Tennessee Health Link: Provider Operating Manual

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All information included herein is subject to further updates and refinement from HCFA.

1 GENERAL INFORMATION

1.1 Objective of Tennessee Health Link

The primary objective of Tennessee Health Link is to coordinate health care services for TennCare members with the highest behavioral health needs.

1.2 Background on Health Link

TennCare has worked closely with providers and TennCare's three Managed Care Organizations (MCOs) to create a program to address the diverse needs of these members. A Health Link Technical Advisory Group of Tennessee clinicians and practice administrators was convened in 2015 to develop recommendations in several areas of program design including, quality measures, sources of value, and provider activity requirements. The design of Health Link was also influenced by federal Health Home requirements.

Through better coordinated behavioral and physical health services, the Health Link program is meant to produce improved patient outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual, and improved cost control for the State. Health Link providers are encouraged to ensure the best care setting for each patient, offer expanded access to care, improve treatment adherence, and reduce hospital admissions. In addition, the program is built to encourage the integration of physical and behavioral health, as well as, mental health recovery, giving every member a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community.

Health Link providers commit to providing comprehensive care management, care coordination, referrals to social supports, patient and family support, transitional care, health promotion, and population health management. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the care coordination tool. These providers are compensated with financial support in the form of activity payments and an opportunity for an annual outcome payment based on quality and efficiency performance.

The Health Link program will launch statewide on December 1, 2016.

Health Link is intended to work in conjunction with the Patient-Centered Medical Home (PCMH) program the State is launching in early 2017. The strategies were designed together to give Tennessee providers across the care continuum the ability to coordinate care in a virtually integrated delivery model. To support this integration, providers are rewarded for coordinating their members' care across providers and settings.

1.3 Scope of Health Link

Members currently receiving Level 2 Case Management 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 Level 2 Case Management 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.

1.4 Roadmap for Health Link

Health Link will launch on December 1, 2016. The first wave of eligible Health Link providers has been designated. The State reviewed applications and designated those practices that qualified to become Health Links based on criteria including; their ability to complete all Health Link activity requirements, meeting provider eligibility requirements, and demonstrating an existing relationship with a minimum of 250 eligible Health Link members based on the State's attribution methodology.

Contracting with Health Link providers will be completed by the Managed Care Organizations (MCOs). The MCOs will work with the Health Link providers of their choice to modify provider contract language to incorporate the incentive structure of Health Link, including the activity payments and the outcome payments. Additional qualifying providers will be able to submit an application for consideration in the future. The next provider application, selection, and enrollment period for Health Link is yet to be determined.

1.5 Overview of benefits for providers

Beyond Health Link's direct financial incentives, participation in the program provides three additional benefits for providers:

1) Improves integration of behavioral health care providers into the health care delivery network;
2) Provides the opportunity for priority assignment of future Health Link eligible members; and
3) Enables providers to influence the evolution of the program as it develops

1.6 Overview of benefits for members

Members assigned to a Health Link will enjoy the benefits of improved access to behavioral health care providers and more integrated primary and behavioral health care coordination. Furthermore, assignment is not binding for the members. They can choose to switch Health Link providers and receive care coordination from a different Health Link. Independent of Health Link, members can still receive fee-for-service treatment from any TennCare provider.

1.7 Sources of value

Health Link is a comprehensive care delivery model designed to improve the quality of behavioral health care services provided to TennCare members while also improving the capabilities and practice standards of behavioral health care providers.

Successfully executed, Health Link will deliver a number of benefits to members, providers, and the system as a whole. A few of the most important benefits are outlined in Table 1.

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 • 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	• 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 member information with which to make decisions • Improved work flows and processes that positively impact productivity and efficiency	• 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 – 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

2 HOW DOES A PRACTICE BECOME A HEALTH LINK?

2.1 Practice Application

The application to become a Health Link provider is voluntary. Practices must submit a complete and accurate application to become a Health Link. The Tennessee Division of Health Care Finance and Administration (HCFA) will identify those practices able to meet the program requirements. The MCOs will then choose to contract for Health Link activities from a list of accepted Health Link providers. Questions about the application process should be directed to TennCare.

2.2 Practice Eligibility Requirements

All rules, processes, and requirements detailed herein apply only to Tennessee Health Link. To be eligible:

1) The provider must be either:

- **a)** a Community Mental Health Center; **or**
- **b)** Another type of qualified provider (i.e., mental health clinic, Federally Qualified Health Center, primary care provider, or provider with a behavioral health specialty) with at least 250 attributable Health Link members across all MCOs. Exceptions to this minimum panel size requirement may be made for rural areas or counties in which there would not otherwise be a Health Link;

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 who, as part of a care team, coordinates with medical professionals. This role is to be filled by a Registered Nurse (RN) who is licensed to practice in Tennessee; and
  - **ii)** Case manager(s) who, as part of a care team, act as the primary point of contact for member and family relationships. All case managers

shall have, at minimum, a bachelor's degree, or an RN and be licensed to practice in Tennessee;

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 (possessing a master's degree tied to mental health practice or related subjects, with an active Tennessee license) and a primary care physician (MD or DO licensed to practice in Tennessee); **or**
- **c)** A psychologist (with an active Tennessee license with a health service provider designation) and a primary care physician (MD or DO licensed to practice in Tennessee);

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 Section 16.

Once enrolled, a participating practice remains in Health Link until:

1) The practice withdraws from Health Link;

2) The practice becomes ineligible, is suspended, or is terminated from the TennCare program or Health Link; or

3) HCFA (Tennessee Division of Health Care Finance and Administration) decides to suspend the Health Link program.

To withdraw from Tennessee Health Link, the participating practice must email intent to withdraw to payment.reform@tn.gov and to their contracted MCO(s).

In addition, if a Health Link provider would like to add a service location, they must email intent to add a service location to payment.reform@tn.gov and to their contracted MCO(s).

2.3 Provider contracting

If selected during the application process, a practice must update its contract(s) with the relevant health plan(s). MCO contracting must be completed prior to the start of the program on December 1, 2016. Practices will not be required to contract with health plans with which they do not have an existing contract.

3 WHICH MEMBERS ARE ELIGIBLE FOR HEALTH LINK?

3.1 Member eligibility for Tennessee Health Link

TennCare members can qualify for Health Link in 3 ways:

	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. 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.

3.1.1 Provider referral

To ensure members gain access to Health Link in a timely manner, providers may communicate directly with MCOs in order to gain Health Link eligibility for members prior to claims verification of member eligibility.

Communication directly from hospitals: Member is granted eligibility if the hospital provides a referral to a Health Link provider and the Health Link provider completes attestation to the relevant MCO that the member meets Category 1 or 2 identification criteria as outlined above. Hospital referrals will follow existing referral protocol.

Communication directly from Health Links: Member is granted eligibility if the provider provides attestation to the relevant MCO that the member meets Category 1, 2 or 3 identification criteria as outlined above.

3.2 Losing eligibility for Health Link

Members can lose eligibility for Health Link for any of the following reasons:

1) **Member loses TennCare eligibility**;
2) **Member begins receiving a duplicative care coordination service; or**

   Examples of duplicative services include:

   - **Member has a long-term nursing home stay**: The member has one or more nursing home facility claims that cover more than 90 consecutive days that is ongoing as of the most recent eligibility update. The member must be discharged to home from a previous nursing home stay to become eligible for Health Link again.
   - **Member has a long-term residential treatment facility stay**: The member has one or more residential treatment facility (RTF) claims that cover more than 90 consecutive days that is ongoing as of the most recent eligibility update. The member must be discharged to home from a previous RTF stay to become eligible for Health Link again.
   - **Member is enrolled in certain programs by the Department of Children's Services (DCS)**: The member was enrolled in level 3 and above programs by the DCS for more than 30 consecutive days, unless the MCO makes an explicit decision to include. Further detail regarding DCS eligibility can be found in Section 15.
   - **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.
3) **Member is not benefiting from Health Link:** The member is no longer considered benefiting from Health Link. The MCO and/or Health Link provider is unable to identify, as evidenced by clinical documentation, member progress toward treatment goals in response to Health Link interventions. The process for identifying members for evaluation is outlined in Section 17.

Members may become eligible for Health Link again if they have a qualifying event or a documented functional need. Losing eligibility is different than a member becoming inactive. Details outlining how a Health Link member can become inactive after attribution or enrollment can be found in Sections 4.3 and 4.4.

4 HOW ARE MEMBERS ATTRIBUTED AND ENROLLED WITH A HEALTH LINK?

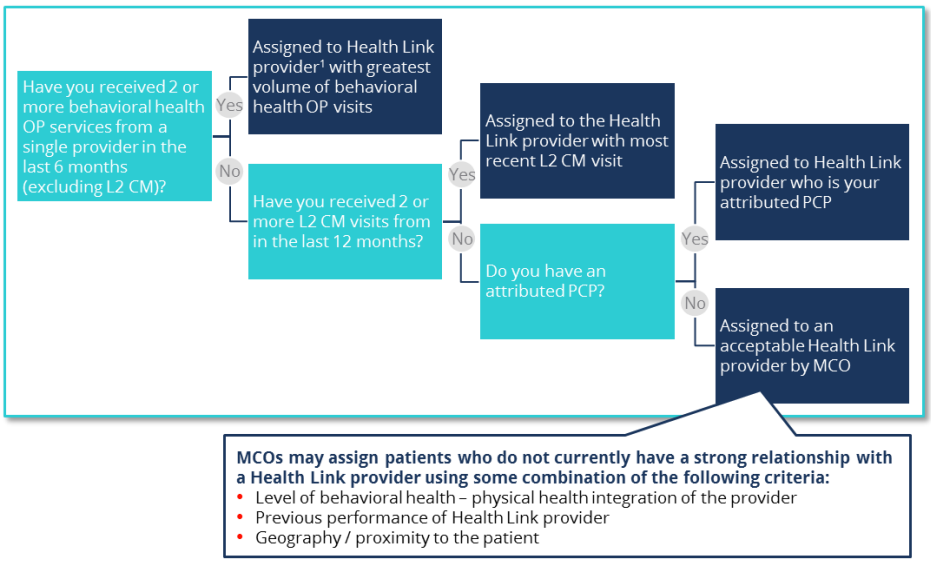
4.1 Member attribution for Tennessee Health Link

Initial attribution:

At program launch, eligible members are attributed to Health Links based on the following criteria, in the following order:

1) If the member has two or more behavioral health outpatient visits (must be of a clinical nature) with any Health Link during the last 180 days, the member is attributed to the Health Link with the most visits. If there is a tie, the member is attributed to the Health Link 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 with the most recent Level 2 Case Management visit during the last 365 days. Note: This is different from the eligibility determination regarding Level 2 Case Management outlined in 3.1.;
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, then the member is assigned to that Health Link; or
4) 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, incorporating factors such as provider performance, geographic proximity, or member characteristics.

Process for attributing eligible members to Health Link providers



1 May exclude certain behavioral health provider types and services

Subsequent attribution:

When the MCOs identify newly eligible members, they will determine attribution for those members using a methodology identical to the initial attribution.

If a Health Link is in remediation, it will not be attributed new members. Remediation occurs when a Health Link provider fails to meet any of the practice eligibility requirements outlined in Section 2.2 for one performance period (i.e., calendar year).

Provider referral/non-claims-based attribution:

If a member is already attributed to a Health Link then their assignment can only be modified if the member requests a change to his/her attributed Health Link. In certain cases, a member will enter the program through a provider referral. If that member was not already assigned to a Health Link, that member will be assigned to the referring provider. Eligible members coming in through provider referral will be attributed to Health Links in the following ways:

1) **Newly eligible members identified through a hospital discharge** – Attributed to referred Health Link
2) **Newly eligible members identified through a Health Link** – Attributed to the attesting Health Link. Before submitting attestation, providers should check with the member's MCO and in the future, Tennessee Online Services, for the current Health Link attribution status of the member. Providers can check with the member's MCO by calling the MCO's customer service number listed on the back of the member's insurance card
3) **Members requesting a switch of Health Link** – Attributed to the requested Health Link
4) **Members switching MCOs** – Remain attributed to their current Health Link if they also contract with the new MCO

If a provider wishes to remove a member from their attributed panel, Health Link will follow the same guidelines/existing rules that each MCO already has in place for member change requests submitted by primary care providers.

4.2 Enrollment of members with their attributed Health Link

Every member must consent to the receipt of Health Link services before they may be provided. Regarding consent, the Centers for Medicare and Medicaid Services (CMS) gives the following guidance: "Enrollment must be documented by the provider, and that documentation should at a minimum indicate that the individual has received information explaining the Health Home program and has consented to receive health home services noting the effective date of their enrollment." – FAQ, December 2015. An attributed member can only be enrolled by the Health Link 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.

4.2.1 Enrollment process for attributed members

For the purposes of this section, the term "new member" refers to an attributed member who was not receiving Level 2 Case Management on or after April 1, 2016 and the term "auto-enrolled member" refers to an attributed member who was receiving Level 2 Case Management on or after April 1, 2016.

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

Auto-enrolled members 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.

4.3 Inactivity of members in Health Link

In certain situations a Health Link member may become inactive after attribution or enrollment. The following are ways that a member could become inactive in Health Link:

1) **Member opts-out from Health Link**: If the member chooses to opt out of Health Link by notifying their MCO or attributed Health Link, then the member is recorded as inactive effective the date of the opt-out indication. If the member chooses to opt out of Health Link by notifying their attributed Health Link, then the Health Link must notify the member's MCO;
2) **Member stops receiving behavioral health related treatments**: If the enrolled member does not receive any behavioral health related treatments, as evidenced in the claims data, within a 6 month window, then the member is considered inactive, effective the date when the claims-based enrollment update was finalized; or

3) **Member unable to be enrolled following attribution**: If a provider, following multiple contacts and good-faith efforts, is unable to contact a beneficiary assigned to their panel for enrollment, the beneficiary's MCO may, at their discretion, reassign them to another provider which may be able to better engage the beneficiary 6 months after attribution but no earlier than June 1, 2016. The MCO will provide the beneficiary and the original Health Link provider all appropriate notice and information.

Members remain in inactive status, unless they resume activities as described in 4.4.

4.4 Activity resumption of previously inactive members

Members who became inactive through the opt-out process or due to lack of qualifying behavioral health treatment may resume activities under 2 conditions:

1) **For members who had previously opted out**: Members can opt back into the program by contacting his/her MCO or a Health Link, if they are identified as eligible for Health Link in the most recent eligibility update. If the member chooses to opt back into the program by notifying a Health Link, then the Health Link must notify the member's MCO. The member can choose to remain with their prior Health Link provider or change Health Link providers; or
2) **For members who resume behavioral health treatment:** Members are no longer considered inactive if they have a qualifying behavioral health treatment while they are still eligible for Health Link. The member is no longer considered inactive effective the date of the behavioral health treatment service.

5 HOW ARE HEALTH LINK MEMBER PANELS DEFINED?

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

1) Activity payment calculation
2) Outcome payment calculation

5.1 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.

5.2 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.

For outcome payment calculations, members are considered to be part of the member panel of the Health Link for which they meet the following requirements:

1) The member has been attributed to the Health Link for at least 9 months of the performance period;
2) The Health Link is the attributed Health Link for the most months during the period covered by the quarterly report. Months during which the member opted out of Health Link are not taken into account in identifying the member panel for quarterly reporting; and
3) If there is a tie, the Health Link which the member was attributed to in the most recent month is the Health Link to which the member is assigned for the purpose of quarterly reporting.

Members are **excluded** from the Health Link performance evaluation and therefore excluded from the outcome payment calculation under any of the following scenarios (i.e., these members are not counted in quality and efficiency metrics):

- **Member is dual-eligible but is not enrolled in an aligned D-SNP.** Health Link explicitly includes individuals who are dually eligible in Medicare and Medicaid if they are enrolled in an aligned D-SNP. However, members could be excluded from performance evaluation if they are dual eligibles not enrolled in an aligned D-SNP health plan (at the MCO's discretion). Being "aligned" means that the member is enrolled in a Medicare Advantage D-SNP plan with the same MCO participating in 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.

- **Member has or obtains third-party liability (TPL) coverage.** Members with confirmed TPL coverage or with a claim within the previous quarter indicating TPL coverage could be excluded from the Health Link performance evaluation.
- **Member has a long-term nursing home stay:** Members with an active nursing home stay that covers 90 or more consecutive days are not included in the Health Link performance evaluation. Members must be discharged to home from a previous nursing home stay to regain Health Link performance evaluation eligibility.
- **Member with long-term residential treatment facility stay:** Members with one or more residential treatment facility (RTF) claims that cover more than 90 consecutive days that is ongoing as of the eligibility update start date are not included in the Health Link performance evaluation. Members must be discharged to home from a previous RTF stay to regain Health Link performance evaluation eligibility.
- **Member has less than 9 months of attribution to that Health Link:** Only those members with at least 9 months of cumulative attribution to the Health Link are counted towards performance outcomes. These 9 months do not have to be consecutive. This policy is in place to ensure that the provider has had adequate time with the member to affect their quality and efficiency outcomes.
- **Member has been excluded from Health Link services for receiving duplicative care coordination services as defined in Section 3.2.**

Member exclusions are determined using a combination of claims and non-claims data sources. Once excluded, a member may become eligible again for the Health Link if his or her exclusion status changes.

6 WHAT SERVICES WILL A HEALTH LINK PROVIDE?

Under the Health Link model, providers will have more flexibility than ever before to support their members in the most effective ways possible. Providers should focus on these key activities, but have flexibility in tailoring these to the specific needs of individual patients. The activities that qualify for receipt of an activity payment are much broader than those that qualified under Level 2 Case Management, making it easier for providers to complete monthly activities on behalf of patients.

The 6 Health Link activities listed below encompass care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health, which is designed to improve quality outcomes. These 6 activities were developed with significant input from a provider-led Technical Advisory Group (TAG) and providers can bill up to once a month for each Health Link member who received an activity or an activity was performed on his/her behalf.

Patient support activities beyond this scope are encouraged but do not count towards the requirement to perform one activity per member per month in order to receive an activity payment, although they can help earn outcome payments if performing them helps to improve quality or efficiency.

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

Additional detail regarding how Health Links will be paid for providing these 6 types of clinical activities can be found in the following section.

This section focuses on member-level activities; however, Health Link providers are required to continue to perform all activities outlined in the practice eligibility requirements in Section 2.2.

7 HOW WILL A HEALTH LINK BE PAID?

7.1 Fee-for-service

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

7.2 Activity payments

Activity payments are intended to provide ongoing support to practices as they commit to the key elements of transformation, including but not limited to care coordination, increasing member access, creating care plans, and several other elements believed to be central to transformation. Although providers are attributed a panel of members, 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. Refer to Section 13 for further details regarding billing practices. Continued receipt of activity payments will depend upon a provider's ability to meet the basic set of eligibility and personnel requirements to be a Health Link, and upon the providers' ability to perform to an acceptable standard against a set of pre-determined quality and efficiency metrics.

7.2.1 Duration and Amount of Activity Payments

Payment for activities will be ongoing, consistent with the approach taken in other models and with the principle of compensating practices for performing required activities. A Health Link can receive one payment per month per member. The Health Link activity payment is disbursed based on the members for whom a Health Link activity claim was billed during the month when the member was actively enrolled with the given Health Link.

An activity payment transition rate will be set for Health Link services rendered until November 30, 2017 (inclusive). A monthly stabilization rate will also be set, that can be paid for 12 months per member, beginning December 1, 2017. These 12 months per member do not need to be continuous. Finally, a recurring activity payment rate will be set for service months beyond the stabilization period. Outreach time was included as part of the overhead costs factored into the staffing model for Health Link activity payments.

Activity payments are not risk-adjusted. There is no risk adjustment performed as there are no available behavioral health-specific risk scores that would create clear segmentation amongst the population.

7.2.2 Requirements for Activity Payments

Each Health Link is eligible to receive activity payments for those members who, when actively enrolled with the given Health Link, had a claim for a Health Link activity billed during a given month. Billing codes for qualifying activity claims are provided in Section 13. Qualifying Health Link activities are listed in Section 6.

7.3 Outcome payments

Outcome payments are designed to reward Health Links annually for providing high-quality care while effectively managing overall spending. Outcome payments for each Health Link are based on performance on the core quality and efficiency metrics described in Section 8.1 and 8.2.

Health Link practices are eligible for outcome payments only if the following 2 conditions are met:

1) The practice earns at least 4 quality stars out of 10 possible stars; **and**
2) The practice shows improved efficiency (i.e. better results on efficiency metrics during the performance year over the previous year).

7.3.1 Outcome savings percentage

Health Link practices may earn between 0 to 100% of the outcome savings percentage based on quality and efficiency stars earned. Each efficiency star earned by a Health Link practice contributes 10% to the outcome savings percentage. Each quality star earned by a Health Link practice contributes 5% to the outcome savings percentage.

For example, the following Health Link would have an outcome savings percentage of 60%.

7.3.2 Efficiency improvement percentage

The efficiency improvement percentage will reward practices which have improved relative to their previous year's performance. The efficiency improvement percentage

is the average of improvement in each efficiency metric compared to the previous year's performance for the Health Link. Efficiency improvement for a given metric is calculated as the following:

$$\begin{pmatrix} Efficiency \\ Improvement \\ Percentage \end{pmatrix} = \frac{\begin{pmatrix} Efficiency\ metric\ 1 \\ Performance\ at\ baseline \end{pmatrix} - \begin{pmatrix} Efficiency\ Metric\ 1 \\ Performance\ since\ 1/1/17 \end{pmatrix}}{\begin{pmatrix} Efficiency\ metric\ 1 \\ Performance\ at\ baseline \end{pmatrix}}$$

After calculating the efficiency improvement percentage for each metric, the average of the 5 is taken.

TABLE: Illustrative Example of Efficiency Improvement Percentage

Note: Values rounded to nearest hundredth decimal place

Efficiency Measure per 1,000 member months	Performance at baseline	Performance since 1/1/17	Efficiency Improvement
All cause hospital readmissions	0.52	0.47	9.62%
ED visits	78.10	76.00	2.69%
Inpatient admissions	2.80	3.00	-7.14%
Mental health inpatient utilization	0.15	0.12	20.00%
Inpatient psychiatric admissions	13.10	13.00	0.76%
EFFICIENCY IMPROVEMENT PERCENTAGE (AVERAGE)			**5.18%**

If the average efficiency improvement percentage results in a negative number, it will be set to 0 and if the average calculation exceeds 20% it will be capped at that value.

7.3.3 Calculation of outcome payments

Health Links must meet the minimum quality star requirement and have an efficiency improvement percentage greater than zero in the performance report at the end of year to qualify for outcome payments. The minimum quality star requirement is 4 stars.

For Health Link providers meeting the minimum requirements, the outcome payment amount is calculated as follows:

Outcome payments										
Average cost of care (PMPM)	×	Efficiency improvement percentage	×	Maximum share of savings	×	Outcome savings percentage	×	Member months	=	Outcome payment
Average		0% to 20%		25%		0 to 100%		# attributed		Calculated

Average cost of care: The average total cost of care for members in Health Links across all of TennCare. For the 2017 performance period, this value is set at $835.

Efficiency improvement percentage: The average of percent improvement in each efficiency metric compared to the previous year for each Health Link, as defined in Section 8.2.

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. Refer to Section 7.3.1.

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.

For example, based on the above example figures in Sections 7.3.1 and 7.3.2 and assuming 3000 member months, the outcome payment would be calculated as follows:

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%		60%		3000		$19,463.85

*Illustrative example, not based on real data

8 HOW WILL QUALITY AND EFFICIENCY BE MEASURED?

8.1 Quality Measures

Quality metrics are tracked to ensure that Health Links are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide.

The majority of quality measures are defined by HEDIS specifications. The HEDIS 2017 specifications will guide the inclusion of members and codes used to calculate these measures.

Core quality metrics for Health Link that will be used to determine outcome payment levels are shown in Table 2. Certain metrics are calculated for a specific age group only, e.g., adults only or children only. Some measures are grouped into composites. Each composite is worth one quality star. All sub-measures within a composite must meet or exceed the threshold in order for a practice to earn that star. Additional reporting only metrics will also be provided on reports. There is a more detailed table with sources and descriptions in Section 14.

TABLE 2- Health Link Quality Metrics

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**

8.2 Efficiency Measures

Efficiency metrics are tracked to ensure that Health Links are meeting specified efficiency performance levels and to provide them with information they can use to improve the quality of care they provide. Core efficiency metrics that will be used to determine outcome payment levels are shown in Table 3. All efficiency metrics are reported per 1,000 member months. Additional reporting only metrics will also be provided on reports. There is a more detailed table with sources and descriptions in Section 14.

TABLE 3- Health Link Efficiency Metrics

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

8.3 Earning stars

In each quarterly report, Health Link practices earn stars based on their performance across the core quality and efficiency metrics. There are 10 quality stars and 5 efficiency stars for a total of 15 stars for each practice.

- Each quality metric or quality composite that meets or outperforms the state threshold translates into 1 quality star.
- Each efficiency metric that meets or outperforms the threshold translates into 1 efficiency star.

Health Link quality and efficiency metrics are defined in Sections 8.1 and 8.2 with further detail in Section 14. State thresholds for each core metric will be provided in a separate document.

Some of these measures are composites with multiple sub-measures. In order to earn a star for a given measure, the Health Link must pass all of the sub-measures.

Health Link practices can only earn credit for quality and efficiency metrics with 30 or more observations in the metric's denominator. For example, a practice will only be measured on the quality measure "use of multiple concurrent antipsychotics in children/adolescents" if it has seen at least 30 members eligible for the metric.

Health Links must meet the minimum quality star requirement in the performance report at the end of year to qualify for outcome payments. The minimum quality star requirement is 4 stars for each practice.

9 REPORTING

Health Link providers will be sent quarterly provider reports by each MCO, 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.

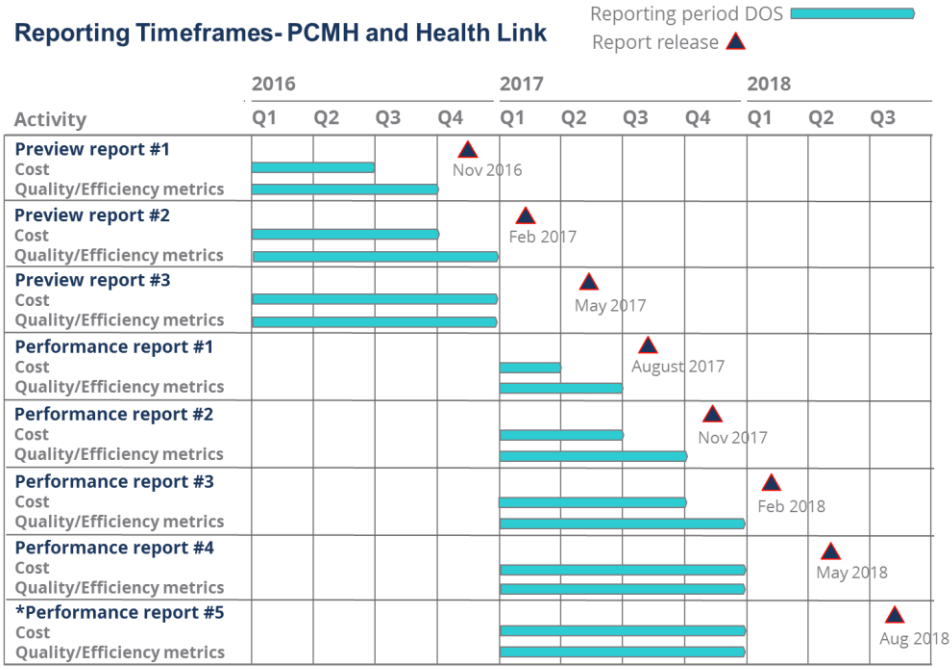
There are 2 types of quarterly provider reports:

- Preview reports; and
- Performance reports.

Initially, at program launch, providers will receive three preview reports on their performance until the first claims run-out is complete, after which they will start to receive quarterly performance reports. These preview reports will give Health Links a sense of how they were performing before the program launched. MCOs will also send providers a final annual report seven to eight months after the end of Q4 which calculates the annual outcome payment. Only data from January 1, 2017 to December 31, 2017 will be included in the performance evaluation.

Each quarterly performance report will provide a summary of the Health Link'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 each quarter. Each performance report will also include the most recent data available for performance on quality and efficiency metrics. The final performance report will calculate the outcome payment. This report will incorporate 180 days of claims run out after the end of the year. The following table represents the timeframes of data that will be included in each report.

TABLE 4 – Data timeframes for each quarterly report



*Note: Performance report #5 will be the basis for each practice's outcome payment.

The reports will contain the following sections (A-G):

A. Health Link Membership: This section will list the percentage of attributed Health Link members that are enrolled with the given Health Link as of the end of the quarter. This percentage allows providers to assess potential for increasing enrollment. The section will also include the activity payments earned, based on activity claims, year to date.

B. Quality Stars: This section summarizes the quality stars achieved by the provider as of the end of the given quarter. Health Link practices will see all 10 applicable quality metrics, with each quality star contributing 5% to the outcome savings percentage.

C. Efficiency Stars: This section summarizes the efficiency stars achieved by the provider as of the end of the given quarter. Each star earned will contribute 10% to the outcomes savings percentage.

D. Efficiency Improvement Percentage: This section includes the calculation of the efficiency improvement percentage, an input to the outcome payment calculation. The provider's current performance (year-to-date) on the 5 efficiency metrics is compared to performance from the prior calendar year to determine the practice improvement. The improvement percentages for each metric are averaged together to generate the total efficiency score. If the average efficiency improvement percentage results in a negative number, it will be set to 0 and if the calculation exceeds 20% it will be capped at that value.

E. Potential for Annual Outcome Payments: This section provides information on potential (or actual, if it is the annual report) outcome payments. It lists the amount of the potential payment, and details of the calculation of that amount. The outcome payment is calculated as detailed in Section 7.

F. Total Cost of Care (for reporting only): This section offers provider total cost of care information, calculated as explained in Section 11, by care category. The provider TCOC figures are compared to a provider average, and are provided on a non-risk adjusted basis for both total cost of care and BH-specific cost of care.

G. Appendix: This section contains more detail on the quality metrics. It includes an indication of whether the provider has met the minimum number of members for each metric and, if not, how many members are included. The section also includes a short description of each quality metric and a visual depiction of the provider performance on each metric as compared to other providers and as compared to the metric benchmark for earning a star.

10 PROVIDER TRAINING

TennCare has contracted with Navigant to deliver provider training and technical assistance services to Health Link and PCMH providers across the State. Navigant will help providers make the needed investments in practice transformation across all of their sites. This in-kind training investment is intended as a co-investment with practices and not as full coverage for the time, infrastructure, and other investments that practices will need to make.

10.1 Scope of provider training

Navigant 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.

The Health Link curriculum will focus on building health care provider capabilities for effective patient population health management to reduce the rate of growth in total cost of care while improving health, quality of care, and patient experience.

This curriculum will include content in the following areas:

a. Delivering integrated physical and behavioral health services;
b. Team-based care and care coordination;
c. Practice workflow redesign and management;
d. Risk stratified and tailored care delivery;
e. Enhanced patient access (e.g., flexible scheduling, expanded hours);
f. Evidence-informed and shared decision making;
g. Developing an integrated care plan;
h. Patient and family engagement (e.g., motivational interviewing);
i. Making meaningful use of Health Information Technology (HIT)/ Health Information Exchange (HIE);
j. Making meaningful use of the care coordination tool (e.g., ADT feeds);
k. Making meaningful use of provider reports;
l. Business support; and
m. Clinical workflow management

Providers will be encouraged to access this curriculum in various ways including:

- **On-site coaching**: on-site coaching for practice staff, e.g., one-on-one coaching sessions with small groups of practice staff including physicians, office managers, care coordinators and/or Health Link Directors.
- **Large format in-person trainings**: large-format regional conferences, trainings, or symposia on a quarterly basis.
- **Live webinars**: live, hosted webinars with live Q&A on a quarterly basis

- **Recorded trainings**: recorded video trainings available to providers online on a self-serve basis.
- **Compendium of resources**: a library of documents and resources available online

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. To enable learning and adoption at the practice level, Navigant will create mechanisms for providers to share best practices, to collaborate on common problems, and to adopt and refine evidence-informed protocols.

Payers may choose to supplement this in-kind training with new or existing programs geared toward Health Link training. Navigant will coordinate support with payers to minimize duplication and maximize efficiency for the payer, vendor, and providers alike. For example, payers will be encouraged to join quarterly on-site coaching sessions where they will be able to share their performance data and advice directly with providers.

10.2 Timeline of provider training

Navigant will begin scheduling initial assessments for both Health Link and PCMH providers in January 2017. Onsite coaching sessions will begin once the initial assessments are complete.

10.3 Duration of provider training

Navigant will develop individualized curricula for both Health Link and PCMH for the first two years of a practice's transformation.

Payments to Navigant on behalf of a participating provider will continue for 2 years. Over time (i.e., once federal funding is no longer available to support the training and technical assistance vendor), the MCOs will take over the Navigant training role.

11 CARE COORDINATION TOOL

A shared multi-payer Care Coordination Tool (CCT) will allow Health Link practices to better coordination care for their attributed members. The tool is designed to offer useful, up-to-date information to Health Link practices.

The State of Tennessee has contracted with Altruista Health for development of the Care Coordination Tool. This tool is based on Altruista's Guiding Care platform. Guiding Care is a cloud based tool accessible online. Practices will not have to install any special programs.

Information in the tool will be populated by claims data from the State and MCOs and Admission, Discharge, and Transfer data received from participating hospitals.

Using the CCT is a provider activity requirement for Health Link; however, we expect practices will each use the tool differently after assessing its capabilities and integrating its usage into their current work flows.

The CCT has several functionalities:

- Shows providers their attributed member panel;
- Calculates members' risk scores and stratifies a providers' panel for more focused outreach;
- Generates, displays, and records closure of gaps-in-care; and
- Displays hospital and ED admission, discharges, and transfers (ADTs)

It is expected that practices will designate staff, ideally care coordinators, to use the CCT daily, however, daily use of the tool is not strictly required. Any staff using the CCT is expected to abide by patient privacy and confidentiality laws and regulations. Altruista will be responsible for setting up all users with logins and passwords.

Altruista will also deliver online trainings, develop easy to understand user materials, and offer onsite training as needed, so that providers are comfortable with all of the functionality available in the CCT. In addition, the provider training vendor (see Section 9) will provide additional training on the effective use of the CCT.

Providers will be able to manually close gaps in care in the CCT. This will enable providers to see in real-time which of their members are in need of a follow-up. At this time, those manual gaps in care closures will not contribute to the quality performance reported from the MCOs each quarter unless a corresponding claim is received to verify the gap has been closed.

12 TOTAL COST OF CARE CALCULATION APPENDIX

Total cost of care (TCOC) refers to average total spending of the members in a Health Link's panel, adjusted for the member months during which the member was eligible for TennCare. At the end of each quarter, the TCOC is generated for the provider report, based on each Health Link's member panel for performance. The following calculations are displayed in each Health Link provider report:

- Non-risk-adjusted TCOC
- Non-risk-adjusted TCOC for behavioral health

For Health Link practices, TCOC amounts will be displayed for informational purposes only. Each of these TCOC calculations is discussed in greater detail in the following sections.

- **Definition of Total Cost of Care**

The total cost of care is meant to capture the total cost of an average member in a Health Link's practice. Using this, the MCOs can calculate the savings a practice has generated and share in those savings with practices.

For purposes of the Health Link program, there are 4 categories of spending excluded from TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life

In addition to traditional claims-based payments, there are 3 types of spending incorporated into the TCOC calculation:

- PCMH activity payments are considered a cost associated with delivering care. As a result, the activity payments from the prior quarter are added to TCOC at the member level;
- Health Link activity payments are also considered a cost associated with delivering care. Health Link payments from the previous quarter are added to TCOC at the member level; and
- Gain-sharing payment made to the Health Link as a Principal Accountable Provider (i.e. Quarterback) of episode-based payment models.

- **Actual Total Cost of Care**

Actual total cost of care for a Health Link is calculated as a per-member-per-month metric, on a separate basis for each MCO with which the Health Link contracts.

Non-risk-adjusted TCOC is defined as the sum of spend included in TCOC divided by the sum of the number of enrollment months with the MCO, for all the members in the Health Link's panel. In other words, across all members of the Health Link's panel within an MCO:

$$Non\ risk\ adjusted\ TCOC = \frac{\sum Included\ Spend}{\sum Member\ months\ with\ MCO}$$

Non-risk-adjusted TCOC for behavioral health is defined analogously with the non-risk-adjusted TCOC above, but taking into account only the BH spend. For non-risk-adjusted TCOC for behavioral health, spend included is spend that meets the BH spend definition as well as the TCOC definition.

13 BILLING AND ENCOUNTER CODES APPENDIX

Billing/ Encounter Codes for Tennessee Health Link Activities

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

Billing Codes and Rates

Transition Rate
The Transition 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 Stabilization rate is for the 1st 12 member months of Health Link activities completed starting 12/01/17. The Billing Code (also acting as the payment trigger code) is S0280 which will pay at $139.

Recurring Rate
The Recurring rate is for Members who have reached the Stabilization service maximum of 12 member months of TN Health Link activity payments. The Billing Code (also acting as the payment trigger code) is S0281. The rate for this code is to be determined and will be announced by TennCare by 1/1/18.

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 UB: Collateral	UC: Face-to-face 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

Enrollment Processes
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.

Enrolling members who were previously receiving Level 2 Case Management and generating an initial activity payment:
For enrolling members who were previously receiving Level 2 Case Management, or 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.

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
4. Track and maintain all members' Health Link eligibility information to know when appropriate transitions are needed between Billing Codes

14 QUALITY AND EFFICIENCY METRICS APPENDIX

TennCare has selected a group of core quality metrics for the Health Link program. TennCare recognizes that this is not the complete set of measures required for a member to be considered compliant across all HEDIS measures. TennCare encourages Health Links to continue to work closely with the MCOs to identify and close those care opportunities.

The descriptions for HEDIS measures below are based on HEDIS 2016 specifications. Practices will always be measured on the most recent HEDIS specifications available.

TABLE 5 – Core Quality Metrics

Category	Core metric	Source	Metric description	Threshold
Behavioral health (BH) metrics	**7- and 30-day psychiatric hospital / RTF readmission rate**			
	• 7- and 30-day psychiatric hospital / RTF readmission rate – 7 days	TennCare	Rate of psychiatric hospital or RTF readmissions within 7 days	≤5%
	• 7- and 30-day psychiatric hospital / RTF readmission rate – 30 days	TennCare	Rate of psychiatric hospital or RTF readmissions within 30 days	≤15%
	Antidepressant medication management (adults only)[1]			
	• Antidepressant medication management (adults only) – Effective acute phase treatment	HEDIS (AMM)	Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)	≥55%
	• Antidepressant medication management (adults only) – Effective continuation phase treatment	HEDIS (AMM)	Percentage of members who remained on an antidepressant medication for at least 180 days (6 months)	≥40%

Category	Core metric	Source	Metric description	Threshold
	Follow-up after hospitalization for mental illness within 7 and 30 days			
	• Follow-up after hospitalization for mental illness within 7 and 30 days – within 7 days	HEDIS (FUH)	Percentage of discharges for mental health illness which the member received follow-up to within 7 days of discharge	≥60%
	• Follow-up after hospitalization for mental illness within 7 and 30 days – within 30 days	HEDIS (FUH)	Percentage of discharges for mental health illness which the member received follow-up to within 30 days of discharge	≥75%
	Initiation / engagement of alcohol & drug dependence treatment[1]			
	• Initiation / engagement of alcohol & drug dependence treatment - Initiation	HEDIS (IET)	Percentage of members who initiated treatment through an inpatient alcohol & drug admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis	≥45%
	• Initiation / engagement of alcohol & drug dependence treatment - Engagement	HEDIS (IET)	Percentage of members who initiated treatment and who had two or more additional services with a diagnosis of alcohol & drug dependence within 30 days of the initiation visit	≥15%

Category	Core metric	Source	Metric description	Threshold
	Use of multiple concurrent antipsychotics in children/adolescents – Total rate	HEDIS (APC)	Percentage of children and adolescents 1-17 years of age who were on two or more concurrent antipsychotic medications (for at least 90 consecutive days during the measurement year)	≤1%
Physical health (PH) metrics	**BMI and weight composite metric**			
	• Adult BMI screening	HEDIS (ABA)	Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year	≥60%
	• Weight assessment and nutritional counseling (children and adolescents only) – BMI percentile	HEDIS (WCC)	Percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year	≥30%
	• Weight assessment and nutritional counseling (children and adolescents only) – Counseling for nutrition	HEDIS (WCC)	Percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for	≥30%

Category	Core metric	Source	Metric description	Threshold
			nutrition during the measurement year	
	Comprehensive diabetes care (Composite #1)			
	• Diabetes care: eye exam	HEDIS (CDC)	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed	≥40%
	• Diabetes care: BP <140/90	HEDIS (CDC)	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had BP of <140/90 mm Hg	≥50%
	• Diabetes care: nephropathy	HEDIS (CDC)	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy	≥85%
	Comprehensive diabetes care (Composite #2)			
	• Diabetes care: HbA1c testing	HEDIS (CDC)	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c testing	≥85%
	• Diabetes care: HbA1c poor control (>9.0%)	HEDIS (CDC)	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) with most recent HbA1c level during the	≤50%

Category	Core metric	Source	Metric description	Threshold
			measurement year greater than 9.0%	
	EPSDT: Well-child visits ages 7-11 years	TennCare	Percentage of members 7-11 years of age who had one or more well-child visits with a PCP during the measurement year	≥55%
	EPSDT: Adolescent well-care visits age 12-21	HEDIS (AWC)	Percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥45%

[1] Designates a unique HEDIS reporting timeframe that is not based on information with a date of service during a standard calendar year.

TABLE 6 – Core Efficiency Metrics

Each MCO will set thresholds for core efficiency metrics. The State has provided each MCO guidance on setting these thresholds. This guidance can be found on the State's Health Link website.

Efficiency metrics	**All-cause hospital readmissions rate per 1,000 member months**	HEDIS (PCR)	For members 18 years of age and older, number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days (non-risk adjusted) per 1,000 member months
	Ambulatory care - ED visits per 1,000 member months	HEDIS (AMB)	Number of ED visits per 1,000 member months
	Inpatient admissions per 1,000 member months – Total inpatient	HEDIS (IPU)	Number of acute inpatient admission per 1,000 member months

	Mental health utilization per 1,000 member months - Inpatient	HEDIS (MPT)	Inpatient mental health services during the measurement year per 1,000 member months
	Rate of inpatient psychiatric admissions per 1,000 member months	TennCare	Member admissions for inpatient psychiatric services per 1,000 member months during the measurement year

15 DEPARTMENT OF CHILDREN'S SERVICES ELIGIBILITY APPENDIX

As noted above in Section 3.2, one reason for Health Link eligibility exclusion is patient enrollment in duplicative DCS programs. This section provides further detail regarding this exclusion, and explains the services that a Health Link can provide to some patients enrolled in DCS programs.

On entering DCS custody, children are assessed and placed at a level of care appropriate to their needs. Programs within some of these levels of care (level 3 and above) have been judged to be significantly duplicative of the care coordination offered by Health Links. Following thirty continuous days of a child's membership in such a level of DCS custody, they will have their Health Link membership suspended for the duration of their time in this level of care. In extraordinary circumstances, the DCS provider may appeal to the MCO for the continuation of the child's membership (on grounds of capacity, continuity of care coordination, or following an assessment of clear need for services provided through Health Links, such as transitional care arrangements using the Care Coordination Tool and Admission, Discharge, Transfer (ADT) feeds or specialized expertise on mental health care coordination for high needs populations).

For children entering DCS custody at levels of care that do not trigger suspension of Health Link membership, the Health Link will continue to be able to offer services for these children and be paid for these services. The DCS provider and Family Services Worker (FSW) will retain overall responsibility for these children and the coordination of their broader needs (e.g., educational, legal, permanency). These providers are expected to coordinate the health needs of these children, but are allowed to incorporate services provided by a Health Link. This pattern also reflects arrangements made under the former Level 2 Case Management program. Working under the auspices of the DCS FSW and provider and their permanency plan for the child, Health Links will be able to provide a range of useful services for the child.

Such interactions might include the following (not intended to be an exhaustive list):

1) Attending the Child and Family Team meetings and contributing to discussions regarding the child's welfare (an example of communicating patient needs to community supports);
2) Communicating to the DCS FSW and provider if the child has been admitted or discharged from a hospital (as indicated through the Care Coordination Tool) and formulating a discharge plan. This is an example of developing a systemic protocol to assure timely access to follow-up care post discharge;
3) Using specialist knowledge of behavioral health services to coordinate behavioral health appointments, or to help with medication management;

4) Working with the child's potential 'forever family' to educate and help them manage the child's behavioral health needs, complementing the work the DCS FSW and provider will do for other aspects of the child's life;

5) Supporting the transition in and out of DCS custody, working with the DCS provider in the first instance to update them of the child's behavioral health needs and current care plan (as appropriate). And, in the latter instance working with the DCS provider to reassume full responsibility for the child's care plan as they prepare to transition out of custody; or

6) Offering extra capacity to the DCS provider during acute spikes in the child's needs, requiring intensive coordination between multiple specialists and facilities.

16 ACTIVITY REQUIREMENTS APPENDIX

Health Link activity requirements (1/4)

TAG RECOMMENDATION

	Member level activity requirements for Health Link providers
1 Comprehensive care management	**Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan (as needed)**, following a comprehensive assessment of the patient's behavioral and physical health needs within 30 days of patient enrollment. The plan should address the patient's behavioral health treatment and care coordination needs, including protocols for treatment adherence and crisis management, incorporating input from: • the patient • the patient's social support • the patient's primary and specialty care providers (within 90 days of enrollment with the Health Home)
2 Care co-ordination	**Participate in patient's physical health treatment plan** as developed by their primary care provider, as necessary
	Support scheduling and reduce barriers to adherence for medical and behavioral health appointments, including in-person accompaniment to some appointments
	Facilitate and participate in regular interdisciplinary care team meetings; include the PCMH / PCP when possible
	Follow up with PCP to understand significant changes in medical status, and translate into care plan
	Proactive outreach with PCP regarding specific gaps in care
	Follow up with other behavioral health providers or clinical staff as needed to understand additional behavioral health needs, and translate into care plan

Health Link activity requirements (2/4)

TAG RECOMMENDATION

	Member level activity requirements for Health Link providers
3 Referral to social supports	**Identify and facilitate access to community supports** (food, shelter, clothing, employment, legal, entitlements, and all other resources that would reduce barriers to help individuals in achieving their highest level of function and independence), including by providing referrals, scheduling appointments, and following up with the patient, their relevant caregivers, and these community supports
	Communicate patient needs to community partners
	Provide information and assistance in accessing services such as: self-help services, peer support services; and respite services.
4 Patient and family support	**Provide high-touch in-person support** to ensure treatment and medication adherence (including medication reconciliation, medication management for specialty medications, medication drop-off, help arranging transportation to appointments)
	Provide caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.
	Identify resources to assist individuals and family supporters in acquiring, retaining, and improving self-help, socialization and adaptive skills.
	Check-ins with patient to support treatment adherence

TAG RECOMMENDATION

Health Link activity requirements (3/4)

	Member level activity requirements for Health Link providers
5 Transitional care	**Provide additional high touch support in crisis situations** when other resources are unavailable, or as an alternative to ED / crisis services
	Participate in development of discharge plan for each hospitalization, beginning at admission to support patient's transition. This includes emergency rooms, inpatient residential, rehabilitative, and other treatment settings
	Develop a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following: • Receipt of a summary of care record from the discharging entity • Medication reconciliation • Reevaluation of the care plan to include and provide access to needed community support services • A plan to ensure timely scheduled appointments
	Establish relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long term services and supports providers to promote a smooth transition if the patient is moving between levels of care and back into the community
	Communicate and provide education to the patient, the patient's supporters, and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning
6 Health promotion	**Educate the patient and his/her family** on independent living skills with attainable and increasingly aspirational goals

TAG RECOMMENDATION

Health Link activity requirements (4/4)

	Activity requirements for Health Link providers
7 Population health manage-ment	**Track and make improvements based on quality outcomes** distributed in reports from MCOs
	Identify highest risk patients on a continuous basis, supported by the Care Coordination Tool, and align with organization to focus resources and interventions
	Meet CMS e-prescribing requirements[1]
	Participate in practice transformation training and learning collaboratives at which best practice on a variety of topics, including health promotion, will be disseminated
	Receive ADT notifications for the patient and continue ongoing use of the Care Coordination Tool

1 Activity requirement comes into effect in Year 2 of the program

17 ENROLLEE EVALUATION CRITERIA APPENDIX

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.

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 quarterly basis for each Health Link contracted provider

4) Record Selection:

- A random selection of a minimum of 10 records will be reviewed on a quarterly basis. Additional files could be requested if results showing potential patterns of concern with services being rendered.

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.