status "Inactive No BH Treatment" or "Inactive No Contact", the output field *Enrollment End Date* is set to be the same as the output field *Assignment Table Update Date.* For members with status "Inactive Opt Out", the output field *Enrollment End Date* is set to be the *Date of Switch or Opt-in/out*.

Output field *Last BH Treatment Date* is set to *Detail To Date Of Service* or *Header To Date Of Service* of the last BH-related treatment as defined for *Member IDs* without BH-related treatments above. Input field *Header To Date Of Service* is used if the last BH-related treatment was classified into a BH Service Category as an entire claim; input field *Detail To Date Of Service* is used if the claim detail line was classified into a BH Service Category.

In subsequent eligibility attribution, and enrollment update, the following exceptions apply. All other fields are set in an identical manner as the initial identification:

- If the previous month's ***Monthly member assignment table*** output field *Status* was "Inactive Opt out" or "Inactive No contact": Output field *Status* and *Enrollment End Date* are set to be identical to the previous month's value. This is to ensure that members identified as inactive in the previous month are maintained as inactive.
- If the previous month's *Monthly member assignment table* output field *Status* was "Inactive No BH treatment" and the current month's output field *Status* is one of "Inactive Opt out", "Inactive No BH treatment", or "Inactive No contact": Output field *Enrollment End Date* and *Last BH Treatment Date* are set to be identical to the previous month's value.

5.4 DEFINE MEMBER PANELS

There are two member panels that need to be generated to support the Health Link program. Definitions of member panels for each purpose are described in the following sections. This section also defines select output fields for the ***Reporting period member table***, ***Monthly Health Link table***, ***Reporting period Health Link table,*** and ***Activity payment table***.

5.4.1 Activity payment panels

Activity payment table output fields created: *Member ID, (for each service month) Status, (for each service month) Enrolled Health Link ID, (for each service month if applicable) Health Link ID for Look Back Payment.*

The ***Activity payment table***, created in this section, supports the calculation of activity payment that needs to be disbursed to each Health Link organization each month.

Output fields for ***Activity payment table*** are set as the following:

- *Member ID*: Set identically to the *Member ID* for ***Member assignment table***. All *Member IDs* in the current ***Monthly member assignment table*** should be included.
- *(for each service month) Enrollment Effective Date, Status, Enrolled Health Link ID*: Set identically to the output fields *Enrollment Effective Date*, *Status,* and *Enrolled Health Link ID* of the ***Monthly member assignment table*** for the corresponding month.

The Health Link organization must have conducted a Health Link activity with the member to qualify for activity payment, which will be further described in Section 5.6.3.

In subsequent updates of the ***Activity payment table***, only the output fields relevant to the given month are updated. The table is updated every month, at the same time as the eligibility, attribution, and enrollment update.

5.4.2 Outcome panels

Reporting period member table output fields created: *Reporting Period Start Date, Reporting Period End Date, Member ID, Member Name (Last, middle, first as separate fields), Reporting Period Eligible Months, Reporting Period Attributed Health Link ID, Reporting Period Attributed Health Link Name, Reporting Period Attribution Months, Reporting Period Enrolled Health Link ID, Reporting Period Enrolled Health Link Name, Reporting Period Health Link Active Months, Reporting Period Health Link Opt-Out Months, Reporting Period Health Link Discharged Months, Reporting Period Total Attributed Months, Reporting Period Total Active Months, Reporting Period Total Opt-Out Months, Reporting Period TPL Status, Reporting Period NF Status, Reporting Period RTF Status, Reporting Period Dual Status, Reporting Period Health Link For Performance*

Monthly Health Link table output fields created: *Monthly Health Link Table Update Date, Health Link ID, Health Link Name, Monthly Number Of Attributed Members, Monthly Number Of Enrolled Members, Monthly Number Of Active Members, Monthly Number Of Opt-Out Members*

Reporting period Health Link table output fields created: *Reporting Period Start Date, Reporting Period End Date, Health Link ID, Health Link Name, Reporting Period Number Of Attributed Members, Reporting Period Number Of Enrolled Members, Reporting Period Attributed Member Months, Reporting Period Active Member Months, Reporting Period Opt-Out Member Months, Reporting Period Number Of Attributed Members Valid, Reporting Period Number Of Enrolled Members Valid, Reporting Period Attributed Member Months Valid, Reporting Period Active Member Months Valid, Reporting Period Opt-Out Member Months Valid*

Outcome panels for each Health Link organization include members who were attributed to the given Health Link for the most months during the reporting period, but excluding members who

were inactive due to opt-out. Reporting period is defined as the months from the beginning of the performance period to the end of the quarter. For the last quarter of each performance period, the reporting period is identical to the performance period, one full calendar year.

This section defines the output fields required to identify the outcome panels, including output fields for ***Reporting period member table***.

The ***Reporting period member table*** provide a view of the eligible members during the reporting period, and also identifies members who should be taken into account for each Health Link organization's quarterly performance report. Output fields are based on the ***Monthly member assignment tables*** generated for the reporting period.

Reporting period member table output field *Reporting Period Start Date* is set to the later of the first date of the given calendar year and Program launch date, listed as a parameter under "01 – Identify eligible members" of the Configuration file. Output field R*eporting Period End Date* is set to the end date of the reporting period.

Output field *Member ID* includes a non-duplicative list of *Member IDs* that appear as input field *Member ID* in the ***Monthly member assignment tables*** generated during the reporting period. *Member Name (Last, middle, first as separate fields)* is the *Member Name (Last, middle, first as separate fields)* associated with the *Member ID* in the most recent ***Monthly member assignment table***.

Output field *Reporting Period Eligible Months* is the number of ***Monthly member assignment tables*** during the reporting period with *Exclusion* set to "Included" for the given *Member ID*.

Output field *Reporting Period Attributed Health Link ID* is the *Health Link Organization Tax ID* that appeared most frequently as *Attributed Health Link ID* for the given *Member ID* in ***Monthly member assignment tables*** generated for the reporting period. Output field *Reporting Period Attributed Health Link Name* is the *Health Link Organization Name* associated with the *Reporting Period Attributed Health Link ID* on the Eligible Health Link Organization List. Output field *Reporting Period Attribution Months* is the number of ***Monthly member assignment tables*** during the reporting period for which the *Reporting Period Attributed Health Link ID* was the *Attributed Health Link ID* for the *Member ID*.

Output field *Reporting Period Enrolled Health Link ID* is the *Health Link Organization Tax ID* that appeared most frequently as *Enrolled Health Link ID* in the ***Monthly member assignment tables*** generated during the reporting period. Output field *Reporting Period Enrolled Health Link Name* is the *Health Link Organization Name* associated with the *Reporting Period Enrolled Health Link ID* on the Eligible Health Link Organization List.

Output fields *Reporting Period Attribution Months, Reporting Period Health Link Opt*-Out *Months* and *Reporting Period Health Link Discharged Months* are defined as the count of ***Monthly member assignment tables*** generated during the reporting period that meet the following requirements respectively:

- *Attributed Health Link ID* on ***Monthly member assignment table*** is the same as the ***Reporting period member table*** output field *Reporting Period Attributed Health Link ID.*
- *Status* on ***Monthly member assignment table*** is “Active”, “Attributed Not Enrolled”, “Inactive No BH Treatment”, “Inactive No Contact”, “Inactive Opt Out” or “Discharged”, respectively.

Output field *Reporting Period TPL Status* is set to value “TPL” if the *Member ID* meets at least one of the following criteria. For all other *Member IDs*, the output field is set to value “Not TPL”:

– *Member ID* has at least one claim with *Header To Date Of Service* that falls within the reporting period (from the beginning of performance period to the end of given quarter, inclusive) and also has *Header TPL Amount* greater than zero

– *Member ID* has at least one claim detail line with *Detail To Date Of Service* that falls within the reporting period (from the beginning of performance period to the end of given quarter, inclusive) and also has *Detail TPL Amount* greater than zero

Output field *Reporting Period NF Status* is set to “NF” if the *Member ID* had a nursing home facility stay of more than 90 days during the reporting period, composed of one or more facility claims, which requires both of the following conditions to be met. For all other *Member IDs*, the output field is set to “No NF”.

– *Member ID* in the current claims extract has one or more facility claim forms with input field *Type Of Bill* that start with the values listed under “Nursing facility - Type of bill” of the Configuration file during the specified look-back window listed as a parameter under “01 – Identify eligible members” of the Configuration file.

– The consecutive time period covered by the identified claims when the input field *Header From Date Of Service* and *Header To Date Of Service* are combined, but not earlier than the first day of the reporting period is greater than the Minimum nursing home duration for exclusion listed as a parameter under “01 – Identify eligible members” of the Configuration file. . If there are overlapping days between multiple qualifying claims, then those days are counted only once.

Output field *Reporting Period RTF Status* is set to “RTF” if the *Member ID* had a RTF stay of more than 90 days during the reporting period, composed of one or more facility claim forms, which requires both of the following conditions to be met. For all other Member IDs, the output field is set to “No RTF”.

– *Member ID* in the current claims extract has one or more facility claim forms with at least one claim detail line with: 1) input field *Detail Procedure Code* with the values listed under “RTF stay – CPT or HCPCS” of the Configuration file during the specified look-back window listed as a parameter under “01 – Identify eligible members” of the Configuration file, or 2) input field *Revenue Code* with the values listed under “RTF stay – Revenue code” of the Configuration file during the specified look-back window listed as a parameter under “01 – Identify eligible members” of the Configuration file.

– The consecutive time period covered by the identified claims when the input fields *Header From Date Of Service* and *Header To Date Of Service* are combined, but not earlier than the first day of the reporting period, is greater than the Minimum RTF stay duration for exclusion listed as a parameter under “01 – Identify eligible members” of the Configuration file. . If there are overlapping days between multiple qualifying claims, then those days are counted only once.

Output field *Reporting Period Dual Status* is set as the following, with the criteria being applied in order listed:

– If the *Member ID* has at least one month for which the ***Monthly member assignment table*** output field *Dual Status* is “Other Dual” for the months in the reporting period, then the output field is set to “Other Dual”.

– For *Member IDs* that did not meet the requirement above, if the *Member ID* has at least one month for which the ***Monthly member assignment table*** output field *Dual Status* is “Aligned D-SNP Dual” for the months in the reporting period, then the output field is set to “Aligned D-SNP Dual”.

– For all other *Member IDs*, the output field is set to “Non-Dual”.

In addition, output fields related to the number of months the member met certain requirements, regardless of *Health Link Organization Tax ID* he/she was attributed to or enrolled with, are created. These fields and definitions follow:

- *Reporting Period Total Attributed Months*, defined as the number of ***Monthly member assignment tables*** that had the output field *Attributed Health Link ID* populated
- *Reporting Period Total Active Months*, defined as the number of ***Monthly member assignment tables*** that had the output field *Status* populated with value “Enrolled”
- *Reporting Period Total Opt-Out Months*, defined as the number of ***Monthly member assignment tables*** that had the output field *Status* populated with value ”Inactive: Opt-Out”

The final output field to be created is *Reporting Period Health Link for Performance*. For *Member IDs* that meet one or more of the following requirements, output field *Reporting Period Health Link for Performance* is set to “Excluded from panel”:

- Output field *Reporting Period Dual Status* is “Other Dual”
- Output field *Reporting Period TPL Status* is “TPL”
- Output field *Reporting Period Intensive Community-Based Treatment Status* is “CTT/CCFT”
- Output field *Reporting Period NF Status* is “NF”
- Output field *Reporting Period RTF Status* is “RTF”
- (for the 4th quarter only) ***Reporting period member table*** Reporting period member table the sum of output fields Reporting Period Attribution Months and Reporting Period Health

Link Active Months is less than the minimum months requirement, specified as a parameter under “04 – Define member panels” of the Configuration file

- (for the 4th quarter only starting in 2020 ***Reporting period member table*** output fields *Reporting Period Attribution Months* net of *Reporting Period Health Link Discharged Months* is less than the minimum months requirement, specified as a parameter under “04 – Define member panels” of the Configuration file

For the *Member IDs* that do not meet any of the criteria above, *Reporting Period Health Link for Performance* is set to be the same as *Reporting Period Attributed Health Link.*

The outcome panel for quarterly performance reporting for Q4 is the panel used to determine the outcome payment and should include only members who meet the 9-month attribution requirement during the year. This means members who are in an attributed and/or enrolled status for 9 member months during the year. Members who were in another status such as “Inactive, Opt-Out” status and the “Discharged” status for 3 or more months are not included.

In addition, this section defines the ***Monthly Health Link table***, which provides a snapshot of each Health Link’s engagement with members for each month, and the ***Reporting period Health Link table***, which provides a summary of the performance of each Health Link during a given reporting period. For these tables, each row represents one Health Link organization.

Monthly Health Link table output field *Monthly Health Link Table Update Date* is identical to *Assignment Table Update Date* of the ***Monthly member assignment table*** for the same month. Output field *Health Link ID* is the unduplicated list of *Health Link Organization Tax IDs* that appeared on the Eligible Health Link organization list from the beginning of the performance period to the *Monthly Health Link Table Update Date.* Output field *Health Link Name* is *Health Link Organization Name* associated with the *Health Link Organization Tax IDs* on the Eligible Health Link organization list.

Output field *Monthly Number Of Attributed Members, Monthly Number Of Enrolled Members, Monthly Number Of Active Members,* and *Monthly Number Of Opt-Out Members* are defined as the number of times the *Health Link ID* appears on the ***Monthly member assignment table*** for the current month:

- *Monthly Number Of Attributed Members*: Number of times *Health Link ID* appears as *Attributed Health Link ID* on the ***Monthly member assignment table***
- *Monthly Number Of Enrolled Members*: Number of times *Health Link ID* appears as *Enrolled Health Link ID* on the ***Monthly member assignment table***
- *Monthly Number Of Active Members*: Number of *Member IDs* for the current month, for which both of the following conditions are met:
  - *Member ID* has the *Health Link ID* as *Enrolled Health Link ID* on the ***Monthly member assignment table***
  - *Member ID* has *Status* with value “Enrolled” on the ***Monthly member assignment table***

- *Monthly Number Of Opt-Out Members*: Number of *Member ID* for the current month, for which both of the following conditions are met:
  - *Member ID* has the *Health Link ID* as *Enrolled Health Link ID* on the ***Monthly member assignment table***
  - *Member ID* has *Status* with value “Inactive: Opt-Out” on the ***Monthly member assignment table***

Reporting period Health Link table output fields *Reporting Period Start Date* and *Reporting Period End Date* are set to identical values as *Reporting Period Start Date* and *Reporting Period End Date* of the ***Reporting period member table*** for the same reporting period. Output field *Health Link ID* is set as an unduplicated list of the *Health Link Organization Tax IDs* that appear on the ***Monthly Health Link tables*** generated during the reporting period. Output field *Health Link Name* is set as the input field *Health Link Organization Name* associated with the *Health Link Organization Tax IDs* on the Eligible Health Link organization list.

Output fields *Reporting Period Number Of Attributed Members* and *Reporting Period Number Of Enrolled Members* are set to be the number of *Member IDs* in the ***Reporting period member table*** with the *Health Link ID* set as the output fields *Reporting Period Attributed Health Link ID* and *Reporting Period Enrolled Health Link ID*, respectively.

Output field *Reporting Period Attributed Member Months* is defined as the sum of *Reporting Period Attributed Months* from ***Reporting period member table*** for *Member IDs* with *Reporting Period Attributed Health Link ID* identical to *Health Link ID.*

Output field *Reporting Period Active Member Months* is defined as the sum of *Reporting Period Health Link Active Months* from ***Reporting period member table*** for *Member IDs* with *Reporting Period Enrolled Health Link ID* identical to *Health Link ID*.

Output field *Reporting Period Opt-Out Member Months* is defined as the sum of *Reporting Period Opt-Out Months* from ***Reporting period member table*** for *Member IDs* with *Reporting Period Enrolled Health Link ID* identical to *Health Link ID.*

Output fields *Reporting Period Number Of Attributed Members Valid, Reporting Period Number Of Enrolled Members Valid, Reporting Period Attributed Member Months Valid, Reporting Period Number Active Member Months Valid,* and *Reporting Period Number Of Opt-Out Member Months Valid* are set analogously to output fields *Reporting Period Number Of Attributed Members, Reporting Period Number Of Enrolled Members, Reporting Period Attributed Member Months, Reporting Period Active Member Months,* and *Reporting Period Opt-Out Member Months*, with the only difference being they need to take into account only *Member IDs* that have *Reporting Period Health Link For Performance* set to be the same as *Health Link ID* on the ***Reporting period member table.***

5.5 CALCULATE PERFORMANCE METRICS

This section calculates the performance metrics for the Health Link program, both at the member and Health Link organization level. The section includes:

- Calculation of core metrics
- Generation of quality and efficiency stars
- Calculation of reporting-only metrics

5.5.1 Core metrics calculation

Reporting period member table output fields created: *Member Core Quality Metric [1a to 9], Member Core Efficiency Metric [1 to 2], Member MCO Months*

Reporting period Health Link table output fields created*: Health Link Core Quality Metric [1a to 9], Health Link Core Efficiency Metric [1 to 2], Health Link Attributed Member MCO Months, (for each metric) Health Link Minimum*

- Core metrics calculation on member level for each reporting period

Reporting period member table output fields *Member Core Quality Metric 1a, and Member Core Quality Metric 1b* are core quality and efficiency metrics that are defined by TennCare (see Appendix). These metrics are calculated based on TennCare's existing definition. Denominators and numerator status for each *Member ID* is defined based on TennCare's definitions. For *Member IDs* that do not meet the denominator criteria for the metric during the measurement timeframe or the continuous enrollment criteria, set the output field value to "Not applicable".

Output fields *Member Core Quality Metric [2 to 9] and Member Core Efficiency Metric [1 to 2]* are core quality and efficiency metrics that are defined by HEDIS, as described in Section 3.5.1. These metrics are calculated based on HEDIS' existing definitions (see Appendix). Denominators and numerator status for each *Member ID* is defined based on HEDIS' definitions. For *Member IDs* that do not meet the denominator criteria for the metric during the measurement timeframe or the continuous enrollment criteria, set the output field value to "Not applicable".

Output field *Member MCO Months* is defined as the number of months during the reporting period with at least one day that is covered between the *Eligibility Start Date* and *Eligibility End Date* associated with the *Member ID* in the ***Member Extract***. If the *Member ID* has multiple input fields *Eligibility Start Date* and *Eligibility End Date*, all records should be taken into account to identify the number of months that meet these criteria.

For *Member IDs* that do not meet the continuous enrollment requirement or those that are not part of the denominator for the metric, then the Quarterly member output field for the given metric is set as “Not applicable.”

Core metrics are calculated based on the following claims and claims detail lines, unless specified otherwise by the metric definition documentation:

  - Facility claim forms with claim type inpatient, as defined in the Glossary, and pharmacy claims that have *Header To Date Of Service* that falls between the first day of the calendar year and the last day of available data when generating the given report (inclusive)
  - Claim detail lines with other claim types that have *Detail To Date Of Service* that falls between the first day of the calendar year and the last day of available data when generating the given report (inclusive).
- Core metrics calculation at the Health Link organization level for each reporting period

Reporting period Health Link table output fields *Health Link Core Quality Metric [1a to 9] and Health Link Core Efficiency Metric [1 to 2]* are computed based on *Member IDs* that meet the following two conditions:

  - *Member IDs* with *Reporting Period Health Link For Performance* on the ***Reporting period member table*** set to be the same as *Health Link ID*
  - *Member IDs* meet the denominator criteria for the given metric, i.e., the output field for the given metric on the ***Reporting period member table*** is not set to value “Not applicable”.

Core metrics are calculated based on the following claims or claim detail lines, unless specified otherwise by the metric definition documentation (see Appendix):

  - Facility claim forms with claim type inpatient and pharmacy claims or claim detail lines that have *Header To Date Of Service* or *Detail To Date Of Service* that falls between the first day of the calendar year and the last day of available data when generating the given report (inclusive).
  - Claim detail lines with other claim types that have *Detail To Date Of Service* that falls between the first day of the calendar year and the last day of available data when generating the given report (inclusive).

For each core metric, output field *(for each core metric) Health Link Minimum* tracks whether the Health Link met the minimum denominator of observation for each metric in its panels for quarterly reporting. The minimum denominator is listed as a parameter under “05 – Calculate performance metrics” of the Configuration file. The number of observations (i.e., the denominator) for each metric for a given Health Link organization is defined as the count of *Member IDs* that meet both of the following criteria:

- *Member IDs* with *Reporting Period Health Link For Performance* on the ***Reporting period member table*** is set to be the same as *Health Link ID*
- *Member IDs* meet the denominator criteria for the given metric, i.e., the output field for the given metric on the ***Reporting period member table*** is not set to value “Not applicable”.

Output fields *(for each core metric) Health Link Minimum* for a given metric is set to “Minimum met” if the count of *Member ID* above is equal or greater than the minimum denominator parameter; for others, the output field is set to “Minimum not met”. If the metric is a composite or has multiple sub-metrics, output fields *(for each core metric) Health Link Minimum* is set to “Minimum met” only if all sub-metrics meet the minimum denominator requirement; if not, then the output field is set to “Minimum not met”.

5.5.2 Star rating based on core metrics

Reporting period Health Link table output fields created*: Health Link Quality Star Count, Health Link Efficiency Star Count* ***Reporting period Health Link table*** output fields *Health Link Quality Star Count* and *Health Link Efficiency Star Count* are generated by comparing output fields for core metrics for the given Health Link organization to the thresholds for each metric, but also taking into account whether the minimum denominator was met:

- If output field *(for core each metric) Health Link Minimum* has value of “Minimum met”, then the Health Link organization’s core metric or all sub-metric results must meet or outperform the threshold to have a quality or efficiency star awarded for the given metric.
- If output field *(for each core metric) Health Link Minimum* has value of “Minimum not met”, then the quality or efficiency star for the given metric is not awarded.

For each core metric meeting or outperforming the respective threshold, one star (quality star or efficiency star) is awarded to the Health Link organization. If the metric is a composite metric or has multiple sub-metrics, all sub-metrics must meet or outperform their respective thresholds for a star to be awarded for the metric. Thresholds will be provided in a separate document.

Output fields *Health Link Quality Star Count* and *Health Link Efficiency Star Count* are the respective totals of the quality and efficiency stars for the given quarterly report based on the table above.

5.5.3 Reporting-only metrics

Reporting period member table output fields created: *Member Reporting-Only Quality Metric [1a to4], Member Reporting-Only Efficiency Metric [1 to 7]*

Reporting period Health Link table output fields created*: Health Link Reporting-Only Quality Metric [1a to4], Health Link Reporting-Only Efficiency Metric [1 to 7]*

- Reporting-only metrics calculation on member level for each reporting period

Reporting period member table output fields *Member Reporting-Only Quality Metric [1a to 4]* and *Member Reporting-Only Efficiency Metric [1 to 7]* are reporting-only quality and efficiency metrics defined by TennCare or a third party such as HEDIS (see Appendix), as specified in Section 3.5.4. Denominators and the numerator status for each *Member ID* are defined based on the same source definitions. For *Member IDs* that do not meet the denominator criteria for the metric during the measurement timeframe, set the output field value to "Not applicable".

Reporting-only metrics are calculated based on the following claims and claims detail lines, unless specified otherwise by the metric definition documentation:

  - Facility claim forms with claim type inpatient, as defined in the Glossary, and pharmacy claims that have *Header To Date Of Service* that falls between the first day of the calendar year and the last day of the reporting period (inclusive)
  - Claim detail lines with other claim types that have *Detail To Date Of Service* that falls between the first day of the calendar year and the last day of the reporting period (inclusive).
- Reporting-only metrics calculation on Health Link organization level for each reporting period

Reporting period Health Link table output fields *Health Link Reporting-Only Quality Metric [1a to 4]* and *Health Link Reporting-Only Efficiency Metric [1 to 7]* are reporting-only quality and efficiency metrics that are defined by TennCare or a third party such as HEDIS (see Appendix), as specified in Section 3.5.4, using the same methodology and scope of *Member IDs* as the one described for core metrics in Section 5.5.1.

5.5.4 Reporting-only metrics for phase-in

Algorithm logic for reporting-only metrics for phase-in will be specified when their adoption timing is finalized.

5.6 CALCULATE ACTIVITY PAYMENTS

Calculation of activity payments includes four sub-sections:

- Identification of number of activity payments due, based on the count of member-service month combination for which qualifying Health Link activity claims are received
- Determination of variation of amount based on each member's Health Link activities
- Calculation of total activity payment due to each Health Link organization in a given month

- Calculation of total annual activity payment due to each Health Link organization

5.6.1 Identification of number of activity payments due

Activity payment table output fields created: *(for each service month) Health Link Claim Date, (for each service month) Activity Claim Receipt Month*

Health Link organizations are eligible for monthly activity payment for members active in the Health Link program, enrolled with the given Health Link organization, and with Health Link activities as evidenced in the claims data. Health Link organizations are also eligible for monthly activity payment for members active in the Health Link program, not enrolled with the given Health Link organization but enrolled with a Health Link organization with a valid look back payment present and with Health Link activities as evidenced in the claims data.

Qualifying Health Link activity claim detail lines that meet those requirements are defined differently depending on whether the member is newly enrolling to the Health Link program, an already enrolled member, or a member yet to be enrolled, during the given month:

- **Members who are newly enrolling in the given service month**: These members are identified by *Member ID* with output field *Status* set as "Enrolled" and the output field *Enrollment Effective Date* is within the service month. In these cases, qualifying Health Link activity claim detail lines are defined as the following:
  - Input field *Detail Procedure Code* of the claim detail line is a value listed under "Health Link payment initial – CPT Or HCPCS" of the Configuration file;
  - Input field *Detail To Date of Service* of the claim detail line falls within the service month;
  - The same claim has a claim detail line with input field *Detail Procedure Code* with a value listed under "Health Link enrollment – CPT Or HCPCS" of the Configuration file;
  - The *Tax ID* that the input field *Billing Provider ID* of the claim detail line is associated with on the Provider extract is the same as the *Enrolled Health Link ID* of the service month on the ***Activity payment table*** for the *Member ID.*
- **Members who are already enrolled in the given service month**: These members are identified by *Member ID* with output *Status* for the service month set as "Enrolled" and the output field *Enrollment Effective Date* is prior to the service month. In these cases, qualifying Health Link activity claim detail lines are defined as the following:
  - Input field *Detail Procedure Code* of the claim detail line is a value listed under "Health Link payment ongoing – CPT Or HCPCS" of the Configuration file;
  - Input field *Detail To Date of Service* of the claim detail line falls within the service month;
  - The same claim has a claim detail line with input field *Detail Procedure Code* with a value listed under "Health Link ongoing activities – CPT Or HCPCS" of the Configuration file;

  - The *Tax ID* that the input field *Billing Provider ID* of the claim detail line is associated with on the Provider extract is the same as the *Enrolled Health Link ID* of the given month on the ***Activity payment table*** for the *Member ID.*
- **Members who are not enrolled**: These members are identified by *Member ID* with the given service month's output field *Status* set to values other than "Enrolled". In these cases, there are no qualifying Health Link activity claim detail lines.

The following ***Activity payment table*** output fields are created to support the identification of these members:

- *Health Link Claim Date (for each month)*: *Detail To Date Of Service* of the claim detail line of the qualifying Health Link activity claim detail line, as defined above. If there are multiple claim detail lines with different *Detail To Date Of Service*, the earliest value is chosen. If there is no qualifying Health Link activity claim detail line, then the output field *Health Link Claim Date (for each month)* is left blank.
- *Activity Claim Receipt Month (for each month)*: Calendar year and month during which the claim detail line that was used to identify the given month's *Health Link Claim Date* was received by the MCO. If there is no qualifying Health Link activity claim detail line, then the output field *Activity Claim Receipt Month* is left blank.

As claims may be filed with a time delay, the month when the Health Link organization was eligible for activity payment may not be the same as the month when the corresponding payment is made. Therefore, activity payment amount and timing for each Member ID-Service month combination needs to be identified separately. Health Link activity claims information on the ***Activity payment table*** is updated at least at monthly. In subsequent updates, only output fields *Health Link Claim Date (for each month)* and *Activity Claim Receipt Month (for each month)* that are blank are updated.

Member ID-Service month combinations that qualify for activity payment disbursement for a Health Link organization in a given month are defined as *Member IDs* that meet the following conditions:

1. *Member ID* has ***Activity payment table*** output field *Activity Claim Receipt Month* set as the given month. If the Member ID has *Activity Claim Receipt Month* for multiple service months set as the given month, then each Member ID-Service month combination counts separately; and
2. *Member ID* has ***Activity payment table*** output field *Enrolled Health Link ID* that is the same as the given Health Link organization's tax ID for the same Member ID-Service month combination as the of *Activity Claim Receipt Month* identified in the first criterion; or
3. *Member ID* has ***Activity payment table*** output field *Enrolled Health Link ID* that is different from the given Health Link organization's tax ID for the same Member ID-Service month combination as the of *Activity Claim Receipt Month* identified in the first criterion, however, the output field *Health Link ID for Look Back Payment* must be present

5.6.2 Variation based on each member's enrollment period and program maturity

Activity payment table output fields created: *(for each service month) Activity Payment Level*

A member's enrollment period with the Health Link program and the program's maturity also determine the activity payment rate, as described in Section 3.6.2.

Output field *(for each service month) Activity Payment Level* is defined as the following:

- For any months from 12/1/16-11/30/17, output field *Activity Payment Level* is set to "Transition Rate".
- For any months from 12/1/17-12/31/18, output field *Activity Payment Level* is set to "Stabilization Rate" and should pay at either 175or $139 depending on when the Health Link organization entered the program.
- For any months after 12/31/18, output field *Activity Payment Level* is set to "Stabilization Rate" and should pay at the reimbursement rate determined by each MCO.

5.6.3 Total activity payment amount due to each Heath Link

Monthly Health Link table output fields created: *Count of Activity Payments Due, Total Activity Payment Due*

The activity payment rate for each Member ID-Service month combination is determined based on the output field *Activity Payment Level*, defined in Section 5.6.2.

- For Member ID-Service month combination with *Activity Payment Level* of "Transition Rate", apply the transition activity payment base rate, listed as a parameter under "06 – Calculate Activity Payment" in the Configuration file.
- For Member ID-Service month combination with *Activity Payment Level* of "Stabilization Rate", apply the appropriate stabilization activity payment base rate, listed as parameters under "06 – Calculate Activity Payment" in the Configuration file.

The activity payment amount for each Member ID-Service month combination that qualifies for activity payment disbursement is defined as the activity payment rate identified.

Monthly Health Link table output field *Count of Activity Payments Due* is the number of Member ID-Service month combinations that qualify for activity payment disbursement. Output field *Total Activity Payment Due* is the total amount of activity payment disbursed for each Health Link organization in a given month, i.e., the total of the activity payment amount for each Member ID-Service month combination that qualifies for activity payment disbursement.

5.6.4 Total annual activity payment amount due to each Health Link

The output field *Total Annual Activity Payment Amount* is defined as the total sum of the output field *Total Activity Payment Amount Due* values for each month in the calendar year. The output field amount for *Total Annual Activity Payment Amounts* can be placed in any location of the activity payment tables of the MCOs choosing for tracking purposes.

5.7 CALCULATE TOTAL COST OF CARE

Calculation of total cost of care includes identifying total spend for each member, including and excluding certain spend to identify the total cost of care, as well as identifying the BH total cost of care. This section also calculates total cost of care on each individual Health Link organization level. This information will be included in the quarterly provider reports for informational purposes only.

5.7.1 Member level total cost of care

Reporting period member table output fields created*: Member Total Spend, Member Dental Spend, Member Transportation Spend, Member NICU Nursery Spend, Member Age 1 Month Spend, Member Included Spend, Member Total Cost Of Care, Member BH Total Cost Of Care, Member Total Cost Of Care By Reporting Care Category, Member BH Total Cost Of Care By Reporting BH Care Category*

Reporting period member table output field *Member Total Spend* is the total spend that the member incurred during the reporting period and is identified as the sum of the following:

- From the ***Claim Extract:*** Input field *Header Paid Amount* of facility claim forms with claim type inpatient, as defined in the Glossary, with *Header To Date Of Service* between the output fields *Reporting Period Start Date* and *Reporting Period End Date* (inclusive) for the *Member ID*
- From the ***Claim Extract:*** Input field *Detail Paid Amount* of facility claim form detail lines or professional claim form detail lines for claim types other than inpatient with *Detail To Date Of Service* between the output fields *Reporting Period Start Date* and *Reporting Period End Date* (inclusive) for the *Member ID*
- From the ***Claim Extract:*** Input field *Header Paid Amount* of pharmacy claims with *Header To Date Of Service* between the output fields *Reporting Period Start Date* and *Reporting Period End Date* (inclusive) for the *Member ID*

Output fields *Member Dental Spend, Member Transportation Spend, Member NICU Nursery Spend,* and *Member Age 1 Month Spend*, are the sum of *Header Paid Amount* or *Detail Paid Amount* of the claim or claim detail lines that are included in calculating output field *Member Total Spend* that meet the following conditions, respectively, for the same *Member ID*. Claims or claim detail lines that qualify to be part of more than one of these output fields are categorized into the first output field they qualified for, rather than being double-counted:

- Output field *Member Dental Spend*: Professional or facility claim form detail lines for claim type other than inpatient, as defined in the Glossary with Claim Extract input field Detail Procedure Code that start with the value for dental spend listed as a parameter under “07 – Calculate total cost of care” of the Configuration file.
- Output field *Member Transportation Spend:* Professional claim form detail lines with claim type “Transportation” as defined in the claim type section of the Glossary.
- Output field *Member NICU Nursery Spend*: Claims or claim detail lines that meet one of the following requirements:
  - NICU and nursery facility claims: Facility claim forms with claim type inpatient that contain at least one detail line with Claim Extract input field *Revenue Code* listed under “NICU and nursery – Revenue code” on the Configuration file.
  - Facility and professional claim form detail lines with claim types other than inpatient during NICU and nursery stay: Out of facility and professional claim form detail lines that are not claim type inpatient, detail lines with both *Detail From Date Of Service* and *Detail To Date Of Service* that falls between the input fields *Header From Date Of Service* and *Header To Date Of Service* (inclusive) of a NICU and nursery facility claim
- Output field *Member Age 1 Month Spend*: Claims or claim detail lines that meet one of the following requirements:
  - Facility claim forms with claim type inpatient and pharmacy claims with *Header From Date Of Service* within 30 days after the Member Extract input field *Date Of Birth* (inclusive) associated with the *Member ID*
  - Other facility or professional claim form detail lines for claim types other than inpatient with *Detail From Date Of Service* within 30 days after the Member Extract input field *Date Of Birth* (inclusive) associated with the *Member ID*

Output field *Member Included Spend* is defined as the output field *Member Total Spend* net of *Member Dental Spend, Member Transportation Spend, Member NICU Nursery Spend,* and *Member Age 1 Month Spend.*

Output field *Member Total Cost Of Care* is defined as the smaller of the following two values, divided by output field *Member MCO Months*:

- Output field Member Included Spend
- Maximum Included Spend, which will be provided with State thresholds

Output field *Member BH Total Cost Of Care* is calculated using the same methodology as output field *Member Total Cost Of Care*, but using only claim or claim detail lines identified as BH spend, as defined in the Glossary.

Output fields *Member Total Cost Of Care By Reporting Care Category*, are nine output fields that break out the *Member Total Cost Of Care* by the reporting care categories as specified in the Glossary. Each claim or claim detail line that is part of the output field *Member Included*

Spend must be categorized into a reporting care category. Depending on how the output field *Member Total Cost Of Care* is calculated, output fields *Member Total Cost Of Care By Reporting Care Category* are calculated as the following:

- If *Member Included Spend* is used in calculating *Member Total Cost Of Care*: Member Included Spend in each reporting care category / *Member MCO Months*
- If Maximum Included Spend is used in calculating *Member Total Cost Of Care*: Member Included Spend in each reporting care category * (Maximum Included Spend / *Member Included Spend*) / *Member MCO Months*

Output fields *Member BH Total Cost Of Care By Reporting BH Care Category* are seven output fields that break out the Member BH Total Cost Of Care by the BH reporting care categories as specified in the Glossary. Depending on how the output field *Member BH Total Cost Of Care* is calculated, output fields *Member BH Total Cost Of Care By BH Reporting Care Category* are calculated as the following:

- If Maximum Included Spend is not used in calculating *Member BH Total Cost Of Care*: *Member Included Spend* that is part of BH spend and included in each BH reporting care category / *Member MCO Months*
- If Maximum Included Spend is used in calculating *Member BH Total Cost Of Care*: *Member Included Spend* that is part of BH spend and included in each BH reporting care category * (Maximum Included Spend / *Member Included Spend* that is part of BH spend) / *Member MCO Months*

5.7.2 Health Link organization level total cost of care

Reporting period Health Link table output fields created*: Health Link Total Cost Of Care, Health Link BH Total Cost Of Care, Health Link Total Cost Of Care By Reporting Care Category, Health Link BH Total Cost Of Care By Reporting BH Care Category*

Reporting period Health Link table output field *Health Link Total Cost Of Care* is defined as the ratio of the following:

- Numerator: Sum of ***Reporting period member table*** output field *Member Included Spend* for *Member IDs* output field *Reporting Period Health Link For Performance* that is the same as the *Health Link ID.* If output field *Member Included Spend* is greater than the Maximum Included Spend, listed as a parameter under “07 – Calculate total cost of care” of the Configuration file, then the Maximum Included Spend is used instead.
- Denominator: Output field *Health Link Attributed Member MCO Months.*

Output field *Health Link BH Total Cost Of Care* is defined as the ratio of the following:

- Numerator: Sum of ***Reporting period member table*** output field *Member Included Spend*, calculated using only claims or claim detail lines classified as BH spend as

defined in the Glossary, for *Member IDs* with output field *Reporting Period Health Link For Performance* that is the same as the *Health Link ID.* If output field *Member Included Spend* is greater than the Maximum Included Spend, listed as a parameter under "07 – Calculate total cost of care" of the Configuration file, then the Maximum Included Spend is used instead.

– Denominator: Output field *Health Link Attributed Member MCO Months.*

Output fields *Health Link Total Cost Of Care By Reporting Care Category* and *Health Link BH Total Cost Of Care By Reporting BH Care Category* are defined as the ratio of the following:

– Numerator: Sum of respective ***Reporting period member table*** output field *Member Total Cost Of Care By Reporting Care Category* or *Member BH Total Cost Of Care By Reporting BH Care Category* multiplied by each member's *Member MCO Months,* for *Member IDs* with output field *Reporting Period Health Link For Performance* that is the same as the *Health Link ID*

– Denominator: Sum of ***Reporting period member table*** output field *Health Link Attributed Member MCO Months*

5.8 CALCULATE OUTCOME PAYMENTS

Reporting period Health Link table output fields created*: Health Link Quality Performance, Health Link Efficiency Performance, Health Link Efficiency Improvement Percentage, Health Link Outcome Payment, Improvement in Health Link Efficiency Metric 1, Improvement in Health Link Efficiency Metric 2*

Health Link organizations need to meet one requirement to qualify for outcome payments:

– Output field *Health Link Quality Star Count* is equal or greater than the quality star count minimum listed as a parameter under "08 – Calculate outcome payments" of the Configuration file.

For the *Health Link IDs* that do not meet these requirements, ***Reporting period Health Link table*** output fields *Health Link Quality Performance, Health Link Efficiency Performance, Health Link Efficiency Improvement Percentage,* and *Health Link Outcome Payment* are set to "Not applicable".

For the Health Link organizations that meet these requirements, ***Reporting period Health Link table*** output field *Health Link Quality Performance* is defined as:

– Output field *Health Link Quality Star Count* multiplied by the star value as determined by the table in Section 3.5.3.

For the Health Link organizations that meet these requirements, ***Reporting period Health Link table*** output field *Health Link Efficiency Performance* is defined as the sum of the following:

- Output field *Health Link Efficiency Star Count* multiplied by the shared savings ratio for each efficiency star, listed as a parameter under "08 – Calculate outcome payments" of the Configuration file.
- Output field *Health Link Efficiency Improvement Percentage.* The definition of output field *Health Link Efficiency Improvement Percentage* and related inputs follows.

Reporting period Health Link table output field *Health Link Efficiency Improvement Percentage* is defined as the lesser of the Maximum Efficiency Improvement Percentage, listed as a parameter under "08 – Calculate outcome payments" of the Configuration file, or the average of the following percentages:

- Output field Improvement in Health Link Efficiency Metric 1. Output field Improvement in Health Link Efficiency Metric 1 is defined as the following:
  - Numerator: Difference between output field *Health Link Efficiency Metric 1* of last performance period and *Health Link Efficiency Metric 1* of this performance period. *Health Link Efficiency Metric 1* of the last performance period for the first year of the program is defined by implementing the Health Link algorithm on the CY2016 data.
  - Denominator: *Health Link Efficiency Metric 1* of last performance period
  - Multiplied by 100 to get a percentage: If the denominator value is "Not applicable", then output field *Improvement in Health Link Efficiency Metric 1* is set to zero.
  - Output field *Improvement in Health Link Efficiency Metric 2* is defined using the same methodology.

For *Health Link IDs* that meet the requirements for outcome payments, output field *Health Link Outcome Payment* is defined as the multiplication of the following five factors:

- Average cost of care (PMPM): $801
- Maximum share of savings: 25%
- Output field *Reporting Period Attributed Member Months Valid*
- Output field *Health Link Quality Performance*
- Output field *Health Link Efficiency Performance*

*Note: See section 3.8.2 for guidance on calculating the efficiency baseline performance and for guidance on when to apply rounding for the efficiency improvement percentage average of the two metrics.

5.8.1 Calculate annual outcome payment cap

For *Health Link IDs* that meet the requirements for outcome payments, output field *Annual Outcome Payment Cap* is defined as 10% of the output field *Total Annual Activity Payment Due*. This represents the maximum value for the output field *Final Health Link Outcome Payment*.

5.9 OUTPUT FIELD *FINAL HEALTH LINK OUTCOME PAYMENT* IS DEFINED AS THE LESSER OF *HEALTH LINK OUTCOME PAYMENT* AND *ANNUAL OUTCOME PAYMENT CAP.* GENERATE DATA FOR CARE COORDINATION TOOL AND PROVIDER REPORTS

5.9.1 Attribution table for care coordination tool

Attribution table for care coordination tool output fields created: *Last Name, First Name, Middle Name, Date Of Birth, Social Security Number, MCO Assigned Member ID, THL Practice Name, THL Practice Tax ID, THL Member Status, Eligibility Category, MCO Change (if applicable),* MCO Change Date (if applicable) File *Effective Date, Termination Date (if applicable),* Program Eligibility Date, Status Start Date, Practice End Date

The ***Attribution table for care coordination tool*** is updated weekly, by incorporating the changes in attribution due to non-claim-based attribution from the last assignment table update date to end of the current week, to the latest Monthly member assignment table available. The Attribution table for the care coordination tool is uploaded to the SFTP server by the end of the day each Friday. The following output fields are set identically to the respective field in the latest ***Monthly member assignment table*** that incorporates the weekly changes:

- Output field *Last Name*: ***Monthly member assignment table*** output field *Member Name (last)*
- Output field *First Name*: ***Monthly member assignment table*** output field *Member Name (first)*
- Output field *Middle Name*: ***Monthly member assignment table*** output field *Member Name (middle)*
- Output field *MCO Assigned Member ID*: ***Monthly member assignment table*** output field *Member ID*
- Output field *THL Practice Tax ID*: ***Monthly member assignment table*** output field *Attributed Health Link ID*
- Output field *THL Practice Name*: ***Monthly member assignment table*** output field *Attributed Health Link Name*
- Output field *THL Member Status*: ***Monthly member assignment table*** output field *Status*
- Output field *Eligibility Category*: ***Monthly member assignment table*** output field *Eligibility Category*
- Output field *MCO Change*: ***Monthly member assignment table*** output field
- Output field *MCO Change Date: **Monthly member assignment table** output field Date the member either joined or left MCO. If no change leave blank*
- Output field *File Effective Date: **Monthly member assignment table** output field Attribution Effective Date. Run date of the file (ex. If today is March 4 and file is generated, run date would be 202000304*)

- Output field *Termination Date*: ***Monthly member assignment table*** output field *Record/status span end date. Leave blank if record/span is current.*
- Output field *Program Eligibility Date:* ***Monthly member assignment table*** *output field. Date member is assigned to either Category 1, 2 or 3 Eligibility Category.*
- Output field *Status Start Date:* ***Monthly member assignment table*** *output field. Record/status span start date.*
- Output field *Practice End Date:* **Monthly member assignment table** output field. *Record/status span end date. Use 99991231 if record/span is current.*

The following output field is set using the ***Attribution table for care coordination tool*** output fields and select input table:

- Output field *Date Of Birth*: ***Member Extract*** input field *Date Of Birth* associated with output field *MCO Assigned Member ID*

The following output field is set using the ***Monthly member assignment table*** and other data sources that each MCO has available:

- Output field *Social Security Number*: Social security number in other member level data sources, associated with output field *MCO Assigned Member ID*

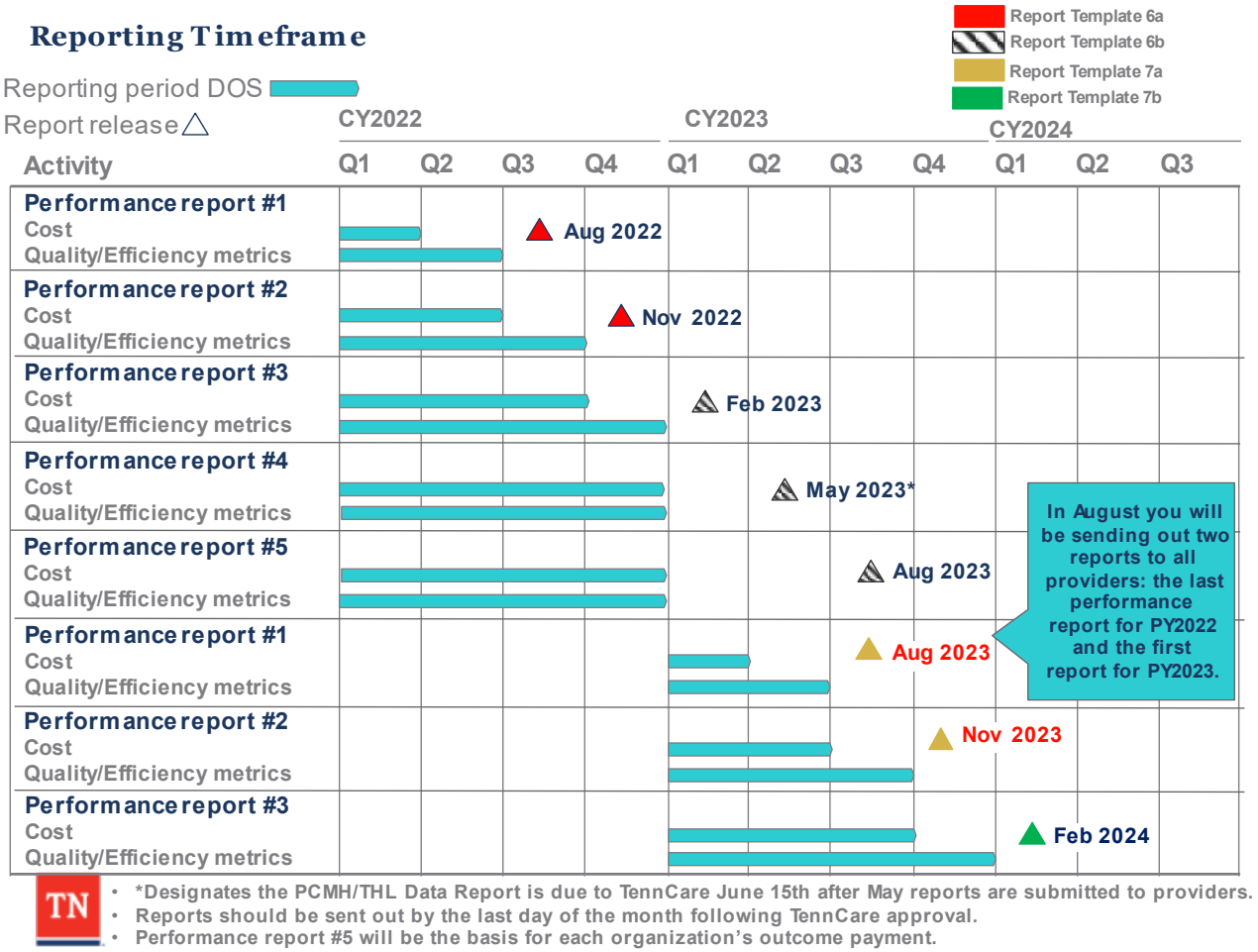
The following output field is set using other data sources that each MCO has available:

- Output field *MCO Change:* MCO change status in other member level data sources

5.9.2 Quarterly Provider Reports

All Health Link organizations should receive quarterly reports showing their data on quality and efficiency metrics. The format of these reports should follow the templates distributed by the State. It is important to follow the templates as closely as possible so that Health Link organizations receive standardized reports.

The following schedule demonstrates when the reports should be delivered to organizations and what time period of data should be included in each report.



Special Notes:

- "Member months counted towards outcome payment" is populated by the output field *Reporting Period Attributed Member Months Valid* in the ***Reporting period Health Link table***. Note that the final number in the annual performance report will be based on 9 month attribution rules. (Please reference sections 3.4.2 and 3.8.5 for guidance on calculating final member months.)
- On the Total Cost of Care pages, the values in Care Categories should not be risk adjusted, but they should have the $100,000 cap applied. The Total Cost of Care and Behavioral Health Total Cost of Care reported at the top of these pages should be clearly identified as "Non Risk Adjusted."
- On the Total Cost of Care pages, use the median value of all Health Link organizations to calculate the 50% value. This follows the design of episode reports.
- For quality, performance should be rounded to the tenth place. If a provider meets the threshold when rounding occurs, the provider should earn a star.

- For efficiency, performance should be rounded to the hundredth place. If a provider meets the threshold when rounding occurs, the provider should earn a star.

6 Glossary

- **Behavioral health (BH) spend definition:** Behavioral health (BH) spend for the purpose of this DBR is defined as the following:
  - **Spend on a claim with a primary diagnosis of BH**: Either on professional or facility claim forms, with input field *Header Primary Diagnosis Code* being a value listed under "BH diagnosis - ICD" of the Service category configuration file. The entire spend on the qualifying claim is treated as BH spend.
  - **Spend on an inpatient facility claim form with header-level BH treatment procedure**: Any inpatient facility claim forms, with input field *Header Surgical Procedure Code (any)* being a value listed under "Header BH treatment – ICD" of the Service category configuration file. If at least one of the input field *Header Surgical Procedure Code* on a given claim matches the values listed, then the entire claim is considered as being part of the BH spend.
  - **Spend on other facility claim forms or a professional claim form detail line, with a detail-level BH treatment**: Any claim detail lines on an outpatient facility claim or any claim detail lines on a professional claim form with input field *Detail Procedure Code* listed under "Detail BH treatment – CPT or HCPCS" of the Service category configuration file. Only the detail line that meets the criterion is included to BH spend
  - **Spend on a facility claim form or facility claim form detail line with a BH revenue code**: Any facility claim detail line with input field *Revenue Code* listed under "BH treatment– Revenue code" of the Service category configuration file. If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.
  - **Spend on a pharmacy claim with a BH drug code:** Any pharmacy claims with input field *National Drug Code* that falls within a HIC3 category listed under "BH s – HIC3".

  If a claim or a claim detail line meets at least one of the criteria listed above, then its spend is considered to be part of the BH spend. Even if the claim or claim detail line meets more than one criteria listed above, its spend counts toward BH spend only once.
- **Behavioral health (BH) service categories:** BH spend, identified in Section 6, is classified into BH service categories. If a claim or claim detail line meets the criteria for multiple categories listed below, the claim or claim detail line is classified into the first category it qualified for, in the order listed:

  Service categories driven by claim form:

  - Medication / Pharmacy: Any BH spend recorded on a pharmacy claim form

  Service categories driven by service setting:

  - Mental health residential
    - Facility claim forms with input field *Type Of Bill* that start with the values listed under "Mental health residential – Type of bill" of the Service category configuration file.

- Facility claim forms with at least one detail line with input field *Revenue code* under “Mental health residential – Revenue code” of the Service category configuration file.
- Professional claim form detail lines with input field Place Of Service listed under “Mental health residential – Place of service” of the Service category configuration file.

– Hospital inpatient care

- Facility claim forms with input field *Type Of Bill* listed under “Hospital inpatient care – Type of bill” of the Service category configuration file.
- Professional claim form detail lines with input field Place Of Service listed under “Hospital inpatient care – Place of service” of the Service category configuration file.

– ED care

- Facility claim forms with input field *Type Of Bill* listed under “ED – Type of bill” of the Service category configuration file.
- Facility claim forms 1) with at least one detail line with input field *Revenue code* under “ED – Revenue code” or *Detail Procedure Code* under “ED – CPT or HCPCS” of the Service category configuration file and also 2) with input field *Type Of Bill* listed under “Hospital outpatient – Type of bill”.
- Professional claim form detail lines with input field *Place Of Service* listed under “ED – Place of service” of the Service category configuration file.
- Professional claim form detail lines with input field *Detail Procedure Code* listed under “ED – CPT or HCPCS” of the Service category configuration file.

Service categories driven by detail type of care:

Classification based on detail procedure codes Facility or professional claim form detail lines with a CPT or HCPCS code in input field *Detail Procedure Code* are classified based on the input field *Detail Procedure Code*. If the input field *Revenue Code* is a value listed under “<Service category> - CPT or HCPCS” or “<Service category> - CPT or HCPCS and Mod” of the Service category configuration file, then the detail line is categorized into the respective Service category.

– Case management, Level 1: Facility or professional claim form detail lines with each MCO’s Level 1 Case Management procedure code and modifier combination in input fields *Detail Procedure Code* and *All Modifiers*.

– Case management, Level 2: Facility or professional claim form detail lines with each MCO’s Level 2 Case Management procedure code and modifier combination in input fields *Detail Procedure Code* and *All Modifiers*.

– Case management, Integrated care team: Facility or professional claim form detail lines with input field *Detail Procedure Code* and *All Modifiers* with a combination listed under “Case management, Integrated – CPT or HCPCS and Mod” of the Service category configuration file.

- Health Link activities: Facility or professional claim form detail lines with input field Detail Procedure Code listed under “Health Link activities – CPT or HCPCS” of the Service category configuration file
- Crisis services: Facility or professional claim form detail lines with input field *Detail Procedure Code* and *All Modifiers* with a combination listed under “Crisis services – CPT or HCPCS and Mod” of the Service category configuration file or facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Crisis services – CPT or HCPCS” of the Service category configuration file.
- Other case management: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Case management – CPT or HCPCS” of the Service category configuration file
- Ancillary services: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Ancillary services – CPT or HCPCS” of the Service category configuration file.
- Assessment & testing: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Assessment & testing – CPT or HCPCS” of the Service category configuration file.
- Counseling/intervention: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Counseling/intervention – CPT or HCPCS” of the Service category configuration file.
- Detox: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Detox – CPT or HCPCS” of the Service category configuration file.
- Medication management: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Medication management – CPT or HCPCS” of the Service category configuration file.
- Medication / Pharmacy: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Medication / Pharmacy – CPT or HCPCS” of the Service category configuration file.
- Psychiatric rehab: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Psychiatric rehab – CPT or HCPCS” of the Service category configuration file.
- Rehab: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Rehab – CPT or HCPCS” of the Service category configuration file.
- Substance use treatment: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Substance use treatment – CPT or HCPCS” of the Service category configuration file.
- Supportive services: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Supportive services – CPT or HCPCS” of the Service category configuration file.

– Therapy: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Therapy – CPT or HCPCS” of the Service category configuration file.
– PT/OT/ST: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “PT/OT/ST – CPT or HCPCS” of the Service category configuration file.
– Radiology, lab, and DME: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Radiology, labs, and DME – CPT or HCPCS” of the Service category configuration file.
– Other BH treatment: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Other BH treatment – CPT or HCPCS” of the Service category configuration file.
– Other E&M: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Other E&M – CPT or HCPCS” of the Service category configuration file.
– Other types of care: Facility or professional claim form detail lines with input field *Detail Procedure Code* listed under “Other – CPT or HCPCS” of the Service category configuration file.

Classification based on detail revenue codes: Facility or professional claim form detail lines without a CPT or HCPCS code in input field *Detail Procedure Code* but with a value in input field *Revenue Code* are classified based on the input field *Revenue Code*. If the input field *Revenue Code* is a value listed under “<Service category> - Revenue” of the Service category configuration file, then the detail line is categorized into the respective Service category.

– Assessment & testing: Facility claim form detail lines with input field *Revenue Code* listed under “Assessment & testing – Revenue code” of the Service category configuration file. If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.
– Detox: Facility claim form detail lines with input field *Revenue Code* listed under “Detox – Revenue code” of the Service category configuration file. If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.
– Rehab: Facility claim form detail lines with input field *Revenue Code* listed under “Rehab – Revenue code” of the Service category configuration file. If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.
– Substance use treatment: Facility claim form detail lines with input field *Revenue Code* listed under “Substance use treatment – Revenue code” of the Service category configuration file. If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.
– Supportive services: Facility claim form detail lines with input field *Revenue Code* listed under “Supportive services – Revenue code” of the Service category configuration file.

If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.

– Therapy: Facility claim form detail lines with input field *Revenue Code* listed under "Therapy – Revenue code" of the Service category configuration file. If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.

– Other BH treatment: Facility claim form detail lines with input field *Revenue Code* listed under "Other BH treatment – Revenue code" of the Service category configuration file. If the spend for the detail line that meets this requirement is not specified, the entire claim is classified in this category.

– Other types of care: Any outstanding professional claim form detail lines.

Classification based on header-level procedure codes: Remaining facility claim forms are categorized based on input field *Header Surgical Procedure Code*. If the input field *Header Surgical Procedure Code* is a value listed under "<Service category> - ICD" of the Service category configuration file, then the claim is categorized into the respective Service category. If the claim has multiple input fields *Header Surgical Procedure Code,* then the claim is classified based on the input field *Header Surgical Procedure Code* that appears first.

– Assessment & testing: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Assessment & testing – ICD" of the Service category configuration file.

– Counseling/intervention: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Counseling/intervention – ICD" of the Service category configuration file.

– Crisis services: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Crisis services – ICD" of the Service category configuration file.

– Detox: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Detox – ICD" of the Service category configuration file.

– Medication management: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Medication management – ICD" of the Service category configuration file.

– Medication / Pharmacy: Facility claim forms with input field Header Surgical Procedure Code listed under "Medication / Pharmacy – ICD" of the Service category configuration file.

– Rehab: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Rehab – ICD" of the Service category configuration file.

– Substance use treatment: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Substance use treatment – ICD" of the Service category configuration file.

– Therapy: Facility claim forms with input field *Header Surgical Procedure Code* listed under "Therapy – ICD" of the Service category configuration file.

- Other BH treatment: Facility claim forms with input field *Header Surgical Procedure Code* listed under “Other BH treatment – ICD” of the Service category configuration file.
- Other types of care: All uncategorized claims are classified into service category Other types of care.

- **BH reporting care categories:** The BH reporting care categories used are:

BH Reporting Care Category	BH Service Category
Inpatient / residential	• Hospital inpatient care • Mental health residential
Emergency	• ED care • Crisis services
Outpatient and other treatment	• Therapy • Assessment & testing • Substance use treatment • Medication management • Counseling / Intervention • Detox • Rehab • Other E&M • Other BH treatment
Pharmacy	• Medication / Pharmacy
Case management	• Case management, level 1 • Case management, level 2 • Case management, integrated care team • Other case management • Health Link activities
Supportive services	• Psychiatric rehab • Supportive services • Ancillary service
Other care	• Radiology, lab, and DME • PT/OT/ST • Other types of care

- **Claim types:** Claim type is defined as follows:

Claim type	Claim form	Type of Bill	HCPCS

Long-term care[1]	UB-04	21x, 66x, 89x	
Home Health[1]	UB-04	32x, 33x, 34x	
Inpatient[1]	UB-04	11x, 12x, 18x, 41x, 86x	
Outpatient[1]	UB-04	13x, 14x, 22x, 23x, 71x-77x, 79x, 83x-85x	
Transportation[2]	CMS-1500		A0000 - A0999, G0240, G0241, P9603, P9604, Q0186, Q3017, Q3020, R0070, R0075, R0076, S0209, S0215, S9381, S9975, S9992, T2001 - T2007, T2049
DME[3]	CMS-1500		A4206 - B9999, C1000 - C9899, E0100 - E8002, G0025, J7341 - J7344, K0001 - K0899, P9044, Q0132, Q0160, Q0161, Q0182 - Q0188, Q0480 - Q0506, Q2004, Q3000 - Q3012, Q4001 - Q4051, Q4080, Q4100 - Q4116, Q9945 - Q9954, Q9958 - Q9968, S0155, S0196, S1001 - S1040, S3600, S4989, S5002, S5010 - S5025, S5160 - S5165, S5560 - S5571, S8002, S8003, S8060, S8095 - S8490, S8999, S9001, S9007, S9035, S9055, S9434, S9435, T1500, T1999, T2028, T2029, T2039, T2101, T4521 - T5999, V5336
Professional[4]	CMS-1500		
Pharmacy	NCPDP		

1. Facility claim forms are defined as claims using claim form UB-04 or equivalent. Note facility claims can fall into different claim types.

2. The entire claim is defined as transportation if one or more of the detail lines has one of these HCPCS codes.

3. The entire claim is defined as DME if one or more of the detail lines has one of these HCPCS codes.

4. Professional claim forms are defined as claims using form CMS-1500 or equivalent. Note professional claim forms can fall into different claim types.

DCS programs with duplicative care coordination services

Program code	Description
DT	Detention
PTC	Primary Treatment Center
L3	Level 3
L3C	Level 3 Continuum
L3SNC	Level 3 Continuum Special Needs
L3SNEAD	Level 3 Special Needs A&D (60 Days)
L3SNESO	Level 3 Special Needs Sex Offender (180 Days)
L3SPE	Level 3 Special Population Enhanced Continuum
L3 AS-ND RTC	Level 3 Autism Spectrum-Neurodevelopmental Disorders RTC
L3 SED-PRTF	Level 3 Severely Emotionally Disturbed PRTF
L3 AS-ND PRTF-M	Level 3 Autism Spectrum-Neurodevelopmental Disorders PRTF-Mid
L3 AS-ND PRTF-H	Level 3 Autism Spectrum-Neurodevelopmental Disorders PRTF-High
L3 SED-PRTF-H	Level 3 Severely Emotionally Disturbed PRTF-High
L4	Level 4
L4SN	Level 4 Special Needs

- **Duration of time windows:** The duration of a time window, the duration of a claim or claim detail line, and the length of stay for inpatient stays is calculated as the last date minus the first date plus one (1). For example, a claim with a *Header From Date Of Service* of January 1, 2014 and a *Header To Date of Service* of January 2, 2014 has a duration of two (2) days.
- **HIC3:** Hierarchical Ingredient Code at the third level based on the classification system by First Databank

- **Look-back windows:** Look-back windows are specified in number of days. For eligibility, attribution, and enrollment updates, look-back windows to identify claims, claim detail lines, or visits that meet certain requirement, are set to end on the day before the update is started, i.e., the day when the data was extracted.
- **Manual attribution by MCO**: For eligible members without an *Attributed Health Link ID* identified based on claim-based and non-claim-based attribution, members could be attributed to the Health Link organization in geographic proximity, for which an illustrative logic follows. MCOs are encouraged to use additional criteria for the attribution at their discretion, such as provider specialty, provider type, or provider performance. Please ensure that pediatric members (age <21) are not attributed to adult-only practices and adults are not attributed to pediatric practices.
  - Input data:
    - Member level: *Member ID, Member Zip Code*
    - Health Link Organization level: *Health Link Organization Tax ID, Health Link Site Zip Code* (for each site for the given Health Link organization)
  - Algorithm logic: *Member ID* is attributed to the *Health Link Organization Tax ID* based on the following criteria, in order of hierarchy. In each step of hierarchy, if there are multiple qualifying *Health Link Organization Tax IDs,* then the *Member ID* is randomly attributed to one of the qualifying *Health Link Organization Tax ID*, while ensuring that the proportion of attributed members across the qualifying Health Link Organization Tax IDs is the same as the proportion based on claim and non-claim-based logic:
    - *Health Link Organization Tax ID* that has a site at the *Member Zip Code*
    - *Health Link Organization Tax ID* that has a site in the same county as the *Member Zip Code*
    - *Health Link Organization Tax ID* that has a site in the same metropolitan statistical area (MSA) as the *Member Zip Code.* Members in nonmetropolitan areas are not attributed based on this criteria.

- **Reporting care categories:** The reporting care categories used, in hierarchical order, are:

Bill Form	Reporting Care Category	Definition	Additional Comments
UB-04	Inpatient facility	Bill Types: 11X, 12X, 18X, 41X, 86X	To include all services provided during an inpatient facility stay including room and board, recovery room, operating room and other services.

Bill Form	Reporting Care Category	Definition	Additional Comments
UB-04	Emergency Department or Observation	Bill Types: 13X, 14X, 22X, 23X, 73X-77X, 79X, 83X-85X AND (Revenue code 045x, 0760, 0761, 0762, 0769 OR CPT 99281-99285, 99291- 99293 OR Place of service = 23)	To include all services delivery in an Emergency Department or Observation Room setting including facility and professional services.
UB-04	Outpatient facility	Bill Types: 13X, 14X, 22X, 23X, 73X-77X, 79X, 83X-85X and NOT Emergency Department	To include all services delivered by a facility during an outpatient surgical encounter, including operating and recovery room and other services.
CMS-1500	Inpatient professional	Place of service = 21	To include services delivered by a professional provider during an inpatient hospital stay, including patient visits and consultations, surgery and diagnostic tests.
CMS-1500	Outpatient laboratory	Place of service = 81 OR Revenue codes 030x OR CPT/HCPCS 80048-88399, G0306,G0307, G0431-G0434, G9143, P codes	To include all laboratory services in an inpatient, outpatient or professional setting.
CMS-1500	Outpatient radiology	Revenue code 035x, 061x, 040x, 032x OR CPT 70010-79999 or HCPCS C8906, C8903, C8907, C8904, C8908, C8905, S8042	To include all radiology services such as MRI, X-Ray, CT and PET scan performed in an inpatient, outpatient or professional setting.
CMS-1500	Outpatient professional	Any remaining, non-categorized CMS 1500 claims (excluding DME and transportation)	To include uncategorized professional claims such as evaluation and management, health screenings and specialists visits.

Bill Form	Reporting Care Category	Definition	Additional Comments
UB-04/ CMS-1500	Other	Any remaining, non-categorized claims	To include DME, home health and any remaining uncategorized claims.
NCPDP post adjudication 2.0	Pharmacy		To include any pharmacy claims billed under the pharmacy or medical benefit with a valid National Drug Code.

- **Treatment of duals and TPL members**

Include for all MCOs | Exclude for State program, but optional at discretion of each MCO | Exclude across all MCOs

	Dual segments		Data availability		CCT	Health Link			PCMH			
	D-SNP	Aligned	TennCare data	MCO data	Panel	Services	Quality Metrics[1]	Efficiency metrics[1]	Services	Quality Metrics[1]	Efficiency metrics[1]	Cost
Duals	No	No	No	No	Yes	Yes	No	No	MCO discretion	No	No	No
	No	Yes	No	Yes	Yes	Yes	No	No	MCO discretion	No	No	No
	Yes	No	Yes	Yes	Yes	Yes	No	No	MCO discretion	No	No	No
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
TPLs	n/a	n/a	No	No	Yes	Yes	No	No	MCO discretion	No	No	No

- For Health Link:
  - For services, any duals and TPLs are included
  - For metrics calculation, only aligned D-SNP duals are included
- For PCMH:
  - For services, aligned D-SNP duals are included; other duals and TPLs are not part of the State's program but the MCOs have the option to include them at their discretion
  - For metrics calculation, only aligned D-SNP duals are included
  - For TCOC calculation, no duals or TPLs are included

Treatment on TPL members is affected by the limitation in data that enables identification of TPL members prospectively. The State should consider putting in pace measures to better identify these members and incorporate the information in PCMH and Health Link operation, and potentially revisit their inclusion

1 Activities will still be monitored even for members not included in metrics calculation

The members included in the CCT attribution files should match the members in the services panel for Health Link and the services panel for PCMH.

- **Visit:** A visit is defined as all claim detail lines for which the following conditions are met:
  - Same detail line start date

– Same billing provider

The duration of a visit is defined as the minimum detail line start date to the maximum detail line end date of detail lines that are part of the visit.

Billing/ Encounter Codes for Tennessee Health Link Activities

The Division of TennCare has defined the billing codes and the rates for the Tennessee Health Link Activities.

Billing Codes and Rates

Health Link joining prior to January 1, 2018:

Transition Rate
The rate is set for 12/1/16-11/30/17.
The Billing Code (also acting as the payment trigger code) is G9003 which will pay at $200.

Stabilization Rate
The rate is set for 12/1/2017-12/31/18.
The Billing Code (also acting as the payment trigger code) is S0280 which will pay at $175

Health Link joining on or after January 1, 2018:

Rate
The rate is set for 1/1/2018-12/31/18.
The Billing Code (also acting as the payment trigger code) is S0280 which will pay at $139.

Beginning January 1, 2020, the TennCare contracted Managed Care Organizations will have full responsibility for negotiating the rate and contracting for the Tennessee Health Link services.

Activity Encounter Codes

Code	Activity	Member or Collateral	Face-to-face or Indirect
G9004	Comprehensive care management *Initiate, complete, update, or monitor the progress of a comprehensive person-centered care plan*	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9005	Care coordination	UA: Member	UC: Face-to-face

		UB: Collateral	UD: Indirect
G9006	Health Promotion	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9007	Transitional care	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9010	Patient and Family Support	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9011	Referral to Social Supports	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect

Methodology for Filing the Billing and Activity Encounter Codes
The Activity Encounter Codes are filed to show the individual Health Link activities provided to the Health Link member. TennCare and the 3 MCOs (Amerigroup, BlueCare and United) have worked to streamline the billing methodology. To ensure that the Billing Codes pay timely and Activity Codes (encounters) are properly recorded, we are providing the following guidance:

- To the extent possible, please file the Billing Code once a month with all applicable encounters. The Billing Code is the trigger code for the case rate payment. We are asking for this to be filed once a month to ensure that all Activity Code (encounters) are captured and so the MCOs can ensure that the case rate is paid timely.
- If there are additional Activity Codes (encounters) after the Billing Code is filed, the provider may submit these, but without the Billing Code.
- All Activity Codes should be billed with at least a $.01 (penny) in the Charges section of the HCFA 1500 professional claim form.
- The Health Link Billing Code Activity Encounter Codes should be filed on a professional claim with the HCFA 1500 at the entity level. Please note that 24 j should remain blank.
- This methodology applies to all rate levels.

Generating an initial activity payment for new members:
A provider must *initiate, complete, update, or monitor the progress of a comprehensive person-centered care plan* (G9004) with the member (UA), face-to-face (UC). A provider must pair this initial Activity Encounter Code with a Billing Code in order to generate an initial activity payment. Following the initial activity, a provider is able to pair the Billing Code with any Activity Encounter Codes to generate future activity payments.

Generating an initial activity payment for members who were previously receiving Level 2 Case Management:
A provider would need to *initiate, complete, update, or monitor the progress of a comprehensive person-centered care plan* (G9004) if clinically indicated and/or if the Care Plan was updated greater than 6 months prior to December 1, 2016. When a provider first completes this activity, it must be completed with the member (UA) and face-to-face (UC). Otherwise, a provider is able to pair the Billing Code with any Activity Encounter Codes to generate activity payments for an auto-enrolled member.

For members attributed to a Health Link prior to December 1, 2016:
First encounter

Eligibility Determination	Attribution	Required 1st Activity in December
Not receiving L2 CM prior to Dec 1	Attributed to THL panel from MCOs	Face-to-face; file G9003 with G9004UAUC
Was receiving L2CM prior to Dec 1	Attributed to THL panel from MCOs	If clinically indicated and/or if the Care Plan was updated greater than 6 months prior to December 1, 2016; complete face-to-face; file G9003 with G9004UAUC Otherwise, complete any THL activity; file the G9003 with any encounter

For members attributed to a Health Link after December 1, 2016:
First encounter

Eligibility Determination	Attribution	Required 1st Activity
Category 1	Attributed to THL panel from MCOs	Face-to-face; file G9003 with G9004UAUC
Category 1 eligible; before claim is paid	Provider evaluates, offers and member accepts THL; provider attests to THL eligibility	Face-to-face; file G9003 with G9004UAUC
Category 2	Attributed to THL panel from MCOs	Face-to-face; file G9003 with G9004UAUC
Category 2 eligible; before claim is paid	Provider evaluates, offers and member accepts THL; provider attests to THL eligibility	Face-to-face; file G9003 with G9004UAUC
Category 3 & meet medical necessity for Health Link	Provider evaluates, offers and member accepts THL; provider attests to THL eligibility	Face-to-face; file G9003 with G9004UAUC

MCO Monitoring Requirements:

MCOs must ensure that the following requirements are maintained:

1. A maximum of 1 Health Link provider is paid for a member per month.
2. A maximum of 1 Health Link Billing Code for a member is paid per month.
3. If the member is enrolled in Health Link, a claim with the Billing Code and Activity Encounter code can trigger a payment.

Health Link Modifier Examples

This table provides information for Health Link providers regarding definitions and acceptable uses of Health Link billing modifiers.

UA - Member	UC – Face to Face
• Member Contact Only	• Face to Face Contact Only (includes telehealth)
UB - Collateral	**UD - Indirect**
• Provider to Provider • Individuals with a Valid Release of Information on File for the Member	• Telephone Call Only[1]

Effective June 1, 2017

[1] The telephone call must be to either the member or a collateral contact and must be associated with one of the six Health Link activities: comprehensive care management, care coordination, health promotion, transitional care, patient and family support or referral to social supports. The call must also be interactive in that the Health Link must be able to successfully reach the member or collateral contact. Voicemails are not considered interactive.

- **For collateral contact**: Providers cannot count/bill staffing a member's case in treatment team as a collateral contact.
- **For provider to provider collateral contact**: The intent is for the provider contacted to be outside of the member's Health Link organization. If the provider contacted is within the member's Health Link organization, they must be outside of the member's behavioral health team. A member's "behavioral health team" is defined as anyone who is directly involved in the behavioral health care of the member (e.g. care coordinator, case manager, therapist, psychiatrist, nurse practitioner, nurse, etc.)
- **For indirect contact**: Text messages and/or emails to enrolled members are not a billable encounter.
- **Group encounters**: Group encounters may be considered a Health Link activity. However, the encounter must be face-to-face (UC) and with the member (UA). Documentation should be included to note individualized progress towards group treatment goals. Additionally, a group encounter may not be the only Health Link activity billed for that month.

Tennessee Health Link Attribution File Instructions

This is a delimited file with maximum characters per fields. If the information for a field is unavailable, please leave that field blank. The list should only contain members in the Tennessee Health Link program.

The file should be named THL_ATT_YYMMDD. The date used should be the date the file was created. The file should be put in the appropriate folder following the SFTP structure provided.

The fields are as follows:

1. **Last Name** – Alpha – 20 bytes. This is the member's last name.
2. **First Name** – Alpha – 20 bytes. This is the member's first name.

3. **Middle Name** – Alpha – 20 bytes. This is the member's middle name. If only a middle initial is available, please include.
4. **Date of Birth** – Numeric – 8 bytes. This is the member's date of birth. Please use yyyymmdd format.
5. **Social Security Number** – Numeric – 9 bytes. This is the all numeric form of the member's SSN.
6. **MCO Assigned Member ID** – Alphanumeric – 15 bytes. This is the member ID number given to the member by the MCO.
7. **THL Practice Name** – Alphanumeric – 30 bytes. This is the name of the Tennessee Health Link a member has been attributed to by the MCO.
8. **THL Practice Tax ID** – Numeric – 9 bytes. This is the Practice Tax ID of the Tennessee Health Link a member has been attributed to by the MCO.
9. **THL Member Status** – 30 bytes. This is the members Tennessee Health Link Status. This list should reflect the member's current status in the Tennessee Health Link program. The options are as follows.
    - **Active** (this status is referred to as "*Enrolled*" in the remainder of the DBR)
        - A member who:
            - Is enrolled in the program
            - AND has started receiving THL Care Coordination services as evidenced by the corresponding HCPCS codes in the member's claims or has transitioned to an Active status via the MCO portal activity
        - Once a member is "Active", they are deemed active~~,~~ unless Inactive criteria are met or the member loses eligibility
    - **Inactive No BH Treatment**
        - A member who did not receive any BH treatment in the past 180 days (with full run-out of 4 months),
        - Whether the member had a BH treatment is checked every month beginning October 1, 2017, but only for members who are in "Active" status; if the member has a BH treatment again, then his/her active status becomes "Attributed Not Enrolled"
        - Exclude all dual members who are not aligned D-SNP duals from consideration for this status
        - A member shall be removed from the attribution file 6 months after it has been determined that Inactive No BH Treatment is the appropriate status for the member.
    - **Inactive No Contact**
        - ~~o~~ A member who could not be contacted for 6 months or more and the MCO has made the explicit decision to put into "Inactive No Contact" status
    - **Inactive Opt Out**

- A member who explicitly expressed the desire to opt out of the Health Link program
- Members remain in "Inactive Opt Out" status, unless they have specifically expressed the desire to opt in. Please populate Termination date when member has opted out.
- Members in the "Inactive Opt Out" status shall be removed as soon as possible from the attribution file, such that there is one week of attribution to the Opt Out status.

- **Attributed Not Enrolled**
  - A member who is attributed to a Health Link but have not yet been enrolled into the program
- **Discharged**
  - Member who has been identified as discharged from the Health Link program for either meeting program goals or having made no progress. Please populate termination date in the file.
  - The date of discharge should be the value in the "Date of Switch, Opt-in/out or Discharged" field from the **Input Data Field for Non-Claims data** table
  - Retroactive dates are not acceptable dates of discharge
  - Discharged members should be removed from visibility in the CCT after 6 months.
  - Discharged members shall be removed from the attribution file 6 months after date of discharge.
  - Members who have been discharged, may become eligible for Health Link following a "requalifying event"
  - A "requalifying event" is defined as an event involving a Category 3 provider attestation of the member having functional need based on the medical necessity criteria.
  -

10. **Eligibility Category** – 2 bytes. This is the eligibility category which made a member eligible for the Tennessee Health Link Program. Please refer to the detailed business requirements for more information on eligibility categories. Please only put one category per member. The categories are:

This is the eligibility category which made a member eligible for the Tennessee Health Link Program. Please refer to the detailed business requirements for more information on eligible categories. Please only put one category per member.

- **Category 1**: Diagnostic criteria only category – The member has one or more claims with a category 1 specific diagnosis within the specified time period.
- **Category 2**: Diagnostic and utilization criteria category – The member has one or more claims with a category 2 specific diagnosis for an inpatient, crisis stabilization unit, residential treatment facilities, or ED (for age less than 18) admission with a BH cause within the specified time period.
- **Category 3:** Functional need category – the member has two or more level 2case management visits within the specified time period.

- As Level 2 Case Management is incorporated into the Health Link Program, the claim-based member eligibility update for Level 2 Case Management will include fewer and fewer claims. Eventually, the Category 3 eligibility will be based on attestation of functional need only.

11. **MCO Change**– Alpha- 7 bytes. Use this field if the member has changed MCOs in the last week. If the member has not changed MCOs please leave this field blank.

Left. Use this status if the member has left the MCO.

Joined. Use this status if the has joined the MCO.

12. **MCO Change Date**- Numeric – 8 bytes. The format should be YYYYMMDD. Date the member either joined or left MCO. If no change leave blank

13**. File Effective Date** – Numeric – 8 bytes. Run date of the file (ex. If today is March 4 and file is generated, run date would be 202000304)
The format should be yyyyymmdd.

14.**Termination Date** – Numeric – 8 bytes.

Record/status span end date. Leave blank if record/span is current. The format should be yyyyymmdd.

15. **Program Eligibility Date**: Numeric – 8 bytes. Date member is assigned to either Category 1, 2 or 3 Eligibility Category. The format should be yyyyymmdd.

16. **Status Start Date**: Numeric – 8 bytes. Record/status span start date. The format should be yyyyymmdd.

17**. Practice End Date**: Numeric - -8 bytes. Record/status span end date. Use 99991231 if record/span is current. The format should be yyyyymmdd.

TN Health Link Attribution Format

Delimiter: |

Max Field Lengths:

1. Last Name – Alpha – 20 bytes
2. First Name – Alpha – 20 bytes
3. Middle Name – Alpha – 20 bytes
4. Date of Birth – Numeric – 8 bytes
5. Social Security Number – Numeric – 9 bytes
6. MCO Assigned Member ID – Alphanumeric – 15 bytes
7. THL Practice Name – Alphanumeric – 30 bytes
8. THL Practice Tax ID – Numeric – 9 bytes

9. THL Member Status – 30 bytes
    a. Active
    b. Inactive No BH Treatment
    c. Inactive No Contact
    d. Inactive Opt Out
    e. Attributed Not Enrolled
    f. Discharged
10. Eligibility Category – 2 bytes
    a. 1
    b. 2
    c. 3
11. MCO Change – 7 bytes
    a. Left
    b. Joined
12. MCO Change Date – 8 bytes
13. File Effective Date – Numeric – 8 bytes
14. Termination Date – Numeric – 8 bytes
15. Program Eligibility Date – Numeric – 8 bytes
16. Status Start Date – Numeric – 8 bytes
17. Practice End date – Numeric 8 bytes

Format Sample:

DOE|JOHNATHON|LEE|19550301|123456789|M12345678911|Acme Med|987654321|ACTIVE|1|Diagnostic Criteria Only|JOINED|20170105|20170106|||20170105||
NOTE: Will contain multiple lines when member has a change

Tennessee Health Link Evaluation Plan

A. Evaluating Enrollees Potentially Not Benefiting from the Health Link Program

1) Rationale for Selection Criteria:

- Claim-based data will be used to identify enrollees for in-depth chart reviews
- Metrics chosen correspond to Health Link outcome measures on which providers will be evaluated
- Initial set of metrics focus on areas that are actionable and have direct impact on behavioral and physical health

- In-depth chart reviews will assess effort as well as outcome. A clear indication that the provider has identified needs, incorporated them into the individualized plan and is actively attempting to address those needs would be considered in assessing whether the enrollee is benefiting from the Health Link program.

- **Engagement Evaluation staff from the MCO may request physician or nurse notes in order to support evidence of integrated care coordination.**

2) Selection Metrics:

- 3 consecutive months of encounter data without a care coordination face-to-face contact with the member, or
- 3 consecutive months without a non-care coordination claim for service (e.g., no claims for any outpatient services), or
- More than 2 Emergency Department visits in 3 consecutive months, or
- At least one gap in care identified for applicable Health Link Quality Metrics.

3) Proposed Timeframe:

- Initial claims analysis to be conducted six months after launch beginning June 2017
- List of enrollees who satisfy one or more of the above metrics will be distributed to providers for informational purposes on a monthly basis beginning June 2017
- Subsequent claims analysis will be conducted nine months after program launch and sample of enrollees charts will be reviewed beginning September 2017
- Claims analysis and chart reviews will be repeated on a semi-annual basis for each Health Link contracted provider

4) Record Selection:

- A random selection of a minimum of 10 records will be reviewed on a semi-annual basis. Additional files could be requested if results showing potential patterns of concern with services being rendered.
- Engagement Evaluation staff will provide Health Link providers with a list of selected charts at least two weeks in advance.
- **Any documentation** made in the file after date of notice for chart review will be **excluded** from the Engagement Evaluation process.

5) Scoring

- Each evaluation tool item is scored individually. All questions have the same value. Providers not meeting the minimum performance threshold of 85% on any one item are required to submit a corrective action plan.

6) Engagement Evaluation Participants:

- The person who has clinical oversight of the Health Link program should be available for MCO staff to consult. This can include but is not limited to the Health Link Lead staff.
- At a minimum, the person who has clinical oversight of the Health Link program should meet with the Engagement Evaluation staff in order to receive the results of the chart reviews.

7) Monthly Sessions:

- In between Engagement Evaluation meetings, MCOs will schedule monthly coaching sessions with the Health Link providers.
- At a minimum, the person who has clinical oversight and is involved with the Engagement Evaluation process should attend this meeting.
- Coaching sessions will be utilized to discuss the following: integrated care, best practices, THL domains, Engagement Evaluation follow-up, overall practice transformation, etc.
- Each MCO will utilize the following documents during the on-site coaching session to monitor practice transformation: Engagement Evaluation Tool, Performance Reports, and any other tool provided by the MCO

If a Health Link provider declines three sessions in a six-month period, MCO staff will notify TennCare.

Note: A separate quality check will be conducted on a quarterly basis that includes random selection of a minimum of 5 records to be reviewed. Additional files could be requested if results show potential patterns of concern with services being rendered.

The evaluation process will be further refined based on ongoing reviews of results.

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