Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

Health Link Provider Information Webinar

10/11/2016

Provider Operating Manual
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Today's presentation will mirror the Table of Contents of the Provider Operating Manual

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The Health Link Provider Operating Manual v1.0 can be found on our website here:
http://www.tn.gov/assets/entities/hcfa/attachments/HealthLinkProviderOperatingManual.pdf

1 General Information

- The primary objective of Tennessee Health Link is to coordinate health care services for TennCare members with the highest behavioral health needs.
- Members currently receiving Level 2 Case Management (L2CM) will be transitioned to Health Link.
- In addition to these members, the program will also include high needs members not receiving care coordination under the current L2CM system.
- There will be no change to the existing fee for service reimbursement process, which is not covered by Health Link.
- The following services will remain paid for through fee for service: evaluation and management services, medication management, therapy services, psychiatric and psychosocial rehabilitation services, and Level 1 Case Management.

Health Link timeline

Health Link model designed	Applications submitted for Health Link	Selection of Health Link practices	Health Link practices activities begin
Spring 2015	*Spring 2016*	*Summer 2016*	*December 1, 2016*
• Design influenced by TAG and federal Health Home requirements		• State announced Health Links to applicants	• Approximately 21 practices begin the Tennessee Health Link Program

Health Link will begin with approximately 21 practices in December 2016

1 General Information

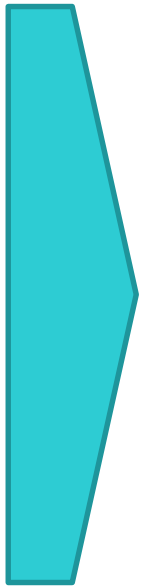
TennCare Health Link Program Overview

Health Link Practices commit to:

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

Health Link Providers receive:

- Financial support in the form of activity payments as well as outcome payments for high performance
- Training and technical assistance
- Actionable quarterly reports on practice performance
- Access to a Care Coordination Tool with member level detail



Benefits to patients, providers, and the health care system:

- Increased quality of care for Medicaid members throughout Tennessee
- Deep collaboration between providers and health plans
- Support and learning opportunities for Health Link providers
- Appropriateness of care setting and forms of delivery
- Enhanced chronic condition management
- Referrals to high-value medical and behavioral health care providers
- Reduced readmissions through effective follow-up and transition management

More information about Health Link can be found on our website: http://www.tn.gov/hcfa/article/tennessee-health-link

2 How Does A Practice Become A Health Link?

Practice Eligibility Requirements

1) The provider must be either:
   a) a Community Mental Health Center; or
   b) Another type of qualified provider with at least 250 attributable Health Link members across all MCOs.
2) The provider must be in the process of obtaining a stated commitment to collaboration with a TennCare primary care provider for each Health Link location. Letters of collaboration for each site are expected to be completed 6 months following the launch of the program – by June 2017.
3) The provider must commit to adopt the State's Care Coordination Tool.
4) The provider must have a documented plan to progress toward CMS e-prescribing requirements by December 2017.
5) The provider must employ at the time of launch:
   a) One individual, designated as the point of contact referred to as the Health Link Administrator; and
   b) A care team, including:
      i) A lead clinical care coordinator (must be a registered nurse); and
      ii) Case manager(s).

2 How Does A Practice Become A Health Link?

Practice Eligibility Requirements

6) The provider must at the time of launch have the capability to provide behavioral health services onsite, with one of the following (either directly employed on staff or that the provider has access to via affiliation):
   a) A psychiatrist with an active license to practice in Tennessee;
   b) A licensed masters-level mental health professional and a primary care physician; or
   c) A psychologist and a primary care physician.
7) The provider must be committed to enabling employed and affiliated personnel to engage in continuous learning, including through participation in relevant seminars, webinars, onsite trainings, and learning collaborative activities; AND
8) The provider must at the time of launch have the capability to provide all of the required Health Link activities outlined in the Health Link Provider Operating Manual.

3 Which Members Are Eligible for Health Link?

Look-back period: The look-back period for Category 1 and Category 3 identification criteria is April 1, 2016. The look-back period for Category 2 identification criteria is July 1, 2016.

Provider referral: To ensure members gain access to Health Link in a timely manner, providers submit an attestation to MCOs in order to gain Health Link eligibility for members prior to claims verification of member eligibility.

Identification criteria

Category 1: Diagnostic criteria only

A new or existing diagnosis or code of:

- Attempted suicide or self-injury
- Bipolar disorder
- Homicidal ideation
- Schizophrenia

or

Category 2: Diagnostic and utilization criteria

One or more behavioral health-related (a) inpatient admissions or (b) crisis stabilization unit admissions (18 or over), ED admissions (under 18), or residential treatment facility admissions; WITH a diagnosis of:

- Abuse and psychological trauma
- Adjustment reaction
- Anxiety
- Conduct disorder
- Emotional disturbance of childhood and adolescence
- Major depression
- Other depression
- Other mood disorders
- Personality disorders
- Psychosis
- Psychosomatic disorders
- PTSD
- Somatoform disorders
- Substance use
- Other / unspecified

or

Category 3: Functional need

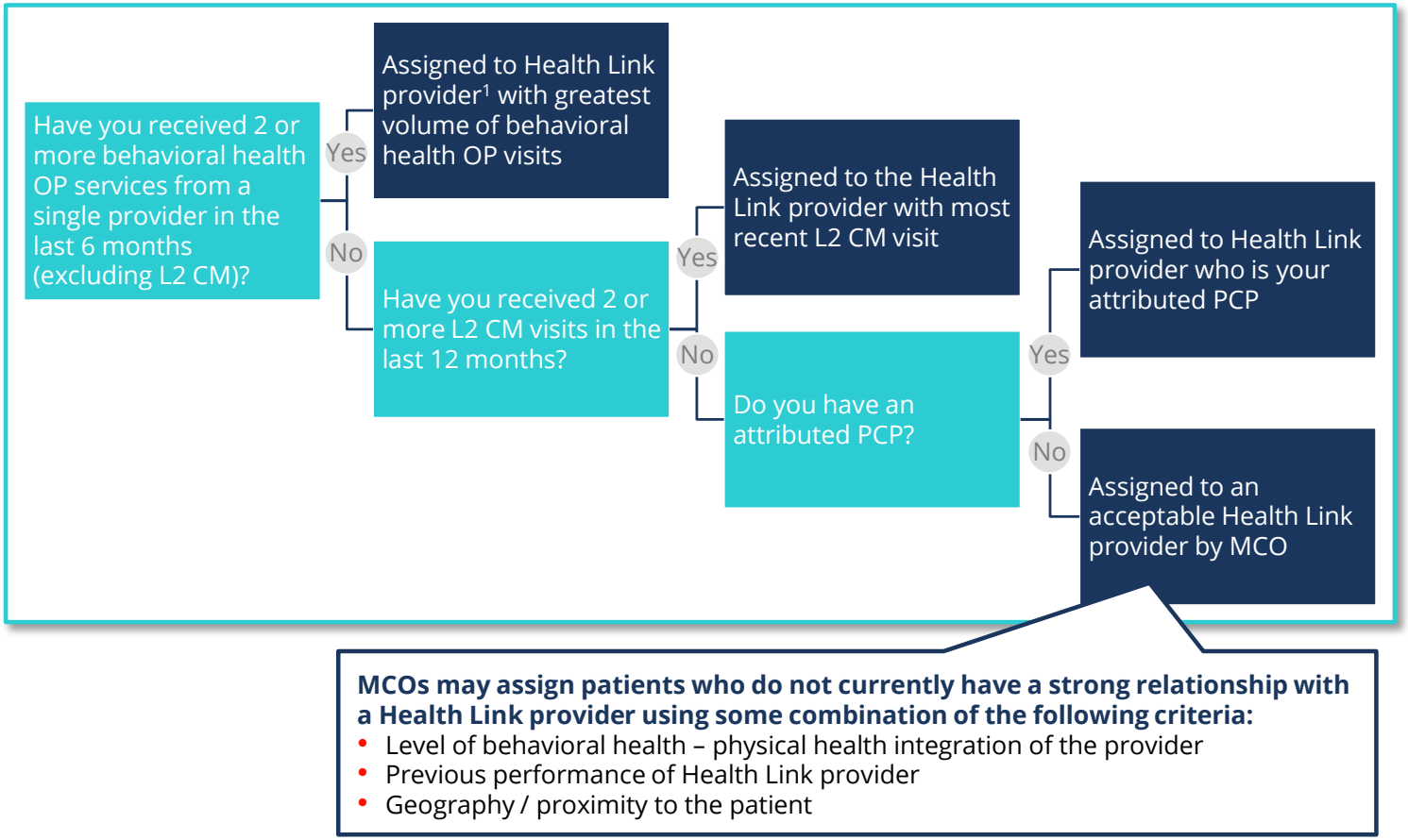
Up to 12/1/16: Receipt of 2 or more Level 2 Case Management (L2CM) services

After 12/1/16: Provider documentation of functional need, to be attested to by the provider.[1]

[1]Note: Functional need is defined as aligning with what the State of Tennessee has set out as the new Level 2 Case Management medical necessity criteria, effective March 1, 2016 for adults and April 1, 2016 for children.

4 How Are Members Attributed And Enrolled With A Health Link?

Process for assigning new patients to Health Link providers



MCOs may assign patients who do not currently have a strong relationship with a Health Link provider using some combination of the following criteria:

- Level of behavioral health – physical health integration of the provider
- Previous performance of Health Link provider
- Geography / proximity to the patient

1 May exclude certain behavioral health provider types and services

4 How Are Members Attributed And Enrolled With A Health Link?

- Enrollment refers to when the member first engages with the Health Link, signs their member consent forms, and the Health Link initiates, completes, updates, or monitors the progress of a comprehensive person-centered care plan.
- A member must be enrolled before a Health Link provider becomes eligible for activity payments.
- A member can only be enrolled by the Health Link provider to which the member is attributed.
- If a member wishes to enroll with a Health Link to which he/she is not attributed, then the member needs first to request of his/her MCO a switch of attribution.
- A member can request a switch by calling the MCO's customer service number listed on the back of his/her insurance card or a Health Link provider may assist the member with the switch in person.

4 How Are Members Attributed And Enrolled With A Health Link?

Enrolling new members and generating an initial activity payment

- To enroll a new member 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 enrollment activity, a provider is able to pair the Billing Code with any Activity Encounter Codes to generate future activity payments.
- The member is considered enrolled as of the service date of the claim that identified the initial Health Link activity

Members previously receiving Level 2 Case Management and generating an initial activity payment

- For auto-enrolled members, 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.

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5 How Are Health Link Member Panels Defined?

Member panels for each Health Link are defined differently for the following 2 purposes:

- Activity payment calculation
- Outcome payment calculation

Activity payment calculation

- The member panel for activity payment calculation is defined as or incorporates all members enrolled in a Health Link who receive a qualifying Health Link activity during the month for which they are enrolled.

Outcome payment calculation

- Outcome payments are calculated for the quarterly report for the last quarter of each performance period. The first performance period for Health Link is **January 1-December 31, 2017**.
- Providers are not held accountable for the quality and efficiency outcomes of some members (such as those with third party liability or those with extended nursing home stays). Those members are not included in the outcome payment calculation.

6 What Services Will A Health Link Provide?

There are 6 types of clinical activities that may be performed to receive an activity payment:

1) **Comprehensive care management:** Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan as needed
   - Example: creating care coordination and treatment plans

2) **Care coordination:** Participate in member's physical health treatment plan, support scheduling and reduce barriers to adherence for medical and behavioral health appointments, facilitate and participate in regular interdisciplinary care team meetings, follow up with PCP, proactive outreach with PCP, and follow up with other behavioral health providers or clinical staff
   - Example: proactive outreach and follow up with primary care and behavioral health providers

3) **Health promotion:** Educate the member and his/her family
   - Example: educating the member and his/her family on independent living skills

4) **Transitional care:** Provide additional high touch support in crisis situations, participate in development of discharge plan for each hospitalization, develop a systemic protocol to assure timely access to follow-up care post discharge, establish relationships, and communicate and provide education
   - Example: participating in the development of discharge plans

5) **Member and family support:** Provide high-touch in-person support, provider caregiver counseling or training, identify resources to assist individuals and family supporters, and check-ins with member
   - Example: supporting adherence to behavioral and physical health treatment

6) **Referral to social supports:** Identify and facilitate access to community supports, communicate member needs to community partners, and provide information and assistance in accessing services
   - Example: facilitating access to community supports including scheduling and follow through

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7 How Will A Health Link Be Paid?

	Objective	Payment
Activity Payment	• Intended to provide ongoing support to practices as they commit to the key elements of transformation • Providers will only receive activity payments for members who are enrolled and who receive a qualifying Health Link activity each month • Health Link activity payments will be reimbursed through claims	• Transition rate of $200 as a monthly activity payment per member to support care and staffing for the first 7 months • Stabilization rate of $139 as a monthly activity payment per member begins July 1, 2017 for additional 12 months • Recurring rate TBD will begin in 2018
Outcome Payment	• Designed to reward Health Links annually for providing high-quality care while effectively managing overall spending. • Annual outcome payment available to high performing Health Links	• Outcome payments based on performance on the core efficiency and quality metrics • Health Link practices are eligible for outcome payments only if practice earns at least 4 quality stars and the practice shows improved efficiency

Current professional fee-for-service delivery model will remain unchanged under Health Link for non-Health Link services.

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7 How Will A Health Link Be Paid?

Health Link Outcome Payment

The outcome payment is meant to reward high quality providers in shared savings opportunities. This outcome payment is based on performance throughout a full calendar year.

Step 1:

Measure Quality

Statewide thresholds are set

Step 2:

Measure Efficiency Performance

Measure efficiency metrics against thresholds

Step 3:

Measure Efficiency Improvement

Measure improvement in efficiency metrics compared to your past performance

Step 4:

Calculate Payment

Eligible for up to 25% of shared savings

7 How Will A Health Link Be Paid?

Step 1: Measure Quality Performance (relative to statewide threshold)

Sample Health Link Provider

Quality Metric	Threshold	Denominator	Performance	Star
Quality Measure 1	≤ 10%	60	15%	☆
Quality Measure 2	≥ 45%	50	60%	★
Quality Measure 3	≥ 65%	65	60%	☆
Quality Measure 4	≥ 30%	80	52%	★
Quality Measure 5	≤ 1%	40	5%	☆
Quality Measure 6	≥ 30%	60	25%	☆
Quality Measure 7	≥ 50%	50	60%	★
Quality Measure 8	≥ 60%	65	35%	☆
Quality Measure 9	≥ 55%	80	58%	★
Quality Measure 10	≥ 40%	5	90%	☆ N/A

Quality stars: ★★★★☆

At least 4 stars earned? ✓ → Outcome payment eligible ✓

Each Quality Star is worth 5%. See Step 2.

A minimum denominator of 30 is required to be measured

7 How Will A Health Link Be Paid?

Step 2: Measure Efficiency Performance (relative to statewide threshold)

Efficiency metric	Threshold	Performance	Star
ED/ 1000 MM	≤ 70	60	★
Inpatient/ 1000 MM	≤ 15	10	★
Mental Health Inpatient /1000 MM	≤ 5	9	☆
All Cause Readmission /1000 MM	≤ 5	6	☆
Inpatient Psychiatric Admissions/ 1000 MM	≤ 25	30	☆

These thresholds are placeholders. They will be set by each MCO.

Efficiency stars: ★★☆☆☆

Outcome savings percentage:

4 Quality stars at 5% 4*5% = 20%

2 Efficiency stars at 10% 2*10% = 20%

Outcome savings percentage: **40%**

7 How Will A Health Link Be Paid?

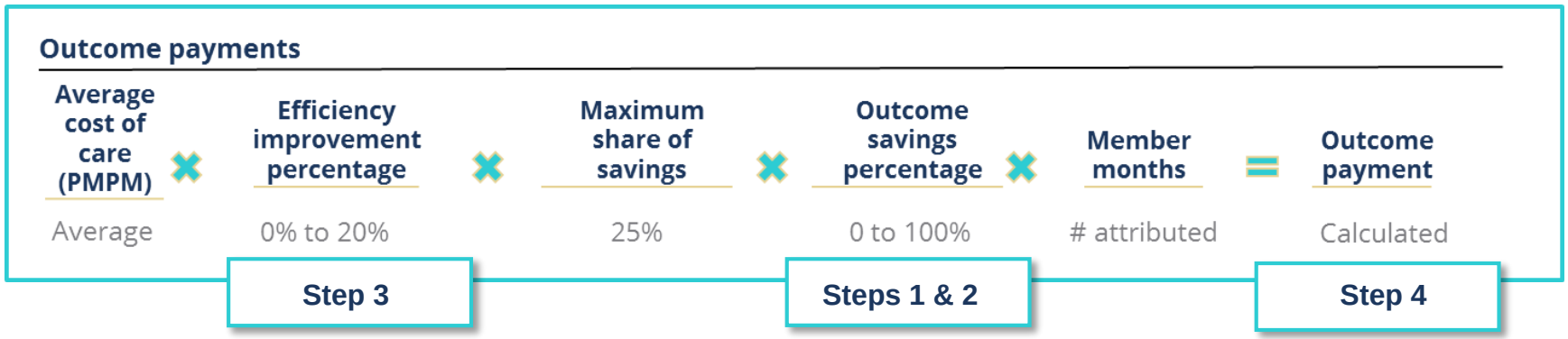
Step 3: Measure Efficiency Performance (relative to self)

Efficiency Measure per 1,000 member months	Efficiency Improvement
All Cause Hospital Readmissions	+9.62%
ED visits	+2.69%
Inpatient Admissions	-7.14%
Mental Health Inpatient Utilization	+20.00%
Inpatient Psychiatric Admissions	+0.76%
Efficiency Improvement Percentage (Average) :	**5.18%**

Updated example from Health Link Provider Operating Manual

7 How Will A Health Link Be Paid?

Step 4: Calculate payment



- **Average cost of care**: The average total cost of care for members in Health Links across all of TennCare.
- **Efficiency improvement percentage:** The average of percent improvement in each efficiency metric compared to the previous year for each Health Link.
- **Maximum share of savings:** The maximum percentage of estimated savings that can be shared with a Health Link. This value is set to one quarter for outcome payments based on total cost of care proxies. This value is the same share available to low-volume PCMH practices.
- **Outcome savings percentage**: The percentage earned from efficiency stars plus quality stars.
- **Member months in panels for quarterly reporting**: Number of attributed member months for members in the Health Link's panel for the performance period. 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.

7 How Will Health Link Practices Be Paid?

Step 4: Calculate payment

Outcome payments

Average cost of care (PMPM)		Efficiency improvement percentage		Maximum share of savings		Outcome savings percentage		Member months	=	Outcome payment
$835	✖	5.18%	✖	25%	✖	40%	✖	10,350	=	$44,766.86

*** Illustrative example, not based on real data ***

8 How Will Quality and Efficiency Be Measured?

Health Link Quality Metrics

1. **7- and 30-day psychiatric hospital / RTF readmission rate**
   - 7-day
   - 30-day
2. **Antidepressant medication management**
   - Acute phase treatment
   - Continuation phase treatment
3. **Follow-up after hospitalization for mental illness within 7 and 30 days**
   - 7-days
   - 30-days
4. **Initiation/engagement of alcohol and drug dependence treatment**
   - Initiation
   - Engagement
5. **Use of multiple concurrent antipsychotics in children/adolescents**
6. **BMI and weight composite metric**
   - Adult BMI screening
   - BMI percentile (children and adolescents only)
   - Counseling for nutrition (children and adolescents only)
7. **Comprehensive diabetes care (Composite 1)**
   - Diabetes eye exam
   - Diabetes BP < 140/90
   - Diabetes nephropathy
8. **Comprehensive diabetes care (Composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (> 9%)
9. **EPSDT: Well-child visits ages 7-11 years**
10. **EPSDT: Adolescent well-care visits age 12-21**

Health Link Efficiency Metrics

1. All-cause hospital readmissions rate
2. Ambulatory care - ED visits
3. Inpatient admissions– Total inpatient
4. Mental health utilization- Inpatient
5. Rate of inpatient psychiatric admissions

9 Reporting

- Each MCO will send providers reports quarterly, detailing their efficiency and quality stars, total cost of care, and potential payments for the relevant performance period.
- These quarterly reports aim to provide Health Links an interim view of the member panels that they will be held accountable for during the performance period.
- The first performance period for Health Link is January 1 - December 31, 2017.
- There are 2 types of quarterly provider reports:
  - Preview reports; and
  - Performance reports.

10 Provider Training

- TennCare has contracted with **Navigant** to deliver provider training and technical assistance services to Health Link providers across the State.

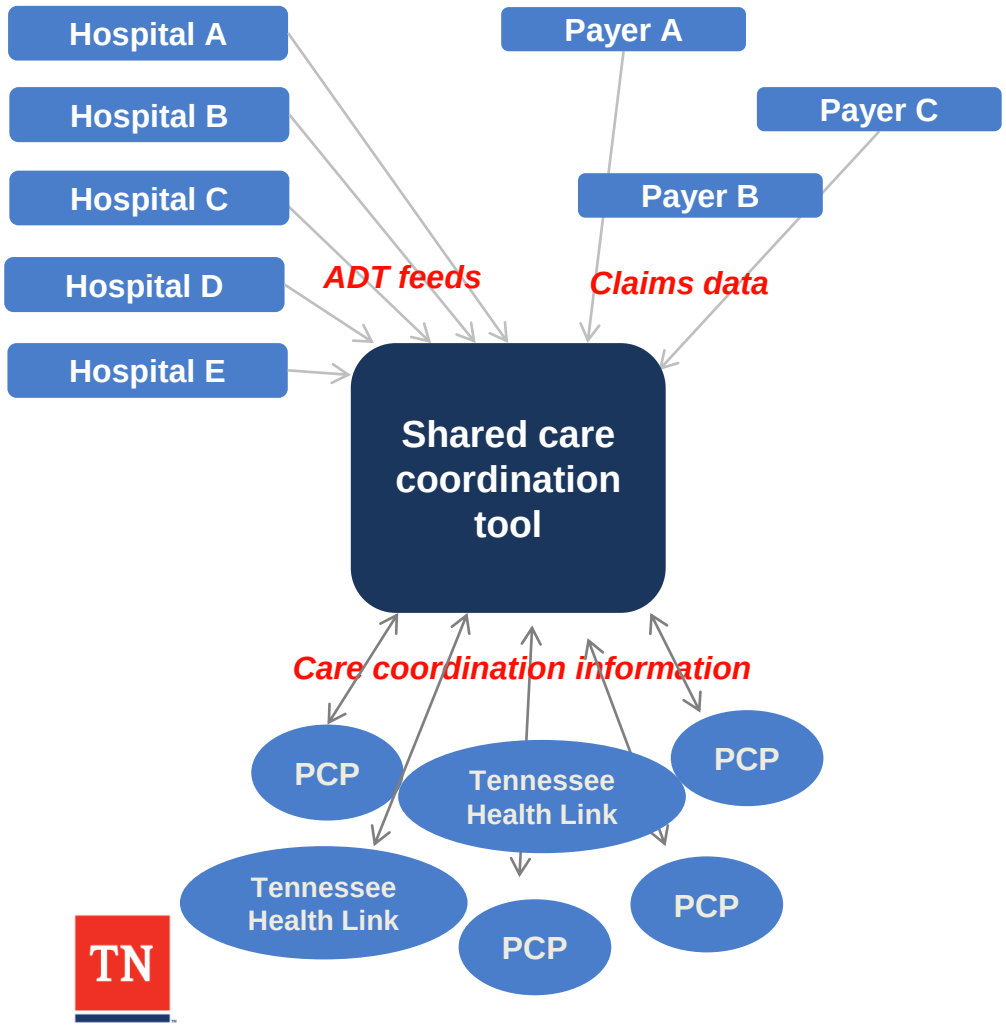
- The training vendor will conduct an **initial assessment** of each Health Link practice that identifies current capabilities. The results of this assessment will allow the trainer to create a **custom curriculum** for each practice to help in meeting transformation milestones. The custom plan will be refined periodically through semi-annual assessments.

- Providers will be encouraged to access this curriculum in various ways including:
  - On-site coaching
  - Large format in-person trainings
  - Live webinars
  - Recorded trainings
  - Compendium of resources

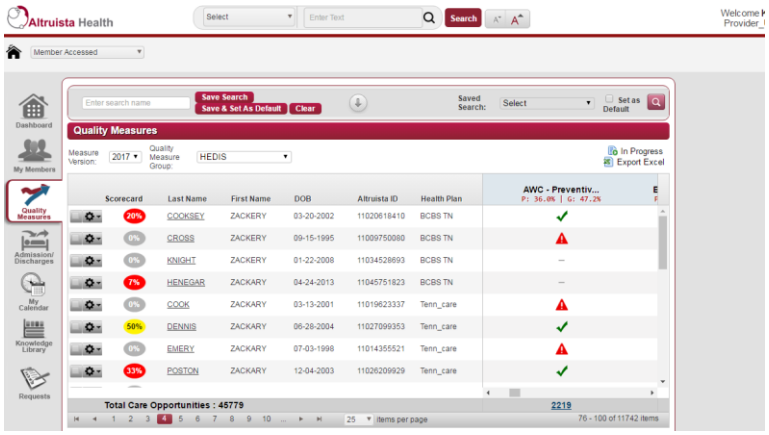
- Navigant will also establish and facilitate peer-to peer **learning collaboratives** among practices to allow Health Link providers to learn from one another's experience.

11 Care Coordination Tool

A multi-payer shared care coordination tool will allow primary care providers to implement better care coordination in their offices.



- Identifies a provider's attributed patients
- Generates and displays gaps-in-care and creates prioritized workflows for the care team
- Maintains, executes and tracks activities against patient-specific care plans
- Alerts providers of any of their attributed patients' hospital admissions, discharges, and transfers (ADT feeds)



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THANK YOU

Questions? Email Constance Payne at Constance.Payne@tn.gov

More information: http://www.tn.gov/hcfa/article/tennessee-health-link