Tennessee Health Link: Provider Operating Manual

Version 1.1
Released August 24, 2020

**This operating manual outlines the Health Link program guidelines and policies effective August 24,2020. The guidelines for 2019 are still valid for all claims with dates of service in 2019.*

TABLE OF CONTENTS

1 GENERAL INFORMATION 3

2 HOW DOES AN ORGANIZATION BECOME A HEALTH LINK? 6

3 WHICH MEMBERS ARE ELIGIBLE FOR HEALTH LINK? 8

4 HOW ARE MEMBERS ATTRIBUTED AND ENROLLED WITH A HEALTH LINK? 11

5 HOW ARE HEALTH LINK MEMBER PANELS DEFINED? 16

6 WHAT SERVICES WILL A HEALTH LINK PROVIDE? 18

7 HOW WILL A HEALTH LINK BE PAID? 20

8 HOW WILL QUALITY AND EFFICIENCY BE MEASURED? 24

9 REPORTING 28

10 PROVIDER TRAINING 31

11 CARE COORDINATION TOOL 343

12 TOTAL COST OF CARE CALCULATION APPENDIX 376

13 BILLING AND ENCOUNTER CODES APPENDIX 409

14 QUALITY AND EFFICIENCY METRICS APPENDIX 443

15 DEPARTMENT OF CHILDREN'S SERVICES ELIGIBILITY APPENDIX 498

16 ACTIVITY REQUIREMENTS APPENDIX 50

17 ENGAGEMENT EVALUATION CRITERIA APPENDIX 532

18 MEDICAL NECESSITY CRITERIA APPENDIX 554

19 UPDATES FROM THE STATE 565

20 NCQA COPYRIGHT NOTICE AND DISCLAIMER 576

21 QUALITY AND EFFICIENCY METRICS APPENDIX ADDENDUM 58

ALL INFORMATION INCLUDED HEREIN IS SUBJECT TO FURTHER UPDATES AND REFINEMENT FROM DIVISION OF TENNCARE.

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 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 launched statewide on December 1, 2016.

Health Link is intended to work in conjunction with the Patient-Centered Medical Home (PCMH) program the State launched in January 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 previously receiving Level 2 Case Management were transitioned into Health Link. In addition to these members, the program also includes high needs members who were not previously receiving care coordination under Level 2 Case Management.

There has been no change to the existing fee for service reimbursement process, which is not covered by Health Link. The following services remain paid for through fee for service: evaluation and management services, medication management, therapy services, psychiatric and psychosocial rehabilitation services, and Intensive Community Based Treatment (ICBT).

1.4 Roadmap for Health Link

Health Link launched on December 1, 2016 with 21 eligible Health Link organizations. The State reviewed applications and designated those organizations that qualified to become Health Links based on certain 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 organizations will be completed by the Managed Care Organizations (MCOs). The MCOs will work with the Health Link organizations of their choice to modify provider contract language to incorporate the incentive structure of Health Link, including the activity payments and the outcome payments.

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 to a different Health Link organization and receive care

coordination from another 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 organizations.

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 timelier 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 AN ORGANIZATION BECOME A HEALTH LINK?

2.1 Organization Application

Organizations interested in providing Health Link services in future program years should contact their MCO provider representative.

2.2 Program Requirements

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

1) The organization must be either:

- **a)** A Community Mental Health Center; **or**
- **b)** Another type of qualified organization (i.e., mental health clinic, Federally Qualified Health Center, primary care provider, or provider with a behavioral health specialty);

2) The organization 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 entry into Health Link;

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 within one year of joining Health Link;

5) The organization must employ:

- **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 organization must 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 organization 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 organization must have the capability to provide all of the required Health Link activities outlined in Section 16.

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

1) The organization withdraws from Health Link;

2) The organization is removed from Health Link by their contracted MCO(s);

3) The organization becomes ineligible, is suspended, or is terminated from the TennCare program; or

4) TennCare decides to suspend the Health Link program.

To withdraw from Tennessee Health Link, the participating organization must email intent to withdraw to payment.reform@tn.gov and to their contracted MCO(s) 60 days prior to withdrawal. Any organization who does not follow this process would not be considered in good standing should they decide to provide services in the future.

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 Organization Contracting

If selected during the application process, an organization must update its contract(s) with the relevant health plan(s). MCO contracting must be completed prior to the Health Link joining the program. Organizations 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 medical necessity criteria, effective May 2017 for adults and children/adolescents. The look-back period for Category 1 identification criteria is April 1, 2016, Category 2 is July 1, 2016 and Category 3 is December 1, 2016.

3.1.1 Provider Attestation

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 provides attestation to the relevant MCO that the member meets medical necessity criteria. 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 medical necessity criteria.

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 discharged 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 or the MCO and/or Health Link provider has identified, as evidenced by clinical documentation, member completion of treatment goals in response to Health Link interventions. Deceased members may also be discharged from the program provided that there is appropriate documentation.

Member eligibility is determined using a combination of claims and non-claims data sources. Once deemed ineligible, a member may become eligible again if his or her exclusion status changes or if they have a newly 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?

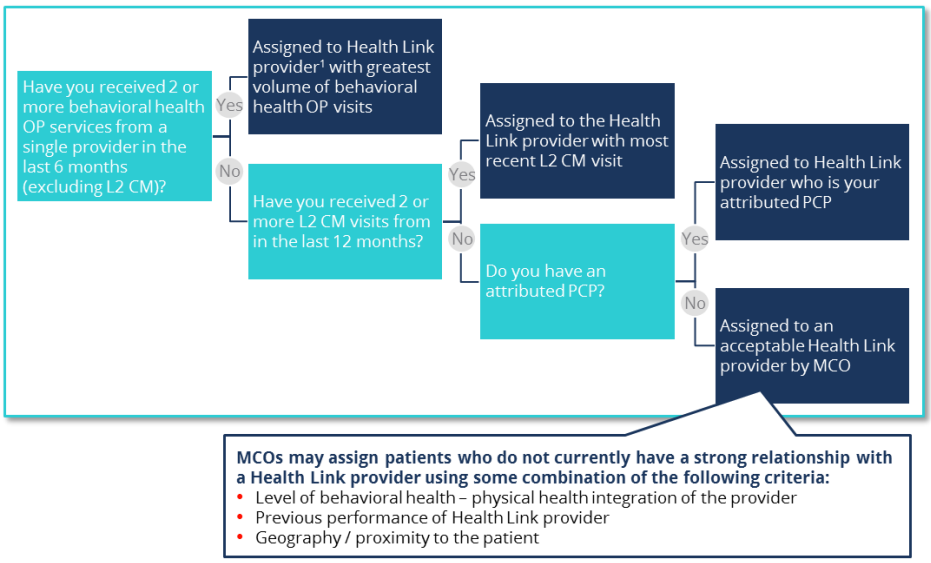
4.1 Member Attribution

Initial attribution:

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

1) If the member had two or more behavioral health outpatient visits (must be of a clinical nature) with any Health Link during the last 180 days before attribution, the member was attributed to the Health Link with the most visits. If there was a tie, the member was 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 received two Level 2 Case Management visits, the member was assigned to the Health Link with the most recent Level 2 Case Management visit during the 365 days before attribution. 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 was attributed to a primary care practice that was a Health Link, then the member was assigned to that Health Link; or
4) If an eligible member did not have an attribution on file after the claims-based attribution update, then the MCO manually attributed 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 determine attribution for those members using a methodology identical to the initial attribution.

Provider attestation/non-claims-based attribution:

If a member is already attributed to a Health Link, then their assignment can be modified if the member requests a change in his/her attributed Health Link. In certain cases, a member will enter the program through a provider attestation. If that member was not already assigned to a Health Link, that member will be assigned to the attesting provider. Eligible members coming in through provider attestation 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 for the current Health Link attribution status of the member either through the MCO portal or member services;
3) **Members requesting a switch of Health Link** – Attributed to the requested Health Link; or
4) **Members switching MCOs** – Remain attributed to their current Health Link if they also contract with the new MCO.

NOTE: Providers must attest to members via MCO-specific methods within 30 days of the initial date of service. Attestations should be submitted at least 14 days prior to filing the claim. Any claims submitted without an attestation submission within 30 days from the date of service will deny appropriately. Effective 07/01/19, MCOs will not pay or reprocess claims without an attestation submission within 30 days from the date of service.

4.2 Member Enrollment

Every member, regardless of their MCO, 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.

For Amerigroup and United, an attributed member can only be enrolled by the Health Link to which the member is attributed. An attributed member is considered enrolled or “Active” once the MCO receives the first claim from the member’s attributed Health Link. For additional instructions regarding filing a Health Link claim, see Section 13. If a member wishes to enroll with a Health Link to which he/she is not attributed, then the member needs to submit a change request. 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.

For BlueCare, an eligible member can be enrolled with a Health Link of their choosing via the BlueCare portal as long as they are not listed as “Active” with another Health Link. Receipt of the first claim from the member’s attributed Health Link is not required for enrollment by BlueCare.

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. The decision to opt out must be member initiated. MCO specific instructions for member opt-out are included below:

   Amerigroup:

   - Members may call the customer service number on the back of their TennCare card to opt out.
   - If a member requests to opt out of Health Link, the interaction with the member should be documented and then the provider may submit an opt out request via the Amerigroup portal.

   BlueCare:

   - Members may call the customer service number on the back of their TennCare card to opt out.
   - If a member requests to opt out of Health Link, the interaction with the member should be documented and then the provider may submit an opt out request via the BlueCare portal.

   United:

- Members may call the customer service number on the back of their TennCare card to opt out.
- If a member requests to opt out of Health Link, the interaction with the member should be documented and then the provider may submit an opt out request via the United portal;
- An opt-out request can only be submitted via the portal by the member's attributed organization.

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 Section 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 by receiving qualified services at 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 either by phone or via MCO portal. The member can choose to remain with their prior Health Link provider or change Health Link providers. Each MCO has the following Opt-in process:

Amerigroup

- If a member wants to Opt back into THL, they need to be attested for via the Amerigroup portal.

BlueCare:

- A member who is in an Inactive Opt Out status can only be reattributed by a BlueCare portal user. BlueCare will perform the reattribution based on a direct request from the member.
- The THL may provide BlueCare with a new consent from the member to initiate the reattribution. Once the member is reattributed to the THL, the THL must go into the portal to enroll the member for the member to become Active in the THL's panel.

United:

- Members may call the customer service number on the back of their TennCare card to opt back in;
- If a member requests to opt back in to Health Link, the interaction with the member should be documented and then the provider may submit a provider attestation via the United portal. This will switch a member in the "Inactive Opt Out" status to either "Active" or "Attributed Not Enrolled", depending on the presence of Health Link claims, to the organization that submitted the attestation.
- Any provider may submit a provider attestation via the portal for a member in the "Inactive Opt Out" status; or

2) **For members who resume behavioral health treatment:** Members are no longer considered inactive if they receive a qualifying behavioral health treatment while they are still eligible for Health Link. The change becomes effective the date of the behavioral health treatment service.

3) For members who were previously Discharged: Members can resume activity in the program by receiving qualified services at a Health Link. The member can choose to remain with their prior Health Link provider or change Health Link providers.

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. Subsequent performance periods for Health Link are from January 1- December 31 of the calendar year.

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 their Health Link:** Only those members with at least 9 months of cumulative attribution to their 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.**

6 WHAT SERVICES WILL A HEALTH LINK PROVIDE?

Under the Health Link model, providers 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. The initial plan is to be completed within 30 days of enrollment with reviews completed every six (6) months afterward. The plan must be signed by the care coordinator, member/guardian, and a licensed clinician. To ensure that care coordination goals remain relevant, members enrolled in THL services should receive an updated functional assessment at a minimum of every six (6) months. The care coordination goals should be updated, as necessary, based on the results of the functional assessment updated and should reflect pertinent information from other sources (Care Coordination Tool, primary care physician, specialist, etc.)

    - 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 program 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 remains unchanged under Health Link for non-Health Link services.

7.2 Activity Payments

Activity payments are intended to provide ongoing support to organizations 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 only receive activity payments for members who are enrolled and who receive a qualifying Health Link activity each month. Health Link activity payments are 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.

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 organizations for performing required activities. A Health Link can only 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. Additional details regarding Health Link activity payments are provided in Section 13. 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.

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 organizations are eligible for outcome payments only if the organization earns at least 4 quality stars**.**

For Health Link organizations who quality for an outcome payment, the outcome payment amount is calculated as follows:

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

The following subsections detail each component of this formula.

Average Total Cost of Care (TCOC) Per Member Per Month (PMPM)

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

Efficiency Performance

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

a. Efficiency Improvement Percentage

The efficiency improvement percentage will have an effect on the efficiency performance, to reward higher levels of improvement in efficiency metrics over the prior year. Note that the prior year values for each efficiency metric are set on calendar year basis, i.e., for performance period CY2017, values based on full calendar year CY2016 are used. The efficiency improvement percentage is the average of improvement in each efficiency metric compared to the previous year's performance for each Health Link. Efficiency improvement for a given metric is calculated as the following:

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

If the efficiency metric value for the previous year could not be calculated, then the efficiency improvement for that given metric is considered to be zero. Both efficiency metrics are averaged together. In addition, each individual measure's efficiency improvement is capped at both positive and negative 20.00%. In other words, if your organization sees a decrease in efficiency of 31.25%, performance will be capped at -20.00%. If your organization sees an increase in efficiency of 31.25%, performance will be capped at +20.00%.

Illustrative Example of Efficiency Improvement Percentage

Note: Values rounded to nearest hundredth decimal place

Efficiency Measure per 1,000 Member Months	Performance at Baseline (CY2019)	Performance Since 1/1/20	Efficiency Improvement
ED Visits	78.10	56.00	20.00%
Inpatient Discharges	3.00	4.00	-20.00%
EFFICIENCY IMPROVEMENT PERCENTAGE (AVERAGE)			**0.00%**

If the value of the average efficiency improvement percentage is less than 0.00%, then the value is capped at 0.00%.

b. Efficiency Stars

Performance must meet or exceed the threshold in order to earn an efficiency star. Each efficiency star earned contributes 15.00% to the efficiency performance.

Maximum Share of Savings

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

Quality Performance

Performance must meet or exceed the threshold in order to earn a quality star. Each quality star earned by the Health Link organization contributes to the quality performance. The maximum total quality performance percentage is 50.00%.

Beginning with the 2018 performance year, the redistribution of quality values may be applied under certain circumstances. Most of the quality metrics are defined by the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS requires that an organization have at least 30 observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least 30 observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed according to the additional guidelines in Section 8.4.

Member Months

Number of member months enrolled with the MCO for all members in the Health Link's panel, as defined in Section 5.2. As a reminder, the Health Link must be a member's attributed Health Link for nine or more months during the performance period for the member to be included in the Health Link's panel for outcome payment calculation.

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 most up-to-date HEDIS 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 outperform the threshold in order for an organization 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 2020

Note: The core quality metrics shown in this section apply to 01/01/20-06/30/20 of CY 2020. Please consult the Quality& Efficiency Metrics Appendix Addendum in Section 21 for the updated CY 2020 measures as of August 2020.

1. 7- and 30-day psychiatric hospital RTF/re-admission rate ➢ 7-day rate ➢ 30 day rate
2. Adherence to antipsychotic medications for individuals with Schizophrenia
3. Antidepressant medication management ➢ Continuation phase
4. Comprehensive diabetes care ➢ Eye exam
5. Controlling high blood pressure
6. Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications
7. EPSDT screening rate: Adolescent well-care visits ages 12-21 years
8. EPSDT screening rate: Well-child visits ages 7-11 years
9. Follow-up after hospitalization for mental illness ➢ Within 7 days of discharge

10. Metabolic monitoring for children and adolescents on antipsychotics

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. It is important to note there is a +/- 20.00% cap on each efficiency measure. There is a more detailed table with sources and descriptions in Section 14.

TABLE 3- Health Link Efficiency Metrics

Health Link Efficiency Metrics
1 Ambulatory care - ED visits per 1,000 member months
2 Inpatient discharges per 1,000 member months – Total inpatient

8.3 Earning Stars

In each quarterly report, Health Link organizations earn stars based on their performance across the core quality and efficiency metrics. There are 10 quality stars and 2 efficiency stars for a total of 12 stars for each organization.

- Each quality metric or quality composite that meets or outperforms the 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.

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 organizations can only earn credit for quality and efficiency metrics with 30 or more observations in the metric's denominator. For example, an organization will only be measured on the quality measure "adherence to antipsychotic medications for individuals with schizophrenia" if it has 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 an outcome payment. The minimum quality star requirement is 4 stars for each organization.

8.4 Value of Stars Earned

Beginning with the 2018 performance year, the redistribution of quality values may be applied under certain circumstances.

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

The guidelines for this quality value redistribution are as follows:

- The value of each star will be rounded to the nearest hundredth place.
- Organizations must still meet or exceed the quality gate to qualify for an outcome payment. For Health Link the quality gate is 4 stars.
- If a provider is panel eligible for less than the minimum required number of stars than their quality percentage toward their outcome payment will always be 0.00%.
- The value of up to 4 stars, which is 20%, may be redistributed.
- The value of the ineligible stars (maximum 4) is redistributed evenly among the remaining measures regardless of the denominator of those remaining measures.
- Composite measures are defined as quality measures which consist of 2 or more sub-metrics.
- The value of composite measures will be re-distributed when the minimum denominator is not met for all of its sub-metrics. In other words, the only way a composite measure's star value is redistributed is if the organization does not meet all of the sub-metric denominators.
- If an organization has an eligible denominator for at least one of the composite's sub-metrics, that organization will be measured against the threshold(s) and may be eligible to earn a star. In other words, organizations will be measured on their performance, and therefore eligible for a star, for any metric for which they have a sufficient denominator in at least one sub-metric.
- Organizations must meet or exceed the threshold for every eligible sub-metric in order to earn a star.

The following table displays the value of each quality star under different circumstances:

NUMBER OF STARS EARNED	NUMBER OF PANEL ELIGIBLE STARS									
	1	2	3	4	5	6	7	8	9	10
	8.33%	8.33%	8.33%	8.33%	8.33%	8.33%	7.14%	6.25%	5.56%	5.00%
1	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
2		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3			0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
4				33.32%	33.32%	33.32%	28.56%	25.00%	22.24%	20.00%
5					41.65%	41.65%	35.70%	31.25%	27.80%	25.00%
6						49.98%	42.84%	37.50%	33.36%	30.00%
7							49.98%	43.75%	38.92%	35.00%
8								50.00%	44.48%	40.00%
9									50.00%	45.00%
10										50.00%

***The blue boxes designate the value of each star based on the number of panel eligible stars.**

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. Subsequent performance periods for Health Link are from January 1- December 31 of the calendar year.

There are 2 types of quarterly provider reports:

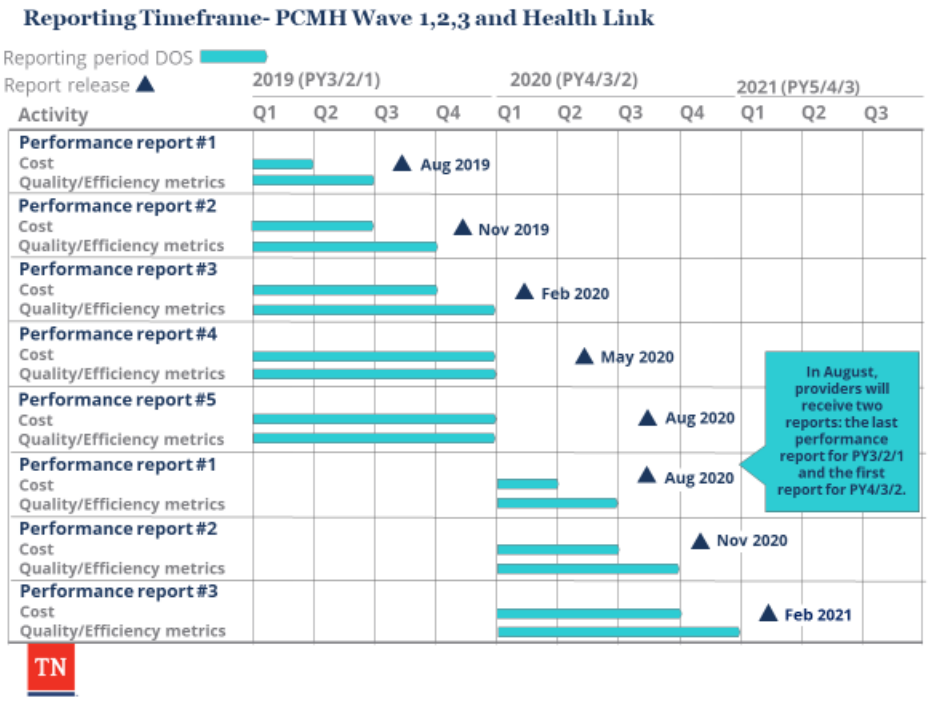
- Preview reports; and
- Performance reports.

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 the performance period 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 tables represent the timeframes of data that will be included in each report.

TABLE 4 – Data Timeframe for Quarterly Reports

Note: The Q1 2020 reports will be delayed. These reports will be released on October 7, 2020.



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

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 Performance: This section summarizes the quality stars achieved by the provider as of the end of the given quarter. Beginning with the 2018 performance year, the redistribution of quality values may be applied under certain circumstances. Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least 30 observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least 30 observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed.

C. Efficiency Performance: This section summarizes the efficiency stars and efficiency improvement score, an input of the outcome payment calculation. Performance must meet or exceed the threshold in order to earn an efficiency star.

Each efficiency star earned contributes 15.00% to the efficiency performance. For the efficiency improvement score, the provider's current performance (year to date) on the two-efficiency metrics is compared to their performance from the prior year to determine the Health Link's improvement. The improvement percentages for each metric are averaged together to generate the total efficiency score.

D. 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 7.3.

E. Total Cost of Care (for reporting only): This section offers provider total cost of care information, calculated as explained in Section 12, 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.

Appendix: This section contains more detail on the quality metrics. The section 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 threshold for earning a star.

10 PROVIDER TRAINING

At the onset of Health Link, TennCare contracted with Navigant to deliver provider training and technical assistance services to Health Link and PCMH providers across the State. Onsite coaching sessions were available for Wave 1 organizations until December 31, 2018. Onsite coaching was available for Wave 2 organizations until December 31, 2019. Beginning January 01, 2020, the MCOs will provide all educational training and support through on-site coaching, curriculum, and various educational offerings. The MCOs given the task of helping 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 organizations and not as full coverage for the time, infrastructure, and other investments that organizations will need to make.

Navigant completed initial assessments for both Health Link and PCMH Wave 1providers in 2017. Wave 2 initial assessments were conducted in the beginning of 2018. The results of this assessment allowed the trainer to create a custom curriculum for each organization to help in meet transformation milestones. The custom plan was refined periodically through semi-annual assessments.

10.1 Duration of Provider Training

Navigant developed an individualized curriculum 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 until the end of 2019. In January 2020 (once federal funding is no longer available to support the training and technical assistance vendor), the MCOs will take over Navigant's training role.

10.2 On-site coaching

Beginning January 01, 2019, on-site coaching and practice transformation support for Wave 1and 2 Health Links will be provided by the Health Link organization's contracted MCO(s). Each MCO will provide on-site coaching and practice transformation support through the Engagement Evaluation process, Joint Operations Committee meetings, and monthly coaching sessions. The Engagement Evaluations will be conducted semi-annually by each contracted MCO (see Section 17).

In between Engagement Evaluation meetings each Health Link is required to have at least one MCO coaching session per month. This session can be conducted in-person or via teleconference (depending on the need and/or desire of the Health Link organization). The coaching sessions will be utilized to discuss the following:

integrated care, best practices, THL domains, Engagement Evaluation follow-up, overall practice transformation, etc. At a minimum, the person who has clinical oversight and is involved with the Engagement Evaluation process should attend this meeting. If a Health Link provider declines three sessions in a six-month period, MCO staff will notify TennCare.

The quarterly Joint Operations Committee (JOC) meetings will be utilized to discuss program implementation, billing, provider relations, etc. Each MCO will utilize the following documents during the on-site coaching sessions in order to monitor practice transformation

- Engagement Evaluation Tool
- Performance Reports
- Any other tool provided by the MCO

10.3 Health Link Curriculum

The Health Link curriculum focuses 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 includes content in the following areas:

a. Delivering integrated physical and behavioral health services;
b. Team-based care and care coordination;
c. Organization 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 organization staff, e.g., one-on-one coaching sessions with small groups of organization 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

11 CARE COORDINATION TOOL

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

The State of Tennessee is contracted with Altruista Health to develop the CCT, based on Altruista's Guiding Care platform. Guiding Care is a cloud- based tool accessible online. Organizations will not have to install any special programs.

Information in the tool will be populated by claims data from the State, 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 organizations will each use the tool differently after assessing its capabilities and integrating its usage into their current work flows.

11.1 CCT Functionalities

The CCT has several functionalities including:

- Displaying providers' attributed member panels;
- Calculating members' risk scores and stratifying providers' panels for more focused outreach;
- Generating, displaying, and recording closure of gaps-in-care; and
- Displaying hospital and ED admission, discharge, and transfer (ADTs) events.

The tool enables providers to see real-time information about members in need of follow-ups, which allows providers to manually close gaps in care. 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**.

11.2 CCT User Expectations

Although daily use of the CCT is not strictly required, it is expected that Health Link organizations will designate staff, ideally care coordinators, to use the tool daily. Any staff using the CCT is expected to abide by patient privacy and confidentiality laws and regulations.

11.3 How to Access the CCT

Altruista is responsible for setting up all users with logins and passwords. If you would like access to the CCT and haven't received a user name and password yet, contact

your organization's point of contact for the CCT. If you do not know who that is, email hcfa.spigcct@tn.gov.

Each user is required to sign security forms to ensure that health information is protected.

Once login credentials have been created and sent to new users via email from Altruista, the CCT landing page can be accessed at: https://tn.guidingcare.com/TennCare/Account/Login?ReturnUrl=%2fTennCare%2f..

If you have **any issues** with **or questions** regarding the CCT, contact the Altruista Help Desk at 855-596-2491 or support@altruistahealth.com.

11.4 CCT Training Sessions and Materials

The State and Altruista have developed easy to understand self-guided user materials so that providers are comfortable with all functionalities available in the CCT. It is recommended that new users review training materials prior to using the tool. If more in-depth training is needed, email hcfa.spigcct@tn.gov.

Self-guided training materials can be found on the State's website: https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/care-coordination-tool.html Updates to the training materials online will be made on an ongoing basis.

11.5 Data in the CCT

Member attribution data in the CCT is derived directly from the Managed Care Organizations and is updated once per week. The primary source of data within the CCT is paid claims which determine patient diagnoses, pharmacy information, risk scores, and gaps in care for members. Please note that information regarding substance use or treatment is not available within the CCT due to federal regulations.

In the future, more member data will be available within the CCT. The State is currently collaborating with the Department of Health to include immunization data from the Tennessee Immunization Information System (TennIIS) in the CCT12 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 organizations, TCOC amounts will be displayed for informational purposes only. Each of these TCOC calculations is discussed in greater detail in the following sections.

12 TOTAL COST OF CARE CALCULATION APPENDIX

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 organization. Using this, the MCOs can calculate the savings an organization has generated and share in those savings with organizations.

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

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life
- PCMH practice new clinical activity payments
- Gain-sharing payments made to the Health Link as a Principle Accountable Provider (i.e. Quarterback) of episode-based payment models
- Mobile Crisis Capitation payments
- Medication therapy management (MTM) payments for CY2020

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

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.

TABLE 5- Total Cost of Care (for reporting-only)

- Each Health Link organization will receive a breakdown of their TCOC by category in each quarterly report for reporting-only.

Category	Description
• Inpatient facility	• All services provided during an inpatient facility stay including room and board, recovery room, operating room, and other services.
• Emergency department or observation	• All services delivered in an Emergency Department or Observation Room setting including facility and professional services.
• Outpatient facility	• All services delivered by a facility during an outpatient surgical encounter, including operating and recovery room and other services.
• Inpatient professional	• Services delivered by a professional provider during an inpatient hospital stay, including patient visits and consultations, surgery, and diagnostic tests.
• Outpatient laboratory	• All laboratory services in an inpatient, outpatient, or professional setting.
• Outpatient radiology	• All radiology services such as MRI, X-Ray, CT and PET scan performed in an inpatient, outpatient, or professional setting.
• Outpatient professional	• Uncategorized professional claims such as evaluation and management, health screenings, and specialists visits.
• Pharmacy	• Any pharmacy claims billed under the pharmacy or medical benefit with a valid National Drug Code.
• Other	• DME, home health and any remaining uncategorized claims.

TABLE 6- Total Cost of Care- Behavioral Health Spend (for reporting-only)

- Each Health Link organization will receive a breakdown of their TCOC Behavioral Health Spend by category in each quarterly report for reporting-only.

Category	Description
• Inpatient/residential	• Hospital inpatient care • Mental health residential
• Emergency	• ED care • Crisis services
• Outpatient and other treatment	• Therapy • Assessment & testing • Substance use treatment • Medication management • Counseling/Intervention • Detox

Category	Description
	• Rehab • Other E&M • Other BH treatment
• Pharmacy	• Medication/Pharmacy
• Case management	• Case management, level 1 • Case management, level 2 • Case management, integrated care team • Other case management • Health Link activities
• Supportive services	• Psychiatric rehab • Supportive services • Ancillary services
• Other care	• Radiology, lab and DME • PT/OT/ST • Other types of care

13 BILLING AND ENCOUNTER CODES APPENDIX

Billing/Encounter Codes for Tennessee Health Link Activities

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

Billing Codes and Rates

Health Link joining prior to January 1, 2018:

Transition Rate
The rate was set for 12/1/16-11/30/17. The Billing Code (also acting as the payment trigger code) is G9003 which will pay at $202.

Stabilization Rate
The rate is set for 12/1/17-12/31/18. The Billing Code (also acting as the payment trigger code) is S0280 which will pay at $176.75.

Health Link joining on or after January 1, 2018:

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

Beginning January 1, 2019, the TennCare contracted Managed Care Organizations will have full responsibility for negotiating the rate and contracting for the Tennessee Health Link services.

Activity Encounter Codes

Code	Activity	Member or Collateral	Face-to-face or Indirect
G9004	Comprehensive care management *Initiate, complete, update, or monitor the progress of a comprehensive person-centered care plan*	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9005	Care coordination	UA: Member 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 TennCare 1500 professional claim form
- The Health Link Billing Code Activity Encounter Codes should be filed on a professional claim with the TennCare 1500 at the entity level. Please note that 24 j should remain blank.
- This methodology applies to all rate levels

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

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

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

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

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

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

MCO Monitoring Requirements

MCOs must ensure that the following requirements are maintained:

1. A maximum of 1 Health Link provider is paid for a member per month.
2. A maximum of 1 Health Link Billing Code for a member is paid per month.

3. If the member is enrolled in Health Link, a claim with the Billing Code and Activity Encounter code can trigger a payment.

Health Link Modifier Examples

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

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

Effective June 1, 2017

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

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

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 2020 specifications. Organizations will always be measured on the most recent HEDIS specifications available.

Note: On July 01, 2020 HEDIS® released updated measures for Calendar Year 2020. Please consult the Quality & Efficiency Metrics Appendix Addendum in Section 21 for the updated CY2020 core measures as of August 2020.

TABLE 7 – Core Quality Metrics 2020

Category	Core metric	Source	Metric description	Threshold
Quality metrics	**7- and 30-day psychiatric hospital / RTF readmission rate**			
	• 7 day rate	TennCare	Rate of psychiatric hospital or RTF readmissions within 7 days	≤5%
	• 30 day rate	TennCare	Rate of psychiatric hospital or RTF readmissions within 30 days	≤13%
	Adherence to Antipsychotic medications for individuals with Schizophrenia	HEDIS (SAA)	The % of members 19-64 years of age during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period	≥59%
	Antidepressant medication management	HEDIS (AMM)	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained	

Category	Core metric	Source	Metric description	Threshold
			on an antidepressant medication treatment. One rate is reported.	
	• Effective Continuation Phase Treatment		The % of members who remained on an antidepressant medication for at least 180 days (6 months)	≥40%
	Comprehensive diabetes care (composite 1)	HEDIS (CDC)	The % of members 18-75 years of age with type 1 and type 2 diabetes: who received:	≥51%
	• Eye Exam		Eye exam (retinal) performed	
	Controlling High Blood Pressure	HEDIS (CBP)	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	≥49%
	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications	HEDIS (SSD)	The % of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	≥82%
	EPSDT Adolescent well-care visits ages 12-21 years	HEDIS (AWC)	The % of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year.	≥47%
	EPSDT Well-child visits ages 7-11 years	TennCare	The % of members 7-11 years of age who had one or more well-child visit with a PCP during the measurement year	≥55%
	Follow-up after hospitalization for mental illness	HEDIS (FUH)	The % of discharges for members 6 years of age and older who were hospitalized	

Category	Core metric	Source	Metric description	Threshold
			for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner	
	• Within 7 days of discharge	HEDIS (FUH)	The % of discharges for which the member received follow-up within 7 days after discharge	≥35%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS (APM)	The % of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing	≥33%

TABLE 8 – 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.

Category	Core metric	Source	Metric description
Efficiency metrics	**Ambulatory care - ED visits per 1,000 member months**	HEDIS (AMB)	Number of ED visits per 1,000 member months
	Inpatient discharges per 1,000 member months – Total inpatient	HEDIS (IPU)	Number of inpatient discharges per 1,000 member months

TABLE 9- Metrics for Reporting-Only

Category	Core metric	Source	Metric description
Quality metrics	**Annual monitoring of patients on persistent medications**	HEDIS (MPM)	The % of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the

Category	Core metric	Source	Metric description
			therapeutic agent in the measurement year
	Comprehensive Diabetes Care (CDC) Nephropathy	HEDIS (CDC)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Nephropathy test
	Statin therapy for patients with cardiovascular disease		The % of males 21–75 years of age and females 40–75 years of age who were identified as having clinical ASCVD:
	• Received Therapy	HEDIS (SPC)	who were dispensed at least one high or moderate-intensity statin medication during the measurement year
	• Statin Adherence	HEDIS (SPC)	remained on a high or moderate-intensity statin medication for at least 80% of the treatment period
	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	HEDIS (APP)	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Efficiency metrics	**Panel opt-out rate**	TennCare	The % of members that opted out of the Health Link program
	Panel enrollment rate	TennCare	The % of members that enrolled in the Health Link program
	Psychiatric inpatient days	TennCare	The total number of days per 1,000 member months for all inpatient psychiatric hospital stays with a discharge date within the measurement timeframe
	Rate of residential treatment facility admissions	TennCare	The rate of residential treatment facility discharges per 1,000 member months
	All-cause readmissions	HEDIS (PCR)	For members 18 years of age and older, the number of acute

Category	Core metric	Source	Metric description
			inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
	Mental health inpatient utilization	HEDIS (MPT)	The number and percentage of members receiving mental health inpatient services during the measurement year.
	Rate of inpatient psychiatric admissions	TennCare	The rate of inpatient psychiatric hospital discharges per 1,000 member months.

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

	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 with PCMH / PCP
	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

	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 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)

	Activity requirements for Health Link providers
5 Transitional care	**Provide 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 Home activity requirements (4/4)

	Activity requirements for Health Link providers
7 Population health management	**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 ENGAGEMENT EVALUATION CRITERIA APPENDIX

Evaluating Enrollees Potentially Not Benefiting from the Health Link Program

1) **Rationale for Selection Criteria:**

- Claim-based data will be used to identify enrollees for in-depth chart reviews
- Metrics chosen correspond to Health Link outcome measures on which providers will be evaluated
- Initial set of metrics focus on areas that are actionable and have direct impact on behavioral and physical health
- In-depth chart reviews will assess effort as well as outcome. A clear indication that the provider has identified needs, incorporated them into the individualized plan and is actively attempting to address those needs would be considered in assessing whether the enrollee is benefiting from the Health Link program.
- **Engagement Evaluation staff from the MCO may request physician or nurse notes in order to support evidence of integrated care coordination.**

2) **Selection Metrics:**

Each MCO will establish their criteria for chart selection, which could include any active or discharged member's record, but at a minimum the criteria may include the following:

- Three (3) consecutive months of encounter data without a care coordination face-to-face contact with the member, or
- Three (3) consecutive months without a non-care coordination claim for service (e.g., no claims for any outpatient services), or
- More than two (2) Emergency Department visits in three (3) consecutive months, or
- More than two (2) inpatient admissions within six (6) consecutive months, or
- At least one (1) 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, at minimum, on a semi-annual basis for each Health Link contracted provider.

4) Record Selection:

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

5) Scoring

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

6) Engagement Evaluation Participants:

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

Note: 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.

18 MEDICAL NECESSITY CRITERIA APPENDIX

Amerigroup

https://providers.amerigroup.com/ProviderDocuments/TNTN_DUALS_AdultMedicalNecessityCriteria.pdf

https://providers.amerigroup.com/ProviderDocuments/TNTN_DUALS_ChildAdolescentMedicalNecessityCriteria.pdf

BlueCare

Tennessee Health Link Guidelines: Adults - For BlueCare and TennCare Select Use Only

Tennessee Health Link Guidelines: Children and Adolesc139ents - For BlueCare and TennCare Select Use Only

UHC

https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-Provider-Information/TN_BehavioralHealth_Tennessee_Health_Link_Adults_Medical_Necessity_Criteria.pdf

https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-Provider-Information/TN_BehavioralHealth_Tennessee_Health_Link_Children_and_Adolescents_Medical_Necessity_Criteria.pdf

19 UPDATES FROM THE STATE

On December 1, 2016, the Division of TennCare launched a new care coordination service based on the Centers for Medicare and Medicaid Services (CMS) Health Home model: Tennessee Health Link. This service was designed within the new Tennessee Health Care Innovation Initiative as a value-based payment program for members with the highest behavioral health needs. The goal of the program is to share total cost of care savings with those participating providers who reach the State-defined quality and efficiency metric goals. Tennessee Health Link is aligned with TennCare's overall goal of moving from paying for volume to paying for value. Our primary mission is to improve the quality and efficiency of the care provided to members while reducing total cost of care over time.

The first performance year for Tennessee Health Link was CY2017. In August 2018, the Managed Care Organizations (MCOs) paid out the first outcome payments to eligible Tennessee Health Link organizations. Across all MCOs, 14 organizations received payments totaling over $6,500,000.

In an effort to ensure the sustainability of the program moving forward and to better plan for yearly expenditures, TennCare is directing the MCOs to cap the outcome payments for Tennessee Health Link starting in performance year 2019. Please note that this will not affect outcome payments for performance year 2018.

The MCOs shall cap the outcome payment for each organization at 10% of the organization's total Tennessee Health Link reimbursements for the performance year. This capitation is effective January 1, 2019 and shall extend into future performance years at the discretion of TennCare.

Thank you,

Mary Shelton
Director of Behavioral Health Operations-TennCare

20 NCQA COPYRIGHT NOTICE AND DISCLAIMER

NCQA Copyright Notice and Disclaimer

The HEDIS® measure specifications were developed by and are owned by the National Committee for Quality Assurance ("NCQA"). The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the materials without modification for an internal non-commercial purpose or to report results as required by the TennCare Program may do so without obtaining any approval from NCQA. Use of the *Rules for Allowable Adjustments of HEDIS* to make permitted adjustments of the materials does not constitute a modification. All other uses, including a commercial use and/or external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA. ©[applicable year] NCQA, all rights reserved.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

The American Medical Association holds a copyright to the CPT® codes contained in the measure specifications.

The American Hospital Association holds a copyright to the Uniform Billing Codes ("UB") contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS measure results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org.

To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit www.ncqa.org/publications.

21 QUALITY & EFFICIENCY METRICS APPENDIX ADDENDUM

Quality metrics are tracked to ensure that THLs are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide. Since program inception, TennCare has thoughtfully selected a group of core quality metrics for the THL program.

Because practices will always be assessed on the most recent HEDIS® specifications available, measures and specifications must be updated upon new releases made by NCQA. On July 1, 2020, to realign the HEDIS® calendar so the measures are released ahead of a measurement year, NCQA issued HEDIS® measure specifications for two years at once – Measurement Year 2020 and Measurement Year 2021. Moving forward, HEDIS® measures will be released for the upcoming measurement year in August of the previous year. For example, in August 2021, NCQA will provide HEDIS® measures for Measurement Year 2022. This change will allow MCOs and providers more certainty about the measures and specifications for an upcoming measurement year sooner.

Summary of changes to THL core quality metrics for Measurement Year 2020 and Measurement Year 2021

In addition to the realignment of the HEDIS® calendar, NCQA released specification changes for several measures for Measurement Year 2020 and Measurement Year 2021, including core measures related to child and adolescent well-care visits. The change that impacts THL is summarized below:

- The former EPSDT well-child visits 7-11 years and the Adolescent Well-Care Visits (AWC) measures have been combined into Child and Adolescent Well-Care Visits (WCV). This combination measure will now include ages 7-11, 12-17 years and 18-21 years.

As result of this change, THL's core metrics will be reduced from 10 core metrics to 9 core metrics for MY2020. The goal is to have a new replacement metric identified for MY2021. More information about the impact of this reduction will be discussed in the August 28th informational webinar.

The descriptions for HEDIS® measures, below, are based on the most recently released HEDIS Measurement Year 2020 and 2021 specifications. The changes to the core metrics impacting the THL program are highlighted in each of the tables. Please note that given the timing of the NCQA HEDIS® specifications' release for MY2020, information for the Child and Adolescent Well-Care Visits composite measure and the Well-Child Visits in the First 30 Months composite measure is not yet available. Thresholds will be updated as soon as possible. It is important to note the Q1 2020 Provider Performance Reports will only reflect 12-17 years and 18-21 years of age. The Q2 2020 Provider Reports will show the correct age groups of 7-11 years and 12-21 years.

Category	Core metric	Source	Metric description	Threshold
Quality metrics	**7- and 30-day psychiatric hospital / RTF readmission rate**			
	• 7-day rate	TennCare	Rate of psychiatric hospital or RTF readmissions within 7 days	≤5%
	• 30-day rate	TennCare	Rate of psychiatric hospital or RTF readmissions within 30 days	≤13%
	Adherence to Antipsychotic medications for individuals with Schizophrenia	HEDIS (SAA)	The % of members 19-64 years of age during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period	≥59%
	Antidepressant medication management		The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. One rate is reported.	
	• Effective Continuation Phase Treatment	HEDIS (AMM)	The % of members who remained on an antidepressant medication for at least 180 days (6 months)	≥40%
	Child & Adolescent Well-Child Visits			
	• 7-11 years	HEDIS (WCV)	% of members 7-11 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year	To be determined at a future date
	• 12-21 years	HEDIS (WCV)	% of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year	To be determined at a future date

Category	Core metric	Source	Metric description	Threshold
	Comprehensive Diabetes Care: eye exam (retinal performed)	HEDIS (CDC)	% of members 18- 75 years of age with type 1 or type 2 diabetes, who had an eye exam (retinal) performed	≥ 51%
	Controlling high blood pressure	HEDIS (CBP)	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	≥49%
	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications	HEDIS (SSD)	The % of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	≥82%
	Follow-up after hospitalization for mental illness		The % of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner	≥55%
	• Within 7 days of discharge	HEDIS (FUH)	The % of discharges for which the member received follow-up within 7 days after discharge	≥35%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS (APM)	The % of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing	≥33%

NCQA Copyright Notice and Disclaimer

The HEDIS® measure specifications were developed by and are owned by the National Committee for Quality Assurance ("NCQA"). The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the materials without modification for an internal non-commercial purpose or to report results as required by the TennCare Program may do so without obtaining any approval from NCQA. Use of the *Rules for Allowable Adjustments of HEDIS* to make permitted adjustments of the materials does not constitute a modification. All other uses, including a commercial use and/or external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2020-2021 NCQA, all rights reserved.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

The American Medical Association holds a copyright to the CPT® codes contained in the measure specifications.

The American Hospital Association holds a copyright to the Uniform Billing Codes ("UB") contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS measure results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org.

To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit www.ncqa.org/publications